Grandfamilies & Grandchild Adverse Childhood Experiences:
An Examination of Service Needs, Utilization, and Best Practices

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Abstract

Grandfamilies, or families in which grandparents are raising their grandchildren, often form due to adverse childhood experiences (ACEs) experienced by the grandchildren. ACEs have been linked to multiple negative short- and long-term behavioral and emotional consequences for children. Yet, having an ACE history does not guarantee negative outcomes, as protective factors such as positive relationships with a safe and caring adult, healthy family functioning, and utilization of formal services can mitigate the negative effects of ACEs. Researchers have regularly called on families to seek timely intervention and services for ACEs; however, many grandparents raising grandchildren report negative interactions with service providers as well as service delivery. Limited research has explored the extent to which grandfamilies with ACEs may have experienced similar interactions while seeking and using formal services. Guided by Andersen’s (1995) Behavioral Model of Health Service Use, this qualitative study sought to explore (1) the service needs of grandchildren with an ACE history who are being raised by their grandparents; (2) the service needs of grandparents raising grandchildren with an ACE history; (3) the process of seeking services when grandparents raising a grandchild with an ACE history look for services for their grandchild; and (4) best practices for delivering services to grandfamilies with an ACE history. The research questions were primarily addressed through via interviewing 10 grandparents from Central Appalachia who were raising a grandchild with an ACE
history and by conducting two focus groups of 8 to 12 formal service providers with experience working with grandparents raising grandchildren with an ACE history. Interview data were analyzed using grounded theory and focus group data were analyzed through thematic analysis. Study findings indicated that grandchildren have emotional and developmental needs. Grandparents described needs related to the emotional impact of raising a grandchild with an ACE history, family and parent involvement, and parenting a grandchild with an ACE history. Study results also highlighted how grandparents can expect to encounter barriers throughout the service seeking and delivery process. Study results also highlighted the critical nature of having a strong relationship with a service provider and the importance of a service provider reducing barriers, being attentive to grandfamily needs, and involving the grandparent in the treatment process. Finally, results from the focus groups revealed best practices such as providing grandparents with education on ACEs, being aware of intergenerational ACE cycles, and engaging in assessment and intervention when working with this population. Implications for clinical practice as well as directions for future research are discussed.
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General Audience Abstract

Historically, grandparents have long been called upon to assist with caring for their grandchildren. In the last forty years, grandparents have increasingly shifted to a new role—that of parent. Grandfamilies are commonly created due to adverse childhood experiences, or ACEs, which can include child abuse, child neglect, or household challenges such as parental substance abuse or parental incarceration. Experiencing ACEs does not guarantee negative outcomes in a child’s life, but their presence and number can affect it, particularly when a child has experienced numerous ACEs. Professional services or treatment are one way to support these children. However, negative interactions with service providers or unfulfilled expectations with service delivery can dissuade grandparents from continuing services. This study sought to understand how grandparents raising a grandchild with an ACE history identify the grandchild’s needs, come to the realization that their grandchild needs professional help, the process and experience of receiving that professional help, as well as what happened after the grandchild received professional services. After interviewing 10 grandparents raising a grandchild with an ACE history, study findings revealed how grandparents identify grandchild needs, and then manage those needs as well as grandchild behaviors. Study findings also illustrated a recursive relationship between grandparents managing grandchild needs and building a relationship of trust with the formal service provider once services have started. Building a relationship of trust with a formal service provider
can then result in creating change or the grandparent deciding to end services. Finally, grandparent interview data revealed that throughout the entire process of service seeking, grandparents raising a grandchild with an ACE history commonly experience barriers hindering their access to services including personal, availability, and systemic barriers. Finally, the study sought to understand best practices for working with grandparents raising grandchildren with an ACE history, which include assessing for and creating interventions targeting ACEs, providing education on ACEs to grandparents, and being aware of intergenerational ACE cycles with these families. Strategies for clinical practice are also identified.
Dedication

I dedicate this dissertation to my wife, who has consistently sacrificed her time and energy to support both me and raise our children during not only this dissertation, but also the years of graduate education. I also dedicate this dissertation to my parents, who taught me the fundamental principles of goal setting and hard work to accomplish my goals, as well as encouraging me to pursue college and higher education. I further dedicate this dissertation to my children, who have buoyed me up with their smiles and invitations to connect on both the easy and the hard days during this program. Finally, I dedicate this dissertation to my participants, both grandparents and formal service providers. I am honored to have had you share your stories with me and could not have accomplished dissertation with you.
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Table of Contents

Abstract.................................................................................................................................................. vii
General Audience Abstract .................................................................................................................... ix
Dedication ................................................................................................................................................... vi
Acknowledgements ...................................................................................................................................... vii
Introduction ............................................................................................................................................... 1

Outcomes Associated with ACEs ............................................................................................................. 4
  Biological ................................................................................................................................................ 4
  Academic ............................................................................................................................................... 6
  Behavioral ........................................................................................................................................... 6
  Financial .............................................................................................................................................. 9

Formal Services and ACEs ....................................................................................................................... 10

The Present Study ...................................................................................................................................... 16

Chapter 2: Literature Review .................................................................................................................. 18

Adverse Childhood Experiences (ACEs) ................................................................................................. 18
  ACEs & Demographic Characteristics ................................................................................................. 23

Adverse Childhood Experiences (ACEs) & Outcomes ......................................................................... 24

Formal Services and Grandparents Raising Grandchildren .................................................................. 31

Grandparent Service Needs ..................................................................................................................... 32

Formal Services as an Intervention for ACEs ......................................................................................... 35

Andersen’s (1995) Behavioral Model of Health Service Use .................................................................... 37
  Environment ........................................................................................................................................ 38
  Population Characteristics .................................................................................................................. 40
  Health Behavior ................................................................................................................................. 46
  Outcomes ......................................................................................................................................... 49

Extending the Literature .......................................................................................................................... 53

Chapter 3: Methods ................................................................................................................................. 56

Research Design ....................................................................................................................................... 56

Semi-Structured Interviews with Grandparents ....................................................................................... 56
  Sample ................................................................................................................................................ 56
  Data Collection Procedures ................................................................................................................. 59
  Measures ............................................................................................................................................ 60
  Data Analysis ..................................................................................................................................... 66
  Trustworthiness ................................................................................................................................. 71

Formal Service Provider Focus Groups ................................................................................................. 77
  Sample ............................................................................................................................................... 77
  Data Collection Procedures .............................................................................................................. 78
  Measures .......................................................................................................................................... 79
Chapter 4: Results ................................................................. 84

Interview Results .................................................................................. 84
Interview Sample Demographics ................................................................. 84
Grandparent and Grandchild ACE History ............................................... 90
Grandchild Service Needs and Utilization ............................................... 92
Grandparent Mental Health Needs ............................................................ 95
Grandparent Service Needs and Utilization ............................................. 95

Process of Seeking Formal Services: A Conceptual Model ....................... 97

Barriers to Service Use ............................................................................ 100
Personal Barriers ....................................................................................... 100
Availability Barriers ................................................................................... 102
Information Availability .......................................................................... 108
Systemic Barriers ....................................................................................... 110

Identifying GC ACE-related Needs ......................................................... 112
Managing GC ACEs, Needs, & Behavior .................................................. 117
SP Being Attentive to GF Needs ................................................................. 128
Creating Change ....................................................................................... 133

Focus Group Results ................................................................................. 137

Types of Services Provided to Grandchildren & Grandparents .................. 139

Familiarity and Use of TIC ........................................................................ 142

Best Practices for Working with Grandfamilies ....................................... 144
Awareness of Intergenerational Cycles ....................................................... 144
ACEs Assessment and Intervention ............................................................. 144
Providing ACEs Education ....................................................................... 147

Conclusion ............................................................................................... 149

Chapter 5 ............................................................................................... 150

Discussion .............................................................................................. 150

Grandfamilies, ACE Histories, & Appalachia ........................................... 150

Grandchild and Grandparent Formal Service Needs .................................... 152
Grandchild Formal Service Needs ............................................................... 152
Grandparent Formal Service Needs ............................................................ 154

The Process of Seeking and Receiving Services ........................................ 157
Recursive Nature of Seeking Services ......................................................... 158
Creating a Working Relationship with the SP ........................................... 162

Third Research Question: Best Practices for Grandfamily Interventions .... 165
Equating ACEs with Trauma ...................................................................... 165
Intergenerational Pattern of ACEs ............................................................... 166
Trauma Informed Care in Appalachia .......................................................... 169

Study Limitations .................................................................................... 172
Recommendations for Future Research .......................................................... 173
Clinical Implications ......................................................................................... 175
  Trauma Informed Care – A Strategy for Creating a Working Relationship .... 177
Conclusion ......................................................................................................... 180
References ........................................................................................................ 182
Appendix A: IRB Approval ................................................................................ 212
Appendix B: Grandparent Flyer ...................................................................... 214
Appendix C: Email to Formal Service Provider for Grandparent Recruitment .... 215
Appendix D: IRB-Approved Facebook Posts for Service Provider Recruitment .... 216
Appendix E: Facebook Recruitment Statistics .................................................... 217
Appendix F: Grandparent Screening Tool and Demographic Questionnaire ........ 218
Appendix G: Grandparent Interview Protocol .................................................... 231
Appendix H: Recruitment Email to Formal Service Provider .............................. 236
Appendix I: Formal Service Provider Research Flyer ....................................... 237
Appendix J: IRB-Approved Facebook Posts for Service Provider Recruitment .... 238
Appendix K: Formal Service Provider Screening Tool and Demographic Questionnaire ... 239
Appendix L: Focus Group Protocol .................................................................... 251
Appendix M: Service Provider Perspective on Grandchild Needs ..................... 255
Appendix N: Provider Assessment of Service Availability and Barriers ............. 256
Appendix O: Training Needs for Service Providers, Identified by Service Providers 257
List of Figures

Figure 1. Andersen’s (1995) Behavioral Model of Health Services.......................... 37
Figure 2. Conceptual Model of Formal Service Utilization by GRG with ACE Histories ............................ 98
List of Tables

Table 1. Grandparent and Target Grandchild Demographics (N = 10) ................ 86
Table 2. Description of Grandparent Sample (N = 10) ................................... 87
Table 3. Types and Frequency of ACEs – GC & GP (N = 10) ............................ 90
Table 4. Grandchild Mental Health Diagnoses (N = 10) ..................................... 91
Table 5. Grandchild Current and Past Services Used (N = 10) ............................ 93
Table 6. Grandparent Mental Health Symptoms (N = 4) .................................... 95
Table 7. Grandparent Current and Past Services Used (N = 10) .......................... 96
Table 8. Summary of Sub-themes for Service Barriers (N = 9) .......................... 112
Table 9/ Summary of Sub-themes for Identifying GC ACE-related Needs (N = 10) ........................................... 117
Table 10. Summary of Sub-themes for Managing GC ACE-related Needs & Behavior (N =10) .......................................................... 126
Table 11. Summary of Sub-Themes for Creating a Working Relationship with SP (N =10) .......................................................................................... 133
Table 12. Summary of Sub-Themes for Creating Change (N =10)b .................. 136
Table 13. Service Provider Demographics (N=10) .......................................... 138
Table 14. Provider-identified Types of Services Provided to Grandchildren and Grandparents Raising a Grandchild with an ACE history (N =10) ............. 139
Table 15. Provider-identified Rewards of Working with Grandfamilies with an ACE history (N =10) ........................................................................ 141
Table 16. Provider-identified Challenges of Working with Grandfamilies with an ACE history (N = 10) ........................................................................ 141
Table 17. Service Provider TIC Awareness and Use (N =10) .............................. 143
Table 18. Facebook Recruitment Statistics – Grandparents Raising a Grandchild with an ACE History ........................................................................ 217
Table 19. Facebook Recruitment Statistics – Formal Service Providers ........... 217
Table 20. Service Provider Perspective on Grandchild Needs ............................ 255
Table 21. Provider Assessment of Service Availability and Barrier .................... 256
Table 22. Training Needs for Service Providers, Identified by Service Providers . 257
Introduction

Close to four percent, or nearly three million, children in the United States are being raised by their grandparents (Generations United, 2018). These families, also known as grandfamilies, are families in which grandparents are functioning as full-time providers and serving in the parental role for their grandchildren (Kaplan & Perez-Porter, 2014). There are approximately 2.7 million grandparent-headed families across the United States (Lee & Blitz, 2014). When grandchildren’s parents are not present in the grandparents’ home, the family structure has also been termed as a “skipped-generation” family (Smith & Hancock, 2010, p. 45). Skipped generation grandfamilies will be the focus of this study.

Grandfamilies form when a child’s parents are unable to provide the child with adequate care. When this occurs, grandparents may immediately or slowly assume the parental role and begin full-time care of their grandchildren. Research studies on grandfamilies have documented numerous parental problems that explain why grandchildren come to live with a grandparent. These include parent mental health problems, parental alcohol/substance use, incarceration, domestic violence, parent death, as well as child abuse (e.g., physical, sexual, emotional), child neglect (e.g., abandonment, physical neglect, and child removal by DSS) (Bullock, 2004; Collins et al., 2016; Kelley et al., 2011; Smith & Palmieri, 2007; Smith et al., 2019; Sprang et al., 2015). Collectively, these reasons for grandfamily formation could be conceptualized as what are known as “adverse childhood experiences,” or ACEs (Felitti et al., 1998).

The Centers for Disease Control (CDC) (2019a) define ACEs as “potentially traumatic events that occur in childhood (0-17 years); for example, experiencing violence or [physical, sexual, or emotional] abuse, witnessing violence in the home or community, [and] having a family member attempt or die by suicide” (para. 1-2). ACEs also include “aspects of the child’s
environment that can undermine their sense of safety, stability, and bonding such as growing up in a household with substance misuse, mental health problems, instability due to parental separation or household members being in jail” (Centers for Disease Control, 2019a, para. 3-4). One of the challenges in defining and measuring ACEs is the lack of standardization among researchers about what is considered an ACE. Since Felitti et al.’s (1998) study, ACEs have been assessed locally and nationally through different surveys, with surveys including different items from Felitti et al.’s (1988) survey. For example, in a representative sample of 1420 children in the United States, Copeland et al. (2007) asked children aged 9 to 16 years old about traumatic events they may have experienced each year, where trauma included ACE-related experiences such as abuse and neglect, and violence in the home. However, this survey also included events such as the loss of someone close to the child as well as more general potentially traumatic events such as natural disasters, violence in the community, military deployments or death, displacement due to war, or assault. Copeland et al. (2007) found that over 60 percent of children have experienced “at least one traumatic event by age 16,” (p. 577), according to their definition of trauma. Similarly, the National Survey of Children’s Health (NSCH) considered ACEs such as parent divorce, parent death, parent imprisonment, as well as family member mental health and substance abuse; however, they also inquired about economic hardship (e.g., difficulty providing for food and housing), discrimination, as well as domestic violence and neighborhood violence (Sacks and Murphey, 2018). Using data from the NSCH, Sacks and Murphey (2018) found nearly 50 percent of children nationally have had one ACE, while 10 percent of children have had three ACEs. Both examples illustrate the lack of consensus regarding what ACEs include as well as the caution that needs to be considered when reporting on ACE prevalence.
Yet, the Centers for Disease Control (2019) suggested that “one in every six adults experience four or more types of ACEs” (p. 1).

Another challenge in measuring ACEs is how to separate ACEs from trauma. Although ACEs and trauma cover similar experiences, they are not the same (Bartlett and Sacks, 2019). While ACEs are “potentially traumatic events that occur in childhood (0-17 years)” (Centers for Disease Control, 2019a, para. 1-2, emphasis added), trauma is defined as “a single event, multiple events, or a set of circumstances that is experienced by an individual as physically and emotionally harmful or threatening and that has lasting adverse effects on the individual’s physical, social, emotional, or spiritual wellbeing” (SAMHSA, 2012, p. 2). Thus, trauma is when the event creates negative symptomology for the child (Bartlett & Sacks, 2019).

Comparatively, limited information is available on the prevalence of ACEs in grandfamilies; however, findings are beginning to emerge (Rapoport et al., 2020; Song et al., 2021). In their sample of 251 custodial grandparents raising their grandchildren, Sprang et al. (2015) found that about three quarters of the grandchildren had a minimum of one ACE and almost a fifth of the sample had experienced more than four ACEs. It is also important to note here that the available evidence for grandchildren raised by their grandparents in this study, while not yet adults, have a higher incidence rate of ACEs of one in five grandchildren (20%), compared to one in six adults (16.7%) noted above.

In addition, Sprang et al. (2014) found, in a sample of 297 Kentucky grandparents raising grandchildren, that common traumas that grandchildren experienced included emotional abuse, having an impaired caregiver, and neglect. Sprang et al. (2014) identified that approximately half of the grandparents in their sample reported having a grandchild with more than one trauma experiences, as well as over 16% of the grandchildren being raised having four or more trauma
experiences. Finally, Smith et al. (2019) presented findings from a sample of 129 custodial grandmother and adolescent grandchild reported ACEs. In their sample, the most common ACEs grandchildren reported included “loss of a parent, verbal abuse, bullying by peers, and living with someone jailed” (p. 283) and that slightly over 65% of adolescent grandchildren reported having more than three ACEs. Yet, despite ACEs existing for children, there is hope to offset or resolve the negative consequences associated with ACEs, if treated early (Brent & Silverstein, 2013).

ACEs create needs for formal, or professional, services for children, but we don’t understand those needs and the service process. This study provides insight about how grandparents raising a grandchild with an ACE history identify service needs for their grandchild as well as their own needs. This study also contributes to the understanding the process by which grandparents raising a grandchild with an ACE history navigate the process of seeking and using formal services.

**Outcomes Associated with ACEs**

Children can experience a variety of outcomes related to their ACE history and the number of ACEs to which a child has been exposed (Substance Abuse and Mental Health Services Administration, 2019). This section will review how ACEs may affect children academically, biologically, behaviorally, and academically, both in the short- and long-term.

**Biological**

When ACEs occur in a child’s life, it was commonly believed that the effects would show up later in life; however, newer research findings are showing that an ACE’s effects can occur sooner than previously thought. For instance, in the general ACE literature, Flaherty et al. (2006) found that in a sample of 1,041 children at ages four and six years old, even having one
ACE nearly doubled the likelihood that a child would have poor health generally but not to the point of serious illness requiring a doctor visit or poor health or illness requiring a physician, compared to children without any ACEs. Flaherty et al. found that when a child had four ACEs, the rate nearly tripled for poor health but not to the point of serious illness requiring a doctor visit or poor health or illness requiring a physician, also compared to children without any ACE history. Flaherty et al. noted that these findings provided associations, rather than a dose response curve, like Felitti et al. (1998).

In their landmark study on ACEs and health, Felitti et al. (1998) found a dose response relationship in the number of ACEs in a child’s life and the later life physical and mental health outcomes. Felitti et al. reported:

Persons who had experienced four or more categories of childhood exposure, compared to those who had experienced none, had 4-to 12-fold increased health risks for alcoholism, drug abuse, depression, and suicide attempt; a 2- to 4-fold increase in smoking, poor self-rated health, 50 or more sexual intercourse partners, and sexually transmitted disease; and a 1.4- to 1.6-fold increase in physical inactivity and severe obesity. (p. 245)

Depending on the duration of the ACE, a child may experience toxic stress, which is an over functioning of the body’s stress response system (American Academy of Pediatrics, 2016). In a study involving 100 children aged 5 to 18, with four or more ACEs and persistent symptoms for three or more months, Elbers et al. (2017) found that children’s toxic stress was linked with negative biological outcomes such as “eating disorders and asthma” (p. 9). One later-life challenge that some people with ACE histories experience is physical health problems, such as those mentioned above.
Academic

In the short-term, even one ACE can negatively impact a child’s school performance and attendance. For instance, in a sample of 95,677 children between the ages of 6 and 17, Bethel et al. (2014) found that children who had at least one ACE demonstrated a reduced level of participation at school. Also, in a sample of 58,765 children between the ages of 6 and 17, Stempel et al. (2017) found that children with at least two ACEs had a higher risk of missing 15 or more days from school. Behavioral problems in high school and beyond may include poor academic performance, short- and long-term school disciplinary action (e.g., suspensions and expulsions) as well as intersections with the justice and social service departments (e.g., truancy) (Substance Abuse and Mental Health Services Administration, 2017). Metzler et al. (2017) highlighted that a child’s problems in school has more far-reaching effects than just the school. Rather, education is the gateway for future work, income, and being a contributing member of society (Metzler et al., 2017). In the context of custodial grandfamilies, Smith et al. (2019), in a sample of 154 grandmother-grandchild pairs with ACE histories, found correlational evidence that male adolescent grandchildren in their sample had more school problems, but their school performance was not connected to their ACE histories, which deviates from the larger ACE literature.

Behavioral

Children with a history of ACEs can have also have short-term behavioral problems across childhood and adolescence such as social or anger difficulties (Jimenez et al., 2016; Sacks et al., 2014). Having multiple ACEs is also associated with premature death, including suicidal thoughts among adolescents (Felitti et al., 1998; Soleimanpour et al., 2017). Long-term outcomes for children with four or more ACEs include an increased likelihood of risky decision-making
such as difficulty maintaining a job and substance misuse in adulthood (Felitti et al., 1998).
Thus, children with four or more ACEs are likely to have complex and significant psychological and behavioral needs that might benefit from services and intervention.

Emerging evidence related to ACEs demonstrates that custodial grandparents are also likely to be impacted by behavioral aspects of their grandchild’s ACE history. For example, Sprang et al. (2014) found that grandparents raising a grandchild with a trauma history had greater parenting stress than grandparents raising a grandchild with no trauma history. In another study, Smith et al. (2019a) found significant correlational relationships between their adolescent grandchildren’s total ACE count and grandmother’s anxiety, self-esteem, emotional problems, and depression.

Many grandparents raising grandchildren also experience psychological stress. In a sample of 480 African American grandmothers, Kelley et al. (2013) found that about 40 percent of the grandmothers had psychological distress while raising their grandchild. When the distress was examined more closely, these researchers found that grandchild internalizing behavior, poor grandmother health, and limited resources contributed to about 30 percent of the grandmother’s distress. Kelley et al. attributed the grandchild’s trauma history (e.g., parent imprisonment, parent substance abuse, abuse, neglect, abandonment, parent death) prior to coming to live with the grandparent, as contributing to the grandparent’s stress.

Specifically, Sprang et al. (2015) explored the relationship of grandchild trauma history (e.g., both ACE-related and trauma generally) and the degree of grandparent-grandchild conflict and grandparent parenting stress. In their sample of 251 grandparent-grandchildren, of which 181 grandchildren had experienced trauma, Sprang et al. (2015) found that grandparent-grandchild conflict mediated the relationship between the amount of grandchild’s trauma. These
researchers also found that grandparents gradually experience more parenting stress as a grandchild trauma exposure increases and behaviorally responds to that trauma. Some grandparents experience psychological distress and may need intervention strategies to help them manage their distress levels and learn strategies for responding to their grandchildren (Hayslip & Kaminski, 2005). Yet, what has not yet been determined is linking the distress grandparents experience while raising their grandchild with specific formal service needs. More research is needed to explore these gaps. This study seeks to explore how grandparents describe their own service needs, as they relate to the impact of raising a grandchild with an ACE history.

Although not yet explored in the grandfamilies literature, it may be that the grandchild’s behavior problems and ACE history are linked. For instance, Smith and Palmieri (2007) found that grandchildren ages 4-17 years old raised by grandparents are more likely to have psychological difficulties such as “emotional symptoms, conduct problems, hyperactivity or inattention, and peer problems” (p. 1307). This finding was echoed by Kelley et al. (2013), indicating that grandchildren commonly experience trauma prior to coming to live with their grandparents, which then creates an uptick in psychological challenges. In an additional research study involving 61 foster caregivers and 53 grandparents raising grandchildren aged 3-13 years old, Harnett et al.’s (2012) suggested that, while grandchildren may do better behaviorally with grandparents than in foster care, these grandchildren still experience risk for behavioral challenges, and they could benefit from intervention from formal service providers. Smith et al. (2019) also highlighted the belief that service providers can aid in facilitating the identification of children that could benefit from formal services. Kelley et al. (2011) similarly found that over thirty percent of [grand]children in their study had “clinically elevated [internalizing and externalizing] behavior problem scores,” (p. 2143). Finally, in a systematic review of kinship
parents, or relatives who are raising their grandchildren, and service use, Coleman and Wu (2016) found that commonly reported grandchild behavior problems, per clinician report, included “attention problems, social problems, aggressive behavior, disruptive behavior” (p. 207) as well as difficulty in school.

While not always explicitly linked to ACEs, it is possible that a grandchild’s ACE history may be contributing to increased behavior problems. The ACEs literature would suggest that this relationship exists (Marie-Mitchell & O’Connor, 2013). Mental health and medical formal services can assist in addressing ACEs by providing a safe environment for the child, as well as a place for the child to feel valued and cared for. Formal services can also aid grandparents by teaching them strategies on how to comfort, interact with, and support their grandchild, as well as learn strategies for themselves. As noted above, Ronnenberg et al. (2020) found that guardians received support and assistance in managing their challenges as part of the mental health services their child was receiving. In comparison, the grandfamilies literature is lacking in understanding what service needs may be specific to grandchildren with ACE histories and their grandparents, as well as how to provide tailored services to managing these needs.

Financial

When individuals experience ACEs, there are significant financial costs. Bellis et al. (2019) estimated that, every year, ACEs cost North America almost $750 billion and Europe slightly over $580 billion in lost productivity, which over 75% of the costs coming from individuals with more than one ACE. Bellis et al. (2019) also found that “a 10% reduction in ACE prevalence could equate to annual savings of $105 billion” (p. e517). Unfortunately, it is difficult to determine the national economic impact of ACEs, given that not all states track ACE data. However, in California, where over 60 percent of adults 18 and older reported having at
least one ACE, Miller et al. (2020) used 2013 California Behavioral Risk Factor Survey data and estimated that having a history of ACEs cost each person almost $600 each year in healthcare costs alone. Miller et al. (2020) also found that individuals with ACEs in California collectively lost slightly over 430,000 years of healthy living.

**Formal Services and ACEs**

Despite the term “formal services” being commonly used in the grandfamilies literature, no clear definition exists for this term. As such, a definition derived from multiple sources must suffice. For the purposes of this study, formal services are those services offered by private and public organizations that provide complementary or additional supports to grandparents raising grandchildren that informal supports, such as friends or family, may not provide them (Collins et al., 2016; Goodman et al., 2007; Janicki et al., 2000).

Formal services are an important component to treating grandchildren with ACE histories. Research studies on mental health offer evidence that both outpatient and play therapy services are helpful for children with ACE histories. For example, in a randomized control trial of the effects of child-centered play therapy for children with a history of two or more ACEs, Ray et al. (2021) found that the child’s unwanted behaviors were reduced. Ray et al. (2021) also found that children in this study made improvements in social and emotional functioning. In addition, in a small, qualitative study of 13 caregivers of children with high ACE scores in outpatient clinical services, Ronnenberg et al. (2020) posited that mental health services were considered a protective factor. These researchers found that outpatient treatment provided not only helpful mental health services but also social support for caregivers.

Emerging research has also highlighted the impact of ACE histories on perceptions of health services. In a sample of 95 self-identifying homeless adults, Munoz et al. (2019) found
that individuals with even one ACE have reduced trust in medical professionals, likely due to the difference of the power dynamic between the child and the perpetrator at the time of the ACE. As a result, it is imperative that service providers use an approach that focuses on the person, their individual context, as well as the root of their problem (e.g., ACE history) rather than the symptoms (Substance Abuse and Mental Health Services Administration, 2017). This practice is unique to ACEs because the professional attempts to reduce the power dynamic by focusing on the person first, rather than their problems or diagnosis.

Moreover, in the sexual abuse literature, researchers have recommended parent education and skill development to appropriately respond to the child’s traumatic symptoms, interventions focused on parent strengths, and evidence-based individual and family counseling approaches (e.g., Cognitive Behavioral Therapy, Eye-Movement Desensitization and Reprocessing, Trauma-Focused Cognitive Behavioral Therapy) (Banyard et al., 2001; SmithBattle, 2018; Tavkar & Hansen, 2011). In addition, Foli et al. (2018) found, in their small study of the benefits of a trauma parenting course for grandparent and kinship providers, that some participants caring for a family member under 18 appreciated trauma education, workbook resources, and a community of support provided. Similarly, services that involve multiple family members is likely to be beneficial for grandfamilies.

Trauma-informed care (TIC) is commonly used by behavioral health providers, child welfare systems, pediatric providers, and juvenile justice organizations working with children with potential trauma histories (Berliner & Kolko, 2016; Bruce et al., 2018; Jankowski et al., 2019; Kassam-Adams et al., 2015). Adults can also receive TIC; however, this practice is less common (Bruce et al., 2018). TIC “is grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety for both
providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment” (Hopper et al., 2010, p. 82). TIC is described as one strategy to promote (a) provider competency in trauma knowledge and skill sets to treat trauma, (b) increasing provider awareness of how individuals they work with may have trauma histories, (c) focusing providers on working with clients from a strengths-based versus problem-focused lens, and finally, (d) raising awareness so that providers do not re-traumatize individuals to whom they provide services (Substance Abuse and Mental Health Services Administration, 2014b). TIC has also been recommended as an appropriate approach in the trauma literature because it equips providers to examine the context of ACEs in the person’s life and how it affects the individual and their decisions, in addition to brain and body ailments (Substance Abuse and Mental Health Services Administration, 2014b; SmithBattle, 2018).

The effectiveness of TIC has yet to be determined as an intervention, due to a lack of definitive findings that support its use (Jankowski et al., 2019). For example, in a statewide study of child welfare offices, Jankowski et al. (2019) found mixed findings about the statistical evidence of TIC in a randomized study. These researchers, however, noted that while the evidence for the effectiveness of TIC intervention was mixed, study participants highlighted the importance of using a TIC approach as one way to relieve trauma symptoms. These researchers also cited limited resources, the opioid epidemic, and political factors as external interfering barriers that may have inhibited their findings.

Despite these findings, trauma-informed care is regularly recommended as part of treatment for individuals who have experienced trauma (Lindstrom et al., 2018; Metzler et al., 2017; Simon et al., 2017; SmithBattle, 2018; Sprang et al., 2015). Trauma-informed care is a strengths-based approach, rather than a pathologizing one. For example, the American Academy
of Pediatrics (2014) recommended that providers consider questions such as, “What happened to you,” rather than “What is wrong with you” when working with patients (American Academy of Pediatrics, 2014). TIC can provide multiple benefits to individuals and their families, such as reduction in potential secondary traumatic stress for family members and development of skills to manage challenging behaviors (Substance Abuse and Mental Health Services Administration, 2014b). Using TIC as part of therapeutic treatment allows providers to adjust their treatment to accommodate the various needs of individuals with ACE histories, as well as their families, and may assist in reducing the intergenerational effects of trauma (SmithBattle, 2018; Steele et al., 2016). As noted above, grandparents raising grandchildren have a variety of available service options; however, few studies have examined services using a trauma-informed care lens. Only one study is known that implemented trauma-informed parenting classes for 16 rural kinship parents (Foli et al., 2018). Findings from this pilot study suggest that a 3-week trauma-informed parenting intervention benefitted kinship parents by helping them apply their new knowledge about how trauma affects their child and respond in a trauma-informed way. Further, kinship parents reported increased support from other parents in the program and being grateful for the educational materials. This TIC program is an example of providing increasing positive supports for a kinship family such as parent education, responding to a child with nurture and support, and a comforting relationship – all factors that may all aid in helping the child heal from their ACEs (Sacks & Murphey, 2018). Given that many grandfamilies are commonly formed due to ACEs and are comparable to kinship families, TIC may be beneficial. However, more information from the perspectives of formal service providers is needed to determine if this type of approach would work for grandparents who have grandchildren with an ACE history. This study attempted
to fill that gap by using focus groups with service professionals to explore whether TIC is among the best practices, or even beneficial for working with grandchildren with an ACE history.

**Formal Services, Grandparents Raising Grandchildren, and ACEs**

The grandfamilies literature has well-documented the informal and formal services available and used by grandparents raising grandchildren but have not considered specific service needs related to grandchild ACE exposure or the process of formal service utilization. This study focused on the formal services that grandparents used to help their grandchildren with ACE histories. Grandchildren with an ACE history have may needs such as emotion regulation, behavior management, trauma exposure, and processing loss. Examples include a lack education about how to respond to a child’s trauma history, not knowing how to manage a grandchild’s behaviors, lack of parenting skills, psychological distress, and lack of support.

Researchers have also commonly identified that grandparents have service needs related to raising grandchildren (Hayslip & Kaminski, 2005; Fruhauf et al., 2015). Formal services for grandparents raising grandchildren can range from parenting education classes to information and referral programs (Kaplan & Perez-Porter, 2014). Formal services can be helpful to grandparents raising grandchildren with an ACE history by helping grandparents learn skills to manage stress and a grandchild’s behavior. Services can also help grandparents with feeling empowered, feeling supported, getting counseling, receiving information and referrals, and receiving case management services (Chan et al., 2018; McLaughlin et al., 2017). Larkin et al. (2018) suggested that communities can help reduce the negative impact of ACEs by partnering with multiple stakeholders to create interdisciplinary services to alleviate the needs of individuals and families with ACE histories, particularly those in poverty. Yet, this type of service has long been a challenge in formal services for grandparents raising their grandchildren, including
creating lasting behavior changes in children (Crowther et al., 2014; Langosch, 2012; Minkler & Fuller-Thomson, 1999). Although many of these services are available to grandparents are raising grandchildren, less is known about whether these services meet the unique needs of grandparents raising a grandchild with an ACE history. This study explored that gap in the literature by examining what needs grandparents raising grandchildren with an ACE history have as well as what services grandparents have used while raising their grandchild.

When services have an ACE history as the focus of treatment, it is known as “TIC” (Substance Abuse and Mental Health Services Administration, 2014b, p. xix). TIC was developed as a result of Felitti et al.’s (1998) study on ACEs (Substance Abuse and Mental Health Services Administration, 2014b). Compared to Feletti et al.’s (1998) ACE definition, the Substance Abuse and Mental Health Services Administration (2014b) takes broader strokes by noting that, despite using trauma as part of the name, the administration is referring to trauma as “a single event, multiple events, or a set of circumstances that is experienced by an individual as physically and emotionally harmful or threatening and that has lasting adverse effects on the individual’s physical, social, emotional, or spiritual wellbeing” (Substance Abuse and Mental Health Services Administration, 2014b, p. 7).

Notwithstanding the many types of services that may exist for grandparents raising grandchildren and the importance of early intervention for ACEs, many grandparents experience multiple barriers to accessing and utilizing formal services. For example, grandparents may experience bureaucratic barriers when seeking assistance for their grandchildren such as restrictive eligibility criteria for services (e.g., age, income, insurance status) or difficulties with proof of legal guardianship (e.g., establishing custodial or guardianship or having adequate documentation) (Kolomer, 2008; Janicki et al., 2000; Tang et al., 2015; Van Etten & Gautam,
Additional barriers may come from judgmental service providers working with grandfamilies or limited-service availability (Coleman & Wu, 2016; Gladstone et al., 2009; Kelley et al., 2011; O’Hora & Dolbin-MacNab, 2015). Barriers may also come from the grandparent and include stigma, fear, or an unwillingness to share problematic grandchild behaviors for fear that their grandchildren will be removed (Coleman & Wu, 2016; Foli et al., 2018). Collectively, these barriers may prevent grandparents from acquiring services for their grandchild with an ACE history, which may result in increased stress for grandparents as well as ongoing or worsening child behavioral outcomes. It is therefore important to understand barriers to treatment for grandchildren with ACE histories to determine if there are additional barriers specific to this population that have not yet been considered within the literature. This study explored the nuances of barriers in formal service seeking and utilization and how these barriers impacted service use.

The Present Study

Formal services are a keystone to promoting stabilization and healing for individuals who have experienced difficult challenges, including ACEs. Grandparents are often raising grandchildren with ACE histories, yet little is known about how these ACEs translate to grandchild-specific formal service needs. Further, limited information is available about what grandparents raising grandchildren with an ACE history need to support their grandchild and manage their own challenges related to raising a grandchild with an ACE history. Even less findings are available that explore the process of seeking services for grandfamilies with they are raising a grandchild with an ACE history. To both address these gaps in the literature and advance the understanding of ACEs within grandfamilies, in the context of service access and delivery, this study examined the following research questions:
RQ 1: How do grandparents raising grandchildren identify formal service needs for themselves and their grandchild with an ACE history?

RQ 2: How do grandparents raising grandchildren navigate the process of seeking and utilizing formal services for their grandchildren with ACE histories?

RQ 3: What do formal service providers describe as best practices for working with grandparents who are raising grandchildren with ACE histories?
Chapter 2: Literature Review

Adverse Childhood Experiences (ACEs)

In both the scholarly and lay literature, the terms ACEs and trauma are often used interchangeably, despite having different definitions. The term adverse childhood experiences, or ACEs, came out of Felitti et al.’s (1998) landmark study of 17,000 adults, which explored the relationship between ten negative childhood circumstances and deleterious later-life outcomes. ACEs are typically organized and operationalized into three categories: “(1) abuse (e.g., physical, emotional, and sexual); (2) neglect (e.g., physical and emotional); and (3) household dysfunction (e.g., parental mental illness, incarcerated relative, mother treated violently, household substance abuse, and not being raised by both parents)” (Center for Youth Wellness, 2017, para. 6). Since this time, researchers have debated what is constituted as an ACE, beyond what Felitti et al. (1998) measured, as well as how to measure ACEs.

As noted in Chapter 1, there are operational challenges in how to define ACEs and trauma, as they are very similar. After a review of the literature, it remains unclear at what point ACEs become trauma, other than negative symptom manifestation. Symptom manifestation occurs when the child’s internal resources are overwhelmed and the child experiences fear and an inability to manage the situation (U.S. Department of Health and Human Services, 2021). Trauma symptom manifestation may include (a) emotions, such as internalizing feelings like shame, self-blame, or fear, (b) disassociation, or disconnecting from being present in the situation, or (c) meaning making of the event and responding in kind, whether towards resiliency or towards maladaptive coping (U.S. Department of Health and Human Services, 2021).

Currently, it is unclear as to what contributes to a child’s symptom manifestations and researchers are exploring the impact of pituitary gland-based genes, cortisol releasing and
environment interactions (De Bellis & Zisk, 2014). Yet, symptomology is not guaranteed due to mitigating factors such as receiving formal services, having a caring and predictable adult, and being in a safe environment (Crouch et al., 2019; Ray et al., 2021; Ronnenberg et al., 2020; Smith et al., 2019). Thus, in this study, when the term “trauma” is used, it is considered as describing negative symptomology resulting from ACEs.

Disagreement also exists in the scholarly literature, when talking about interventions that are informed by a child’s ACE history, in terms of calling them TIC or ACE-informed interventions (e.g., Foli et al., 2018; Larkin et al., 2018, respectively). The Substance Abuse and Mental Health Administration (2014) noted that the work by Felitti et al.’s (1998) informed the development of TIC, although Larkin et al. (2018) refer to the practice as ACE-informed care. The difference in the terms appears to reflect the timing of care for individuals with ACE histories, be it before (ACE-informed care) or after (TIC) symptom manifestation. Given that part of this study focuses on (1) the process of grandparents seeking and utilizing formal services for their grandchildren, (2) grandparent and grandchild formal service needs, and (3) best practices that service professionals use when working with grandparents raising grandchildren with ACE histories, the term “TIC” will be used, as it describes the treatment of ACE symptoms.

In addition to symptoms, one of the more salient factors in determining the impact of ACEs on a child’s outcomes is the duration of the adverse experience. When a child experiences stress, three types of stress responses can occur: “positive, tolerable, and toxic” (American Academy of Pediatrics, 2016, p. 5). A positive stress outcome is developmentally normal and is defined as “brief increases in heart rate and mild elevations in hormone levels” such as the anticipation before a performance or doing something new (Harvard University Center on the Developing Child, 2022, para. 3). A tolerable stress is when a child’s stress response is more
enduring and straining on the body; this response can be triggered by more sustained challenges, such as a car accident or hospitalization; however, if a trusted adult is near, this response can be buffered (Harvard University Center on the Developing Child, 2022). Toxic stress occurs when a child experiences ongoing and extreme stress without intervention from an available, supportive, or trusted adult (Harvard University Center on the Developing Child, 2022). Examples of ACEs where this chronic, toxic stress may occur include “physical or emotional abuse, chronic neglect, caregiver substance abuse or mental illness, exposure to violence, or the accumulated burdens of family economic hardship” (Harvard University Center on the Developing Child, 2022, para. 3). Additional non-ACEs that could also contribute to a child’s toxic stress include “chronic disease, poverty, and disability” (American Academy of Pediatrics, 2016, p. 5).

Toxic stress has been associated with several negative outcomes for children (American Academy of Pediatrics, 2016). For instance, a child’s brain regularly gathers feedback from its environment and uses that information to build new synapses in the brain (American Academy of Pediatrics, 2014; Harvard University Center on the Developing Child, 2022). But when a child experiences an ongoing level of toxic stress, the cortisol and adrenaline released can rewire the brain’s stress response and change the brain structure over time (American Academy of Pediatrics, 2014; 2016; Harvard University Center on the Developing Child, 2022; De Bellis & Zisk, 2014). Not only does toxic stress affect brain structure, but it can also alter genes and decrease immune system functioning (De Bellis & Zisk, 2014; Franke, 2014). Thus, the body’s stress response is a critical factor that can change the brain and body (U.S. Department of Health and Human Services, 2021). Insomuch that “children who experience four or more ACEs are 32 times more likely to have learning and behavioral problems” (p. 21). Furthermore, in a study of nearly 50 women aged 18 to 45, Heim et al. (2000) examined the differences between four
groups of women based on their depression and anxiety symptoms as well as the existence of physical or sexual abuse in their past. Results showed that “women with a history of childhood abuse and a current major depression diagnosis exhibited a more than 6-fold greater ACTH [Adrenocorticotropic hormone] response to stress than age-matched controls” (p. 592). Finally, toxic stress is suspected to negatively influence individuals psychologically, such as the ability to regulate emotions or deal with post-traumatic stress (American Academy of Pediatrics, 2014; Franke, 2014).

The relationship between toxic stress and ACEs is of particular concern for grandchildren being raised by grandparents, given that some of the primary reasons why grandfamilies are formed—neglect, having an impaired caregiver, and parent substance abuse (Sprang et al., 2014)—match situations where toxic stress is more likely to occur. Although an empirical link has not been made to establish that grandchildren with ACE histories are more likely to experience toxic stress, having an ACE creates.

In addition to duration, the number of ACEs can also impact some children’s long-term consequences due to their ACE count. One of the hallmark findings from Felitti et al.’s (1998) ACE study was that individuals who have four ACEs or higher are likely to experience a greater risk of negative health consequences. The Harvard University Center on the Developing Child (2022) stated that as ACE count increases, so does the probability for not reaching developmental milestones on time, and there is an increased risk of depression, as well as chronic health problems later in life. In addition to Felitti et al.’s (1998) dose response findings about ACEs and long-term mental and physical health outcomes above, McCrory et al., (2014) found a similar dose-response curve in their sample of 6,408 adults who had childhood ACE experiences. McCrory et al. found that these individuals were more likely to experience diseases
linked with the body’s stress response (e.g., cardiovascular system, arthritis, asthma, and psychiatric disorders). Scott et al. (2011), in their cross-sectional sample of 18,303 adults across ten different countries found these physical findings as well as physical health conditions such as chronic spinal pain and chronic headache being reported to occur after the individual is over 20 years old. Contrary to many researchers’ reports, however, Scott et al. found that these health conditions occurred when a child had at least three ACEs, which is one fewer than what is commonly reported. Scott et al. also found evidence for the mental health diagnoses of anxiety and depression being reported to occur when the individual was younger than 21 years old. In the grandparent raising grandchildren literature, Sprang et al., (2015) noted that although almost 75% of their sample had a traumatic event occur, “only 16.3% (41 out of 251 grandparents) reported that their child had been diagnosed with a trauma-related disorder such as posttraumatic stress disorder, acute stress disorder, or anxiety disorder” (p. 318).

Having multiple ACEs may also be a risk factor for both physical and mental health for grandchildren with ACE histories. In the ACE literature, McCrory et al. also found that children with higher ACE scores were more likely to experience these diseases sooner, than those children who had lower ACE scores. Similarly, in the grandfamilies literature, researchers have documented reasons the grandchild comes into the care of the grandparent - reasons which often include multiple ACEs. For instance, in their sample of 251 custodial grandparents raising grandchildren, Sprang et al. (2015) found that about three quarters of the grandchildren had a minimum of one traumatic event, and over 50% had experienced one to three traumatic events, with the most common instances being emotional abuse (30%), adult substance use (27%), and neglect (27%), where trauma was defined as “any event that causes intense feelings of fear and anxiety) has the potential to interrupt physiological, emotional, and interpersonal processes.
leading to poor mental and physical health outcomes across the lifespan.” (Sprang et al., 2015, p. 316).

Research also documents differences in risk based on the ACE type (e.g., abuse, neglect, household dysfunction). For instance, in a sample of 352 individuals with a mean age of 18 years old, Negriff (2020) found that the type of ACE can increase the risk for mental health challenges. Negriff (2020) found that participants experienced worse mental health symptoms when they had a history of physical and emotional neglect, compared to a history of household dysfunction. While it is unknown how these findings might extend to grandchildren with ACE histories, they highlight the need to understand grandchild ACEs, including how those needs might be addressed with formal services.

**ACEs & Demographic Characteristics**

Finally, there is evidence that ACE exposure may be associated with demographic characteristics. For example, Sacks and Murphey (2018) found that “economic hardship and divorce or separation of a parent are the most common ACEs reported nationally” (p. 4). For example, 76.1% of grandfamilies are living at 100% of the poverty level versus 25.2% of those who are not (Ellis & Simmons, 2014). Anderson (2019), in her analysis of opioid prescription rates, noted that there is a relationship between prescription rates and poverty, as well as a relationship between poverty and grandfamilies. Thus, it is important to understand how these disadvantages affect grandfamily service needs, if at all, while seeking services, not just for their grandchild. In addition to the influence of economic status, race may be relevant as well. Sacks and Murphey’s (2018) findings revealed that American children who were Black ranked as having the highest ACE scores. Grandfamilies are commonly among communities of color. According to Ellis and Simmons’ (2014) analysis of 2010 U.S. Census data, 25.2% of
grandfamilies are African American, and these families may be at risk for higher ACE counts. Ellis and Simmons (2014) also found that among the grandchildren that were being raised by grandparents, 37% were male and 63% were female.

Finally, there may also be a connection between geographic location and ACEs. According to Hatcher et al. (2018), the number of grandparents raising grandchildren in rural communities is growing. The opioid epidemic has recently called attention to the Appalachian region, which has historical ties to steel production and coal mining. Anderson (2019) found a direct correlation between the high number of grandfamilies in Appalachia and the opioid prescription rates in those states, “after controlling for a number of demographic characteristics (e.g., race, poverty, total population, metropolitan status)” (p. 209). Anderson (2019a) suggested in her paper that when an overdose death occurs, children commonly go to live with their grandparent(s). Parent death, as well as abuse, or neglect are other potential adverse outcomes related to the opioid epidemic (Dolbin-MacNab & O’Connell, 2021). These possibilities are indicative of ACEs (Felitti et al., 1998).

Common reasons why grandfamilies form include parental drug/substance use, neglect, abuse, parent imprisonment, emotional abuse, domestic violence, and separation/divorce (Collins, Fruhauf, & Bundy-Fazioli, 2016; Kelley et al., 2011; Smith & Palmieri, 2007). Although not attributed to ACEs as part of these studies, these reasons reflect ACEs on their own.

**Adverse Childhood Experiences (ACEs) & Outcomes**

Emerging research is beginning to show that differences exist in child outcomes based on the types of ACEs they have experienced. For example, Crittenden et al. (2009) noted that children with an ACE of parental substance abuse had a greater likelihood of experiencing
“health, developmental, and emotional challenges that vary in longevity and severity” (p. 292). In addition, children with a history of maltreatment (e.g., abuse or neglect) may experience lasting cognitive challenges such as reduced brain mass, damage to executive functioning abilities, or developmental delays (Glaser, 2000; Hart & Rubia, 2012; Milot et al., 2010; Strong et al., 2010; The National Child Traumatic Stress Network, n.d.). Individuals with neglect histories have also been found to be about twice as likely to develop depression, anxiety, or conduct disorders, or make a suicide attempt and three times as likely to develop an eating disorder (Norman et al., 2012).

ACE exposure can vary in duration and severity, which can affect individuals psychologically and physically in both the short- and the long-term. There is limited evidence available on how ACEs affect children in the short-term, given that Felitti et al.’s (1998) study focused on long-term health outcomes. However, an immediate outcome children may experience following a trauma is a lack of trust in adults or fear of the world, particularly if an adult was the cause of the trauma (The National Child Traumatic Stress Network, n.d.). The National Child Traumatic Stress Network (n.d.) noted that it is through a child’s interactions with safe adults that children learn how to manage their emotions, develop their identity, and perceive the world. Because many ACEs are created through harmful relationships, safe adults who create a relationship of trust can help mitigate the effects of ACEs by showing the child a trusting and safe perspective on the world, rather than fear (The National Child Traumatic Stress Network, n.d).

Additional short-term psychological responses for children affected by trauma are categorized by school level (i.e., preschool, elementary school, middle school, high school) (The Substance Abuse and Mental Health Services Administration, 2017). Short-term outcomes of
ACE exposure for preschool age children may include separation anxiety, weight fluctuations, and bad dreams (Substance Abuse and Mental Health Services Administration, 2017). Preschool children who had three or more ACEs were at risk for having negative outcomes such as reduced reading, speaking, and math skills (Jimenez et al., 2016). In Kerker et al.’s (2015) study, they found that three- to five-year-old children in their sample had between three and four ACEs on average and were at increased odds of demonstrating behavior problems, social problems, and the odds of developing an ongoing medical condition also increased. In elementary school, children may experience anxiety, have trouble focusing, or have trouble staying asleep (Substance Abuse and Mental Health Services Administration, 2017). In middle and high school, adolescents with histories of ACEs may experience loneliness, depressive symptoms, or experiment with drugs, alcohol, or sex (Garrido et al., 2017; Substance Abuse and Mental Health Services Administration, 2017).

Long-term outcomes of ACE exposure may include psychological and cognitive challenges. In a cross-sectional national survey of 7,080 adults aged 65 and older, Raposo et al. (2013) found that the different “types of childhood adversities were associated with higher odds of personality disorders and somewhat higher odds of anxiety disorders” (p. 1241). Raposo et al. (2013) also found that “older adults who experienced childhood adversity had higher odds of having mood, anxiety, and personality disorders after adjusting for covariates” (p. 1241). Researchers have also found a greater risk of mental health conditions such as depressive disorders due to ACEs (Chapman et al., 2004; Font & Maguire-Jack, 2016; Nurius et al., 2015), insomuch that the CDC estimates that ACEs are likely responsible for over 20 million individuals with depression in the United States (Centers for Disease Control, 2021). Another possible long-term psychological outcome for individuals with an ACE history includes
difficulty learning (Substance Abuse and Mental Health Services Administration, 2017). For example, in a sample of 48 older adults with a history of trauma, Petkus et al. (2018) found a relationship between trauma history and worse cognitive performance, particularly for older adults with anxiety or depression and histories of physical and sexual abuse.

Individuals with ACE histories can also experience negative long-term physical health and genetic outcomes, particularly when individuals have higher numbers of ACEs. For example, when individuals have four or more ACEs, they can experience “significantly increased risk for 7 out of 10 leading adult causes of death, including heart disease, stroke, cancer, COPD, diabetes, Alzheimer’s and suicide” (Center for Youth Wellness, 2017, para. 7; Font & Maguire-Jack, 2016; Hughes et al., 2017). Felitti et al. (1998) commented that the mechanisms for creating these long-term health outcomes lie in the coping strategies of individuals who have ACE histories. That is, Felitti et al. noted that these coping efforts are behaviors such as “smoking, alcohol or drug abuse, overeating, or sexual behaviors” (p. 253) that provide immediate relief to mitigate stresses the individual experiences due to the ACE history as well as help the individual stabilize their emotions. Yet, these coping strategies may be linked with the above listed negative health outcomes.

In addition to physical and psychological challenges associated with ACE exposure, there is evidence that ACE histories can be part of an intergenerational cycle, which may affect families for generations. It is important to note that parents, just like children, experience ACEs differently and may have varying symptomology. The American Academy of Pediatrics (2014) wrote that parents who have their own ACE history may experience increased parenting challenges or make inappropriate comments that do not support the growth of their children. For example, parents can help children learn how to regulate their behavior and emotions; however,
parent emotion regulation problems associated with their ACE histories and contextual stressors can contribute to a parent’s increased likelihood of poorly responding to their child (Bridgett et al., 2015; SmithBattle, 2018; Woods-Jaeger et al., 2018). On the other hand, parents with ACE histories may also strive to improve their child’s lives by parenting differently than their parents did as well as supporting their children (Woods-Jaeger et al., 2018).

Intergenerational trauma research is beginning to emerge in the grandfamilies and kinship care literature. In a sample of 23 grandparents raising their grandchildren, one of the key findings was how family trauma stretched across the generations, affecting not just the parent (e.g., parent substance use, incarceration, or mental illness), but also the grandchild (e.g., separation anxiety, difficulty building relationships) (Lee et al., 2015). In this study, Lee et al. (2015) further found that some grandparents had the foresight to get their grandchild enrolled in services to address their difficulties. Furthermore, Smith et al. (2019a) found evidence for ACEs existing in their 164 grandmothers-adolescent grandchildren dyads as part of a randomized clinical trial from a national sample, where nearly 50% of these dyads reported 4 or more ACEs.

Although having an ACE history may be part of an intergenerational cycle, it does not have to be a risk factor for future generations. For instance, in a sample of 11 low-income, urban parents of children with ACE histories, Woods-Jaeger et al. (2018) found that, despite parents having their own ACE histories, there was still a desire to protect their children from the negative effects of ACEs. Study participants reported believing that having a community of support as well as access to interventions like parenting assistance, education, and counseling services would help them mitigate intergenerational ACE transmission. Limited information is available on what grandparents raising a grandchild with an ACE history believe they need to
help their grandchild with an ACE history; this study will explore that gap in understanding the needs and service experiences of these families.

It is perhaps unsurprising that, in both the broader child trauma and child ACE literature, there is evidence of a child’s trauma impacting their parents (Banyard et al., 2001; Cummings, 2018; Figley, 1998; Kilroy et al., 2014; van Toledo & Seymore, 2013; Woods-Jaeger et al., 2018). For example, Klarić et al. (2013) conceptually described how caregivers may experience compassion fatigue (e.g., sympathy and sitting in the emotions of the afflicted person); burnout (e.g., personal exhaustion in all areas of the carer’s life as a result of caregiving); and secondary traumatization (e.g., when the caregiver separates from the recipient for a time) when caring for a family member with a trauma history. Similarly, in a sample of thirteen parents, Kilroy et al. (2014) described parent reactions to children who had experienced sexual abuse. Kilroy et al. (2014) found a theme of “systemic trauma” (p. 498), where family members were impacted by (1) the knowledge of the sexual abuse, (2) new providers coming into the home, and (3) parents responding out of fear and emotion, and cut-off of some relationships. In comparison, parents more commonly respond by shifting their parenting by adding more predictability, nurture, and focusing on the tasks that matter most when their children have experienced sexual or interpersonal trauma (Cummings, 2018; Kilroy et al., 2014; Kiser et al., 2008; Lawson & Sibla, 2016). Thus, parents are impacted by their children’s ACE history, so it would be expected that grandparents would also be impacted by a grandchild’s ACE history.

Just as a child’s trauma can affect other family members, other family members can affect the child. For example, in the grandparent raising grandchildren literature, grandparent distress has been found to be associated with a grandchild’s trauma, through grandparent-grandchild conflict (Sprang et al., 2015). Past research in the trauma literature has found that,
when family members exhibit negative emotions in response to their child’s trauma, they are less likely to help a child heal from sexual trauma or exposure to violence (Hernandez et al., 2009; Lindstrom Johnson et al., 2018). In these situations, parent responses can be detrimental to grandchild progress, rather than helpful. For example, in the sexual abuse literature, whether a parent responds positively (e.g., encouraging mental health use, listening to the child, validating the child’s feelings) or negatively (e.g., blaming the child, dismissing the child’s concerns or problem) can either respectively, promote or discourage, the child’s healing from the sexual abuse (Elliot & Carnes, 2001; Kilroy et al., 2014; Matsakis, 2004). To perhaps counter this possibility, Holt et al. (2014), speaking from the larger trauma literature, suggested that one way to help a child was to first help the parent by providing strategies to cope with their reaction to the trauma so they can work with the clinician to aid their child’s healing.

Yet, it is unknown what formal services grandparents have sought and used services to help their grandchild with an ACE history or how those formal services have helped, or not helped, these families. In addition, without exploring what steps grandparents have taken to manage their grandchild’s ACEs, it is impossible to know whether the grandchild or grandparent needs intervention and, if so, how to best intervene to assist them. Therefore, more research not only into the service needs of both grandchildren with an ACE history and grandparents raising the grandchildren is warranted, but also what factors about the process of seeking services are beneficial or even harmful to grandfamilies. This study addressed this gap in the literature by conducting interviews with ten grandparents who were raising a grandchild with an ACE history and inquired them about the process of identifying grandchild needs, seeking services for their grandchild, and then receiving services. In addition, as supplemental data, this study also sampled the voices of formal service providers on strategies they use when working with
grandfamilies. To date, few studies have explored what interventions exist to treat grandfamilies with ACEs, specifically. A recent study from Fruhauf et al. (2020), identified service provider modalities when working with grandparents raising grandchildren generally and found that enhancing grandparent parenting practices, providing case management, or teaching resourcefulness, as well as seeking services, but not those with a specific ACE history. Both Chan et al. (2019) and Fruhauf et al. (2020) proposed that grandfamilies would benefit from a resilience-based, family-centered intervention that is tailored to the specifics of the grandfamily.

Formal Services and Grandparents Raising Grandchildren

Grandparents raising grandchildren have also experienced barriers to service use such as transportation, childcare, and time constraints, which can prevent participation in services for themselves (Dolbin & Targ, 2001; Janicki et al., 2000). For example, if a grandparent wants to utilize a formal service such as a support group, common barriers to accessing the service are transportation and childcare, especially if their grandchildren are not school age (Littlewood, 2014). In their study of 208 grandparents raising grandchildren, Janicki et al. (2000) found that, if a grandchild has special needs (e.g., learning problems, attention-deficit hyperactivity disorder, developmental disability, etc.), finding childcare so the grandparent can receive services may be even more difficult. These barriers could also be applied to seeking services for grandchildren. For example, making an appointment for a grandchild to receive services requires transportation and time and perhaps childcare as well, if the grandparent is raising multiple grandchildren. In addition, if the grandparent is seeking services for a grandchild’s more specialized need, finding a provider in their region may be a barrier for treatment, particularly if they reside in a rural community.
Choi et al. (2016) noted that limited research has explored interventions designed to deal with the abuse, neglect, and other traumas that contribute to the formation of grandfamilies. Presently, formal services available to custodial grandparents and grandchildren is to use interventions that have been empirically tested. In a review of the intervention literature, Choi et al. (2016) found that “tested and evaluated interventions include case management approaches, support groups and services, empowerment programs, parenting programs, and physical activity and nutrition programs” (p. 125) for grandparents raising grandchildren. In a sample of 50 African American grandparents raising their grandchildren, Ross and Aday (2006) found emerging evidence that counseling could be beneficial for grandparents by lowering their stress levels due to raising their grandchild. Examples of other formal services available to grandparents raising their grandchildren include respite care; peer to peer assistance, educational workshops, and kinship navigator services (Collins et al., 2016; Janicki et al., 2000; Kelley et al., 2011; Langosch, 2012; Kaplan & Perez-Porter, 2014; Yancura, 2013). Thus, more information is needed on what strategies or modalities work effectively with grandparents raising a grandchild with an ACE history. In sum, grandparents and grandchildren have complex needs and addressing barriers to formal services is crucial to assist grandparents and their grandchildren in obtaining relevant services (Dolbin & Targ, 2001).

Grandparent Service Needs

Three formal service needs grandparents may experience while raising grandchildren who have ACE histories include (a) parenting support and education, which include child behavior management; (b) findings ways to care for themselves; and (c) being linked with resources and relevant information.
By nature of the role transition that grandparents experience as they shift from being a singular grandparent to grandparent and parent, are updated parenting strategies that align with local law and are trauma informed. Grandchildren commonly have ACE histories when they come to live with their grandparents, and as such, likely need emotion-based parenting, rather than traditional, corporal punishment parenting. In this light, grandparents need to understand strategies that are attuned to the needs of their grandchild, rather than the needs of the grandparent’s culture.

Thus, the first formal service need grandparents raising grandchildren who have ACE histories may have is parenting support and education, due to the psychological distress and challenging grandchild behaviors that grandparents may frequently have to manage while parenting. Parenting education and support has also been suggested as a strategy to break an intergenerational ACE cycle (Woods-Jaeger et al., 2018). Effective parenting approaches is a commonly addressed topic in grandparents raising grandchildren interventions, including support groups and the Grandparent Triple P Parenting Program (Kaplan & Perez-Porter, 2014; Kirby & Sanders, 2014). While few, if any, formalized parenting groups exist for grandparents raising a grandchild with an ACE history, grandparent can benefit from education about their grandchild’s ACE history, particularly if the grandparent does not have their own ACE history. For example, in the sexual abuse literature, Banyard et al. (2001) noted that parents are often distressed upon finding out their child has been sexually abused and these parents often need support in handling their distress as well as learning appropriate ways to respond to their child’s trauma.

In the kinship literature, Foli et al. (2018) conducted a pilot study on a trauma-informed parenting class, and some of the kinship parents commented that the knowledge they learned about trauma in the course translated to greater compassion and tolerance in their parenting and
handling of their child’s behaviors. Kinship parents also reported noticing the child’s trauma and being able to respond to their grandchild in a way that promoted healing (Foli et al., 2018). Foli et al.’s (2018) study further highlights the need for more research on ACE-specific needs that both grandparents and grandchildren have so that services may be tailored to best help these families.

Connecting with a child on an emotional level is an important first step for managing a child’s ACE-related behaviors; however, additional considerations need to be made when children have ACE histories. For example, in a study with a small sample of six caregivers of 12 children with various ACE histories, Lawson and Sibla (2016) found that parents utilized parenting strategies that were sensitive to individuals who have experienced trauma. More specifically, these parents used strategies to create a routine for family members and were attentive to the needs of their children by responding to sensory needs and understanding social delays—which can occur as part of the brain’s response to the ACE. Although the ACEs and trauma literature has extensively documented strategies to use when helping parents and other guardians, less is known about how to best support grandparents raising a grandchild with an ACE history.

A second formal service need may psychiatric medication or outpatient therapy to assist grandparents in findings ways to care for themselves so they can be a present and safe adult for their grandchild. Grandparents raising their grandchildren have been hailed as individuals who can provide an environment—another protective factor—that is familiar as well as safe and research supports that grandchildren do better with grandparents and other kinship members, than in foster care. Since many ACEs are created through harmful relationships, safe adults who create a relationship of trust can help mitigate the effects of ACEs by showing the child a
A trusting and safe perspective on the world rather than fear (The National Child Traumatic Stress Network, n.d). These mitigation efforts are known as protective factors in the trauma research literature. Protective factors are theorized to reduce the negative impacts of trauma once they have occurred. Grandparents are in a unique position to provide these protective factors such as being a safe and loving adult to a grandchild, following a traumatic event.

A third formal service grandparents may have is being linked with resources. Case management services commonly enable grandparents to be connected with resources and information in the area, which can assist in reducing grandparent challenges. Case managers may assist in managing challenges that grandparents raising grandchildren are commonly known to have, including lack of respite care, financial challenges, lack of childcare, difficulty managing grandchild behaviors, lack of information about local formal service providers, as well as their personal physical and mental health challenges.

In sum, grandparents may have formal service needs beyond these suggestions; however, more research needs to be done to know. This study sought to fill this gap by asking grandparents about their service needs as they are raising their grandchildren, in addition to those of their grandchildren with ACE histories.

**Formal Services as an Intervention for ACEs**

Larkin et al. (2018) found that for each additional ACE a child experienced, the likelihood of using mental health services rose by almost 40%. The Substance and Mental Health Services Administration (2020) characterized formal services as one way to offset the negative effects of ACEs. Thus, ACE exposure may increase the need for service utilization because ACEs are likely to create service needs. To reduce the deleterious effects of a history of ACEs, United States government organizations, practitioners, and researchers have called for
intervention as soon as possible after ACE exposure (Centers for Disease Control, 2020; Moore & Ramirez, 2016; Raposo et al., 2013; Tavkar & Hansen, 2011). Research from the ACE literature suggests that earlier intervention may provide a reduction in lasting mental health problems (Raposo et al., 2013). Woods-Jaeger et al. (2018) further emphasized the importance of effective early intervention for children with ACE histories, citing the importance of healthy brain development and learning, which may be disrupted by non-intervention and create later-life challenges. For example, in 912 caregiver interviews and caseworker reports from an early intervention program for children aged 18 to 71 months, Kerker et al. (2015) found there was a negative relationship between ACEs and “poor early childhood mental health and chronic medical conditions” (p. 510) as well as social challenges for children in their sample aged 3 to 5.

Although several researchers have examined the needs and services available for grandparents raising grandchildren and kinship families broadly (Coleman & Wu, 2016; Kaplan & Perez-Porter, 2014; Yancura, 2013), no research to date has explored (a) the service needs of grandparents as well as grandchildren with an ACE history or the process by which grandparents seek services in the context of ACEs (Gibson, 2003; Gladstone et al., 2009). Finally, even less information is available from providers, detailing the services they provide to grandfamilies (Fruhauf et al., 2015; Sprang et al., 2015). To address these limitations, I interviewed ten grandparents raising a grandchild with an ACE history about what they identify as their and their grandchild’s needs as well as what the service seeking, and utilization process was for them. In addition, this study incorporated two focus groups with formal service providers from various sectors (e.g., social services, health, school) who worked with grandchildren with ACE histories to learn what they described as best practices for working with this population.
Andersen’s (1995) Behavioral Model of Health Service Use

This examination of grandparent service seeking and use for their grandchild with an ACE history was informed by Andersen’s (1995) Behavioral Model of Health Service Use. Andersen (1995) explained that his model was originally designed to explore the context behind healthcare service use and how individuals decided to use services. However, Andersen’s model has been through four iterations and has been used to explore other service types beyond healthcare, such as counseling and social services for grandfamilies (Montoro-Rodríguez et al., 2012). This model was selected because of its ability to (a) focus on the process of service seeking, which aligns with my second research question; (b) capture the systemic and personal contextual factors that contribute to service seeking for an individual; and (c) show interactions between concepts in this model.

Figure 1
Andersen’s (1995) Behavioral Model of Health Services
As noted in Figure 1 above, Andersen’s (1995) Behavioral Model of Health Service Use depicts four concepts as they relate to participating in service use: “environment, population characteristics, health behavior, and outcomes,” (p. 8) with many of these concepts interacting with each other. Looking at the model from left to right, Andersen (1995) submits that an individual’s environment (e.g., the health care system, external environment) influences population characteristics (e.g., predisposing factors, enabling resources, need) that may predict service use. Service use is then theorized to influence health behaviors (e.g., personal health practices, use of health services) and then finally, outcomes (e.g., individual perceived health, the provider’s evaluation of the individual’s health status, consumer satisfaction).

The concepts of environment, population characteristics, health behavior, and outcomes from Andersen’s (1995) Behavioral Model of Health Service Use guided and contextualized my research questions. For example, my first research question is about the service needs of the grandparent and the grandchild with an ACE history, which fits under the concept, population characteristics. My second research question about the process of seeking services reflects the remaining concepts from the model (e.g., environment, health behavior, and outcomes) where I explored grandparents’ process of seeking and using formal services for their grandchildren with ACE histories.

**Environment**

In Andersen’s (1995) model, the environment is comprised of meta-systems such as the (1) broad political, economic and physical forces that affect service use as well as (2) established rules and procedures of the service providers. The interaction between these two systems creates the landscape for individuals who receive services, such as eligibility requirements. For example, formal service systems are commonly centered on the verification of a legal relationship between
parents or guardians and children, yet grandparents who raise their grandchildren do not always have the luxury of a legal relationship (Baker et al., 2008; Van Etten & Gautam, 2012). For example, in a local Area on Aging chapter in Virginia, eligibility criteria for services requires that older adults be at least 60 years old (New River Valley Agency on Aging, 2019). This can be a problem for many grandparents raising grandchildren given that, in the 2012 Census data, nearly half of coresident grandparents raising their grandchildren were below the age of 60 (Ellis & Simmons, 2014). In the grandfamilies literature, restrictive eligibility requirements (e.g., legal qualifications) have been noted as hindering grandparents from receiving assistance for their grandchildren (Baker et al., 2008). In informal care situations, the inability of grandparents to provide proof of their legal relationship to the grandchild can prevent grandchildren from receiving needed medical, psychological, or behavioral services, or grandparents from receiving government assistance stipends (Baker et al., 2008; Cox, 2003).

Regarding health care organizations, Gibson (2003) found that grandmothers believed that organizational policies around care, such as long wait times for services, lengthy paperwork, and navigating multiple providers, created additional barriers to accessing services. Unfortunately, when organizations are subject to policy and procedural guidelines, flexibility for grandparents raising grandchildren may be less possible. Seeking formal services can also be personally taxing and burdensome for grandparents, which may further dissuade them from seeking services. In the context of the current study, Andersen’s (1995) Behavioral Model of Health Service Use provided an avenue to learn about possible barriers to services for grandchildren with an ACE history and how their service providers mitigated those barriers, if at all.
Andersen (1995) also theorized that the environment interacts with both population characteristics and outcomes of formal service use. The external environment can affect individuals on “historically, economically, culturally, and developmentally” (Boss, 2002, p. 40). This is particularly relevant for African American and American Indian populations, who have experienced historical challenges and traumas such as slavery and government oppression (Byers et al., 2017; Kira et al., 2014), in addition to present day traumas such as marginalization and poverty (Hegar & Scanapieco, 1996; Kira et al., 2014; SmithBattle, 2018).

**Population Characteristics**

An individual’s *predisposing characteristics* (e.g., race, age, gender, cultural values about health, attitudes about health system), *enabling resources* (e.g., community, personal), and *need* (e.g., perceived need and evaluated need) are considered in this concept. In the context of grandfamilies, age and gender may play a particularly important roles in service seeking. In the grandfamilies literature, Carr et al. (2012) and Yancura (2013) found that demographic characteristics such as age and grandparent gender impacted grandparents seeking formal services. More specifically, in their sample of 93 African American grandmothers, Carr et al. (2012) found that grandmother age had an inverse relationship with information need, where older grandmothers used fewer information resources. In terms of gender, in a Hawaiian sample of 177 grandparents raising grandchildren, Yancura (2013) found that grandmothers used services more than grandfathers; however, this may also be reflective of the broader population in which most custodial grandparents are female. Thus, grandparent demographic factors are important when considering what influences grandparents to seek formal services.

In addition to demographic characteristics, Andersen (1995) theorized that another *predisposing characteristic* for service seeking is attitudes toward service utilization. In a
systematic review on kinship parents and service use, Coleman and Wu (2016) found that kinship parents have a more negative attitudes toward formal services, whether those services came from an agency or social services. Many grandparents have expressed distrust and fear in formal services, due to the likelihood of DSS involvement (Harnett et al., 2014; Janicki et al., 2000; Letiecq et al., 2009). When DSS is involved, Coleman and Wu (2016) suggested that some grandparents who needed help refused to ask due to fearing their grandchild would be taken from the home. This belief has also been echoed in the ACE literature when low-income parents sought out services from pediatricians (Marie-Mitchell et al., 2016). Andersen (1995) also theorized that predisposing characteristics predict enabling resources. A grandparent’s distrust and fear in formal service providers is one example of predisposing characteristics possibly reducing the number of resources a grandparent can access.

In Andersen’s (1995) model, enabling resources (e.g., social support, income, health insurance, treatment accessibility) encompass both communities and individuals. One of the prominent facets of enabling resources as it relates to rural grandparents is treatment accessibility. Mayberry and Heflinger (2013) also found that interventions, such as support groups or referrals for mental health providers, were needed in their rural communities. This study highlights how more research is needed to better understand what factors contribute to grandparent perception of grandchild need so that grandchildren can receive services in a timely manner, particularly if their ACE histories are negatively impacting their mental health and functioning. Another noteworthy part of enabling resources for rural grandparents raising their grandchildren is social support. For example, in many parts of Appalachia, a strong connection to one’s family is commonly found (Whitt-Woosley et al., 2018). Due to this external factor,
rural grandparents may rely on their family for informal support and assistance when in need, rather than seeking help from formal services.

According to Andersen, the community portion of enabling resources encompass formal service provider availability as well as the availability of services. In the ACE literature, Larkin et al. (2018) suggested that a community can provide fundamental support to individuals who experience ACEs. For example, Hall et al. (2012) analyzed Washington state county data of both funded and unfunded community coalitions designed to intervene with ACEs in a sample of over 4,500 individuals aged 18 to 34. These coalitions were comprised of community members who facilitated partnerships to strengthen areas of need in the community (Hall et al., 2012). Hall et al. (2012) also found that, in a ten-year period, counties that received state funding significantly reduced ACE severity in young adults, although it was unclear what the mechanism was contributing to this change. In addition, treating trauma requires collaboration from multiple community partners, particularly for youth with multiple traumas. In a national sample of over 11,000 youth with trauma histories, Briggs et al. (2013) found that children and adolescents with high trauma counts commonly needed multiple services from multiple providers (e.g., social services, criminal justice, and school systems). Thus, community commitment and the availability of service providers may be enabling resources that contribute to the reduction of ACEs over time.

In the context of population characteristics, Andersen (1995) also theorized that individuals also need personal resources (e.g., “insurance, income” (p. 3)) to utilize formal services, in addition to information about where to find those services. In a systemic review of service use and kinship parents, or extended family members who step in to raise a child, Coleman and Wu (2016) found that kinship parents generally have a low income, which may
make them eligible for government services such as Medicaid or TANF, but that their low income may also preclude them from receiving services from private providers who may not take Medicaid. Another resource that grandparents raising their grandchildren have available to access services are the school systems. In a national sample of over 600 grandparents raising their grandchildren, Montoro-Rodríguez et al. (2012) found that grandparents often utilized school services more than community-based services for their grandchildren. This finding aligns with Andersen’s (1995) claim that need predicts health behavior, or in this case, service use. Montoro-Rodríguez et al. (2012)’s evidence also aligns with Smith et al.’s (2016) finding that, when fewer barriers such as accessible and applicable services exist, grandmothers raising a grandchild are more likely to try and use them. Both Montoro-Rodríguez’s (2012) and Smith et al.’s (2016) findings highlight Andersen’s (1995) belief that, when services are available (e.g., due to barrier reduction or service availability for grandmothers), grandmothers will use those services more often. Yet, despite researchers reporting that grandparents raising their grandchildren are using services, less is known about what that service use process is like (e.g., receiving and experiencing services). Andersen’s (1995) model guided this study by providing a framework to examine the relationship between grandchild need (e.g., population characteristics), use of formal services (e.g., health behavior), through both grandparent and formal service provider perspectives (e.g., outcomes) in grandparents raising a grandchild with an ACE history.

In line with Andersen’s (1995) model, a parent’s perceived need (e.g., population characteristics) of a low-income child’s behavior may play a role in seeking services. For example, a sample of over 200 economically disadvantaged eight-year-old children, Thompson and May (2006) found that these children were more likely to receive mental health services if
they had a child abuse or neglect history or who acting out, or externalizing behaviors. Yet, children with internalizing behaviors in this sample did not end up receiving services (Thompson & May, 2006). Few findings detail the timing of or conditions that determine when grandparents raising grandchildren decide to seek help; however, evidence from the broader intervention literature suggests that how a caregiver perceives a child’s behavior may indicate when services are sought (Mayberry & Heflinger, 2013). In a sample of 21 mothers, aunts, and grandmothers, who had the primary responsibility of caring for their child, Mayberry and Heflinger (2013) found that, when parents contextualized their child’s behavior as being from a “stressful event” (e.g., ACE history), caregivers were more likely to acknowledge their stress, feel control, and seek formal services, than if the caregiver perceives the behavior as a “response” (p. 108). Montoro-Rodriguez et al.’s (2012) findings from 610 grandmothers raising a grandchild that grandchildren were likely to use mental health services in either the community or at school if they were (a) acting out, or showing disruptive behaviors, (b) other grandchildren in the home had physical or mental health diagnoses, and (c) services were already being received in either the community or school. Aside from Montoro-Rodriguez et al.’s (2012) findings, less is also known, in the grandparent raising grandchild literature, about the process that grandparents raising grandchildren go through to identify perceived need(s) of their grandchild with an ACE history beyond these factors.

Another relevant factor to perceived need and seeking out services is severity of grandchild symptoms. Emerging evidence suggests that anywhere from 16% to 50% of some research samples have grandchildren with three or more ACEs (Smith et al., 2019; Sprang et al., 2014; Sprang et al., 2015). The Substance Abuse and Mental Health Services Administration (2017) has indicated that children with four or more ACEs are more likely to experience worse
symptoms than a child with one ACE. As a result, a grandchild’s ACE history may make the grandparent perceive the grandchild’s needs as more severe. However, seeking help may not always feel like the easiest or safest choice for grandparents raising grandchildren (Van Etten & Gautam, 2012). For example, in Gladstone et al.’s (2009) study of 22 grandparents raising their grandchildren who worked with social service departments highlighted concerns of being judged and treated differently, as well as a lack of transparency from caseworkers. As Gladstone et al. (2009) point out, grandparents may create their own barriers to treatment, particularly when raising a grandchild with an ACE history. More research is needed so that formal service providers have a better understanding as to what barriers exist in precluding grandparents raising a grandchild with an ACE history from seeking formal services.

In Andersen’s (1995) Behavioral Model of Health Service Use, \textit{evaluated need} is defined as a provider’s “professional judgement about people’s health status and their need for medical care” (Andersen, 1995, p. 3). In both the larger ACE and grandfamilies literature, there is evidence of individuals not seeking services due to uncertainty about how providers will respond to their request for help. For example, in a sample of 18 mothers and their children, mothers held the fear that the Department of Social Services (DSS) would remove their children if mothers were to admit they had a mental health problem (Marie-Mitchell et al., 2016). Similarly, grandparents may fear negative perceptions from providers as well as the consequences of what potential negative perceptions from formal service providers during treatment (Coleman & Wu, 2016; Janicki et al., 2000; Van Etten & Gautam, 2012). For example, Coleman and Wu (2016) noted that grandparents sought to maintain permanency for their grandchild so that when there was DSS involvement, grandparents would be less forthcoming about their needs or challenges.
This fear may prevent grandchildren with an ACE history from getting needed services, which may affect them long-term, in terms of their mental and physical health.

Grandparents raising grandchildren may also experience stigma from providers. Provider stigma can be an influential barrier to treatment, particularly in low-income families. In a study of 230 grandchildren being raised by African American grandparents, Whitley, Kelley, and Campos (2011) speculated that older grandmothers who faced stigma from service providers were perhaps less interested in being proactive in acquiring services. In addition, Hayslip and Glover (2008) noted that grandparents raising grandchildren are often subject to “social stigma” (p. 164), due to the choices of the parent in contributing to grandfamily formation. Hayslip and Glover (2008) also found that grandparents in their sample (n = 610) felt a sense of “failure” (p. 165) when considering their child’s choices and their circumstances. These feelings are evident in a sample of 12 grandparents raising grandchildren, where grandmothers reported “feeling ashamed” when considering seeking help due in part to the circumstances for raising a grandchild as well as personal feelings of inadequacy (Gibson, 2003, p. 62). Further understanding can be garnered by examining what personal barriers, whether they are internal feelings, thoughts, or beliefs, or external policies, procedures, or interactions with formal service providers, contribute to barriers affecting grandparents seeking services for their grandchild.

Health Behavior

In Anderson’s model, health behavior covers personal health practice and the use of health services, where personal health practices included characteristics like “diet, exercise, and self-care” (Andersen, 1995, p. 6). When grandchildren have more than four ACEs, their long-term health can be at risk. Thus, it is essential that they receive services as early as possible
(Woods-Jaeger et al., 2011). In the grandparenting literature, grandparents have reported that they tended to prioritize their grandchild’s needs rather than their own (Janicki et al., 2000).

Andersen (1995) defined the use of health services as “type, site, purpose, and coordinated services during an episode of illness” (Andersen, 1995, p. 6). Interdisciplinary approaches have been used in the larger ACE literature and these approaches commonly cover cognitive, behavioral, and emotional needs for the child (Lindstrom Johnson et al., 2018; Woods-Jaeger et al., 2018). For example, in a systematic review of ACE interventions, Marie-Mitchell and Kostolansky (2019) found that most randomized clinical trials bundled multiple services together (e.g., “parenting education, mental health counseling, referrals, social support” (p. 756)), targeted, and obtained improvement between parents and children aged 0-5 years old. The idea of working with the child as well as supporting the parent has been echoed in the medical literature (Schor, 2015) and ACEs literature (Larkin et al., 2014).

A multitude of articles in the grandparent raising grandchildren literature discuss grandparent formal service needs. Yet, few articles discuss the process that grandparents take to acquire services for their grandchild as well as the process of utilizing those services. Exploring these processes further can assist in new and nuanced understanding about the service seeking and utilization process for grandchildren with ACE histories in Central, North Central, and South Central Appalachia.

Grandparents raising grandchildren have multiple types of formal services available to them such as support groups, workshops, parenting programs, empowerment training, resourcefulness training, and counseling. Yet, Smith et al. (2008) recommended that grandparents raising grandchildren utilize multiple formal services such as parent coaching or therapy to learn how to manage their stress. In the grandfamilies literature, interdisciplinary
approaches can include services from a mixture of state, agency, university, grandparent, or grassroots organizations (Fruhauf et al., 2012). In fact, Clottey et al. (2015) suggested that, when services have a multi-prong approach, they were more effective for their sample of 12 African American rural grandparents raising grandchildren. Thus, communities that bundle multiple services or resources together can aid grandparents by making them more effective than singular agency focused interventions (Dolbin & Targ, 2001; Kaplan and Perez-Porter, 2014). More research is needed to determine whether an interdisciplinary approach is considered a best practice by formal service providers who work with grandparents raising a grandchild with an ACE history. This study filled this gap by exploring what formal service providers considered as best practices for working with grandchildren with ACE histories.

These interdisciplinary approaches are one way to meet multiple needs for a grandparent raising a grandchild with an ACE history due to it being more (1) cost effective than several individual programs doing similar things; (2) multiple services are being provided at once, thus reducing the time burden; and (3) the increased likelihood of being more effective (Bunch et al., 2007; Kaplan & Perez-Porter, 2014). Despite the number of programs and types of programs available to grandparents, less is known about what services grandchildren with an ACE history have used or are currently using. It is also unclear what services grandparents may use for themselves while they are raising their grandchild with an ACE history.

In Andersen’s (1995) model, there is an interaction between health behavior and enabling resources. In the custodial grandparenting literature, researchers have repeatedly documented that grandparents want to be treated as equal partners in the case management and treatment process, rather than seen as problems or less-than (Gibson, 2003; Gladstone et al., 2009; Simpson & Lawrence-Webb, 2007). In addition, O’Hora and Dolbin-MacNab (2015)
noted that, if grandparents raising grandchildren do not feel acknowledged or included, they are less likely to continue services. There is a need to understand not only at what points in the service delivery process grandparents are likely to feel acknowledged, included, as well as what influences their decisions to continue or end formal services, but also what the service delivery and utilization process is like for grandparents, which has not been extensively explored.

In his model, Andersen (1995) further theorizes that health behaviors, which are defined by personal health practices and the use of health services, affect a community’s enabling resources. This is evident in the grandfamilies literature, where many grandparents have inadequate services that fit their multi-layered needs or have limited information about services available to them (Edwards & Daire, 2003; Gibson, 2003; Harnett et al., 2014; Simpson & Lawrence-Webb, 2007; Van Etten & Gautam, 2012). Formal service providers, such as social workers and other organizations that work with grandfamilies, can reduce this information barrier by providing a handout that can be given to grandparents raising grandchildren about services available to them (Gibson, 2003; Kaplan & Perez-Porter, 2014). For example, Marie-Mitchell et al. (2016) suggested that a formal service as simple as case management may be enough to break the passing of ACEs from one generation to the next. Intergenerational ACEs are one area that has been less explored in the grandfamilies literature.

Outcomes

Andersen (1995) defined outcomes of services as (1) perceived health status by the individual, (2) evaluated health status from a professional, and (3) consumer satisfaction. However, Andersen failed to define or elaborate on “perceived health status” (p. 8). Due to the lack of guidance by Andersen about the definition of perceived health status, this concept will not be discussed. However, the grandparent raising grandchildren and formal service literature
could benefit from understanding what factors contribute to how a grandparent identifies that their grandchild with the ACE history had a formal service need (e.g., counseling, medical care, developmental treatment) and the process by which grandparents identify and acquire services in their communities.

Andersen (1995) described evaluated health status as “maintaining and improving the health status of the population” (p. 6). For grandparents raising grandchildren with an ACE history, one way to accomplish this is through a trauma-informed lens (Sprang et al., 2015). As noted previously, the Substance Abuse and Mental Health Services Administration (2014a) defines a trauma-informed approach as one that focuses on “six principles: (a) safety; (b) trustworthiness and transparency; (c) peer support; (d) collaboration and mutuality; (e) empowerment, voice, and choice; and (f) cultural historical and gender issues” and seeks to “not re-traumatize the individual” (p. 10). First, safety is defined as providing an environment for services that reduces as many stressors as possible and communicates both felt and perceived safety. Second, trustworthiness and transparency are defined as when organizations and formal service providers are communicative with clients about service practices and changes. Third, peer support is defined as when service providers utilize both supportive family members and information the client has shared with the provider to promote recovery. Fourth, collaboration and mutuality are defined as acknowledging the power the provider has and setting it aside to instead focus on the relationship and needs of the client. Fifth, empowerment, voice, and choice are defined as highlighting the strengths that the client has, rather than the deficits, and building on those strengths. Finally, cultural, historical, and gender issues are defined as areas for the provider to be particularly sensitive to by considering how these issues may affect the client while the provider attends to the client’s needs.
A trauma-informed approach is non-pathologizing and approaches individuals with the question of “What happened to you?” instead of “What is wrong with you?” (Substance Abuse and Mental Health Services Administration, 2014b). In the medical literature, Marie-Mitchell et al. (2016) suggested that using a trauma-informed approach may help to “gain the trust of high-risk families” (p. 133). Green et al. (2015) found that using TIC in a medical setting improved doctor-patient interactions as well as patient experience. TIC appears to be a promising way to attend to grandfamily needs, particularly with ACE histories, but more research needs to be done to determine if providers are using TIC, how frequently it is used, and if it is effective for grandchildren with ACE histories. To address this gap in the literature, was to explore how grandparents seek and use formal services for their grandchildren. Another strategy to address this gap in the literature which this study examined service providers’ recommendations of best practices for working with grandparents who are raising grandchildren with ACE histories.

Lastly, Andersen (1995) defined consumer satisfaction as “convenience, availability, financing, provider characteristics, and quality” of the service (p. 6). Individuals seeking services, particularly minority populations, may experience a host of challenges just getting to the service provider. In addition to the barriers already mentioned, there is evidence in the grandfamilies literature that some formal service providers lack adequate training and working knowledge on how to help grandfamilies (Collins et al., 2011; Gibson, 2003; Kaplan & Perez-Porter, 2014; Sprang et al., 2015). Further, many grandparents raising grandchildren have experienced stigma from formal service providers. SmithBattle (2013) noted that “providing non-stigmatizing services is important for at least two reasons: stigma subverts the helping relationship and contributes to [a parent’s] stress, mistrust, and avoidance of health care” (p. 7).
To counter the possibility of stigma, service providers could use a trauma-informed approach by including grandparents in each step of treatment to communicate “transparency, collaboration, and voice” (Gladstone et al., 2009; Janicki et al., 2000; Sprang et al., 2015; Substance and Mental Health Services Administration, 2014a, p. 11). Limited information is available about whether a trauma-informed approach is considered among the best practices service providers use while treating a grandchild with an ACE-history, despite the many recommendations to use it in the larger ACE literature.

Finally, Andersen (1995) proposed that service outcomes affect population characteristics. One example of this could be the intersection between service outcomes and predisposing characteristics, such as interactions between service providers and grandparents. Interactions between formal service providers and grandparents raising grandchildren can also make an impact. Coleman and Wu (2016) reported that a professional’s engagement with clients affects client perception and engagement level in services. Similarly, in Gladstone et al.’s (2009) sample of 22 grandparents raising grandchildren, some grandparents commented on the poor interpersonal skills and behaviors of their social worker, which created strained relationships between some grandparents and their provider. As noted previously, some grandparents may feel judged, which may create a barrier for service use. Multiple researchers have suggested that education and self-awareness are powerful tools to understand personal biases about grandparents raising grandchildren (Cox; 2007; Dolbin-MacNab, 2015; Kaplan & Perez-Porter, 2014; Van Etten & Gautam, 2012). Doing so can strengthen the relationship formal service providers have with their service recipients and may continue the service longer, which will likely further aid in grandchild healing from their ACEs. Less is known, however, about how a
relationship of trust is built between grandparents raising a grandchild with an ACE history during the service seeking process, which is a gap that is filled by this study.

**Extending the Literature**

Despite many grandfamilies commonly being formed through ACEs, such as neglect or parent substance use history (Hirshon & Jan Van, 2000; Kelley et al., 2011), there is limited understanding of grandchild and grandparent ACE-related service needs as well as what the process is for grandparents seeking formal services for their grandchild with an ACE history. Given that grandparents are commonly a support person for their grandchild, understanding what formal service needs they may have, may assist in alleviating the stress grandparents may feel and thus increase a grandparents’ ability to assist in decreasing their grandchildren’s ACE-related behavior problems. Furthermore, reducing common barriers for grandparents raising a grandchild with an ACE history is also crucial so that the grandparent can obtain formal services, education, and resources for their grandchild. This study extended the literature on grandparents raising grandchildren and ACEs by exploring the service needs of grandchildren with an ACE history and the formal service needs of grandparents. This study offered practitioners new ways to understand grandfamilies—both through their respective formal service needs as well as the nuanced process of service seeking and utilization.

Andersen’s (1995) Behavioral Model of Health Service Use been used in research on grandparent raising grandchildren to describe the service needs and service options for African American (Carr et al., 2012; Montoro-Rodriguez et al., 2012), White (Montoro-Rodriguez et al., 2012) and Hawaiian grandparents raising grandchildren (Yancura, 2013); however, these studies have only focused on the “population characteristics” (Andersen, 1995, p. 8) of the Behavioral Model of Health Service Use, rather than the full model as a whole. Evidence from the larger
ACE literature suggests that ACEs can affect a child’s needs and behaviors in both the short- and in the long-term. Formal services can play a role in mitigating those effects. The Behavioral Model of Health Service Use (Andersen, 1995) offers a contextual framework for exploring the process of service seeking and utilization. This study’s research questions aligned with each factor of the Behavioral Model of Health Service Use. For example, the first research question explored what grandparents identify as their grandchildren’s formal service needs as well as their own service needs, which is aligned with the population characteristics factor of Andersen’s (1995) Behavioral Model of Health Service Use. The second research question explored the environment and health behavior factors of Andersen’s (1995) Behavioral Model of Health Service Use by exploring the process of formal service seeking grandparents go through to acquire services for their grandchild. Finally, the third research question aligned with Andersen’s (1995) outcomes factor by investigating what formal service providers considered as best practices when working with grandfamilies. This research question is also aligned with Andersen’s (1995) outcomes concept of “evaluated health status” (p. 8).

In conclusion, ACEs are a pandemic that can affect many children—physically, mentally, emotionally, and developmentally—both in the short- and long-term. Researchers are gaining additional understanding of how ACE type, frequency, and duration of ACEs contribute to these effects. Grandchildren and their grandparents can also be subject to ACEs and their effects, yet few researchers have investigated grandchild ACEs in grandfamilies. Formal services are one strategy grandparents can use to help their grandchildren and their ACE-related challenges. Yet, grandparents have sometimes had a complicated relationship with service use, with both external and internal barriers affecting whether grandparents are able to identify and use available services. It is perhaps one reason why Hayslip et al. (2017) called for better understanding of the
relationship between grandparents raising grandchildren and service providers by using both the grandparent and the provider’s perspectives of services provided. In this study, a service-focused model, Andersen’s (1995) Behavioral Model of Health Service Use was used to explore these processes and nuances related to service utilization in the context of grandchild ACEs. This study addressed three research questions:

RQ 1: How do grandparents raising grandchildren identify formal service needs for themselves and their grandchild with an ACE history?

RQ 2: How do grandparents raising grandchildren navigate the process of seeking and utilizing formal services for their grandchildren with ACE histories?

RQ3: What do formal service providers describe as best practices for working with grandparents who are raising grandchildren with ACE histories?
Chapter 3: Methods

Research Design

The aim of this study was to better understand the service needs of grandchildren with an ACE history as well as to better understand the process for grandparents who seek and use formal services for their grandchildren. To accomplish this, I identified three research questions, two of which focused on (a) grandchild and grandparent needs and (b) the process of grandparents seeking and utilizing formal services for their grandchild with an ACE history. Using constructivist grounded theory (Charmaz, 2014), I explored these research questions via semi-structured interviews with grandparents raising a grandchild with an ACE history.

To supplement this primary data collection, I also conducted two focus groups with service professionals who had experience working with grandfamilies. The purpose of these focus groups was to address the third research question regarding best practices when working with grandfamilies. Data from the focus groups were analyzed using thematic analysis (Braun & Clarke, 2006). These focus groups served as a form of data triangulation with the interview data, which added to the trustworthiness of both analyses (Lincoln & Guba, 1985).

Semi-Structured Interviews with Grandparents

Sample

The sample for this study consisted of 10 grandparents raising a grandchild with an ACE history living in Central, North Central, and South Central regions of Appalachia (Appalachian Regional Commission, 2021). Charmaz (2014) indicated that smaller sample sizes can occur in grounded theory research. Inclusion criteria for participation in the study were grandparents who: (a) were able to speak and understand English; (b) live in Central Appalachia (comprising Central or Eastern Kentucky, Western North Carolina, Southeast or Southwest Ohio, Central or
Eastern Tennessee, Southwest or Western Virginia, or West Virginia (except for Marshall, Ohio, Brooke, and Hancock counties); (c) were currently raising (e.g., providing basic needs, parenting, full-time care) to at least one grandchild under the age of 18; (d) lived in a home with neither of the grandchild’s parents, (e) were currently raising a grandchild with at least one ACE, as defined by the Centers for Disease Control (2019) measures; and (f) were raising a grandchild who has received or is currently receiving professional services. Demographic information about the sample can be found in Chapter 4.

Grandparents were recruited through convenience sampling (Patton, 2002) and snowball/word of mouth sampling (Patton, 2002). As part of my recruitment, I visited and received verbal permission from grocery stores, gas stations, pharmacies, and library managers to post recruitment flyers in the Southwest Virginia cities of Abingdon, Blacksburg, Big Stone Gap, Coeburn, Pearisburg, and Pulaski. I shared the research study flyer with nearly every church in Southwest Virginia. Additionally, I emailed and sometimes called organizations such as Big Brothers Big Sisters, Head Start, and county DSS offices. I also shared information about the research study and study flyer with county DSS offices in North Carolina, Ohio, Virginia, and West Virginia; and every Extension Office and Area on Aging in Central Appalachia.

In addition to these strategies, I used social media as part of my recruitment strategy. Initially, I reached out to several Facebook groups related to grandparents raising grandchildren (e.g., Grandparents Raising Grandkids support space, Grandparents Raising Grandchildren Virginia FB Group, GrandsPlace – Grandparents Raising Grandchildren, Grandparents raising Grandchildren, and Grandparents Raising Grandchildren GRAND CONNECTIONS). Later in the study, I acquired IRB approval (Appendix A) to create a research study Facebook page for grandparent recruitment. I then asked formal service professionals who were in contact with
grandparents raising grandchildren to like and share the Facebook page with their networks. I continued recruitment efforts by making IRB-approved Facebook posts (Appendix C), as well as contacting administrators of grandparent raising grandchildren related Facebook groups (e.g., GRANDPARENTS MATTER; Helping Grandparents; Attachment Parenting for Littles; Parents of children with O.D.D./ADHD/ADD/Anxiety/OCD) and requesting to post study information on their group pages, or to have them post on my behalf. I eventually reached out to nearly 50 Facebook groups related to grandparents raising grandchildren.

Recruitment efforts via the online Facebook snowball sampling approach were largely successful in spreading information about the study when administrators reposted the research study Facebook page on their group page. These included the West Virginia Family-to-Family Health Information Center, Behavioral Health at Rainelle Medical Center, Legal Aid of West Virginia, Greenbrier County WVU Extension, Preston County Starting Points Family Resource Center, United Way of Cherokee and Clay Counties, NC, and Wood County Family Resource Network. A total of 29 individuals or groups shared information about the study on their personal or group feeds, and this information reached over 35,200 people on Facebook (Appendix E).

Across the 10 grandparents who participated in the study, three came from Facebook recruitment efforts, two came from church contacts, one came from a word-of-mouth referral, one came from a professional referral, one came from either a word of mouth or professional referral, and two grandparents did not report on their referral source.

I continued recruitment and data collection until reaching data saturation (Saunders et al., 2017). I concluded that data saturation was reached when I was not hearing any new ideas emerging from the participant interviews. Data saturation reinforces trustworthiness of qualitative research by supporting its confirmability, where study findings could be similarly
found by other researchers who replicate the study (Lincoln & Guba, 1985). Data saturation also supports credibility, due to research findings reflecting information that comes from participant interviews (Lincoln & Guba, 1985).

**Data Collection Procedures**

Virginia Tech IRB approval (IRB #20-444) was initially granted in August 2020. Interested grandparents raising a grandchild with an ACE history contacted the researcher by phone or email, received information about the study and its purpose, and had any questions answered. If the grandparent was interested in participating, I acquired the grandparent’s email address and explained that I would first send the consent form for the grandparent to review, and then 24 hours later, the grandparent would receive (via email) a link to the Virginia Tech REDCap online eligibility screening form as well as a research identification number. Grandparents were informed that they would answer a series of eligibility questions via REDCap, and if they qualified for the study, they would see the consent form. Grandparents who met the study’s inclusion criteria and consented to participate in the study then entered their research identification number. Following this step, grandparents then completed an online demographic questionnaire (Appendix F) through RedCAP about themselves and their grandchild. As part of this questionnaire, grandparents selected a grandchild with an ACE history (Target GC) that had previously or was currently receiving professional services. While some grandparents reported raising multiple grandchildren, the information presented here reflects only the Target GC. If the grandparent was raising multiple grandchildren who had histories of ACE and service utilization, I invited the grandparent to select the grandchild with the next upcoming birthday and to think of that grandchild throughout the demographic questionnaire. After completing the online demographic questionnaire, I contacted grandparents via phone call
or email to schedule the interview and sent a text or email, depending on grandparent’s preferences, reminder 24-hours before the interview, if requested.

Prior to beginning the interview, I read an introduction statement about the study and its purpose, as well as a statement about mandatory reporting of suspected or stated current child or elder abuse or neglect. Next, I answered any additional questions the grandparent may have had. I then re-acquired verbal consent from the grandparent to proceed with and record the interview. Recording only began when the grandparent confirmed their permission to record the interview. Interviews were semi-structured (see Appendix G) and lasted between 43 and 93 minutes, with the average time of the interview being 84 minutes. I completed the interview over the phone in a private location. Grandparents chose their own location for the interview. To prevent potential data loss, interviews were recorded using two portable digital recording devices. At the conclusion of the interview, grandparents were thanked for their time and asked if they had any remaining questions. A $20 Amazon gift card was provided as compensation to nine of the ten grandparents; one grandparent chose not to receive the compensation. Each grandparent who participated in the study was also provided with the opportunity to receive a summary of the study results at the end of the study, which was emailed to those grandparents who requested it following data analysis and write-up.

Measures

Grandparent & Grandchild ACEs. Grandparent and grandchild ACE history was measured using a simplified version of the Adverse Childhood Experiences-Questionnaire (ACE-Q; Zarse, Neff, Yoder, Hulvershorn, Chambers, & Chambers, 2019). The ACE-Q was developed through a partnership between the Centers for Disease Control and Kaiser Permanente (Centers for Disease Control, 2021). In the original study, over 17,000 White, middle- to older-
adults self-reported about their upbringing, lifestyle choices, and health from birth to age 18 (Centers for Disease Control, 2021). The purpose of that study was to examine how various childhood experiences may predict later life health risks (Felitti, 2002). The ACE-Q contains 10 items with 7 follow up questions that assess three types of challenging environments for children: household dysfunction (e.g., domestic violence, substance use, mental illness, parent separation or divorce, imprisonment), abuse (e.g., physical, emotional, sexual), and neglect (e.g., physical, emotional). To score the ACE-Q, each affirmative answer is indicated by a “1,” which denotes that that person has experienced that particular ACE. In comparison, questions marked with a “0” reflected no presence of an ACE. Affirmative answers are then summed to acquire the total ACE score.

For the purposes of this study, the instructions for the ACE-Q were simplified to the following statement, “The Centers for Disease Control (CDC) (2019) define adverse childhood experiences as ‘potentially traumatic events that occur in childhood (0-17 years)’ (para. 1) and includes events such as parent death, parent separation or divorce, abandonment, family member mental health condition, family member substance use, emotional abuse, physical abuse, sexual abuse, physical neglect, domestic violence, emotional abuse to another adult, or parent incarceration. Have YOU experienced one of these events?” was asked to grandparents. When asked regarding the Target GC, the phrase “Have you” was changed to “Has your grandchild.”

The original ACE-Q asks nuanced questions about an individual’s ACE history, as well as health conditions later in life, rather than only the presence/absence of an ACE history. In the interest of reducing participant burden and due to the sensitive nature of ACE histories for grandparents and grandchildren, I shortened ACE-Q questionnaire so that it only reflected the presence or absence of 13 ACEs for grandparent and grandchild. The simplified version still
covered the three ACE domains of abuse, neglect, and household dysfunction. Grandparents were provided with a checklist of 13 answer choices from the above CDC description to account for the presence or absence of multiple potential ACEs that grandparents may have experienced growing up. Grandparents marked all ACEs that applied to their life experience. Answer choices that were checked were counted as an affirmative and the grandparent’s total score was reflected by the summed value of the checked boxes. After completing the simplified ACE-Q for themselves, grandparents then completed the ACE-Q with regard to the Target GC’s ACE exposure. The ACE-Q for the grandchild was scored like the grandparent version.

The ACE-Q has strong evidence for its validity. For example, in a 20-year review of research involving the long-term effects of ACEs, Zarse et al. (2019) noted that two sets of researchers (i.e., Dube et al., 2004; Hardt et al., 2010) found evidence for predictive validity with the ACE-Q. Wingenfeld et al. (2011) has also concluded that the German version of the ACE-Q was a valid and reliable measure, despite its retrospective nature, in their sample of 99 students and 100 adults. The ACE-Q continues to be used widely by researchers across multiple disciplines (Centers for Disease Control and Prevention, 2021a).

In terms of reliability, the ACE-Q questionnaire has been found to have good internal consistency across multiple studies. For example, Murphy et al. (2014), in a sample of women, internal consistency of ACE responses was found to be 0.88. In addition, in a diverse sample of 233 American Indian/Alaskan Native older adults, aged 50 and above, Roh et al. (2015) noted that the ACE-Q had an internal consistency value of 0.78, which indicates good reliability. In a sample of almost 700 adults, Dube, Williamson, Thompson, Felitti, and Anda (2004) found that the ACE-Q also has good test-retest reliability, both for responses related to individual ACE
items as well as over ACE scores. Due to the small sample size, test-retest reliability was not calculated for this study.

**Demographic Questionnaire.** The questionnaire had demographic questions, a checklist of ACEs the grandparent and grandchild have experienced, and what formal services the family had received. The first part of the demographic questionnaire asked questions about the grandparent, and then the second part of the survey asked questions about the grandchild (see Appendix F). Grandparents were asked about their race, education, age, income, race, ethnicity. I also asked how many grandchildren the grandparent is currently raising, the number of grandchildren the grandparent has ever raised, the nature of the legal relationship to the Target GC, whether there was any involvement with the Department of Social Services, and about past and current services that the grandparent is currently receiving or has received. For past and present services, grandparents marked the services they had utilized from a list of services, and were provided with an open-ended question for “other” services that weren’t listed. The list of services included community services (e.g., food pantries, housing assistance, support groups), government programs (e.g., Medicare, Social Security, food stamps/supplemental nutrition assistance program (SNAP), Comprehensive Health Investment Program (CHIP), Temporary Assistance to Needy Families (TANF), Women, Infants, and Children (WIC), TANF child only grants, supplemental security income (SSI)), medical services (e.g., going to the hospital, doctor visits), psychiatric (e.g., case management, counseling, psychiatric hospitalization, parent coaching, crisis management), and legal services (e.g., legal aid/assistance, going to court).

For the grandchild portion of the demographic questionnaire, I asked about the target grandchild’s gender, race, ethnicity, and the number of years the grandchild had been raised by the grandparent. I also asked about the formal services the grandchild has used and is currently
using. This list of services was formatted like the list that was provided to grandparents. The list included community services (e.g., free/reduced school breakfast/lunch, foster care, support groups), government programs (e.g., Medicaid, Headstart, Foster care, Social Security, food stamps/supplemental nutrition assistance program (SNAP), Comprehensive Health Investment Program (CHIP), Temporary Assistance to Needy Families (TANF), Women, Infants, and Children (WIC), TANF child only grants, Family Access to Medical Insurance Security (FAMIS)), medical services (e.g., going to the hospital, doctor visits), psychiatric (e.g., case management, individual and family counseling, psychiatric hospitalization, psychiatric services such as medication, crisis management), services focused on grandchild development (e.g., mental health skill building, mentoring, development clinic, physical therapist, occupational therapist, speech therapist), and court services (e.g., probation officer).

**Interview Protocol.** The semi-structured interview, with relevant follow-up probes, was divided into four major sections: context, seeking services, grandparent experience, and receiving services. The complete interview protocol is available in Appendix G.

In the context section, grandparents were asked about how their grandchild came to live with them, as well as the relationship between the grandchild’s ACE history and their behaviors. Examples of interview questions include “Do you think there is a connection between what happened to your grandchild prior to living with you (e.g., ACEs) and how your grandchild is doing now? (e.g., behaviors, sleeping patterns, attention) Why or why not?” Additional interview questions in this section focused on the grandparent’s perspective of what could be done about the grandchild’s ACE history. For example, “How much do you think you can help your grandchild with their ACE history?” Examples of follow-up questions included “Do you think
the ACE history is just something that is part of their life that they just have to deal with?” and “Can you do something about your grandchild’s ACE history affecting your grandchild?”

The second major topic in the interview was seeking services. In this section, I asked grandparents about their experiences identifying their grandchild’s needs and challenges, as well as how they came to their decision to seek help. Examples of interview questions in this section include: “Tell me of a time when you realized your grandchild needed additional help from a professional” and “Would you share a time when you decided to get help for your grandchild with the ACE history?”

The third major section of the interview inquired about what grandparent identify as their needs and challenges as well as what grandparents use to obtain support for these needs. Examples of questions in this section include, “Would you please share with me some of the needs and challenges you have experienced as you have raised your grandchild?” and “Is there anything in your history that impacts how you manage your grandchild’s needs? (If yes, will you tell me more about that? If no, what makes you think so?).”

The final major section of the interview was about the formal services the grandchild has received or is currently receiving and the processes by which grandparents navigated those formal services for their grandchildren. I asked grandparents questions such as, “When you think about the services your grandchild has received, what would you say has been helpful for your grandchild?”; “Would you share a time when there was a conflict between you or your grandchild and the provider while your grandchild received formal services?”; and “How would you describe the level of involvement you had in your grandchild’s formal service?”
**Data Analysis**

**Constructivist Grounded Theory.** To analyze the interview data, I used Charmaz’s (2014) constructivist grounded theory (CGT). CGT highlights the narratives and patterns research participants share, aligning with the nature of qualitative methods (Charmaz, 2014). CGT is an effective tool for understanding the nuances of service utilization among grandparents raising grandchildren with an ACE history, particularly in terms of examining how grandparents navigate the process of identifying, seeking, and utilizing services. As illustrated in Chapter 2, individuals who have an ACE history may have unique experiences with services, as a result of how the ACE affects the grandparent and the grandchild. CGT can assist in furthering the understanding of this substantive need in the literature and provide guidance to the practice of providing services to these families.

In CGT, data analysis occurs concurrently with data collection (Charmaz, 2014). As such, I continued to collect interview data while I also analyzed the data I had already gathered. Charmaz (2014) outlined three stages of data analysis once interviews are transcribed: a) initial coding; b) focused coding; and c) axial coding. In the following sections, I outline the details of my analysis for each of these stages.

**Data Preparation.** After the interviews were conducted, the audio recordings were uploaded to a secure Google Drive and, after testing to ensure full audio transmission, the recordings were deleted off the recorder. I transcribed the first two interviews within the Google Drive. After transcription, I listened to the audio file while reviewing the transcript to ensure accuracy. I then used the transcription service, TranscribeMe! to transcribe the remaining interviews. When I received a completed transcript from TranscribeMe!, I again listened to the
audio file and reviewed the transcript to ensure accuracy and to correct any errors before beginning to code.

**Initial Coding.** Initial coding is the act of considering what directions, perspectives, and actions arise from the data (Charmaz, 2014). Prior to beginning initial coding, I read through each interview transcript twice to familiarize myself with the data. Then, I engaged in line-by-line coding using paper transcripts, which involved choosing code names that reflected what the data said, which allowed me to follow Charmaz’s guidance that initial coding should be “grounded in the data” (p. 117). Since CGT primarily focuses on actions, I reflected this focus by using gerunds in my coding. Examples of some of my initial codes are, “not knowing all programs;” “applying online for services;” and “receiving information from DSS.” I also paid particular attention to using in vivo codes, or codes that captured the grandparent’s story by using the grandparents’ own words. For example, one grandparent described “feeling almost ashamed” when she needed financial assistance from her local DSS.

While I initially coded my data, I kept my research questions visible and used three different colored pens to capture data that appeared to align with each research question. Data that aligned with my first research question of grandparent and grandchild needs were marked in red and black ink, respectively. Data related to my second research question was marked in blue ink. This marking system helped me to organize my codes during later stages of the analysis, though I stayed open to the possibility that some codes might align with more than one research question. After coding each interview, I wrote a memo outlining my impressions and an overview of the interview (Charmaz, 2014).

When I completed the initial coding stage with the first two paper transcripts of my interviews, I transferred the interview codes to an Excel document. In this document, I created
five columns: interview number, page the code was on, the line number of the code, the initial code, and what research question the code most aligned with. I then typed each code into the Excel document and organized them accordingly. Once the codes were entered, I then reviewed the codes and looked for redundancies. When I found redundancies, I looked at the context of the codes and, after determining that a redundancy did exist, combined the codes together. This step assisted me in reducing the number of codes and further clarifying key ideas emerging from the analysis.

After reviewing the codes from the first two interviews, I purchased the student version of the NVivo software program (released in March 2020). When I switched to NVivo, I uploaded all my interviews and then recoded my first two interviews into NVivo, using the newly combined initial codes, as well as the remaining unmerged initial codes from the Excel document. I continued to code interviews in NVivo as I interviewed new participants. I also completed memos after initially coding each interview. After I had some definitive directions emerging from the data, I shifted my analysis to focused coding (Charmaz, 2014).

**Focused Coding.** Focused coding is described as “using codes to sift, sort, synthesize, and analyze large amounts of data…highlight[ing] what you find to be important in your emerging analysis” (Charmaz, 2014, p. 138). I conducted my focused coding within NVivo. Due to the large number of initial codes, I found that exporting the codes initial codes from NVivo into a Word document was helpful for me to visually see all my initial codes. Then, as I began to review the initial codes and group them together into focused codes, I found that using an Excel document was more time efficient than continuing to use the exported Word document, as I could more easily create and maneuver lists of codes in Excel, compared to Word. Ultimately, my work in the Excel spreadsheet streamlined my ability to create focused codes as well as look
at emerging trends in the data (Charmaz, 2014). After the focused codes were organized in the Excel document, the codes were then created and arranged within the NVivo platform. During this stage of coding, I was combining codes that shared similar meanings and reducing the redundancy of my initial codes.

As I created focused codes within NVivo, I documented these changes separately in a Microsoft Word document. In this document, I noted the date of the change, the rationale for the focused coding decision, and the new name of the code. For example, on October 20, 2021, I wrote, “Created focused code ‘timing of behavior.’ Combined [initial] codes ‘having delayed issues and Behaviors starting early’ to just be ‘behaviors starting early’ code.” Another example from October 25, 2021, read, “Created focused code ‘Seeing change in GC.’ Includes codes: 1) creating a routine at home; 2) discussing changes; 3) experiencing change; 4) improve behavior generally – GC; 5) informal services as helpful; 6) knowing things to help GC; 7) linking structure with reduced behaviors. These codes were chosen because they are linked to how the GC changes or describing the GC’s change.” This focused coding document also served as an audit trail during focused coding.

**Axial Coding.** The final stage in my analysis was axial coding. This type of coding is where the conceptual model is developed, and relationships are created among the themes of the model. In accordance with Charmaz’s (2014) approach, I created themes from my focused codes and then looked at relationships among my themes to create my conceptual model. Charmaz (2014) stated that axial coding makes analysis more “systematic” (p. 147). During axial coding, I continued to use the Excel document that listed all my focused and initial codes. I began my axial coding by focusing on the research questions I wanted to answer and began to create sub-themes and themes to answer those questions. For instance, my first research question focused on
the service needs for a grandparent raising a grandchild with an ACE history, as well as the grandparent. For an example for the grandchild portion of the research question, I looked at the different focused codes available to me and observed that focused codes such as “Having emotional needs; developmental delays; having physical needs, grandchild anger and aggression, and having other needs,” were all related, and I created the sub-theme titled “Grandchild needs – developmental, Emotional, physical” to reflect those relationships. I then looked at how this sub-theme may connect to other sub-themes in my data. I subsequently identified the sub-theme “grandparent has experience or professional training; grandparent or service provider observing grandchild behavior; grandchild history as a catalyst” and combined those sub-themes to create the theme, “Identifying GC Needs.”

To answer the grandparent part of the question, I considered Strauss and Corbin’s (1988) questions of “when, where, why, who, how, and with what consequences” (p. 125) as I looked for answers of grandparent formal service needs. I identified that focused codes such as “grandparent feelings” and “mental health challenges” fit the sub-theme of “Impact on GP Raising GC,” a sub-theme that was one part of the larger theme of “Managing GC ACEs, Needs, & Behavior.” Other themes that were developed that aligned with my second research question included, “Ending the service” which was created due to the common thread between the focused codes of “grandparent decision” and “service provider decision.” Alternatively, the theme, “Building a relationship of trust with service provider” was created because it was the common thread between the focused codes of “service provider removing barriers; service provider involving grandparents in services; and service provider being attentive to grandfamily needs.”
After I identified the themes and sub-themes from the data, I started to develop my conceptual model by writing out the themes and considering how they created a process for grandparents seeking and using formal services for their grandchild with an ACE history. For example, I initially had barriers to service use at different points in my horizontal conceptual model. After considering Andersen’s (1995) model as well as the looking at the complexity of the model, I opted to simplify my model by putting the barriers on the outside of my model to represent how these barriers affect the entire service seeking process. My conceptual model was informed by Andersen (1995)’s Behavioral Model of Health Service Use. As I was doing the axial coding, I reviewed how my themes and emerging conceptual model compared to Andersen’s (1995) model. Andersen’s (1995) model assisted in providing a loose organization of my themes as well as suggesting linear pathways among the themes. Initially, I drafted my themes and sub-themes horizontally, comparable to Andersen’s model, as I sought to clearly illustrate my data findings. However, after multiple conversations with my advisor about the processes and interactions between themes and iterations of my conceptual model, I chose to make the model vertical to highlight such themes and processes. When I did so, my conceptual model noted themes such as the impact of a grandchild’s ACE history as well as the service barriers that grandparents face when seeking services for their grandchild with an ACE history, which were two things that were not identified in Andersen’s (1995) model.

**Trustworthiness**

I used multiple strategies to establish the trustworthiness of the data analysis. These strategies included (a) peer debriefing, (b) audit trail, (c) memo writing, (d) reflexivity, (e) data triangulation, and (f) thick description (Charmaz, 2014; Lincoln & Guba, 1985; Marshall & Rossman, 2011; Patton, 2002; Shenton, 2004).
To ensure the credibility of the analysis, I used peer debriefing (Shenton, 2004). I utilized peer debriefing in two ways. First, I met with my advisor multiple times during initial, focused, and theoretical coding. Prior to data analysis, we also both coded a sample of the data individually and then met together to discuss our initial codes, which greatly overlapped. Then, in later meetings, we discussed codes and themes arising from the data (Marshall & Rossman, 2011). We also discussed how my experiences may have influenced my wording and perspective in coding, as well as the development of my conceptual model. Another outcome of these peer debriefings was developing and refining multiple iterations of my conceptual model to reflect my analysis more fully.

I used an audit trail to satisfy dependability, or the degree to which other researchers can replicate the study findings (Lincoln & Guba, 1985). I also kept an audit trail to ensure that my findings actually came from the data, which addresses confirmability (Nowell et al., 2017; Patton, 2002). The audit trail most notable in my IRB materials and each IRB amendment is an example of a record that notes changes related to the study procedures. I also kept records of what happened to each initial and focused code during the data analysis and kept a rationale for why any codes were changed, combined, or added to another code. Finally, during recruitment, I kept a detailed Excel file of individuals, groups, and organizations that I contacted, with the date, email, phone number, and notes about contact. I also kept detailed records about communication with potential and actual research participants. Examples of research study recruitment and interview and focus group protocol materials (e.g., emails to potential recruitment sources (Appendix D & Appendix H for grandparent and formal service provider, respectively); research study flyer (Appendix B & Appendix I for grandparent and formal service provider, respectively)), and study data collection materials (e.g., interview (Appendix G) and focus group
protocol (Appendix L)) can be found in the appendices, while data analysis materials such as theme development and definitions from the coding process can be found in the results section. I used memo writing to support the confirmability of the analysis (Marshall & Rossman, 2011; Patton, 2002). I wrote memos at the end of each interview transcription as well as in the margins of Excel documents when coding and reflecting on developing themes throughout the coding process (Richards & Morse, 2012). Memos supported the rigor of my study by creating a space for regular analytical thought and interaction with the data (Charmaz, 2014). In my memos, I gave a synopsis of the interview, beneficial and unhelpful grandparent formal service experiences, as well as my key points from the interview that resonated with me. For example, one grandparent made the connection that their grandchild’s behavior and ACEs and trauma was linked; however, she did not mention ACEs or trauma anywhere else during the interview. This memo assisted me in my analysis by considering how grandparents may lack the understanding of how ACEs can affect a child, and instead focus on a grandchild’s behaviors, as compared to the grandchild’s underlying needs. In another memo I wrote, I commented in my observations section of how the grandchild has had therapy for five years. I also commented that the grandparent had to bring in a lawyer to a school meeting for her grandchild’s needs to be taken seriously. This comment emphasizes how grandparents may encounter barriers to additional services even while receiving services. This example helped me in my analysis of the data by examining the nuances of service barriers that grandparents raising a grandchild with an ACE history face.

I engaged in reflexivity, which added to the confirmability of the study, by developing greater self-awareness (e.g., exploring my assumptions, beliefs, and biases) and examining how my perspective affected my analytic lens (Patton, 2002). I used peer debriefing in tandem with
reflexivity to explore the intersection of my biases and assumptions that arose with while I coded the data. In my reflexivity statement, I commented on how my experiences both as a parent and a clinical professional intersected with the data analysis. For example, I tended to code grandparent experiences with more compassion and empathy or to link the context of what was happening from the grandparent’s description to the grandchild’s ACE history, per the multiple professional trauma trainings that I have attended.

To add to credibility of the study, I utilized data triangulation (Lincoln & Guba, 1985). This data triangulation was accomplished by using two different methods to “make the data believable” (Lincoln & Guba, 1985, p. 306), which in this study looked like service providers and grandparents commenting on similar findings, but from separate sources. For instance, both formal service providers and grandparents shared information related to intergenerational ACEs in this study. Although the service providers who participated in the focus groups were not linked to the grandparents in the interviews, data from the focus groups largely confirmed the data obtained from the grandparents.

Finally, to address transferability, or the ability of readers to apply the findings to populations they interact with, I used thick description when presenting the findings (Lincoln & Guba, 1985). To accomplish this, in Chapter 4, I included a table of grandparent age, grandparent ACE type, the number of grandchildren the grandparent is raising, grandchild age, the number of years the grandparent has been raising the grandchild, reason for caring for grandchild, grandchild ACEs, and grandparent ACEs so that readers will be aware of the context of findings, should they wish to transfer it (Shenton, 2004).

**Reflexivity.** As I consider my experiences that have influenced the coding process, I am at a unique crossroads. My personal and professional experiences have closely paralleled with
my research experience. On a personal level, I’ve experienced what can occur when an adopted child enters a home. In comparison, as a professional, I see the impact of a child’s trauma and the difficulties grandparents and guardians have in both, identifying the trauma and knowing how to remediate that trauma.

First is my personal experience with raising adopted children. As I have lived some of the things that grandparents have shared in my research, I found myself being more empathic to grandparents in their dual relationships with the birth parents. I also experienced empathy for grandparents raising grandchildren with an ACE history as I coded the sections on mental and physical health challenges that grandparents often experience with their grandchildren, as well as the challenges they experience themselves. In addition, I could empathize with the participants’ experience of role shifts as they began raising children. My personal experience has also paralleled some of the grandparents’ experiences seeking services for their grandchildren. Ultimately, these personal experiences permitted me to understand and empathize with grandparents and capture their experiences with more neutral or positive initial codes. I think these somewhat comparable personal experiences also influenced me by helping me pay attention to the things the grandparents were doing to help the grandchild—gathering information, seeking out resources, advocating for mental well-being, etc.—as well as working with providers. Because of this, I believe that I had a more favorable view of grandparents and their efforts to help their grandchild, which likely influenced my coding.

Second, is my professional or clinical experience. As a mental health clinician, I have worked as a provider to grandfamilies, as I have provided mental health services within the local community. These experiences have given me a more nuanced perspective of how each grandfamily is unique, with their own ACE history and family background. My clinical and
professional training have also taught me about using a trauma-informed lens and seeing behavior as an outward symptom of an inner difficulty, or in the cases of grandfamilies—of trauma. As a result, I tended to conceptualize the behaviors being shared by the grandparent as being linked to the grandchild’s ACE history and environment, which was regularly confirmed in the data by grandparents and their descriptions of the situation. During the coding process, I further had to put aside my “clinical hat,” to instead focus on my research questions, rather than my clinical curiosities about the interactions between grandparent and grandchild or how the grandchild’s diagnosis affected the grandparent’s perception about the grandchild’s behaviors. I also paid attention to timing when I coded my research data. During the coding process, I was mindful of doing data analysis on days where I was not seeing grandfamilies to avoid countertransference from my clinical work into my analysis.
Formal Service Provider Focus Groups

To address my third and final research question, I conducted two focus groups with formal service providers. These focus groups supplemented the grandparent interview data and were used as a form of data triangulation. In addition to the focus group questions, demographic questions were also asked formal service providers. Focus group data was analyzed through thematic analysis (Braun & Clarke, 2006).

Sample

The focus groups included 10 formal service providers (i.e., three in the first group and seven in the second group), which is the recommended sample size for focus groups (Krueger, 1994). Formal service providers were recruited from North Central, Central, and South Central Appalachia regions and had regularly worked with grandfamilies. Professionals were intentionally recruited to create a diverse sample and to get a variety of professional perspectives during the focus group. Professionals were also chosen because they represented institutions or services that often interact with grandfamilies (Gibson, 2003; Gladstone et al., 2009). Convenience sampling was used, followed by snowball/word of mouth sampling (Patton, 2002). Inclusion criteria for the focus group included (a) having worked with grandchildren with ACE histories for at least a year and (b) an ability to speak and understand English. Focus group participant demographics will be discussed in Chapter 4.

Formal service providers in were recruited through three methods. The first recruitment strategy involved emailing formal service provider organizations and asking if they would distribute the study flyer (see Appendix I). Organizations that were contacted include community mental health organizations, Departments of Social Services, Areas on Aging, State Extension Services, as well as individual formal service providers. The second recruitment strategy was
through creating a Facebook page and including information about the study and its focus on the page (Appendix J), as well as through contacting administrators of Facebook groups related to formal service providers and requesting that the administrator to post a study flyer on the Facebook webpage. Examples of Facebook groups contacted include “Professional Counseling Connections”; ‘School Counselors Connect”; “West Virginia Counseling Association”; and “Southern Highlands Community Mental Health Center.” The third recruitment strategy was through personal connections and word of mouth. I reached out to formal service providers whom I have a working relationship and with their permission, introduced the study and asked whether they were interested in learning more. If they indicated affirmatively, I acquired their email address and sent additional information and the research flyer to them about the study. Formal service provider recruitment strategies for the actual participants were not collected for this study.

*Data Collection Procedures*

Interested professionals contacted me by email or phone and indicated their interest in participating in a focus group. Potential participants were contacted by phone, and any questions were answered. Participants who indicated an interest in participating were then sent a copy of the informed consent form and, then 24 hours later, were sent an email with their research identification number as well as the link to complete an online screening form through Virginia Tech’s REDCap survey platform. Potential participants completed the screening form about the eligibility criteria for the study through the REDCap platform. Eligible participants then gave their consent to participate in the study, indicated their availability for focus group days and times, as well as preferences for 2- and/or 1-week reminders (Krueger, 1994). After this information was shared, participants then completed an online demographic questionnaire.
Following the completion of the survey, professionals received an email with the time and date with a link to a Zoom meeting prior to the scheduled focus group. The focus groups lasted approximately 60 minutes and were recorded using two handheld audio recorders, after acquiring permission to record from all focus group participants. (Eliot & Associates, 2005). Participants were thanked for their time and compensated with a copy of state, national, and online resources for grandfamilies.

**Measures**

**Demographic Questionnaire.** The demographic questionnaire began with questions related to age, gender, race, ethnicity, and education level. Additional questions focused on the types of services provided to grandchildren with an ACE history, and the amount of experience an individual had providing services to grandchildren with ACEs, both currently and historically. Finally, formal service providers were asked to subjectively rate their frequency of working with grandchild ACEs on a five-point scale (e.g., never-rarely-sometimes-often-very often), as well as their knowledge of ACEs (e.g., very poor-below average-average-above average-excellent). They also rated their comfort level (not comfortable-somewhat comfortable-moderately comfortable-very comfortable), skill (no skill-some skill-moderate level of skill-very skilled), and level of familiarity with TIC (not at all-not very-somewhat-very-extremely familiar) on a four-point scale. See Appendix K for the demographic questionnaire.

**Focus Group Protocol**

The focus groups were a semi-structured group discussion that covered three major topics: grandparents and grandchild ACE histories, the grandparent role in a grandchild’s service utilization, and intervention strategies. Questions asked during the focus groups came from topics that were derived from gaps in the grandparent raising grandchildren and ACE literatures.
For the first topic area, focus group participants were asked, “Do you assess or find out about the grandparent or grandchild ACE history? With follow questions such as “What do you ask about?” and “When you find out about a grandparent or grandchild’s ACE history, how does this information influence your approach to service provision?”

Next, the focus group discussion focused on the grandparent’s role in a grandchild’s service utilization. The main question for this topic area was, “What do you think grandparents could do to better engage or get more out of your services?” The inclusion of topic of discussion was informed by interview data regarding variations in grandparent involvement or lack of involvement in services.

Finally, the last major area of the focus group discussion was intervention strategies. An example of a question in this area was, “What do you consider as best practices or effective strategies for working with grandfamilies? (e.g., theoretical lens, strategies for communicating, interventions)” Follow-up questions included, “If you have heard of trauma-informed care, how might this approach help grandfamilies you work with?” and “In your experience, have you noticed that these families tend to have intergenerational trauma (grandparents have trauma, grandchildren and parents have trauma)?” For more information about the focus group protocol, please see Appendix L.

**Data Analysis**

Focus groups were analyzed through Braun and Clarke’s (2006) guidelines for thematic analysis. Following the completion of the focus groups, the audio recordings were transcribed through the transcription service, TranscribeMe! After transcription was complete, I conjointly listened to the audio files and read through each focus group transcript to ensure accuracy of the transcription. Any errors were corrected. De-identified transcripts were then uploaded into
Virginia Tech’s secure Google Drive program as well as the qualitative software program, NVivo, for analysis.

**Initial Coding.** Prior to beginning initial coding, I familiarized myself with the focus group data by reading through the transcript twice, as informed by Braun and Clarke’s (2006) guidelines for thematic analysis. I initially coded the focus group data in NVIVO by staying close to maintain as much context as possible (Braun & Clarke, 2006). I coded short phrases such as “education as prevention” or education about GC’s [grandchild’s] trauma” as well as quotes that illustrated what the focus group was discussing like “GP [grandparent] not seeing ACEs as ACES – “It’s just Tuesday.” I coded both focus group transcripts prior to moving on to theme development.

**Thematic Coding.** During Braun and Clarke’s (2006) searching for themes stage, I looked for emerging patterns or themes that were arising from the data (Braun & Clarke, 2006). I also considered which initial codes could be collapsed together into themes, due to a shared context or meaning, as informed by Braun and Clarke’s (2006) suggestions. For example, I identified that initial codes, “expecting grandparent or grandchild to have ACEs; intergenerational transmission of ACEs; and living in poverty” for the theme, “Intergenerational Cycles.” Both “providing information to grandparent on about their grandchild” and “acknowledging ACEs” sub-themes made up the theme, “ACES education.” Codes that did not fit into a specific theme were placed under an “uncategorized” code in the NVivo program (Braun & Clarke, 2006).

In the reviewing themes stage, I displayed my codes visually within NVivo and reviewed where codes connected and might form themes, as informed by Braun & Clarke’s (2006) guidelines. Braun and Clarke (2006) recommended that, during this stage, I review whether my
themes fit an overall pattern. After I had identified my themes as building a relationship of trust, COVID impact on service providers, ACEs education, intergenerational cycles, and trauma-informed assessment and intervention from my focus group data, I met with my advisor to discuss focus group findings. As a result of this discussion, I chose to focus on only the novel themes related to my research question, “What do formal service providers describe as best practices for working with grandparents who are raising grandchildren with ACE histories?” In Braun and Clarke’s final thematic analysis stage, they recommended providing definitions and names for themes, and then presenting those themes in the final report. For definitions, names, and a summary of the themes developed, please refer to the focus group results section in Chapter 4.

**Trustworthiness.** I employed a few strategies to maintain the trustworthiness of my focus group thematic analysis. These strategies include (a) peer debriefing, (b) memo writing, and (c) audit trail.

During my analysis, I used peer debriefing with my advisor to discuss the development of themes from the focus group data codes (Marshall & Rossman, 2011). As a result of these conversations, I refined my focus group codes and thematic development to highlight themes that reflected an overall pattern of answering my third research question of “What do formal service providers describe as best practices for working with grandparents who are raising grandchildren with ACE histories?” I also occasionally discussed my different roles and perspectives with my advisor to reflect on my perspectives that I was bringing into the analysis. These conversations assisted me to ensure my interpretations of the data as they come from the data, rather than coming from my personal experience.
I wrote a memo after the initially coding the first focus group, where I provided a summary of the content of the discussion as well as my emerging observations. Unfortunately, no memo was written for the second focus group during the focus group process; however, I referenced notes that I created during focused coding thematic analysis to track my theme construction.

Finally, like the grandparent component of the study, I used an audit trail for my formal service provider recruitment efforts (Patton, 2002). I followed my IRB procedures outlined for recruitment and I kept a detailed Excel file of individuals, groups, and organizations that I contacted, with the date of contact, email, phone number (if applicable), and notes about the contact. I also kept detailed records about communication with potential and actual research participants. Furthermore, during the analysis, I keep notes from meetings with my advisor about focus group data, notes about the process of how initial codes became focused codes as well as notes about focus codes becoming themes.
Chapter 4: Results

The purpose of this research study was to examine how grandparents raising grandchildren with an ACE history identified service needs for their grandchildren and the process grandparents have went through when they have sought and used professional services for their grandchildren. To achieve this goal, I interviewed ten grandparents raising a grandchild with an ACE history and utilized constructivist grounded theory (Charmaz, 2014) to develop a conceptual model to explain the grandparents’ process of identifying their grandchild’s needs, seeking, and receiving professional services for their grandchild. As a means of data triangulation (Marshall & Rossman, 2011; Patton, 2002), I also conducted two focus groups with formal service professionals who provide services to grandparents raising grandchildren with an ACE history. The purpose of the focus groups was to explore what these professionals considered as best practices when working with this type of grandfamily.

Interview Results

Interview Sample Demographics

Ten grandparents raising a grandchild with an ACE history participated in this study. Grandparents were, on average, 57 years old (SD = 8.55; Range 42-71) and ranged in age from 42 to 71 years old. Eighty percent (n = 8) of the grandparents were female, while 20% (n = 2) identified as male. In terms of race, 80% (n = 8) of the grandparents identified as White, while 20% (n = 2) identified as Black or African American and self-identified as Black White Mixed, respectively. In the demographic survey, half of the grandparents reported being single, while the other half indicated that they were married. Twenty percent of the grandparents had a high school education or less, while 40% reported having an associate degree. The remaining 40% of the grandparents had either a college or graduate degree. Regarding annual household income,
40% of the grandparents made $40,000 or less, while 50% made $40,0001 or above. One
grandparent did not respond to this question.

Most grandparents were raising more than one grandchild (60%; n = 6). Of this number,
three were raising two grandchildren, two were raising three grandchildren, and one grandparent
was raising five grandchildren. Grandparents had been caring for their target grandchild for an
average of 6 years (SD = 4.13; Range 1-12.67). Ninety percent (n = 9) of the grandparents in
this sample had a legal relationship to their grandchild; however, the type of legal relationship
(e.g., custody vs. guardianship vs. adoption) is not known due to the nuances not being asked
about or shared. In addition, a majority of grandparents (70%; n = 7) reported having DSS
involvement at some point while raising the target grandchild. For more information about the
demographic characteristics of the grandparent interview participants, refer to Tables 1 and 2
below.
Table 1

*Grandparent and Target Grandchild Demographics (N = 10)*

<table>
<thead>
<tr>
<th>Variable</th>
<th>Target Grandchild</th>
<th>Grandparent</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M (SD</td>
<td>range)</td>
</tr>
<tr>
<td>Age</td>
<td>9.82 (4.80</td>
<td>3-17)</td>
</tr>
<tr>
<td>Gender (%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>5 (50)</td>
<td>2 (20)</td>
</tr>
<tr>
<td>Female</td>
<td>5 (50)</td>
<td>8 (80)</td>
</tr>
<tr>
<td>Race</td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>8 (80)</td>
<td>8 (80)</td>
</tr>
<tr>
<td>Non-White</td>
<td>2 (20)</td>
<td>2 (20)</td>
</tr>
<tr>
<td>Marital Status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>5 (50)</td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>5 (50)</td>
<td></td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High school or Less</td>
<td>2 (20)</td>
<td></td>
</tr>
<tr>
<td>Associate degree</td>
<td>4 (40)</td>
<td></td>
</tr>
<tr>
<td>College/Graduate degree</td>
<td>4 (40)</td>
<td></td>
</tr>
<tr>
<td>Number of custodial GC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>One</td>
<td>4 (40)</td>
<td></td>
</tr>
<tr>
<td>Two</td>
<td>2 (20)</td>
<td></td>
</tr>
<tr>
<td>Three or more</td>
<td>4 (40)</td>
<td></td>
</tr>
<tr>
<td>Legal responsibility</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>9 (90)</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>1 (10)</td>
<td></td>
</tr>
<tr>
<td>DSS involvement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>7 (70)</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>3 (30)</td>
<td></td>
</tr>
<tr>
<td>Time caring for target GC (years, M (SD</td>
<td>range)</td>
<td>6.40 (4.13</td>
</tr>
</tbody>
</table>
Table 2

Description of Grandparent Sample \((N = 10)\)

<table>
<thead>
<tr>
<th>Name</th>
<th>GP age, sex</th>
<th>GP ACEs</th>
<th>Number of GC raising</th>
<th>Target GC age</th>
<th>Years raising target GC</th>
<th>GC ACEs</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP1</td>
<td>42, Female</td>
<td>N/A</td>
<td>2</td>
<td>6</td>
<td>3.58</td>
<td>Parent separation or divorce, Family member with mental health condition, Family member substance use, Physical neglect, Emotional neglect, Domestic violence, Seeing another adult be emotionally abused</td>
</tr>
<tr>
<td>GP2</td>
<td>65, Female</td>
<td>N/A</td>
<td>2</td>
<td>12.75</td>
<td>11.75</td>
<td>Family member substance use, Physical neglect, Emotional neglect</td>
</tr>
<tr>
<td>GP3</td>
<td>60, Female</td>
<td>N/A</td>
<td>1</td>
<td>12.92</td>
<td>10.50</td>
<td>Parent separation or divorce, Family member with mental health condition, Family member substance use, Emotional abuse, Physical neglect, Emotional neglect, Domestic violence, Seeing another adult be emotionally abused, Having a parent in jail or prison</td>
</tr>
<tr>
<td>GP4</td>
<td>71, Male</td>
<td>Parent separated or divorced</td>
<td>Family member with mental health condition</td>
<td>Family member substance use</td>
<td>Emotional abuse</td>
<td>Domestic violence</td>
</tr>
<tr>
<td>------</td>
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<td>--------------------------------------------</td>
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</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>2</td>
<td>15</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>GP5</td>
<td>52, Female</td>
<td>Parent separated or divorced</td>
<td>Family member with mental health condition</td>
<td>Family member substance use</td>
<td>Emotional neglect</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td>5</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>GP6</td>
<td>53, Female</td>
<td>Family member with mental health condition</td>
<td>Family member substance use</td>
<td>Emotional abuse</td>
<td>Emotional neglect</td>
<td>Physical neglect</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td>3.5</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>GP7</td>
<td>63, Female</td>
<td>Parent separated or divorced</td>
<td>Abandonment</td>
<td>Family member with mental health condition</td>
<td>Family member substance use</td>
<td>Emotional abuse</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td>13</td>
<td>12.67</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>GP8</strong></td>
<td>55, Female</td>
<td>Sexual abuse</td>
<td>3 17 5</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| **GP9** | 65, Female | Parent separated or divorced
Seeing another adult be emotionally abused
Having a parent in jail or prison | 3 7 2.50 |
| **GP10** | 52, Male | Parent separated or divorced
Family member with mental health condition | 5 6 6 |

- Emotional abuse
- Sexual abuse
- Physical neglect
- Emotional neglect
- Parent death
- Family member substance use
- Emotional neglect
- Having a parent in jail or prison
- Abandonment
- Family member substance use
- Emotional abuse
- Physical neglect
- Emotional neglect
- Having a parent in jail or prison
**Grandparent and Grandchild ACE History**

The target grandchildren had experienced an average of 5.6 ACEs ($SD = 2.17$; Range 3-9). Nine grandchildren (90%) had experienced four or more ACEs, which has been shown to be linked with higher risk of substance use, risky decision making, mental health problems, chronic health problems such as heart disease, cancer, and diabetes, as well as suicide (Hughes et al., 2017). The most common grandchild ACEs, as reported by grandparents, were emotional neglect (90%), family member with substance use (80%), physical neglect (70%), and emotional abuse (60%).

In comparison, grandparents reported an average 2.80 ACEs ($SD = 2.90$; Range 0-8). Four (40%) grandparents experienced four or more ACEs. The most common ACEs for grandparents were parent separation (50%), family member with a mental health condition (50%), and family member substance use (40%). See Table 3 for more information about grandparent and grandchild ACE exposure.

**Table 3**

*Types and Frequency of ACEs – GC & GP (N = 10)*

<table>
<thead>
<tr>
<th>ACE Type &amp; Number</th>
<th>Grandchildrena</th>
<th>Grandparent</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$n$ (%)</td>
<td>$n$ (%)</td>
</tr>
<tr>
<td>4 or more ACEs</td>
<td>9 (90)</td>
<td>4 (40)</td>
</tr>
<tr>
<td>ACEs M (SD, range)</td>
<td>5.60 (2.17</td>
<td>3-9)</td>
</tr>
<tr>
<td>Emotional neglect</td>
<td>9 (90)</td>
<td>3 (30)</td>
</tr>
<tr>
<td>Family member substance use</td>
<td>8 (80)</td>
<td>4 (40)</td>
</tr>
<tr>
<td>Physical neglect</td>
<td>7 (70)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>Emotional abuse</td>
<td>6 (60)</td>
<td>3 (30)</td>
</tr>
<tr>
<td>Family member mental health condition</td>
<td>5 (50)</td>
<td>5 (50)</td>
</tr>
<tr>
<td>Parent in jail</td>
<td>5 (50)</td>
<td>2 (20)</td>
</tr>
<tr>
<td>Seeing adult be emotionally abused</td>
<td>4 (40)</td>
<td>2 (20)</td>
</tr>
<tr>
<td>Parent separation</td>
<td>3 (30)</td>
<td>5 (50)</td>
</tr>
<tr>
<td>Domestic violence</td>
<td>3 (30)</td>
<td>1 (10)</td>
</tr>
<tr>
<td>Child abandonment</td>
<td>2 (20)</td>
<td>1 (10)</td>
</tr>
</tbody>
</table>
Sexual abuse 2 (20) 2 (20)
Parent death 1 (10) 0 (0)
Physical abuse 1 (10) 2 (20)

a Grandparents reported on the type and number of ACEs their grandchild had experienced

Grandchild Mental Health Needs

Fifty percent \( (n = 5) \) of the target grandchildren had received a mental health diagnosis of Anxiety, Attention-Deficit Hyperactivity Disorder (ADHD), Autism, Depression, Intermittent Explosive Disorder, Mood Dysregulation Disorder, Oppositional Defiant Disorder (ODD), or Reactive Attachment Disorder (RAD), with 30% of the total number of target grandchildren having two or more mental health diagnoses. The most commonly reported diagnoses were attention-deficit hyperactivity disorder (ADHD) (40%) and Depression (20%). Grandparents also reported on suspected diagnoses such as RAD and Autism; however, for one reason or another, these diagnoses had not been given formally given by a professional. Had these diagnoses been given, 60% of the target grandchildren would have had at least one mental health diagnosis.

Grandchild mental health diagnoses were not explicitly asked about in the survey or interview process; however, they were often disclosed during the interview, at the grandparent’s discretion. See Table 4 for information about grandchild mental health diagnoses.

Table 4

Grandchild Mental Health Diagnoses \((N = 10)\)

<table>
<thead>
<tr>
<th>Mental Health Diagnosis Information</th>
<th>Grandparent report of GC diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnosis Provided by Grandparent(^a)(^b)</td>
<td>5 (50)</td>
</tr>
<tr>
<td>Multiple diagnoses/co-morbidity(^b)</td>
<td>3 (30)</td>
</tr>
<tr>
<td>Attention-deficit hyperactivity disorder (ADHD)</td>
<td>4 (40)</td>
</tr>
<tr>
<td>Autism</td>
<td>1 (10)</td>
</tr>
<tr>
<td>Depression</td>
<td>2 (20)</td>
</tr>
<tr>
<td>Reactive Attachment Disorder (RAD)</td>
<td>2 (20)</td>
</tr>
<tr>
<td>Anxiety</td>
<td>1 (10)</td>
</tr>
<tr>
<td>Intermittent Explosive Disorder</td>
<td>1 (10)</td>
</tr>
</tbody>
</table>
Mood Dysregulation Disorder 1 (10)
Oppositional Defiant Disorder (ODD) 1 (10)

Six grandparents disclosed their grandchild’s diagnosis, while four did not, although not disclosing a diagnosis does not mean the grandchild did not have a diagnosis.

b Three grandparents reported that their grandchildren had multiple diagnoses.

**Grandchild Service Needs and Utilization**

Grandparents identified that their grandchildren had several service needs, which were attended to by multiple past and current services they used for their grandchildren. Grandparents identified more current services M = 6.70 (SD = 3.16; Range 1-10) being used by their grandchildren than services used in the past M = 2.40 (SD = 3.57; Range 0-11). The most common services that grandparents identified their grandchildren as *currently* using included Medicaid (90%), free/reduced school breakfast/lunch (80%), and medical services (e.g., doctor visits, visiting a health clinic; 70%). Another service area was mental health counseling; however, due to changes in the survey questions mid-way through the study, it was difficult to determine which grandchildren were currently receiving counseling versus has received counseling in the past. Yet, according to grandparents, at some point in time almost all (90%) of the target grandchildren had received counseling. When counseling was considered whether it happened in the past or the present, which is attributed to insufficient data, services as happening at all, the mean and standard deviation changed for grandchildren from M = 6.70 to M = 7.50 (SD = 3.03; Range 2-10). The most common services grandchildren received in the *past* were WIC (40%), case management (20%), medical services (20%), and free/reduced school breakfast/lunch (20%). Please refer to Table 5 below for more information about formal services that the target grandchildren had previously received or were currently receiving.
### Table 5

**Grandchild Current and Past Services Used (N = 10)**

<table>
<thead>
<tr>
<th>Services Used</th>
<th>Current</th>
<th>Past</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n (%)</td>
<td>n (%)</td>
</tr>
<tr>
<td>Total services used</td>
<td>a</td>
<td>a</td>
</tr>
<tr>
<td>Counseling</td>
<td>a</td>
<td>a</td>
</tr>
<tr>
<td>Medicaid</td>
<td>9 (90)</td>
<td>1 (10)</td>
</tr>
<tr>
<td>Free/Reduced School</td>
<td>8 (80)</td>
<td>2 (20)</td>
</tr>
<tr>
<td>Breakfast/Lunch</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Services (e.g., doctor visits, health clinic)</td>
<td>7 (70)</td>
<td>2 (20)</td>
</tr>
<tr>
<td>Individual Counseling</td>
<td>5 (50)</td>
<td>--</td>
</tr>
<tr>
<td>Case Management (e.g., social worker)</td>
<td>4 (40)</td>
<td>2 (20)</td>
</tr>
<tr>
<td>Psychiatric Services (e.g., medication, appointments)</td>
<td>4 (40)</td>
<td>--</td>
</tr>
<tr>
<td>Kinship Care</td>
<td>3 (30)</td>
<td>--</td>
</tr>
<tr>
<td>Support Group</td>
<td>3 (30)</td>
<td>--</td>
</tr>
<tr>
<td>Mental Health Skill Building</td>
<td>3 (30)</td>
<td>--</td>
</tr>
<tr>
<td>Speech Therapist</td>
<td>3 (30)</td>
<td>1 (10)</td>
</tr>
<tr>
<td>Comprehensive Health Investment Program (CHIP)</td>
<td>3 (30)</td>
<td>1 (10)</td>
</tr>
<tr>
<td>Women, Infants, and Children (WIC)</td>
<td>3 (30)</td>
<td>4 (40)</td>
</tr>
<tr>
<td>Emergency Services</td>
<td>3 (30)</td>
<td>--</td>
</tr>
<tr>
<td>Temporary Assistance to Needy Families (TANF) Child Only Grants</td>
<td>2 (20)</td>
<td>1 (10)</td>
</tr>
<tr>
<td>Court Services (e.g., probation officer)</td>
<td>2 (20)</td>
<td>--</td>
</tr>
<tr>
<td>Occupational Therapist</td>
<td>2 (20)</td>
<td>--</td>
</tr>
<tr>
<td>Service</td>
<td>Count 1</td>
<td>Count 2</td>
</tr>
<tr>
<td>---------------------------------------------</td>
<td>---------</td>
<td>---------</td>
</tr>
<tr>
<td>Crisis Management (e.g., crisis counselor)</td>
<td>2 (20)</td>
<td>1 (10)</td>
</tr>
<tr>
<td>Foster Care</td>
<td>1 (10)</td>
<td>--</td>
</tr>
<tr>
<td>Head Start</td>
<td>1 (10)</td>
<td>2 (20)</td>
</tr>
<tr>
<td>Family Counseling</td>
<td>1 (10)&lt;sup&gt;b&lt;/sup&gt;</td>
<td>--</td>
</tr>
<tr>
<td>Mentoring</td>
<td>1 (10)&lt;sup&gt;b&lt;/sup&gt;</td>
<td>--</td>
</tr>
<tr>
<td>Developmental clinic</td>
<td>1 (10)&lt;sup&gt;b&lt;/sup&gt;</td>
<td>--</td>
</tr>
<tr>
<td>Physical Therapist</td>
<td>1 (10)</td>
<td>--</td>
</tr>
<tr>
<td>Psychiatric Emergency Services</td>
<td></td>
<td>1 (10)&lt;sup&gt;b&lt;/sup&gt;</td>
</tr>
<tr>
<td>Family Access to Medical Insurance</td>
<td>1 (10)</td>
<td>1 (10)</td>
</tr>
<tr>
<td>Security (FAMIS)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>1 (10)</td>
<td></td>
</tr>
<tr>
<td>Waiver services</td>
<td>1 (10)</td>
<td></td>
</tr>
</tbody>
</table>

<sup>a</sup> 90% (n = 9) of grandchildren received counseling at some point while living with their grandparents; however, insufficient data makes it impossible to discern whether the counseling had occurred in the past or present; M = 7.50 (SD = 3.03; Range 2-10)

<sup>b</sup> Due to a change in survey questions partway through the study, four grandparent respondents did not have the opportunity to answer this question.
**Grandparent Mental Health Needs**

In comparison to grandchildren, 30% of the grandparents self-reported mental health symptoms, with 20% of the grandparents reporting co-morbid diagnoses (e.g., anxiety and depression; anxiety and panic attacks). The most common mental health symptom for grandparents was anxiety, which three grandparents disclosed having. Grandparent mental health symptoms were not explicitly asked about in the survey or interview process; however, they arose through the interview at the grandparent’s discretion. See Table 6 for more information about grandparent self-reported mental health.

**Table 6**

**Grandparent Mental Health Symptoms (N = 4)**

<table>
<thead>
<tr>
<th>Mental Health Information</th>
<th>Grandparent</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Multiple diagnoses/co-morbidity</td>
<td>2 (20)</td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td>2 (20)</td>
<td></td>
</tr>
<tr>
<td>Anxiety</td>
<td>3 (30)</td>
<td></td>
</tr>
<tr>
<td>Panic attacks</td>
<td>1 (10)</td>
<td></td>
</tr>
<tr>
<td>General emotional challenges</td>
<td>2 (20)</td>
<td></td>
</tr>
<tr>
<td>Emotional stress</td>
<td>1 (10)</td>
<td></td>
</tr>
<tr>
<td>Mental health concerns</td>
<td>2 (20)</td>
<td></td>
</tr>
<tr>
<td>Feeling stressed more easily</td>
<td>2 (20)</td>
<td></td>
</tr>
<tr>
<td>Trouble thinking about the future</td>
<td>2 (20)</td>
<td></td>
</tr>
<tr>
<td>Trouble accomplishing tasks</td>
<td>2 (20)</td>
<td></td>
</tr>
</tbody>
</table>

**Grandparent Service Needs and Utilization**

Grandparents also sought out services for themselves, both currently and in the past. Based on the total number of current service count grandparents reported using, grandparents reported a mean 5.20 (SD = 5.20; Range 0-12). The most common services that grandparents reported *currently* receiving included Social Security (60%), medical services (60%), Medicare (50%), and case management (50%). For past services used, grandparents reported a mean 3.30
The most common past services that grandparents reported receiving included counseling (50%), WIC (40%), and case management (40%). More information about grandparents’ current and past service utilization is available in Table 7.

**Table 7**

*Grandparent Current and Past Services Used (N = 10)*

<table>
<thead>
<tr>
<th>Service Used</th>
<th>Current</th>
<th>Past</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n (%)</td>
<td>n (%)</td>
</tr>
<tr>
<td>Social Security</td>
<td>6 (60)</td>
<td>1 (10)</td>
</tr>
<tr>
<td>Medical Services</td>
<td>6 (60)</td>
<td>2 (20)</td>
</tr>
<tr>
<td>Medicare</td>
<td>5 (50)</td>
<td>1 (10)</td>
</tr>
<tr>
<td>Case Management</td>
<td>5 (50)</td>
<td>4 (40)</td>
</tr>
<tr>
<td>Women, Infants, and Children (WIC)</td>
<td>4 (40)</td>
<td>4 (40)</td>
</tr>
<tr>
<td>Counseling</td>
<td>4 (40)</td>
<td>5 (50)</td>
</tr>
<tr>
<td>Psychiatric (e.g., medication, appointments)</td>
<td>3 (30)</td>
<td>1 (10)</td>
</tr>
<tr>
<td>Support Group</td>
<td>3 (30)</td>
<td>2 (20)</td>
</tr>
<tr>
<td>Emergency Services</td>
<td>2 (20)</td>
<td>--</td>
</tr>
<tr>
<td>Comprehensive Health Investment Program (CHIP)</td>
<td>2 (20)</td>
<td>--</td>
</tr>
<tr>
<td>Legal Aid/Assistance</td>
<td>2 (20)</td>
<td>2 (20)</td>
</tr>
<tr>
<td>Temporary Assistance to Needy Families (TANF)</td>
<td>2 (20)</td>
<td>2 (20)</td>
</tr>
<tr>
<td>Temporary Assistance to Needy Families (TANF)</td>
<td>2 (20)*</td>
<td>1 (10)*</td>
</tr>
<tr>
<td>Child Only Grants</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parent Coach</td>
<td>--</td>
<td>1 (10)</td>
</tr>
<tr>
<td>Crisis Management (e.g., crisis counselor)</td>
<td>1 (10)</td>
<td>--</td>
</tr>
<tr>
<td>Food pantries</td>
<td>1 (10)</td>
<td>3 (30)</td>
</tr>
<tr>
<td>Housing Assistance</td>
<td>1 (10)</td>
<td>--</td>
</tr>
<tr>
<td>Social Security (SSI)</td>
<td>--</td>
<td>1 (10)</td>
</tr>
<tr>
<td>Food Stamps/Supplemental Nutrition Assistance</td>
<td>1 (10)</td>
<td>1 (10)</td>
</tr>
<tr>
<td>Program (SNAP)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Court Services (e.g., going to court)</td>
<td>1 (10)*</td>
<td>1 (10)*</td>
</tr>
<tr>
<td>Other</td>
<td>1 (10)</td>
<td>1 (10)</td>
</tr>
<tr>
<td>HFWA Services</td>
<td>1 (10)</td>
<td>--</td>
</tr>
<tr>
<td>Waiver services</td>
<td>--</td>
<td>1 (10)</td>
</tr>
</tbody>
</table>

*Due to a change in survey questions partway through the study, four grandparent respondents did not have the opportunity to answer this question.*
Process of Seeking Formal Services: A Conceptual Model

Figure 2 is the conceptual model that arose from my grounded theory analysis of how grandparents raising grandchildren with an ACE history to examine the process of seeking and receiving formal services for grandparents on behalf of the grandchild with an ACE history. Figure 2 visually depicts the answers to my first and second research questions, which inquired about (a) the formal service needs for grandparents and their grandchild with an ACE history, as well as the (b) process of seeking and utilizing formal services for their target grandchild with an ACE history.
Before presenting the interview findings, I will provide an overview of the conceptual model.

After that, I will describe each theme and sub-theme within the model, illustrate them with participant quotes, and highlight their connections to one another. Starting with the outside of the model, on the outer edge are Barriers to Service Use which grandparents raising grandchildren with an ACE history encountered when seeking or receiving services. These Barriers to Service
Use are represented by a dotted line to illustrate that most grandparents experienced at least one type of these barriers and that those barriers shaped the entire service seeking process. Next, is the interior of the figure. Starting from the top of the figure, prior to starting services, Identifying GC ACE-related Needs and then made attempts to Managing GC ACE-related Needs & Behavior. Double-sided arrows are used between these themes to capture the back-and-forth process of identifying and managing needs, and then going back to identifying new needs and managing those needs that occurred for some grandparents. The circle with a dotted line, labeled GC ACE history surrounds the themes Identifying GC ACE-related Needs and Managing GC ACE-related Needs & Behavior to capture how a grandchild’s ACE history impacted both themes.

Moving to the bottom half of the model, Managing GC ACE-related Needs & Behavior eventually yielded to the grandparent seeking services for their grandchild, which begins with the Creating a Working Relationship with the Service Provider (SP). The double-sided arrows between Managing GC ACE-related Needs & Behavior and Creating a Working Relationship with the SP, which represent how SP were instrumental in assisting the grandparent with managing the grandchild’s needs by removing barriers, involving the grandparent in services, and being attentive to grandfamily (GF) needs. Creating a Working Relationship with the SP then yielded on of two outcomes: Creating Change or Grandparent Deciding to End the Service. Creating Change occurred when grandchildren benefitted from the formal service (e.g., decreasing ACE symptoms, grandchild making alternative choices, grandchild experiencing success), grandparents created change in their home (e.g., creating a routine at home, using increased ACE knowledge to help the grandchild, adding additional services to help grandchild, having an open relationship with the provider), and when the grandparent benefitted from the
formal service (e.g., understanding the grandchild better, feeling less worry, feeling like the formal service worked, knowing the grandchild had an outlet, someone to talk to or work with. Alternatively, formal services ended when Grandparent Decided to End the Service due to a mandated report being made, poor child-formal service provider-fit, an inability to pay for the service, or dissatisfaction with the quality of care.

**Barriers to Service Use**

Service barriers \((n \ = \ 9; \ 90\%)\) included personal, familial, or environmental challenges that impeded or prevented grandparents from accessing the services they were seeking for their grandchild with an ACE history. This theme includes three sub-themes: personal barriers, availability barriers, and systemic barriers. A summary of these service barriers is in Table 8. Service barriers, which is depicted in Figure 2, encompassed the entire process of identifying and managing grandchild needs all the way through seeking and receiving services. These barriers were sometimes one-time events, while others occurred conjointly with other barriers.

**Personal Barriers**

Personal barriers are barriers which originated from the grandparent or grandchild and created deterrents to seeking or receiving services for the grandchild. Common personal barriers that grandparents described prior to seeking treatment were believing they would be treated differently due to hearsay as well as the grandparent’s own opinions about not qualifying for professional assistance. For instance, GP6 shared:

They’re [Professionals are] not going to help me. I’m not his real parent…I guess it was just not so much professional people, but other people saying, ‘Well, I heard this, and I heard that, and so I didn’t think I’d get the help I needed, but I did and then some.’
In addition, some grandparents made assumptions about the type of help and eligibility that formal services could offer which prevented them from initially seeking services for their grandchildren. For instance, GP1, who had received an advanced degree and whose grandchild had experienced seven ACES, explained, “I just don’t fit the demographic that, Social Services, what I assumed was the demographic that Social Services would normally work with.” Similarly, GP6 commented, “I thought [name of formal service organization] was just for abused women who were abused by their partners. But they really helped a lot.” Other reasons that grandparents did not seek services initially was assuming that formal services are not helpful, due to (a) thinking their grandchild would not participate, talk, or show their behaviors in counseling or (b) nobody can handle their grandchild’s needs GP3, whose grandchild had experienced nine ACEs shared the belief, “there’s no one else to meet [my grandchild]’s needs than me.”

Grandchildren also contributed to creating barriers to receiving formal services. A couple of grandparents commented that their grandchild would not participate in services or show their difficult behaviors in counseling. For example, GP2, who was raising a granddaughter born addicted to substances, shared that her granddaughter was resistant to attending services and told her, “You think there’s something wrong with me.” This statement highlights the grandchild’s perception that her grandparent wants to fix her, which was something that GP2 acknowledged during her interview, “I wanted to fix her issues so she could be more of a normal acting child.” GP2 summed up her experiences of taking her granddaughter to counseling, “You can lead a horse to water, but you can’t make it drink, is basically it.”

Grandparents also commented that services were also unhelpful when grandchildren did not show concerning grandchild behavior, which was be another reason where personal barriers affected formal services, in both wanting to participate (personal barriers) and investing in the
formal service process (*Creating a Working Relationship*). For instance, GP2, who was raising her grandchild due to both parents being arrested, shared her experience observing her grandchild and the counselor, prior to ending formal services:

Well, it wasn’t hard to get help… [the counselors] never saw what we saw. And it was just difficult for them to get a grasp of what we were talking about because they’d never, they didn’t see it… We only went a couple of times, and I could see that they just weren’t going to be able to figure anything out and they didn’t see anything different.

This example highlights how the grandparent experienced the presence of *personal service barriers from the grandchild*, which affected the grandchild’s ability to *create a working relationship with the service provider*. As a result, this *personal service barrier* impacts the service outcomes of *Grandparent Deciding to End the Service*, due the grandchild did not want to utilize the service the grandparent had found for the grandchild, and no behavior changed.

Finally, some grandparents felt that their grandchildren resisted formal services during service utilization because they were not ready to address their past. GP4 identified that his granddaughter needed counseling; however, she was not ready for it. For instance, GP4’s grandchild had 6 ACEs and slept at the end of his bedframe each night out of fear, shared his perspective about his granddaughter, “Getting the child to agree to it, at first, she didn’t want to. She did not want to talk about it. She didn’t want her past brought up. It upset her every time [it was].”

**Availability Barriers**

Grandparents also described availability barriers, which included limitations to the supply of services, personnel, and information available to grandparents as they sought services for their grandchildren with an ACE history.
Service Availability. Many grandparents indicated that the limited availability of services were the biggest barriers for them when seeking formal services for their grandchild. By not having services available to help grandparents, grandparents are left to themselves to figure out solutions for managing their grandchild’s behaviors. GP7, who was raising a grandchild with nine ACEs and living in a very rural area commented, “I can’t think of any child psychiatrists in my area…I get angry and aggravated sometimes because of trying to find the services and they’re not there.” GP7’s grandchild was diagnosed with depression, anxiety, and ADHD—all three of which can be treated with medication; however, the lack of a psychiatric provider limits the amount of help this grandparent can acquire for her grandchild. The lack of available services can also affect grandparents. When asked about how she has been affected as she has raised her grandson, she reported, “I’ve had to go back on medicine for anxiety. My blood pressure medicine has had to be raised.”

In addition, GP3 echoed the challenge that some grandparents experienced, in that grandchildren with higher ACE scores tended to need more providers with specialized skill sets to meet the grandchild’s significant needs. For instance, GP3, was raising a grandchild with nine ACEs and autism during the COVID-19 pandemic, described the ongoing barriers to services such as organizations that offer the services her grandchild needs as well as the organization’s willingness to work with her grandchild:

Well, we have waiver services for him. However, a lot of the teams that are in the new waiver are not available in [Region] and that has been an extreme challenge is finding places that offer the services that [Grandson] is entitled to. Example, [Grandson] is entitled to have attendant services and we cannot find agencies willing to work with [Grandson].
GP3 addressed the challenges of not having formal services for her grandson,

So that makes it very difficult. They'll [Formal service providers will] say, ‘Oh, well, there's all these services there.’ Well, yes, there is all these services there. But to be able to fill what those services offer has been a tremendous challenge and battle…I ended up having to quit my job in order to care for [Grandson] because we could not find attendants.

Thus, when some grandparents do not receive formal services for their grandchild, they can experience additional burdens such as loss of income, in addition to mental health stressors.

*Pay Wall for Services.* In addition, GP2, was raising a granddaughter with three ACEs, identified that she needed to know more about her grandchild’s behaviors at school, yet the school failed to share regular updates with her. GP2 reported finding a specialized school for children with behavioral problems or high needs and commented, “We put her [in a school] for two years…I paid for it myself, I moved to [new location] because it was too far to drive…we don’t have schools like that in our area.” Prior to pursuing this school option, GP2 reported pursuing a $10,000 not-covered-by-insurance neurofeedback testing evaluation in hopes to discover new information about their grandchild. Despite following through and completing this procedure, this testing did not yield any new or helpful information. As discussed above, this grandparent was willing to seek services for her grandchild but was unable to find the needed care, whether through relocation or seeing a specialized provider. Yet, even when these services or providers existed, the services were often still cost-prohibitive, which tapped a more common barrier for grandfamilies in general (i.e., of lack of financial resources). For example, as an extension of the previous example, GP2 could afford to pay only two years’ tuition at this school
for her granddaughter. She shared, “But to keep your child there for any length of time was like paying for a college education!”

An emerging barrier that this grandparent identified was a metaphorical “pay wall” for more specialized care. GP2 shared how the public school failed to provide regular updates on her grandchild’s academic progress and behaviors in the classroom. This grandmother stated how it was not until she enrolled her grandchild in an expensive and distant private school tailored specifically to children with significant mental health needs that the grandparent received the quantity and quality of feedback, she was looking for to understand what was happening for her grandchild.

**Personnel Availability.** Another availability barrier was having formal service professionals who have specialized training to work with grandchildren with high levels of need or special needs, and who acted professionally. For instance, GP7, who was also raising a grandchild with 9 ACEs, remarked, “I think if there were more providers in the community that could work with children that have behavior issues like my child, I believe that would help...finding the help that would specialize in a child so young.”

To address **Barriers to Service Use**, grandparents recommended that formal service providers, particularly school personnel, need to receive general trainings about grandfamilies and their needs, as well as trainings on diverse examples of grandfamilies. As an example, GP7, who was raising a grandchild due to parent substance use, recommended that formal service providers look at grandfamilies and their needs as unique, rather than being from a mold. Grandparents also discussed examples of diverse grandfamilies such as step-grandparents raising grandchildren, grandparents raising multiple grandchildren, one parent vs. two parents with issues, single vs. married grandparents raising grandchildren, and differences in grandchild
diagnosis. To help grandfamilies more, grandparents also recommended that formal service providers (a) thoroughly assess the grandparent’s situation and (b) provide an ordered list or form of things grandparents need to do or seek (e.g., seeking government-funded services like Medicaid, WIC, health department, etc.) after having a grandchild come to their home.

**Poor Provider Fit.** Another personnel barrier found in the data was a poor fit of formal service provider with the grandfamily. Examples of poor fit can include the formal service provider’s skill level, professionalism, or ability to form a working relationship with the grandchild or grandparent. This finding of a poor fit may be one reason for cancelling formal services. For example, GP5’s granddaughter was being raised due to mother substance use. GP5’s was taking her grandchild to see a counselor who did not set age-appropriate expectations and use language a five-year-old could understand—despite the grandparent’s suggestion to use different words. As a result, this grandparent decided to “take a break and re-evaluate this [counseling]. And we did. And now she's seeing somebody different.” This example illustrates the formal service providers’ skill deficits (*Availability service barrier*) in not knowing how to work with children in counseling services. GP1 reflected what it felt like to have a provider who had a limited competency when doing play therapy with her grandchild. GP1 shared her experience of feeling “kind of like an experiment…it was kind of like, you could tell it wasn’t completely natural for her to interrupt the child.”

**Unprofessional Providers.** Grandparents also identified that one of the more unhelpful factors of receiving services was when they had an unprofessional provider. Half of the grandparents in this study identified examples where providers were unprofessional. Examples included formal service providers talking casually with grandparents, demanding that a grandparent or grandchild comply with program expectations, becoming irritated by the
grandchild’s behaviors, or creating situations that created conflicts of interest. For example, GP4 shared how a counselor interacted with his granddaughter and the negative impact it had on her:

[The counselor] would demand that [my granddaughter] tell her what went on in her past, what went on in the house that she was in when the abuses and things were taking place. And I'd say it made [my granddaughter] get worse instead of better, for being withdrawn. She'd come out of there crying every time she went to that. [The counselor] went in with an attitude that she wanted to find out what went on so she could do something about it, I guess.

Not only can having an unprofessional provider be unhelpful to services, but it can also impede service continuation (Service Barriers). For example, GP4 shared that the counselor’s behaviors and his granddaughter’s reaction to both the counselor and the upcoming counseling appointments ultimately led to the Grandparent Decision to End Services. In this example, the formal service provider creates a service barrier to the grandchild’s treatment. GP1 also cited a similar experience of having an unprofessional provider, which resulted in part of the Grandparent Decision to End Services.

Consistent Provider in Service Delivery. A final barrier to personnel availability was not having a consistent provider involved in service delivery. Providers would often change during treatment, which resulted in delays for the grandchild’s needs being met. The lack of provider consistency also created feelings of not progressing in the grandchild’s treatment. For example, GP3 who was raising a grandchild with nine ACEs and had several needs. GP3 commented, “for [my grandchild’s] waiver, we’re on the fourth case manager and it’s like starting over every time, and things not getting followed through.” was illustrated by GP5, who was raising a grandchild with four ACEs. GP5 shared what can happen after turnover among
service providers: “Three weeks after we started, we had a hearing and then by the following
Friday, [our case worker] had left the agency. Poof! I didn’t know who our ongoing caseworker
was, and I didn’t have anybody’s name.” Overall, grandparents in this situation wondered about
the effectiveness of services for their grandchildren, especially when turnover was so high, and
grandparents found themselves having to catalogue the same information again and again.

Information Availability

Lastly, a few grandparents described the challenge of having limited information about
types of formal services, as well as the application process necessary to acquire services for their
grandchild with an ACE history. This was a barrier to accessing services because the lack of
information precluded some grandchildren from receiving the full level of care that may require.
For example, GP3, who was raising her grandchild due to parental substance use, jail time,
domestic violence, and child neglect, described her experience looking for information about
services in her area, “there’s not one place where you can go to and say, ‘Tell me all the services
that are available that I could possibly pull from.’ That doesn’t exist. And that is a major, major
roadblock.” GP3 also emphasized how this lack of information was a barrier for not receiving
crucial assistance for years, despite her grandchild’s eligibility status:

There’s just constant roadblocks and challenges to get those things that are there that my
grandchild’s entitled to. And it’s just a constant uphill battle to get what he needs…Even
when I got him in and got him with the first help, it’s 12 years later. I’m still learning
some services now that my grandchild has been entitled to for years that nobody told me
about.

As grandparents reflected on the availability barriers to accessing services for their
grandchildren, they offered some recommendations for ways that service providers and
policymakers could remove these barriers: creating an agency designated specifically to helping grandparents find and navigate services, creating online and local support groups, creating more in-home based services, and finally, keeping TANF as a program.

Two grandparent-specific recommendations for service providers who are working with grandparents raising a grandchild with an ACE history is to first, have a list or an awareness of local and state resources pertinent to the types of needs that grandparents raising a grandchild with an ACE history tend to have and then, to ask questions to remove redundant resources or services the grandparent has already tried. For example, GP3, who was raising a grandchild with nine ACEs and had significant difficulty finding formal service providers who could work with her grandson, “I still wish there was some kind of agency that literally was to help grandparents…just some kind of agency that helps overall.” Grandparents also indicated that formal service providers should tailor their services based on the needs and culture of the counties they work in. GP5 illustrated this idea with her unique perspective and recommendation:

I think one of the things that [formal service providers] should keep doing is focusing on a county level because the various counties are so different. Just the makeup of the county. The average age, education, industry, earnings are so vastly different across the state.

While this grandparent suggested county-level programming across the state, this recommendation may hold true in wider regions of Appalachia, given that many counties or areas of Appalachia have their own culture, in addition to demographics, as this grandparent suggested.
Systemic Barriers

Systemic barriers referred to how systems of care (e.g., agency policies, courts) and service providers (e.g., service professionals) created barriers for grandparents by nature of individual or organizational policies, state laws, or court decisions. Systemic barriers such as lack of legal custody, organizational gatekeeping, and eligibility for state assistance programs were the last group of Barriers to Service Use that grandparents raising a grandchild with an ACE history experienced as they sought to initiate or continue services for their grandchild.

Lack of Legal Custody. A lack of legal custody was one of the prominent barriers to accessing services that grandparents experienced and is defined by situations where grandparents have legal entities have so declared it. GP6 was raising her grandchild due to parental neglect. GP6, shared the following experience: “There were certain services I can’t recall now that I couldn’t get because I wasn’t his biological parent and hadn’t adopted him.” Similarly, GP1 noted that despite having legal rights to her grandchild, she still experienced barriers, by way of the custody agreement,

There were some instances where the initial court order that gave us primary physical and joint-legal custody was not enough for us to be requesting help for the [grand]child they had to have the permission of us as well as both parents since we shared legal custody in order to get the children help.

While this grandparent was able to return to court and get revisions to the court order that allowed her to obtain services for her grandchild, the intersection of legal rights and grandparents raising grandchildren is not always so clear cut, particularly when the grandchild’s parents are in-and-out of the family’s life.
Organizational Gatekeeping. Organizational gatekeeping was another systemic barrier that grandparents faced. Organizational gatekeeping is described as ways an organization prevents an individual from receiving information in a timely manner. This gatekeeping was most common with government organizations such as Social Service Departments. GP5 noted two instances where she encountered Barriers to Service Use with her local DSS office. First was when she first received her grandchild and she needed to take her grandchild to the doctor within the first five days, as part of her agreement of being a foster care family with the State. GP5 commented on how this barrier affected her:

But they [DSS] didn't give me paperwork within five days. So, I was like, "How can I take her to a different doctor, a new doctor, any doctor without having the correct insurance card and whatever I need?" I need the letter stating that I was her-- that I had her medical power of attorney, except if she needed anesthesia.

Second, GP5 commented on her process of the difficulty of trying to find answers about who her new worker was after her current case worker quit:

And if you've ever tried to contact somebody in the Department of Health and Human Resources, they have a lot of gatekeeping. So, I had to get a little bitchy, and send emails and make phone calls and just put my foot down and say, ‘I'm not going away. You do have to answer me, and I will keep calling until you get back to me.’

Organizational perspectives were another piece that grandparents raised concerns about in regard to working with formal service providers. Organizational perspectives where ones where organizations maintained or used unhelpful perspectives in their provision of care to grandfamilies raising a grandchild with an ACE history. GP7, raising a grandchild due to parent substance use, raised a concern of how she believed formal service providers created barriers for
grandparents. GP indicated that formal service providers held unhelpful beliefs and assumptions when working with grandfamilies. She recommended, “Stop using the history against the family. Stop looking at families like it’s their fault. Treat the families that they work with as though it’s [the service provider’s] own family.”

**Table 8**

**Summary of Sub-themes for Service Barriers (N = 9)**

<table>
<thead>
<tr>
<th>Sub-themes</th>
<th>Definition</th>
<th>(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal barriers</td>
<td>• Barriers which originate from the grandparent or grandchild</td>
<td>8 (80)a</td>
</tr>
<tr>
<td>Availability barriers</td>
<td>• Limitations on the supply of services, personnel, or information available to grandparents</td>
<td>8 (80)a</td>
</tr>
<tr>
<td>Systemic barriers</td>
<td>• How systems of care create barriers for grandparents</td>
<td>9 (90)a</td>
</tr>
</tbody>
</table>

*a This percentage is from the whole sample.

**Identifying GC ACE-related Needs**

It is within the backdrop of service barriers that grandparents identified their grandchild’s formal service needs and behaviors prior to seeking services (n = 10; 100%). In this research study all grandparents overtly linked their grandchild’s ACE history with their grandchild’s behavior. The sub-themes included in this theme were the grandparent observing grandchild ACE-related needs and behavior, using professional and personal life experience, a combination of factors, and grandchild behavior change. Table 9 includes a summary of these subthemes.

**Grandparent Observing GC ACE-related Needs and Behaviors**

This sub-theme addresses what grandparents’ observation of their grandchild and how the grandchild’s behaviors were a sign of underlying needs and professional intervention.

**Grandchild Behavior Change.** Grandchild behavior change is described as the grandchild behaving one way and then changing how they behaved, which grandparents viewed
as a sign that formal service intervention needed to occur. Grandparents also reported that common grandchild ACE-related behaviors in this study included anger and aggression, emotion regulation, isolation, and social immaturity. For example, GP5, who was raising her grandchild due to parent substance use, commented on their observation of their grandchild, whom they had raised for a year: “She went through a period where instead of being bright, chirpy, happy, up, to being a bit somber and withdrawn. And that was so noticeable so quickly, that yeah, I pulled in [a local service].” In accordance with the conceptual model, this grandparent identified her grandchild’s ACE-related needs and behavior for services based on the grandchild’s change in behavior, and then managed the grandchild’s ACE-related needs and behavior through seeking services, which will be described in the next theme.

**Grandchild Attachment Needs.** Attachment needs are described as behaviors that result from an underdeveloped emotional need. Grandparents commonly identified grandchild behaviors such as feeling abandonment, needing attention, wanting to be with grandparent, struggling with attachment, and needing love. For example, GP3, who was raising her grandson with 9 ACEs, including physical and emotional neglect, commented, “He’s afraid someone’s going to leave him alone.” She also shared, “Oh, he’s suffered a lot of abuse mentally when he was small. And it still reflects into his behaviors today, especially the attachment. And he really struggles with relationships, whether they be with adults or peers.”

Similarly, GP1, who was raising a grandchild with 7 ACEs, also including parent separation, physical neglect, and emotional neglect, reframed her grandchild’s attachment needs as abandonment. She said,

He [My target grandchild] feels a sense of abandonment…they [the grandchildren] ask questions like, ‘Are you guys going to leave us?’ or, ‘Can I always live with you’… There
are times that he just—he will follow me through the house because he doesn’t want to be alone.

Similarly, GP10, who was raising his grandson with a history of physical and emotional neglect, as part of his sum 6 ACEs commented on the effects of his grandchild’s ACEs. He said, “He [My grandson] would not allow me to go anywhere or leave the room. He would scream for us.”

Finally, GP4, who was raising a grandchild with six ACEs, identified that his granddaughter’s behavior resulted from the physical abuse she experienced when she lived with her father.

When she first moved in with us, we had to put a bed in our bedroom, and she slept at the foot of our bed till she was probably 10 years old. She would not come out of that room. She wouldn’t sleep by herself. She was too afraid…It was just her behavior and how she was acting that we seen [sic] she needed some help.

This example demonstrates a back-and-forth relationship between the double-sided arrow for the themes Identifying GC ACE-related Needs and the next theme, Managing GC ACEs-related Needs & Behaviors, whereby the granddaughter refuses to sleep by herself (a need), then the grandparent seeks to Manage his Granddaughter’s ACE-related Need & Behaviors by allowing his granddaughter to sleep at the foot of his bed. The grandparent then identified that the grandchild had significant fear (a need), and to manage that fear, the grandparent identified that the grandchild needed help, which will later segue into the theme of Managing these ACE-related Needs and Behaviors.

**Grandchild Developmental Needs.** Grandchild developmental needs include any under-developed physical or cognitive need that a grandchild may experience such as speech/language,
gross motor, or sensory challenges. GP10 shared his experience identifying how his grandson’s attachment and physical needs were formed as well as his grandson’s need for formal services:

It's been a challenge because he has a lot of neurological and sensory issues…Oh, because both parents were known drug users, and the drug abuse not only led to what he's going through right now, but it affected his other siblings as well. He was neglected—he was stuck in the pen the whole time since he was a baby… [His gait] was not within the normal limits for him when we actually got him. but it's just my wife and I got a little concerned when he was falling everywhere and not walking the way he should've been and just— yeah. Just was an everyday thing. We were concerned from the time we actually got him.

When looking at the conceptual model, this grandparent decided to seek services for his grandchild due to his ACE-related mobility challenges from the first time he arrived in the grandparents’ home, due to being “stuck in the pen the whole time since he was a baby.” This grandparent Identified the GC’s ACE-related Need as it related to the GC’s ACE history.

Using Professional and Life Experience

This section is described as parental (e.g., raising multiple children), educational training (e.g., background in early childhood education, being a retired teacher), or professional experiences (e.g., working for an organization focused on providing services to children with ACE histories) that grandparents had prior to raising their grandchildren that contributed to their identifying an ACE-related need existed for their grandchild. For instance, GP6, was raising a grandchild with a history of emotional and physical neglect. She attributed her educational background as helping her to identify her grandchild’s behaviors. She described her experience:
“And his behavior now and before with the impulses and things, I definitely chalked that up to my early childhood development experience and the books that I’ve read on it and so forth.”

Some grandparents also reported having professional experiences with children with ACE histories and were thus more attuned to identifying ACE-related needs. For instance, GP7, who was raising a grandchild due to parent substance use, stated: “I guess you would say I already raised four children and professionally, I work with families that have children like mine. So, I’ve had a lot of trainings in different types of behaviors, mental health, [and] substance abuse.” This grandparent shared that the skills she has developed prior to her grandchild coming to her home helped her to identify her grandchild’s need.

**Combination of Factors**

This section is defined as when two or more of the previous pieces are combined to aid in grandparent [Observing] GC ACE-related Needs. For example, GP1, was raising her grandchild due to parent separation, shared that she realized her grandson needed help based on information she had received about his discipline record. She reported on the ways she identified her grandchild’s needs: “I picked him up from daycare every day and what kinds of actions he was having and just his overall discipline record and also the way he interacted with us at home and with his sister.” This grandparent decided to seek services because her grandchild was acting out at school by being aggressive with other children, as well as his interactions at home with his grandparents and sibling. This grandparent’s comment highlights how sometimes multiple sources contribute to a grandparents’ decision to seek formal services for their grandchild with an ACE history.

In another example, GP2 was raising her grandchild because of the grandchild’s parent being arrested, being born addicted, in addition to physical and emotional neglect. During the
interview, GP2 commented on her grandchild’s social challenges; however, she didn’t seek services for her grandchild until a formal service provider commented on the grandchild’s behavior and behaviors began to occur at home:

But she was very destructive…I think she was four [years old] when we took her to the first counselor and I’m just like, ‘something is not right; Something is just off here.’ And even when she went to pre-K, the teacher said, ‘Something is different about her.’

Both of these examples demonstrated that grandparents were aware of the grandchild’s needs at home and then received a confirmation from a formal service provider about what was happening.

Table 9

Summary of Sub-themes for Identifying GC ACE-related Needs (N = 10)

<table>
<thead>
<tr>
<th>Sub-themes</th>
<th>Definition</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grandparent observing GC ACE-related needs and behaviors</td>
<td>• How a grandchild’s history or ACE history affected the grandchild’s needs and behavior</td>
<td>10 (100)a</td>
</tr>
<tr>
<td>Using professional and personal life experience</td>
<td>• Professional and personal experience and educational knowledge that contributes to identifying a need</td>
<td>4 (40)a</td>
</tr>
<tr>
<td>Combination of factors</td>
<td>• When multiple sources identify the GC has a need or behavior</td>
<td>2 (20)a</td>
</tr>
</tbody>
</table>

a This percentage is from the whole sample.

Managing GC ACEs, Needs, & Behavior

The theme, Managing GC ACE-related Needs & Behavior (n= 10; 100%) reflects how grandparents raising grandchildren with an ACE history handled their grandchild’s ACEs-related Needs, and Behavior once they had identified them. Within this theme of Managing GC ACE-related Needs & Behavior, there were three sub-themes that reflected challenges that arose for
grandparents as they sought to help their grandchild manage their ACEs and needs. These sub-themes also revealed the path that grandparents took to seek services for their grandchild. Sub-themes for this theme include (a) stresses of parenting a grandchild with an ACE history, (b) family and parent involvement, and (c) GP seeking services for the grandchild. For a summary of these subthemes, please refer to Table 10.

**Stresses of Parenting a GC with an ACE history.** This sub-theme captures the different strategies grandparents used to parent their grandchild with an ACE history. In addition, grandparents shared examples of how they felt stressed and preoccupied by raising a grandchild with an ACE history, which impacted how they Managed their GC’s ACE-related Needs and Behaviors.

Grandparents raising a grandchild with an ACE history identified several strategies that they used to try and Managing their GC’s ACE-related Needs and Behaviors. These strategies included caring for the grandchild, teaching the grandchild, and setting boundaries as common strategies they used to manage grandchild behaviors and raise their grandchild. When grandparents demonstrated care for their grandchild, they were trying to be attentive to the grandchild’s needs, whether physical, or emotional. For example, GP9, who was raising a granddaughter with emotional neglect in her history shared that she “[doesn’t] ignore her [granddaughter]when she requests things.” GP10 also described the type of care he provides to his target grandchild, who had 6 ACEs, among which were a history of emotional abuse, emotional neglect, and physical neglect, “I'm hoping that while they're living with me, I can show them more of the love and care and attention that they didn't receive… we are focusing on him and his growth and just doing the best for him.”
One grandparent identified that they tried teaching their grandchild strategies to control her actions. GP3 highlighted the challenges though of managing her grandchild’s sensory needs, co-morbid diagnoses of Oppositional Defiant Disorder, Reactive Attachment Disorder, and Mood Dysregulation Disorder, in addition to autism, and teaching her grandchild in a way that he will understand. She said,

But it's been a battle because he doesn't understand it sometimes. He was diagnosed with autism, so it's a battle sometimes between just sensory inputs and his other behaviors—finding the right balances for him; helping him understand how he needs to react; how he needs to cope; and deal with the sensory input and things.

Finally, grandparents cited setting and using boundaries to help their grandchild with their ACE history. GP1 cited that using discipline such as “one minute of time out for every year of their age, restrictions on what he could and couldn’t do” or therapy. In comparison, GP9 reported setting boundaries such as providing “a loving structured home environment” and “re-establishing healthy household patterns” to help her granddaughter with her ACE history.

Second, grandparents who were raising the target grandchild with an ACE history identified the challenges of Managing the target GC’s ACE-related needs and behaviors due to managing young and multiple grandchildren, juggling appointments, and grandchild behavior fluctuations, as well as a lack of self-care. Grandparents also commonly cited fear, worry, and stress as they raised their grandchild with an ACE history. GP10 depicted his experience attempting to Manage his Grandchild’s ACE-related Needs and Behaviors when he shared the following about his emotional experience raising his grandchild, who was born addicted to substances: “[I feel] stresses, yes. Because the child [is] having tantrums and neurological issues, that causes a lot of stress on you.” In addition, GP3 described her experience with her grandson’s
behavior, who has 9 ACEs and autism, “He can escalate very quickly and become into a massive meltdown where police may end up having to be called.” In addition, grandparents identified not being able to accomplish their work and home responsibilities as they raised their grandchild with an ACE history. For instance, GP5, who was raising a grandchild with four ACEs, commented on this point when he said,

I felt pulled in a lot of different directions, and I personally didn't feel like I was performing any of them as well as I might have because there were just not enough hours in the day to focus on whatever. Work, home, child, me. Not a lot of room for self-care when we started this journey.

Family and parent involvement. Grandparents indicated that family and parent involvement were two external impacts that affected managing the grandchild’s ACEs-related needs and behavior. For example, some grandparents described relatives as helpful because they provided respite for the grandparent, allowing both the grandchild and grandparent to have a break from one another, whereas other family members inserted their unsolicited opinions about parenting a grandchild with an ACE history.

Respite care was identified as a need and important, according to 50% of the total grandparents in this study; however, only 30% of the grandparents in this study shared about the ability to have their family provide that respite care. These three grandparents had older children who lived nearby and were able to provide respite care. For example, GP7 shared, “My oldest son is my respite provider. When I need a break, he takes him… If I didn't have my oldest son for the respite, that would be a huge challenge.” This grandparent underlines not only the need for respite care, but the challenge that could result in not having it. In addition, GP10 talked about the support team that helps him and his wife have breaks when needed. He said, “My
daughters come in and they'll watch the kids so me and my wife can go out for dinner or something or just get a couple of hours out by ourselves. My boys do the same thing.”

Yet, family involvement for some grandparents was not helpful while raising a grandchild with an ACE history. GP6 noted that her grandchild’s behaviors of “being a runner. We can’t let him go without holding onto his hand or having him wear a harness when he goes out anywhere. He has no boundaries. He has impulse control where he really doesn't know fear.” These behaviors posed a challenge for her family members. As noted in the parenting a grandchild with an ACE history section above, respite is very important for grandparents who are raising grandchildren with ACE histories. Some grandparents shared how their family members were either unsupportive or unwilling to help provide respite. For instance, GP6, who was raising a grandchild with a history of neglect, stated,

It’s hard to get the family to want to babysit when you have a grandchild who’s a lot younger than their cousins. And then you have the older people in your family who don't want to deal with some of the challenges that you deal with having a grandchild from a troubled background or what have you.

GP6 identified another layer of family involvement that made her question their ability to provide appropriate care. She commented that her family did not understand appropriate discipline strategies for her grandchild and would share uninformed parenting advice. GP6 described:

And then you have the older people in your family who don't want to deal with some of the challenges that you deal with having a grandchild from a troubled background or what have you. I mean, I've, yeah, I've had people, "Well, you need to spank him," and I'm like, "You can't spank out of a child what they're dealing with. I'm sorry, you don't do
that." But I've been told that he needs that and I'm like, "No, we're getting him what he needs."

This interference that GP6 described is an example where the lack of family involvement made it more difficult for GP6 because it reduced who GP6 decided to ask help with respite or talk to for support in *Managing her GC’s ACE-related Needs and Behaviors*.

In fact, 30% of all grandparents in this study noted that parent involvement made grandchild ACE-related behaviors intensify, which then created additional stress for grandparents in *Managing their GC’s ACE-related Needs and Behaviors*. In addition, grandparents suggested that parent involvement often exacerbated their grandchild ACE-related behaviors, especially in cases where the parent created an environment for ACEs. Examples of challenging grandchild behavior included acting out, reverting to unwanted behaviors—despite progress being made. For instance, GP1, who was raising her grandchild due to parent separation, described how she had to let her grandson see his parents due to a court order, despite the grandchild having unwanted behaviors following parent visits:

He was still seeing is parents on and off through court-ordered visitations during this period so a lot of his behaviors as soon as they’d improve, then he would see one or both of his parents again and those actions would come back, sometimes worse than ever.

Similarly, another behavior that one grandchild did was to tantrum. GP5 was raising her grandchild due to the parent’s substance use and CPS involvement. She described her experience after a parent visited with her grandchild: “[My grandchild] was having tantrums, which was a completely new behavior. They were recurring, and it was very difficult to get her settled down…full-on, open-mouth howling…it was after she had contact [with her mom].”
While many encounters with the grandchild’s parent are not beneficial to the grandchild, one exception arose from the data where the grandchild’s parent worked with the grandparent during a period of sobriety to get the grandchild formal services. GP5, explained her decision to take pre-emptive action, after considering what may happen in the future. GP5 noted how she looked to the future and GP5 shared, “[The program] sent home some information, and my daughter and I discussed it.” GP5 then acquired the parent’s permission to enroll the grandchild in services, which the parent provided and GP5 later commented how less than a year later, the parent was in the throes of substance use.

**GP seeking services.** The final sub-theme in the theme, *Managing GC ACE-related Needs & Behavior*, captures the different reasons that grandparents had to seek services for their grandchildren, once they had identified a need and realized that they were not able to manage it entirely themselves. Grandparents sought services for reasons such as thinking services would help the grandchild or mitigate against the trauma; shared a desire to learn skills to manage unwanted behaviors; wanted to help the grandchild know that other people have ACE histories; and not the grandchild to not feel guilty about the past. For example, GP9, who was raising her grandchild due to parent substance abuse, shared, “At four and a half year[s] old, you don’t know what’s in their mind. But I wanted her to know that not everybody grows up like that and things will get better, and people care.”

Additional reasons for seeking services included wanting to “fix” the grandchild. Most grandparents (80%) identified thinking that seeking formal services would make a positive impact on the grandchild and the effects of the grandchild’s ACE history would be reduced. For instance, GP6, raising her grandchild due to child neglect commented, “I think it [grandchild’s ACE history] can be remediated probably 80% of it, maybe 100%...I think [my grandson] can 80 to 90 percent with the help that he’s getting from us and professionals, that he's going to do better.” This grandparent still expressed her hesitancy to reach out for assistance due to personal barriers; however, she shared, “but anything for him, I swallowed my pride and said, ‘This is what we need,’ and it all worked out…and it’s funny, you got to reach out to find out.”
Most grandparents identified wanting someone to help them with their grandchild and many grandparents had multiple providers working with them. Grandparents provided justifications such as knowing they “can’t [help their grandchild] alone” (GP7) and “[not knowing] what to do, because I couldn’t help him” (GP6). Grandparents both wanted assistance mitigating or resolving the trauma as well as to be involved in services. Grandparents also self-advocated for the importance of having the right service provider fit as well as commented on their personal strengths and characteristics to find services for their grandchild. GP1, raising her grandchild due to parent separation, captured this belief when she said, “I guess in a good and bad way, I’m a micromanager, so I like to be hands-on with a lot of things.”

In addition, some grandparents also shared that they used other services such as doctors, agencies, and schools to find services for their grandchildren. Several grandparents commented on how the doctors they visited provided them with either recommendations for providers or referrals for services. For example, GP6 shared “I talked to his doctor about [my grandson’s mobility delays] and that’s when we went to [the program].” Other grandparents commented on how they received information about formal service providers through agencies or the grandchild’s school. GP1 said, “We got a lot of information from [Agency] itself, from his case worker and we got a lot of information, a lot of help from our local Social Services office.” GP10, who was raising a grandchild with five ACEs, also described a statewide program that bridged to the school once his grandchild aged out of the statewide program.

Furthermore, grandparents used informal resources such as word-of-mouth referrals to find formal service providers for their grandchildren. GP7, who was raising a grandchild with 9 ACEs, stated that she found out about a formal service “through one of the groups that I belong to through work.” GP3, who was also raising a grandchild with 9 ACEs, commented, “Someone
gave me a name to call to see if they might be able to help me out and get me in the right
direction about trying to find some services for [Grandchild].” In comparison, GP6 was raising a
grandchild with 4 ACEs, with two of them being histories of emotional and physical neglect, and
the grandchild with a speech delay. She pursued services after she heard from others, “Yeah,
they worked with my child and now you’ll never know that he had a speech delay.”
Grandparents noted how these positive reviews of services from individuals in their social
networks influenced their willingness to seek out the service.

The bidirectional relationship, as shown by the double arrow, between *Identifying GC
ACE-related Needs*, and *Managing GC ACE-related Needs & Behaviors*, as depicted in Figure 2,
is captured by GP2’s *Managing her GC’s ACE-related Needs and Behavior* by seeking out a
diagnosis for her granddaughter’s behavior. For example, GP2 was raising her grandchild with
three ACEs and shared her observations of her granddaughter’s behavior at home:

She would come in or she would walk into your room, or she would just break everything
off the kitchen table. Like if the boys were doing their homework or something, she’d
just take her arm and walk by and never flinch, just throw it all down on the floor and go
her way. And she would have these huge, huge tantrums. They were just unbelievable.
Sometimes…she would kick and scream, it was like she was outside of herself, she had
no control over the way she was acting.

She shared, “the first time [my granddaughter] was diagnosed was when she was six. They came
back with this diagnosis of Explosive Disorder and Early Onset Depression.” GP2’s *Identifying
her GC’s ACE-related Needs* in her home reflects the stress and grandchild behaviors that may
come when raising a grandchild with an ACE history. This example also illustrates how
grandparents seek formal services for assistance in *Managing GC ACE-related Behaviors, and Needs*.

**Table 10**

**Summary of Sub-themes for Managing GC ACE-related Needs & Behavior (N =10)**

<table>
<thead>
<tr>
<th>Sub-themes</th>
<th>Definition</th>
<th>n (%)</th>
</tr>
</thead>
</table>
| Stresses of parenting a GC with an ACE history | • How grandparents were affected by raising a grandchild with an ACE history  
• Emotional experience and coping strategies to mitigate the stress of raising a grandchild | 10 (100)\(^a\) |
| Family and parent involvement       | • Familial challenges that influenced both the grandparent and grandchild.   | 9 (90)\(^a\) |
| GP seeking services                 | • Captures the different steps that grandparents took to seek services.     | 10 (100)\(^a\) |

\(^a\) This percentage is from the whole sample.

**Creating a Working Relationship with SP (n = 10; 100%)**

Just as *Managing GC ACE-related Needs & Behaviors* was a turning point for seeking services, the theme, *Creating a Working Relationship with SP* was the pivot point for service outcomes in the conceptual model, where services were either continued or ended. Grandparents attributed *Creating a Working Relationship with SP* to several reasons, namely grandparents trusting SP and SP attentiveness to GF needs. These strategies are summarized in Table 11 and captured in the sub-themes.

**Grandparents Trusting SP**

This sub-theme is characterized by how grandparents trust their formal service providers. When grandparents were asked about how they came to trust their formal service provider, 50% of grandparents noted different reasons such as naturally trusting formal service providers, having experienced the service before, identifying that the formal service provider understands
them, projecting that trust onto the new provider, and building it as part of the service process, viewing the service provider as being on the grandchild’s side. For example, GP1, whose husband was a social worker, shared, “I had an innate trust for those kind of people who worked in that kind of environment… I just trusted those people and that relationship just naturally blossomed.” GP9 echoed this practice when she shared, “I just trust[ed] her form the beginning. I didn’t not trust her.” In addition, GP8 stated that she built her trust in her granddaughter’s formal service provider due to “she had a little experience to where her grandmama raised her. And she was still living with her grandmother. So that’s where I gained trust in the last one. Rest of them? No.” These grandparents’ accounts of their process of trusting their formal service provider mostly contributed to *Creating a Working Relationship with the SP*, which led to *Creating Change*.

However, GP8’s comment of not trusting the past service providers, due to a mandated child protective services report, echoes the impact of how trust can be ruptured in some cases, if not approached the right way. When GP8 initially sought counseling services for her granddaughter, she described the first two counselors’ approach to starting formal services with their grandchild as seeking answers to file a child protective services report:

She didn’t get in there to get to know [my granddaughter] first. She just started asking questions…and when she asked a question about the molesting, that just turned all of us off, because that’s a very touchy and sensitive moment at that time. She just went in there. She just went in there talking about she's going to call the police and all that. And we had to go through all that right there. And they didn't want to go through all that because they had felt like they had got over that, right there and then. The second one, she done the same thing too…She didn't get in there with them. She didn't gain their trust. She didn't
show them love. She just got in there and just started asking questions, okay? She didn't prep them.

This grandparent described how the formal service provider did not approach the situation by prepping the grandchild or creating trust, but rather to get answers. Similarly, GP3 described her experience with formal service providers making a child protective services report. In this situation, the formal service provider found out some information in the home. Instead of talking with the grandparent about the situation, this provider spoke with her supervisor, which resulted in a child protective services report. GP3 commented on how this incident affected her trust in the formal service providers:

And that we were working on that, and they all knew there was stuff all over this house when we moved in. And [Grandson] was real honest. he didn't even try to hide them. And so, it was just stuff like that. I was like, “Why? You want me to just hide everything now and not tell you what I find or do?” So that was very discouraging. The second go-around with KPACT because I felt like I couldn't tell them-- his crisis worker--she was really upset [with KPACT]. She said, "How do you expect us to take care of problems and fix problems if you're going behind our back for something that didn't need to take place?

These two instances reflect ways formal service providers did not Create[er] a Working Relationship with the SP and may have inadvertently created Service Barriers, leading to, at least in the case of GP8, the Decision to End the Service.

**SP Being Attentive to GF Needs**

This sub-theme is defined as the ways grandparents described service providers as attending to grandfamily needs. This is accomplished through (a) involving grandparents in formal services and (b) removing grandfamily barriers.
**SP involving GP in Formal Services.** Grandparents commonly indicated their desires to be involved in their grandchild’s services, which when it happened, *Created a Working Relationship with the Service Provider.* GP10, who was raising five grandchildren with his wife, shared his perspective that services providers working with his family understood “the extra need for help.” GP10, whose target grandchild was born addicted, described his relationship with service providers as “actually great,” and highlighted how when he communicated a need, he felt like the formal service providers listened. He shared, “It seems like everybody knew that we were concerned, and they dealt with our concerns as they popped up.” This grandparent highlighted how the formal service provider’s listening and responding to grandfamily needs helped this grandfather creating a working relationship with the formal service provider.

GP2 was another grandparent who had a high level of involvement in her grandchild’s formal services. GP2 was raising her grandchild due to the grandchild’s parents being arrested and made sure to have high involvement in a private school tailored to children with special needs. GP2 said about her involvement in services: Oh, I loved it. It was great because you always knew what was going on there. You always knew about what her grades were going to be.” GP10 who was involved in a local community program shared, “[I was] very involved. They made sure that we were involved with everything. They gave us stuff to do after they left. Unfortunately, though, this service did not last beyond two years for this grandparent and grandchild, due to the cost of school tuition and lack of social opportunities for her grandchild.

As noted previously in Figure 2, grandchildren can have developmental and emotional needs. These needs, particularly emotional needs, can manifest as behaviors such as aggression or emotion dysregulation. GP2, who was raising her grandchild due to both her parents being arrested commented on the tantrums and fits her granddaughter displayed at home commented
on her participation in services when she played a tape recording to her grandchild’s counselor to reflect the grandchild’s behaviors at home. GP2 commented,

Until we had a counselor that did seem to push her buttons and get her riled up, because she would never show her true self. And she did, she did in front of this counselor. But this was also the counselor that I had listened to her on tape. So, she actually knew what we were going through at home… I, remember, she handed me a sheet, and I had never heard of reactive attachment disorder [RAD] and she handed me a sheet and she said, “Does this sound like her?” And it described her to a T, except one or two things, and they were like 25 things. And she didn’t fit just a couple of them. And I said, this is her, right here. So, she actually gave me an idea of what was wrong with her.

In applying this example to the conceptual model, the grandchild has a tantrum at home (Identification of ACE-related GC Needs), which impacts the grandparent, and the grandparent tapes the tantrum (Managing GC ACE-related Needs & Behavior). The grandparent reaches out to the grandchild’s counselor and shares the tape with her (Managing GC ACE-related Needs & Behavior), which provides the counselor with additional information to help the counselor understand the grandchild’s behaviors (Creating a Working Relationship with the SP) and thus better help the grandchild and the grandparent by providing the grandparent with information about a possible diagnosis and additional information, which removes barriers, and the grandparent is then able to look up resources pertinent to the diagnosis (Creates Change).

Not all grandparents experienced a lack of reciprocity in terms of their being involved in formal services with their providers. Half of the grandparents reported having limited to no involvement in their grandchild’s services. Some grandparents described their minimal
involvement in services as being limited to the first meeting, and then being excluded. GP4, raising a grandchild due to parent substance use and child neglect, described his experience, I was expecting a lot better response than what we got through the counseling that we received. They didn't want to hear our thoughts. They just wanted her [thoughts]. They didn't want to hear what the background was or what we thought the way she was treated or anything like that. We were basically shut out of it and only the child would go back with her. The [counselor] let us talk a little bit to start with. Then they shut us out and wouldn’t let us go into the room with her.

This being ‘shut out’ from the formal services hampered a working relationship between the grandparents and the formal service provider. In addition, GP9 reported trusting formal service providers in the beginning of services and attempted, for two years, to be involved in monthly service meetings for her grandchild’s care and was regularly ignored until she gave up trying to contact the child protection services case worker. She shared, “I’ve never been involved. I requested to be notified of the meetings. They refused to notify me. They just say, ‘Oh yeah, we’ll let you know.’ And I never hear anything.” This lack of involvement created Service Barriers, which hindered not only the working relationship that both GP4 and GP9 had with their grandchild’s formal service provider, but also the ability to Create Change. In the case of GP4, it ultimately led to the Grandparent Deciding to End the Service.

**SP Removing Barriers.** SP removing barriers is defined as ways service providers make services more accessible for grandparents by actively removing barriers that grandparents experienced, which created a working relationship between the grandparent and the formal service provider. Grandparents raising a grandchild with an ACE history addressed how service providers removed barriers for their grandfamily by providing financial relief, financial subsidies
for grandchildren to attend childcare, waivers for clothing, and offering to help the grandparent with Christmas shopping. Grandparents also had formal service providers link them with additional programs that they could benefit from, with removed Service Barriers. Another way grandparents had barriers removed was through formal service providers advocating for the grandfamily. For example, GP6 shared an experience with a local program providing services to the grandchild by attending to their needs with Child Protective Services (CPS), which as evidenced by advocating for the grandfamily:

Someone had called CPS who came here. And of course, there was never a case made. It was just someone threatening not to be nice. [Program] called CPS on our behalf and said, ‘Look, we've been working with this child and this family, and we know this is lies. He is being cared for. He is 100% healthy. He's not abused.’ So, I mean, they have your back, and they still have my back all the way through.

In this example, GP6 emphasized feeling like the formal service providers she was working with were there to support her and her family (Creating a Working Relationship with the SP). GP1 echoed this sentiment and shared an instance where her formal service provider advocated for her grandson and family in court. She said, “The case manager that my grandson had at [Agency] presented evidence in a couple of hearings for us in court about what she was seeing as his case manager about how he’s grown and changed.” GP1 concluded that her working relationship with the DSS provider was strengthened when they “went out to their way to just be helpful and to reach out to us when they found other things that may be of help to us.” This example demonstrates a relationship between the double-sided arrow for the themes Managing GC ACEs, Needs, & Behavior (going out of their way to be helpful to the grandfamily) and Creating a Working Relationship with the SP (presenting findings in court), as noted in Figure 2.
Table 11

**Summary of Sub-Themes for Creating a Working Relationship with SP (N =10)**

<table>
<thead>
<tr>
<th>Sub-themes</th>
<th>Definition</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grandparents Trusting SP</td>
<td>• Grandparents trusting SP from the beginning of services</td>
<td>5 (50)</td>
</tr>
<tr>
<td>SP involving GP in services</td>
<td>• The level to which service providers involve grandparents in services</td>
<td>10 (100)</td>
</tr>
<tr>
<td>SP removing barriers</td>
<td>• Ways service providers reduce hinderances to grandfamilies</td>
<td>8 (80)</td>
</tr>
</tbody>
</table>

*a This percentage is from the whole sample.

**Creating Change**

This theme described how change is observed in grandfamilies during service utilization for both grandchild and grandparent, which are explored in sub-themes below (n=10; 100%).

When the grandchild benefitted from the service, grandparents remarked on changes such as increased maturity, improvement in developmental needs, behavioral changes, and greater grandchild-grandparent communication. In comparison, when grandparents benefitted from the service, they identified having less worry about their grandchild, an ability to maintain their employment, enhanced awareness of available resources, receiving compassion from professionals working with their grandchild, and learning skills to help their grandchild. Sub-themes are summarized in Table 12. When connecting the theme *Creating Change* to the conceptual model, the benefits grandparents and grandchildren received reflected themes such as *Creating a Working Relationship with the SP* (e.g., enhanced awareness of available resources; receiving compassion from professionals working with their grandchild; improvement in developmental needs, behavioral changes), *Managing GC ACE-related Needs & Behaviors* (e.g., learning skills to help their grandchild; grandchild-grandparent communication) as well as
having Service Barriers (e.g., enhanced awareness of available resources) removed.

Grandparents attributed the presence of services as well as their implementation to changes for grandchildren

**GC benefitting from the service.** This sub-theme describes how the grandchild benefitted from professional services. Some examples included increased grandchild maturity, improved speech, language, and gross motor skills, creating a routine, and an increase in the grandchild sharing their experiences with her family. For example, GP4, who was raising her grandchild due to substance abuse and child neglect, identified how counseling was helpful for their granddaughter, “It started bringing her out of the situation she was in where she was so withdrawn. She actually would start talking to us and expressing her feelings.” GP4 remarked on her grandchild’s benefits by contrasting the change in grandchild behavior.

GP10, whose grandchild had been born addicted, and had language and mobility problems shared,

> There was never a time what [professional services weren’t] helpful. Seeing him now versus seeing him when he first came—it’s a complete turnaround. I would say speech therapy was great because he’s talking 95% better now. You can understand him, and he can make words, make sentences, phrases. And the physical and occupational therapy helped him with his motor skills as far as walking, learning how to use hands and stuff to grab things and feed himself.

This grandparent attributed his relationship of trust with the formal service providers to outlining the challenges that his grandson was experiencing and making sure that these providers understood and dealt with concerns as needed.
In addition, GP5 and GP9 were both raising grandchildren with at least one parent with a substance use problem. Both grandparents noted how helpful it was to have a routine in their lives. For example, GP9 shared, “And the counselor would ask me, ‘Is anything going on?’ I said, ‘No. Except I can't get her to sleep at night, it's 2 o'clock.’ She said, ‘Well, you need a routine to do this, and here's a suggestion.’ And it worked.” In this situation, GP9 requested help from her grandchild’s counselor (Creating a Working Relationship with SP) and followed through on the recommendation (Managing GC ACE-related Needs & Behavior). This example demonstrates the double-sided arrow between Managing GC ACE-related Needs & Behavior and Creating a Working Relationship with SP, in that when grandparents and formal service providers have created a working relationship, grandparents can feel comfortable asking for assistance in managing challenges, such as creating routine for sleep. This example also demonstrates the relationship between the theme Creating a Working Relationship with SP and Creating Change, in that the grandparent implemented the formal service provider’s suggestion about a sleep routine, and “it worked,” which benefitted the grandchild and helped the grandparent in Managing GC ACE-related Needs & Behavior.

**GP benefitting from the service.** This sub-theme describes how the grandparent benefited from the grandchild’s service experience. Examples of grandparent benefits included worrying less about their grandchild, having the ability to keep working, gaining information about available services, talking with a professional who is also working with the grandchild, and learning specialized skills related to navigating a child’s diagnosis. For example, GP1 recounted that, before receiving formal services for her grandchild, she would regularly worry about getting a call from the day care to come retrieve her grandson due to aggression while she was at work. GP1 expressed, however, “as time went on, and there was more case management and more
services rendered, more growth, especially with my grandson...those feelings of worry were
lessened.” I knew he had somebody to talk to or to work with.” This grandparent highlighted that
the changes she was seeing with her grandchild were related to the services he was receiving,
which reduced her worry. Another grandparent, GP8, who was raising her grandchild due to the
granddaughter not feeling safe in her home, talked about the benefit of having a provider who
came to her home, had an understanding of the current family situation was going on in the
family, and who checked in on GP8’s status. GP8 commented on her appreciation for the
“compassion,” and space to feel and discuss her feelings, that her grandchild’s provider gave her
during occasional check-ins. GP8 emphasized that this provider’s “compassion…made a big
difference.” This is an example of the pathway of not only a double-sided arrow between
Managing the GC’s ACEs, Needs, and Behavior and Building a Relationship of Trust with SP,
where a grandparent leaned on her relationship of trust with her grandchild’s formal service
provider. GP8 not only asked for help in Managing the GC’s ACEs, Needs, and Behavior, but
also created change, as evidenced by the grandparent reporting that the “compassion…made a
big difference” for her.

Table 12

Summary of Sub-Themes for Creating Change (N =10)b

<table>
<thead>
<tr>
<th>Sub-Themes</th>
<th>Definition</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>GC benefitting from the service</td>
<td>• How the grandchild benefits from the service</td>
<td>9 (90)a</td>
</tr>
<tr>
<td>GP benefitting from the service</td>
<td>• How the grandparent benefits from the service</td>
<td>9 (90)a</td>
</tr>
</tbody>
</table>

a This percentage is from the whole sample.

Grandparent Deciding to End the Service

The theme, Grandparent Deciding to End the Service (n= 10; 100%) is defined as how
grandparents decide to end formal services. Grandparents chose to end formal services primarily
due to not seeing change in their grandchild, which was characterized by grandchildren with an ACE history not acting any differently at home or at school. For example, GP8, who was raising her grandchild due to parent substance abuse, stated, “I had her in counseling, but it didn’t seem to be helping.” In addition, GP1, who was raising her grandchild due to parent separation, described her experience with her grandchild’s counseling service, “I don’t know if it was [the counselor], the type of the therapy (play therapy), the age of the patient, what exactly the issue was. It left me wanting more.” This grandparent also described how taking time off work, getting kids during the middle of the day, and not paying for services, in addition to not seeing results, contributed to her decision to end services. This practice of attending “a few times” was a common response among grandparents who eventually decided to end formal services.

**Focus Group Results**

To answer my third research question, “What do formal service providers describe as best practices for working with grandparents who are raising grandchildren with ACE histories?” I conducted two focus groups, with the first group having three formal service providers and the second focus group having seven formal service providers. A total of ten formal service providers participated between the two focus groups. All formal service providers identified as women and the average age of the professionals was 39 years old (SD = 13.38; Range 26-69). All focus group participants identified as White. One participant identified as Hispanic, and the remaining participants identified as non-Hispanic. Formal service providers had a bachelor’s degree (20%), some graduate school (20%) or a master’s degree (60%). Occupations or job titles were not reported on the survey form. A majority (80%) of focus group participants reported working with over 10 grandchildren when asked how many grandchildren they have ever worked with and estimated that they worked with an average of 4.56
grandchildren each year ($SD = .882; \text{Range} \ 3-5$). Fifty percent of focus group participants ($n = 5$) reported having 5-10 years of experience working with a grandchild with an ACE history, while 30% ($n = 3$) reported having 3-5 years. The remaining 20% ($n = 2$) reported having over ten years of experience working with grandchildren with ACE histories. These numbers may seem contradictory, which may be due to two formal service providers estimating high on the number of grandchildren they have ever worked with and then giving a more conservative number when the service provider was asked for an estimate of how many grandchildren they worked with on a yearly basis. For more information about the service provider demographics, refer to Table 13.

**Table 13**

*Service Provider Demographics (N = 10)*

<table>
<thead>
<tr>
<th>Demographic Variable</th>
<th>Service Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M (SD</td>
</tr>
<tr>
<td>Age</td>
<td>38.89 (13.38</td>
</tr>
<tr>
<td>Gender (%)</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>10 (100)</td>
</tr>
<tr>
<td>Race</td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>10 (100)</td>
</tr>
<tr>
<td>Hispanic</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>1 (10)</td>
</tr>
<tr>
<td>No</td>
<td>9 (90)</td>
</tr>
<tr>
<td>Education</td>
<td></td>
</tr>
<tr>
<td>Bachelor’s degree</td>
<td>2 (20)</td>
</tr>
<tr>
<td>Some graduate school</td>
<td>2 (20)</td>
</tr>
<tr>
<td>Master’s degree</td>
<td>6 (60)</td>
</tr>
<tr>
<td>Number of GC ever worked with</td>
<td></td>
</tr>
<tr>
<td>3 to 5</td>
<td>2 (20)</td>
</tr>
<tr>
<td>More than 10</td>
<td>8 (80)</td>
</tr>
<tr>
<td>Number of GC worked with in a year</td>
<td></td>
</tr>
<tr>
<td>0-9</td>
<td>4 (40)$^a$</td>
</tr>
<tr>
<td>10-19</td>
<td>3 (30)</td>
</tr>
<tr>
<td>20-29</td>
<td>2 (20)</td>
</tr>
<tr>
<td>Over 30</td>
<td>1 (10)</td>
</tr>
</tbody>
</table>
Years of experience of working with grandchild with an ACE history

<table>
<thead>
<tr>
<th>Years</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>3-5 years</td>
<td>3 (30)</td>
</tr>
<tr>
<td>5-10 years</td>
<td>5 (50)</td>
</tr>
<tr>
<td>Over 10 years</td>
<td>2 (20)</td>
</tr>
</tbody>
</table>

*a This number contradicts the data in the previous row due to two participants overestimating the number of grandchildren they have worked with on a yearly basis. Two participants initially estimated 10 grandchildren, but later reported three and four-to-six grandchildren worked with per year, respectively.

**Types of Services Provided to Grandchildren & Grandparents**

Service providers also identified the types of services they provided to grandchildren and/or grandparents. The most common services provided by the focus group participants to grandchildren with an ACE history were mental health skill building (66.7%), emotional support (44.4%), crisis intervention (44.4%), and case management (44.4%). In comparison, the most common services provided to grandparents were general support (66.7%), parent coaching (44.4%), and education (33.3%). Only two providers elaborated on their definition of general support, which included general case management and providing trauma-informed psychotherapy. For more information about types of services provided by the focus group participants, refer to Table 14.

**Table 14**

*Provider-identified Types of Services Provided to Grandchildren and Grandparents Raising a Grandchild with an ACE history (N =10)*

<table>
<thead>
<tr>
<th>Service</th>
<th>Grandchildren n (%)</th>
<th>Grandparent n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental health skill building</td>
<td>6 (66.7%)</td>
<td>2 (22.2%)</td>
</tr>
<tr>
<td>Emotional support</td>
<td>4 (44.4%)</td>
<td>3 (33.3%)</td>
</tr>
<tr>
<td>Crisis intervention</td>
<td>4 (44.4%)</td>
<td>3 (33.3%)</td>
</tr>
<tr>
<td>Service</td>
<td>A (11.1%)</td>
<td>B (11.1%)</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>-----------</td>
<td>-----------</td>
</tr>
<tr>
<td>Case management</td>
<td>4 (44.4%)</td>
<td>3 (33.3%)</td>
</tr>
<tr>
<td>Counseling</td>
<td>3 (33.3%)</td>
<td>2 (22.2%)</td>
</tr>
<tr>
<td>Education</td>
<td>3 (33.3%)</td>
<td>3 (33.3%)</td>
</tr>
<tr>
<td>Parent coaching</td>
<td>3 (33.3%)</td>
<td>4 (44.4%)</td>
</tr>
<tr>
<td>General support</td>
<td>2 (22.2%)</td>
<td>6 (66.7%)</td>
</tr>
<tr>
<td>Mentoring</td>
<td>1 (11.1%)</td>
<td>--</td>
</tr>
<tr>
<td>Support Group</td>
<td>--</td>
<td>1 (11.1%)</td>
</tr>
<tr>
<td>Legal aid/assistance services</td>
<td>--</td>
<td>1 (11.1%)</td>
</tr>
<tr>
<td>Financial assistance</td>
<td>--</td>
<td>1 (11.1%)</td>
</tr>
<tr>
<td>Other services</td>
<td>3 (33.3%)</td>
<td>1 (11.1%)</td>
</tr>
<tr>
<td>Other services: Intensive Care</td>
<td>1 (11.1%)</td>
<td>1 (11.1%)</td>
</tr>
<tr>
<td>Coordination</td>
<td>1 (11.1%)</td>
<td>1 (11.1%)</td>
</tr>
<tr>
<td>Parenting classes in positive behavior support and linking with resources</td>
<td>1 (11.1%)</td>
<td>1 (11.1%)</td>
</tr>
<tr>
<td>Service Coordination</td>
<td>1 (11.1%)</td>
<td>1 (11.1%)</td>
</tr>
<tr>
<td>General case management</td>
<td>1 (11.1%)</td>
<td>--</td>
</tr>
<tr>
<td>Providing the full extent of family trauma-informed psychotherapy</td>
<td>1 (11.1%)</td>
<td>--</td>
</tr>
</tbody>
</table>

**Formal Service Provider Assessment of Services in Their Area**

Formal service providers also provided their assessment of the number of services available to grandfamilies in their area. Of the ten formal service providers who participated in this study, 40% indicated that services available to grandfamilies were below average in their area, while the remaining 60% reported that they thought the available services were average. Forty percent of the formal service providers opted to give explanations of their answers to the above questions, with some individuals providing more than one explanation. Among these responses, all respondents \( n = 4 \) indicated that being in a rural area creates service limitations, such as resources and services being dependent on grandparents having legal custody of the grandchild. The remaining justifications included (a) grandparents not being recognized by the local school; (b) transportation challenges; (c) deterioration of community groups; (d) lack of grandparent-specific education; and (e) the need for respite and group therapies.

**Areas of Reward & Challenge When Providing Services to Grandfamilies**
Formal service provider participants also identified areas of reward and challenge when providing services to grandfamilies. Common rewards included providing grandparents with information and resources (77.8%) as well as providing them with needed services (77.8%). Alternatively, common challenges providers reported were grandparent lack of understanding of the services (e.g., techniques being taught, skills, depth of the problem, etc.; 66.7%) and financial challenges (66.7%), however, no additional explanation about financial challenges was given by the focus group participants. See Tables 15 and 16 for more information about provider identified rewards of working with grandfamilies with an ACE history and provider-identified challenges of working with grandfamilies with an ACE history, respectively. For more information about formal service provider perspective on grandchild needs; assessment of service availability and barriers for grandfamilies; and training needs for service providers, identified by service providers, please refer to Appendices M-O where Tables 19-21 are located.

Table 15

Provider-identified Rewards of Working with Grandfamilies with an ACE history (N = 10)

<table>
<thead>
<tr>
<th>Reward</th>
<th>Service Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Providing information and resources</td>
<td>7 (77.8%)</td>
</tr>
<tr>
<td>Providing needed services</td>
<td>7 (77.8%)</td>
</tr>
<tr>
<td>Helping families learn skills to manage their challenges</td>
<td>6 (66.7%)</td>
</tr>
<tr>
<td>Helping grandchildren learn to manage their emotions</td>
<td>6 (66.7%)</td>
</tr>
</tbody>
</table>

a Participants were permitted to select multiple rewards

Table 16

Provider-identified Challenges of Working with Grandfamilies with an ACE history (N = 10)

<table>
<thead>
<tr>
<th>Challenges</th>
<th>Service Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of grandparent understanding (e.g., techniques you are teaching, skills, depth of the problem, etc.)</td>
<td>6 (66.7%)</td>
</tr>
<tr>
<td>Financial</td>
<td>6 (66.7%)</td>
</tr>
<tr>
<td>Lack of Transportation</td>
<td>5 (55.6%)</td>
</tr>
</tbody>
</table>
Expecting the grandchild to change 5 (55.6)
Wanting a “quick fix” 5 (55.6)
Time/Scheduling difficulties 3 (33.3)
Lack of engagement (unclear about whether GP or GC) 3 (33.3)
Lack of motivation (unclear about whether GP or GC) 2 (22.2)
Cancellations/No shows 2 (22.2)
Lack of Childcare 2 (22.2)
Long travel distances 1 (11.1)

Familiarity and Use of TIC

Given that the focus of this study was on grandchild ACEs, I was interested to know how providers ranked their familiarity with and using TIC. TIC, as referenced in Chapter 2, is a practice approach that formal service providers can use when working with individuals with histories of trauma. Given that many providers equate trauma and ACEs, I inquired about whether these providers use TIC as well as formal service providers’ comfort and familiarity in addressing ACE topics.

Seventy percent of the formal service providers identified being “Very Familiar” with working within a TIC lens. The remaining comfort levels included “Extremely Familiar (20%) and “Somewhat Familiar (10%). The focus group participants indicated that they commonly learned about TIC from college courses (40%), job trainings (40%), and community groups (30%). Less frequent learning sources included community mental health center trainings (20%), personal research (20%), workshops (20%), and certification trainings (10%).

In addition, regarding the frequency of ACEs in their work, formal service providers indicated that they often (50%) or very often (30%) work with a grandchild with an ACE history and that their knowledge of ACEs and the impacts of ACEs is above average (60%) or excellent (20%). The formal service providers also reported on their comfort and skill levels in talking about ACEs, in general. They reported feeling moderately comfortable (50%) or very
comfortable (40%) when talking about ACEs. Finally, the service providers indicated believing they had a moderate skill level (70%) in talking about ACEs. For a comprehensive report of these findings, please refer to Table 17.

Table 17

Service Provider TIC Awareness and Use (N =10)

<table>
<thead>
<tr>
<th>Exposure to and use of TIC</th>
<th>Service Provider n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Familiarity working with trauma-informed care (TIC)</td>
<td></td>
</tr>
<tr>
<td>Somewhat familiar</td>
<td>1 (10)</td>
</tr>
<tr>
<td>Very familiar</td>
<td>7 (70)</td>
</tr>
<tr>
<td>Extremely familiar</td>
<td>2 (20)</td>
</tr>
<tr>
<td>Where learned about TICa</td>
<td></td>
</tr>
<tr>
<td>College courses</td>
<td>4 (40)</td>
</tr>
<tr>
<td>Job trainings</td>
<td>4 (40)</td>
</tr>
<tr>
<td>Community group</td>
<td>3 (30)</td>
</tr>
<tr>
<td>Community mental health center training</td>
<td>2 (20)</td>
</tr>
<tr>
<td>Personal research</td>
<td>2 (20)</td>
</tr>
<tr>
<td>Workshops</td>
<td>2 (20)</td>
</tr>
<tr>
<td>Certification training</td>
<td>1 (10)</td>
</tr>
<tr>
<td>Frequency of working with a GC with an ACE history</td>
<td></td>
</tr>
<tr>
<td>Sometimes</td>
<td>2 (20)</td>
</tr>
<tr>
<td>Often</td>
<td>5 (50)</td>
</tr>
<tr>
<td>Very often</td>
<td>3 (30)</td>
</tr>
<tr>
<td>Knowledge of ACEs and their impacts</td>
<td></td>
</tr>
<tr>
<td>Average</td>
<td>2 (20)</td>
</tr>
<tr>
<td>Above average</td>
<td>6 (60)</td>
</tr>
<tr>
<td>Excellent</td>
<td>2 (20)</td>
</tr>
<tr>
<td>Comfort level in talking about ACEs</td>
<td></td>
</tr>
<tr>
<td>Somewhat comfortable</td>
<td>1 (10)</td>
</tr>
<tr>
<td>Moderately comfortable</td>
<td>5 (50)</td>
</tr>
<tr>
<td>Very comfortable</td>
<td>4 (40)</td>
</tr>
<tr>
<td>Skill in talking about ACES</td>
<td></td>
</tr>
<tr>
<td>Moderate skill 1</td>
<td>7 (70)</td>
</tr>
<tr>
<td>Very skilled</td>
<td>3 (30)</td>
</tr>
</tbody>
</table>

aParticipants identified multiple answers in this response, so percentages will not add up to 100.
Best Practices for Working with Grandfamilies

The thematic analysis of the focus group data yielded three themes related to best practices for working with grandfamilies. These practice guidelines included: intergenerational cycles, assessment and intervention, and ACEs education.

Awareness of Intergenerational Cycles

The best practice, of professional awareness of intergenerational cycles, is described as professionals considering that ACE histories are likely to occur in both grandparents and the grandchildren they raise. Focus group participants shared their experiences of seeing an intergenerational cycle of ACEs in that an ACE history was frequently transmitted across the generations. For example, the presence of intergenerational ACE histories in grandfamilies led SP4 to comment in this way: “So whether grandchild or grandparent, and so I guess it’s just kind of par for the course and feels like it’s just kind of expected in my service.” In addition, SP5 shared, “Currently with the grandparents I work with, 100% [have intergenerational trauma] …Oh, I think it’s repeating.” SP8, however, illustrated this best practice the most when she said, “we have to look at intergenerational trauma in a larger framework,” or the clinical context of which the family is embedded and where the problems are occurring.” That is, within this best practice is not only the understanding that intergenerational cycles exist, but also the idea that approaching this trauma from an intergenerational perspective is essential, as the presence of these cycles will affect intervention efforts and outcomes.

ACEs Assessment and Intervention

The theme, “assessment and intervention,” includes the ways in which focus group participants acquired information about a grandchild’s ACE history, as well as the strategies they used to intervene. In both focus groups, service provider participants shared that they assessed
for grandchild ACEs by 1) using a condensed 10-question version of Felitti et al.’s (1998) study questionnaire as a screening tool; 2) using the ACEs questions as part of their initial assessment; or 3) broadly asking questions about the grandchild’s ACE history. Service providers from one focus group also shared that they often received information about a grandchild’s ACE history from the local Child Protective Services worker. Some service providers shared their rationale for the importance of assessing for a grandchild’s ACE history. For example, SP6 explained:

We complete the ACEs study with the families. Like we have a laminated copy and provide it and talk about it. They complete and they just tell me that number, they don’t have to talk about the questions unless they want to. But it’s mainly getting the number, and then we go from there and build resilience.

Similarly, SP5 shared, “I do the 10-question survey with them. And we begin to look at how it’s affected themselves, their children, and their grandchildren, and how they may heal from that.”

Under this lens, focus group service providers indicated that they intentionally used assessment as a means of intervention with ACEs.

An additional intervention avenue discussed within both focus groups, when working with grandparents raising grandchildren with an ACE history, was practicing TIC. SP5 offered their own definition on TIC:

[W]ith trauma care, we’re building that trust with the family. And to me, what I may not think is a trauma may be horrendous for the family dealing with it or vice versa. So, I think with trauma-informed are, you’re working with where the grandparents [are] at and what’s trauma to them, not me. So, I feel like trauma and care is across the board. You’re normalizing, you’re making that family feel comfortable and sharing with you. And I think with the trauma-informed care, what’s what it is. You’re building that trust.
Other participants agreed and extended the definition of trauma informed care. For example, SP6 extended the TIC definition to also include “offering education, support, in the same positive way.” Another provider SP1 shared her understanding of the essence of TIC:

I think it’s helpful to know, not only what the facts of trauma are, but how to create more PCEs, so those positive childhood experiences and resiliency building techniques. And I think that that’s really important with that trauma-informed care is—just to not just leave them like, ‘Oh, well, trauma affects the body and everything else,’ but to make sure that they now how to build some resilience and make some connections and to really build those support networks.

Other intervention approaches described by the focus group participants, when working with grandparents raising grandchildren with an ACE history included cognitive behavioral therapy, family systems theory, trauma-focused cognitive behavioral therapy, and making the service family-directed and strengths-based or focused on what the family wants and non-pathologizing.

Best practices that arose out of this theme, as identified by formal service providers, include: (a) adequate assessment of a grandchild’s ACE history; (b) utilizing the ACE history as a place to develop resilience as well as strengths-based mindset, which includes TIC; and (c) using a research-backed modality.

The first best practice is adequate assessment, which requires for a provider to have a fuller understanding of a grandchild’s history and challenges as well as areas for future intervention. Most of the formal service providers highlighted that assessment is a needed component to treating grandchildren being raised by their parents.

The second best practice formal service providers identified was to utilize the ACE history and harness it into an intervention that promoted strengths-based, rather than deficit-
based mindsets in treatment. For example, a provider in the second focus group stated her approach to helping grandparents raising a grandchild with an ACE history. This provider shared the language she uses when talking to grandparents at the onset of service use: “We're here to help you. Nobody's broken. It's just something to help.”

The third best practice was to use research-backed techniques to promote healing and change in treating the grandchild’s ACE history. This is a best practice because modalities such as cognitive behavioral therapy, family systems theory, trauma-focused cognitive behavioral therapy have been tested and determined to be efficacious to individuals with ACE histories.

**Providing ACEs Education**

The theme, *Providing ACEs Education* captured the importance of service providers offering trauma-informed education to grandparents raising grandchildren with an ACE history. This education can range from providing information about the grandchild’s trauma to helping grandparents understand a grandchild’s experience and situation. For example, SP15 stated,

I think that providing psychoeducation is really important. So just helping the grandparent to understand the condition or the situation that their grandchild is in…and sometimes that psychoeducation can also help the grandparents to recognize, "Oh, well, that's why I was experiencing this or that. It's because of my own trauma.

This service provider identified how psychoeducation can help grandparents to develop insight into their behaviors as well as understanding why grandchildren with ACE histories act the way they do.

The service providers also identified the challenges of sharing education about ACEs with grandparents. SP3 commented about the difficulty of grandparents acknowledging the presence of ACEs. She said “these families—this isn’t ACEs. This isn’t trauma. It’s just Tuesday
in their family and in their world.” SP1 similarly observed, “I don’t know that they see them as ACEs. They just see them as that’s always how it’s been.” Providers highlighted that a relationship of trust and education with grandparents was crucial to having them be more open to receiving psychoeducation about ACEs. For example, SP7 said:

But some people are not won over as easily, and they don’t really feel comfortable talking about their ACEs or describing them until they trust someone. I know that in the Appalachian region where I practice, there’s a culture of kind of pulling yourself up by your own bootstraps and handling it on your own because, in the past, a lot of grandparents that was their only option. They learned how to do it that way. So, I found that I get a lot further with the grandparents and they’re more open to my feedback when they build that trust with me.

Despite these challenges, participants across both focus groups identified that providing education is a best practice when working with grandparents. The participants indicated that educational materials used for working with grandparents raising grandchildren with ACE histories should include parenting children with trauma histories, discipline strategies, information about how to be more positive, taking the grandchild’s perspective, understanding normal grandchild behavior, understanding trauma and the impact of ACEs on the family, and how to move forward or build resilience past ACEs. SP2 shared, “I think giving them [grandparents] concrete ideas is really helpful. So how to, giving examples, showing them how to make a visual schedule, or a calming place, and setting up a time every day to have one-on-one attention…things that are very helpful in getting some implementation from grandfamilies.”
Conclusion

In summary, formal service providers reported having a high familiarity with TIC and indicated that they had received information about TIC through college or job training sources. Participants indicated that ACEs often appear in their work with grandchildren raised by grandparents and that they felt well equipped to both talk about ACEs and to draw from their knowledge about ACEs. The thematic analysis from both focus groups revealed three themes related to best practices for working with grandparents raising a grandchild with an ACE history. The first theme is an awareness of intergenerational cycles, which translates to considering that ACE histories are likely present for both grandparents and the grandchildren they raise, which knowledge can be considered as treatment is planned. The second theme was the importance of ACEs assessment and intervention. The best practices associated with this theme were adequate assessment of an individual’s ACE history; leveraging the ACE history to promote resilience for the future; and using evidence base practices for treatment. The last theme was distributing trauma-informed education about the grandchild’s ACE history to the grandparent. Best practices related to this theme included sharing concrete ideas with grandparents to help their grandchild with schedule reminders, emotion regulation strategies, or grandparent-grandchild relationship time. Additional best practices included education about trauma and the impact of ACEs on the family, as well as how to build resilience in the family, after the ACE.
Chapter 5

Discussion

The purpose of this qualitative study was to (a) gain an understanding of how a grandchild’s ACE history influences grandchild and grandparent formal service needs; (b) examine the process of grandparents seeking and utilizing formal services for their grandchildren with ACE histories and (c) explore what formal service providers describe as best practices for working with grandfamilies raising a grandchild with an ACE history. After interviewing ten grandparents from Central, North Central, and South Central Appalachia, as well as conducting two focus groups with ten total formal services, the major study findings included the impact of ACEs on both grandchildren and grandparents and how a grandparent’s path to seeking services for their grandchild with an ACE history is not a linear process, but a recursive one. This is particularly evident as the grandparent seeks to manage grandchild needs on their own, has challenges, then talks with the formal service provider and applies formal service provider recommendations, which builds a relationship of trust. This study also found how the impact of building a relationship of trust with grandparents affected service delivery, and finally, the impact of TIC with grandfamilies

Grandfamilies, ACE Histories, & Appalachia

Approximately three million grandchildren are being raised by their grandparents in Appalachia (Keller et al., 2019). Furthermore, grandparents are believed to be raising their grandchild full-time in Central Appalachia between twice and two and a half times the national rate (Phillips et al., 2020; Pollard & Jacobsen, 2016). Factors that contribute to being a grandparent raising a grandchild include “poverty status, having a high school education, and being married all increased the probability of grandparent caregiving status” (Phillips et al. 2020,
Anderson (2019) echoed these findings when she found relationships between both opioid use and individual poverty as well as poverty and grandparents raising grandchildren. Both of these researchers raised the possibility that grandparents are raising their grandchildren due to the opioid crisis, which introduces the possibility of these grandchildren experiences ACEs.

Compared to grandparents in other regions in the United States, grandparents raising grandchildren in Appalachia experience financial strains, health challenges, and stress (Hansen et al., 2020; Keller et al., 2019; Rawn et al., 2021). Kaye et al. (2010) also noted that rural grandparents may also feel isolated in their caring for their grandchild as part of living in a rural community. Yet, grandparents in Appalachia also have unique strengths, such as a culture of familialism, community connection, and religious beliefs, which can serve as protective factors for individuals with ACE histories (Dunfee et al., 2020; Whitt-Woosley et al., 2018).

Yet, Appalachia is a region that is in need of services. Stucki (2020), using data from Grandfamilies’ 2017 State Fact Sheets found that in the Appalachian region,

Excluding state and federal public benefits, most common service types were emotional support, information and referral, financial assistance, and education. Least common service types included grandchild special health needs, legal services, and early childhood intervention. For service availability, four of the five Appalachian sub-regions had no services in over 65% of their counties. South and North Central Appalachia regions had no services in over 90% of their counties (p. 608-609).

This lack of services, particularly those that cater to grandchildren with ACEs or with ACEs and special needs, can also be a challenge for grandparents raising grandchildren.
Grandchild and Grandparent Formal Service Needs

My first research question was “How do grandparents raising grandchildren identify formal service needs for themselves and their grandchild with an ACE history?” In this section, I will discuss what formal service needs grandchildren and grandparents have, as a result of this study.

Grandchild Formal Service Needs

In response to my first research question, “How do grandparents raising grandchildren identify formal service needs for themselves and their grandchild with an ACE history?”, study findings revealed that all grandparents linked their grandchild’s ACE history to their grandchild’s service needs. While some grandparents in the present study did not explicitly use the term “ACEs” or “trauma,” they did discuss their grandchildren’s attachment and developmental needs, and that these needs were linked to the grandchild’s ACE history, which they frequently framed in terms of the grandchild’s life prior to coming to live with the grandparent. This study offers evidence that grandparents are aware that their grandchildren’s ACE histories contributed to their grandchild’s needs and many grandparents connected these grandchild needs to needing formal services. Therefore, the findings in this research study adds additional evidence to previous literature, in that children with trauma histories can have significant emotional and physical challenges (Balistreri & Alvira-Hammond, 2016; Hayslip et al., 2019; Kerker et al., 2015; Woods-Jaeger et al., 2018).

Study findings further identified that most grandparents indicated that their grandchildren commonly experienced developmental (e.g., under-developed physical, cognitive, language, sensory needs) and attachment needs (e.g., feeling abandonment, needing attention, wanting to be with grandparent, struggling with attachment, and needing love). Developmental needs have been reported in the foster care literature, where children commonly experience ACEs related to
an adult in their life, as well as being removed from their home. Chipungu and Bent-Goodley (2004) noted that children in foster care have “seven times the developmental delays of similar children who are not in foster care” (p. 85). In the trauma literature, researchers have found that trauma can affect a child’s mind and cognitive development. For instance, in a meta-analysis, researchers Malarbi et al. (2017) found that 323 children who had been exposed to trauma had worse performance than their peers. Furthermore, these researchers found that 412 children who had had trauma exposure and a diagnosis of post-traumatic stress disorder given experienced cognitive delays for processing information, using language, learning, and executive functioning. Due to this, service needs grandchildren with an ACE history may experience include developmental delays such as gross- and fine-motor skill delays as well as cognitive delays such as processing delays for understanding information, speaking, and making decisions.

Howe (2005) described a child’s parents and guardians as the key individuals who will lead a child through the complexities of life. In addition to this leadership, “Infants learn to regulate their arousal (and their behavior) and make sense of their emotions as they relate intersubjectively with their caregivers” (Howe, 2005, p. 7). Attachment then, is the way that a child is able to rely on a parent to meet his or her needs (Howe, 2005). Yet, when trauma occurs in children, particularly between ages 6 and 10, children are more likely to have greater problems with managing their emotions (Dunn et al., 2018). Howe (2005) noted that when children do not have an attachment figure available to meet their needs, these children experience negative emotions such as “fear when alone, anger when abandoned, [or] sadness” (p. xiv). In addition to this, Allen (2011) wrote, “the essence of trauma is feeling terrified and alone” (p. 4). It is in this process, that the child then learns behaviors to survive in their environment (Howe, 2005). So,
while grandchildren may have attachment needs, these needs will commonly express themselves as survival behaviors, or decisions the grandchild is making to try to get their needs met.

It is perhaps unsurprising then how high the reported attachment needs were in these grandchildren given the high numbers of grandchildren whose grandparents reported emotional \((n = 9)\) and physical neglect \((n = 7)\). Grandchildren with attachment needs have service needs to building a relationship with a safe, consistent, and caring guardian or other adult so they may have their attachment needs met (Crouch et al., 2019). Another service need for grandchildren would be to be treated either an attachment perspective (Poehlmann, 2003) or from a family-therapy based, systems and attachment-focused treatment model, which has been suggested in the grandparent raising grandchildren literature by Strong et al. (2010). Another service need is for grandchildren to learn appropriate emotion-regulation strategies as well as social skills, which were likely not taught to them by their guardian due to the high prevalence of neglect that occurred across the target grandchildren reported on in this sample.

**Grandparent Formal Service Needs**

In addition, study findings revealed that grandparents regularly discussed grandchild behavior problems but linked these problems to ACEs. Focus group participants highlighted the strengths of using education to help grandparents understand their grandchild’s challenges. This is an area of the focus group and interview data reinforcing each other. While grandparents may see the link between a grandchild’s ACE history and behaviors, it is evident that they did not always name or talk about the behavior as an ACE. This lack of connection further indicates the need for ACE education, and further supports Foli et al.’s (2018) study. Foli et al. found that when kinship providers have more education and awareness about TIC, they may parent their grandchild differently. Grandparents in this study identified an awareness of ACEs with their
grandchild’s behavior; however, most of them did not seem to understand the implications of how an ACE history manifests in a grandchild. Therefore, a grandparent service need is to first, receive education about how ACEs affect their grandchild with the ACE history, and then, second, learn how to integrate that education into their parenting and thinking about their grandchild’s needs.

The second important finding is that grandparents are affected by their grandchildren’s ACEs. Findings suggest that grandparent experience significant challenges when they decide to raise and parent a grandchild with an ACE history. Specifically, grandparents reported grandchild-specific challenges such as managing complex grandchild diagnoses (e.g., autism, ADHD, or intermittent explosive disorder); parenting a grandchild who had difficulty forming trusting relationships; supporting grandchildren with poor peer and social relationships; having grandchildren who are developmentally delayed; having grandchildren who exhibit challenging behaviors (e.g., extreme fear, aggression); or are raising multiple grandchildren with ACE-related needs and symptoms. As a result of these challenges that grandparents face, a service need that arose out of this study for grandparents was respite care, where grandparents can take a break from their grandchildren.

The grandparent challenges discussed above have been referenced in the larger grandfamily literature and have been suggested as increasing grandparent psychological distress (Gerard et al., 2006; Hayslip et al., 2017; Kelley et al., 2013). In fact, the grandparenting literature has documented that grandchildren raised by their grandparents have significantly more behavioral issues than other children (Conway & Li, 2012; Smith & Palmieri, 2007; Smith et al., 2019). However, grandchild behavioral issues have not been overtly linked to ACEs, which is a contribution of this research study.
Study findings illustrated that grandchildren with ACE histories have challenging needs as it is; however, when parents become involved, the grandchild’s needs, or feelings of anger, sadness, rage, or fear can be recalled. This may very well be attributed to the grandchild’s ACE history, if the parent was involved, suggesting that distance alone does not fully produce healing for the grandchild. As observed in this study, parent visitations can create unwanted grandchild behaviors afterwards, confirming findings from the foster care literature (Mapp, 2002; Simms, 1991). Service needs grandparents can benefit from to support their grandchild are learning how to set and then implementing boundaries with the grandchild’s parent.

An additional new finding from this study was the presence of intergenerational ACEs, where 70% of the grandparents raising their grandchild and their own ACE history. The pattern of intergenerational ACEs has not been commonly documented in the grandparent raising grandchildren literature, except for Foli et al. (2018), although it has been documented in the larger ACE literature (Narayan et al., 2021; Woods-Jaeger et al., 2018). Intergenerational transmission of ACEs in children commonly occurs when parents have high ACE histories (Narayan et al., 2021; Schofield et al., 2018). In addition, children are more likely to have ACE histories if a parent has post-traumatic stress disorder (PTSD; Narayan et al., 2021).

Furthermore, Narayen et al. (2021) suggested that when parents are about to experience a role transition (e.g., conception or after a child is delivered), parents may be more thoughtful about how to raise their child, as they draw on memories of their upbringing, be they of unacknowledged ACEs or uplifting memories. This finding may extend to grandparents raising grandchildren in that grandparents also experience a role transition when they agree to raise a grandchild or multiple grandchildren. Consequentially, there is also a possibility that grandparents’ own history of ACEs may affect them, either positively or negatively, while
raising their grandchild. Hence, Harper Browne (2014) captured the potential implications related to parenting a child with an ACE history when she wrote:

Parents need interventions that help them to manage clinical symptoms and reactions to their own histories of poor attachments and trauma, to protect children from adversity and trauma as best they can, and to provide more nurturing care that promotes secure emotional attachment and healthy development in their children (p. 24).

Thus, these interventions may also apply to grandparents raising a grandchild with an ACE history as well. Service needs grandparents may have include being mindful of their own ACE histories, as well as learning how to manage feelings or experiences that arise from those ACE histories, where applicable. Additional formal service needs include learning strategies to provide nurture and attachment to their grandchild to promote meeting the grandchild’s needs.

**The Process of Seeking and Receiving Services**

My second research question was: “How do grandparents raising grandchildren navigate the process of seeking and utilizing formal services for their grandchildren with ACE histories?” In the interview data that I completed with grandparents raising a grandchild with an ACE history, grandparents highlighted a recursive nature of seeking services, which started with facing personal, information, and availability barriers for many grandparents. These barriers persisted throughout the model, affecting grandparents during grandchild needs identification, followed by managing the grandchild’s ACE-related needs and behaviors, even up to creating a working relationship with the formal service provider and the grandparent deciding to end the formal service. The conceptual model also illustrated bidirectional relationships between identifying ACE-related needs and managing ACE-related needs and behaviors, as well as
managing ACE-related needs and behaviors and creating a working relationship with the formal service provider.

**Recursive Nature of Seeking Services**

Contrary to Andersen’s (1995) depiction of a linear model of seeking services, grandparents, this study found that grandparents engaged in a more recursive and winding path to seeking services. Specifically, the study highlighted three components to this recursive process: identification of grandchild ACE-related needs, seeking services, barriers to services, and creating a working relationship with the formal service provider.

**Identification of Grandchild ACE-related Needs.** In Andersen’s (1995) model, he identified a linear process of seeking, receiving, and evaluating services; however, little is depicted regarding the nuances of how needs are identified or managed prior to a person seeking services. This study addressed this deficit and found that two factors assisted with grandparents’ identification of grandchild needs: the target grandchild’s ACE history and the target grandchild’s behaviors and needs. Regarding a grandchild’s ACE history, nearly all grandparents attributed reasons for a grandchild’s behavioral problems such as attributing behavior to the grandchild’s ACE history. Since grandchild needs are often manifested through behavior, almost half of the grandparents cited instances where their grandchildren had worse behaviors following a visit with their biological parent, which has also been echoed in the grandparent raising grandchildren literature (Williamson et al., 2003). The medical research literature has cited trauma as being linked with emotional and behavioral behaviors because of ACEs and that behaviors related to this trauma can be alleviated if treatment is sought (Cohen et al., 2008).

Andersen (1995) also theorized that an individual’s—in this case, grandchild’s—needs drive health behavior. The findings from this study confirm this thought and explored the
nuance related to this. For example, findings further revealed that grandparents identified their grandchild’s ACE-related needs by (a) observation such as grandchild behavior changes, grandchild attachment needs, or grandchild developmental needs, (b) grandparents using their personal or professional experience, or (c) a combination of the above factors.

Past grandparent raising grandchildren research has focused on the emotional state of grandchildren, such as their mental stability, their feeling loved and supported, or acknowledging their past (Crowther et al., 2014). These are strategies that reflected in the data findings of this study of ways that grandparents focused on their grandchildren, prior to deciding to seek formal services. As highlighted above, grandparents attempted to care (e.g., attentiveness to grandchild needs) for the grandchild (Crowther et al., 2014), teach the grandchild (Strom & Strom, 2011), and set boundaries, particularly after parent visits (Williamson et al., 2003) as common strategies they used to manage grandchild behaviors and raise their grandchild.

**Seeking Services.** Findings from the study revealed four factors that resulted in grandparents deciding to seek services for their grandchildren’s needs. These factors included: (a) the belief that services would help, (b) seeing a behavioral need (e.g., externalizing like acting out or internalizing like becoming more withdrawn) and (c) seeing a grandchild’s physical or verbal developmental need. The findings from this research study extend those of Mayberry and Heflinger (2013) of the formal services literature, where these researchers found that caregivers in their study were more likely to seek services when caregivers perceived their situation as stressful, rather than as a random occurrence, where the more stress a grandparent experienced, the more likely they were services. In this study, however, the grandparent’s decision to seek services was based on their grandchild’s needs, rather than their own, revealing new findings about what contributes to the grandparent’s timing of seeking services.
Seeking services was not just for the grandchild. Grandparents, when involved, also benefitted from interactions with their grandchild’s provider as well as with their involvement in services. It is important to note that grandparents *wanted involvement* in their grandchild’s services. It is possible then, that grandparents raising grandchildren with an ACE history may also benefit from family-level services, such as family therapy (Strong et al., 2010). The broader trauma literature supports the importance of both individuals and families receiving services to promote healing after a trauma has occurred (Feiring et al., 2002; Little et al., 2011; Narayan et al., 2021).

**Barriers to Services.** Barriers to services is a theme that was very prominent in my conceptual model, compared to Andersen’s (1995) model. For instance, Andersen’s (1995) model simply outlined the health care system as part of an individual’s environment, which he ultimately hypothesized would affect individual outcomes. Yet, in my model, barriers to services encompassed not only a grandparent’s individual environment, but the entire process of identifying, seeking, and receiving services. Findings from this study largely supported the existing grandparenting literature, which has identified service availability barriers such as limited services and service providers, lack of financial resources, and limited information about resources available to grandparents raising grandchildren (Crowther et al., 2014; Dolbin-MacNab & Few-Demo, 2018; Hansen et al., 2020; Hayslip et al., 2018). Finding and accessing high quality information about a challenging topic was also difficult for grandparents raising their grandchild, in this study. For example, several grandparents highlighted how they were left to figure out things on their own due to the difficulty in acquiring information about available formal services to meet their grandchild’s ACE-related needs. Thus, there is a need for formal service providers to know not only about additional local services pertaining to treating ACEs in
families, but also how those services can help grandfamilies. It is possible, that presence of ACEs in their grandchild added an additional barrier to the typical barriers that grandparents raising grandchildren experience when seeking formal services. Another possibility is that the presence of ACEs made it more difficult as well to navigate the formal service system to find specialized professionals, highlighting the presence of service availability barriers.

Another interesting systemic barrier identified above was the metaphorical pay wall for additional information. As noted in Chapter 4, in this example, the systemic barrier was one where grandparents with financial flexibility and means can receive the level of information and support needed to make informed decisions about their grandchild’s care, while more financially disadvantaged grandparents are left to the mercy of more marginal feedback. For example, many grandparents raising their grandchildren tend to have limited financial resources and be in low socio-economic situations, where well-off grandparents, tend to be in the minority in grandfamily situations (Collins et al., 2016; Ellis & Simmons, 2014). This division of information based on income seems to be evidence of classism, as it oppresses low-income grandfamilies from receiving needed services due to their income level (Dolbin-MacNab & Few-Demo, 2018). Furthermore, this oppression may also reinforce negative societal narratives in judging grandparents for not being able to adequately manage their grandchild’s ACE-related needs.

A final systemic barrier found in this study was lack of a legal relationship between the grandparent and grandchild, which created problems for being able to take children on vacation out of the state, since they were in the state’s custody, as well as not being able to sign up for some services, by nature of their custodianship status for the grandchild. These examples echoed the results of previous studies highlighting how this type of barrier that can affect grandfamilies
(Kaye et al., 2010; Van Etten & Gautam, 2012). My study, however, highlighted the nuances of how this barrier intersected with grandchild ACEs. Another grandparent saw that court-ordered parenting visits were affected her grandchild, due to the grandchild’s ACE history, causing him to behaviorally regress, despite the positive behavior progress he had made prior to these visits. However, until the court order was amended, the grandmother was required to follow through with these visitations. In summary, these examples provide evidence for a lack of understanding by both judicial and child welfare systems, of ACEs and their impacts, where a lack of TIC care exacerbated the grandchild’s behaviors, rather than promoted the “child’s best interest” (Kohm, 2007).

Creating a Working Relationship with the SP

Overall, findings from this study revealed nuances of how grandparents raising a grandchild with an ACE history created a working relationship with a service provider, which was critical to yielding positive outcomes in their treatment. This research study not only extends the existing literature on the grandparent-service provider relationship, but also offers ideas for promoting more positive outcomes. This study found that a working relationship was generally born out of (a) grandparents trusting formal service providers and (b) service providers being attentive to grandfamily needs, which included service providers involving grandparents in services and removing barriers for grandfamilies. As noted in Chapter 4 above, grandparents raising grandchildren with ACE histories can encounter many barriers both in the seeking and in the receiving of services. When formal service providers remove barriers for these grandparents, they are facilitating opportunities for the grandchild to receive assistance to be exposed to protective factors that can mitigate the effects of the grandchild’s ACE history. In addition, in this data, having a working relationship with a formal service provider was the crux of whether
services resulted in positive outcomes such as creating change, or negative outcomes, where the grandparent decides to end the services. In these ways, building a working relationship between professionals and grandparents lends itself to more successful outcomes than situations where a provider does not create a relationship with the provider, which confirmed Leach’s (2005) findings.

In comparing these findings to Andersen’s (1995) model, one of the more notable pieces missing from Andersen’s (1995) model is the explanation for how an individual’s seeking of services creates health behavior outcomes. This research study suggested that creating a working relationship with the formal service provider is one way to create health behavior outcomes, as evidenced by the theme, creating change. For example, 70% of the grandparents in this study chose to end services because they did not see a change in the grandchild’s behavior. Grandparents commonly gave formal service providers “a few times” before they made the decision to end services. This seems to reflect that grandparents are bringing their grandchildren in for relief from behavioral challenges, and when this does not occur, grandparents may seek services elsewhere or stop altogether. In addition, in times where the formal service provider is unprofessional, the ACE-related service needs that the grandchild has may not be met, which may prevent the grandchild from achieving relief from their needs. In summary, this study offers nuanced information about how grandparents raising a grandchild with an ACE history approach and end service use.

**Service Provider Attentiveness to Grandfamily Needs.** The study findings emphasize the importance of service providers being aware of and working to meet a grandfamily’s needs to create a working relationship with the grandparent. For instance, some grandparents naturally trusted formal service providers due to having a connection with the service or past experience
with the service. However, other grandparents created a working relationship with providers as they coordinated services, responded to grandchild behavioral challenges as well as checked in on the grandparent. This relationship was particularly evident when a grandparent had a voice in the relationship. The grandparent then benefitted from the relationship when they had a problem and would come to the formal service provider for a suggestion, rather than going to a friend, family member, or colleague, further strengthening the working relationship.

**Grandparent Involvement in Services.** This research study found that grandparents want to have a voice and participate in their grandchild’s formal service. Grandparents also wanted to be active participants in sharing information about the grandchild’s history as well as receiving check-ins with formal service providers about weekly events and behavior. The relationship between the grandparent and formal service provider was reinforced when the grandparent reached out for assistance and the formal service provider provided suggestions that were helpful to the grandfamily. This is an example of how the grandparent builds a working relationship with the service provider and the service provider attends to the grandchild's needs by involving grandparents in services. Further, even when services are identified and pursued, the grandchild’s needs continue to exist and be managed by not only the grandparent, but now, also through the service provider.

In addition, this study also confirmed Kaye et al.’s (2010) findings on rural kinship families that these families want a formal service provider who is (a) attentive to the family’s needs and (b) communicative with the guardian. This study supports the existing literature on formal services and grandparents raising grandchildren by providing an additional example of why grandparents ought to be recognized and have a voice in their service experiences, particularly when child welfare services are involved (Gladstone et al., 2009; Ziminski, 2007).
Furthermore, this study reinforced Gladstone et al.’s (2009) statement when they said, “programs are more likely to be successful [in kinship families] when helping professional establish trusting relationships, use a strengths-based approach, and enable family members to be actively involved in the helping process” (p. 57). In considering how ACEs can affect the worldview and perspective of individuals who have experienced ACEs, involving grandparents in formal services may assist them in being exposed to their own protective factors (e.g., caring, consistent adult), if they have an ACE history, and if not, then these protective factors are being modeled for the grandparent to reflect to the grandchild. Each of the benefits Gladstone et al. (2009) noted were characteristics of protective factors, which promote resilience, which can mitigate the short-and long-term effects of ACEs.

**Third Research Question: Best Practices for Grandfamily Interventions**

My third research question for this study was: “What do formal service providers describe as best practices for working with grandparents who are raising grandchildren with ACE histories?” Two of the more notable findings, in terms of best practices for working with grandparents raising a grandchild with an ACE history, were (a) how service providers equate ACEs with trauma, (b) perceptions of pattern of intergenerational ACEs, and (c) the wide use of TIC across the sample.

**Equate ACEs with Trauma**

One important finding from the focus groups was that service providers commonly equated ACEs with trauma. While ACEs are described as a “potentially traumatic event,” (Centers for Disease Control, 2019a), the term trauma is when “a person perceives an event or set of circumstances as extremely frightening, harmful, or threatening—either emotionally, physically, or both” (Bartlett & Sacks, 2019, p. 5). Participants in the focus group tended to treat
the terms synonymously, which creates a misconception. This is potentially problematic from a service delivery perspective because the provider focuses on the belief that the grandchild has a deficit, rather than focusing on their strengths, such as having the skills or supports necessary to mitigate the trauma—which also undermines the idea of TIC, which is discussed later in this chapter.

I suspect that multiple factors are influential here. Perhaps service providers combine the two terms, given that the information is not articulated well enough in training settings, nor are training professionals capturing the nuances of the differences between ACEs and trauma. Or perhaps, service providers are learning more in their experience of working with grandfamilies and know that many of the grandchildren and even the families have intergenerational trauma, which was noted by a few of my focus group participants. Another possibility may be that formal service providers are not aware of or taught about the distinctions between ACEs and trauma. A final possibility may be that by the time service providers are working with the grandchild, the grandchild is already exhibiting symptoms of trauma.

*Intergenerational Pattern of ACEs*

Another important finding from the focus groups was that formal service providers who work with grandparents raising grandchildren in the Central Appalachian regions (Central, North Central, and South Central) identified many of these families as having a pattern of intergenerational ACEs. This perception was confirmed by the interview data; 70% of grandparents identified having at least one ACE in their history. In the ACE literature, multiple researchers (Narayen et al, 2021; Woods-Jaeger et al., 2018) have emphasized the idea that ACEs are best mitigated or resolved through resilience, such as “high numbers of childhood family strengths, such as support, closeness, loyalty, protection, love… positive parenting, social
support, and opportunities for success” (Narayen et al., 2021, p. 4). Characteristics of resilience that grandparents raising a grandchild with an ACE history reflect in this study included support, protection, love, and opportunities for success (e.g., taking the grandchild to formal services).

**Resilience.** To understand resilience, it is essential to understand how protective factors contribute to its creation. Protective factors are environmental factors which can mitigate the long-term negative effects of ACEs on an individual (Crouch et al., 2019). For example, Afifi and MacMillan (2011) noted that a predictable family environment and caring adults promote resilience among children. In addition, an adult that creates felt safety—where the child knows and feels they are safe, compared to the adult knowing the child is safe—for a child, a loving and consistent adult, and residing in a safe neighborhood are all ways that can somewhat or completely moderate the negative consequences of ACEs (Crouch et al., 2019). Vanderbilt-Adriance and Shaw (2008) also found evidence of a parent-child relationship and parent responsiveness as being protective factors in their sample of 225 low socio-economic status boys from infancy to early adolescence. Furthermore, Von Cheong et al. (2017) highlighted that social support may also contribute to both decreased depression and medication used to treat later-life depression for individuals with ACE histories. In a system review of 85 papers focused on resilience and protective factors for individuals with abuse or neglect histories, Meng et al. (2018) found that protective factors can moderate or eliminate the unwanted consequences of ACEs, if timed right. Egeland et al. (1993) perhaps captured protective factors best when they stated, “the capacity for resilience develops over time in the context of environmental support” (p. 518). Communities can also support families in mitigating the reoccurrence of ACEs. For example, in the ACE literature, Schofield et al. (2018) found that perceived community
connectiveness was linked with lower intergenerational ACEs in a sample of 451 White, low socioeconomic status parents with ACE histories with a child in seventh grade in rural Iowa.

Grandparents raising their grandchildren with ACE histories are uniquely situated, as they can provide many of these protective factors to their grandchildren, such as creating felt safety for their grandchild, particularly those grandchildren with Attachment Needs, as discussed in Chapter 4. In the grandfamilies literature, systemic protective factors such as church, social networks, and family supports, as well as support from formal service providers, also exist (Dolbin-MacNab et al., 2013; Kelley et al., 2000). Rawn et al. (2021) suggested that facets of Appalachian culture, such as support networks and spirituality, can also be protective factors for grandparents raising grandchildren. This focus on resilience then, highlights how crucial it is for grandparents to be provided with the resources, formal services, and respite they need so they can continue to support their grandchild in mitigating the possible effects of ACEs.

However, grandparents do not have to provide these protective factors on their own. Bartlett and Steber (2019) discussed how resilience can be reinforced through multiple environmental contexts such as the grandchild’s family, school system, community groups and community services. Despite the environmental contexts available to assist grandchildren with ACE histories, which can be instrumental for helping the grandchild gain resilience, formal service providers offer additional supports that can help the grandchild and grandparent in the service process such as evidenced-based practices (e.g., Eye Movement Desensitization and Reprocessing; trauma-focused cognitive behavioral therapy, neurofeedback, Dialectical and Behavior Therapy, Brainspotting, etc.), tailored education, tailored interventions and resources (Hayslip et al., 2019). For example, regarding resilience, formal service providers can utilize interventions focused on resilience “including enhancing protective factors (e.g., social support,
better health management and reducing risk factors (e.g., social isolation), may be fruitful avenues for promoting grandparent well-being” (Hayslip et al., 2019 p. 153). Furthermore, formal service providers can also influence a grandchild’s development of resilience in a safe, caring, and supportive environment, as well as modeling a relationship of trust to the grandchild, in other words, reflecting TIC, which is discussed next (Bartlett & Steber, 2019).

**Trauma Informed Care in Appalachia**

Assessment of trauma is another component of TIC (Substance Abuse and Mental Health Services Administration, 2014b). During the focus groups, formal service providers shared how they assessed for trauma, whether it was through Felitti et al.’s (1998) original study questionnaire, or through a blend of paperwork and informal conversation, or conversation, with no formal questionnaire. The focus group findings confirmed the Substance Abuse and Mental Health Services Administration (2014b) position that a foundational piece of TIC is assessment for ACEs. In a recent study by Palfrey et al. (2019), the researchers found that of the 43 formal service providers who received education on TIC that enhanced their understanding of trauma and its impact as well, taught providers skills and resources to share, as well as share information on how to respond to a client with a trauma history, 51% of workshop participants were still assessing for trauma in their clients a year later, with 17 of the follow-up respondents choosing to pursue additional, specialized training. Findings from my study aligned with Palfrey et al.’s (2019) findings, in that many of the service providers in the focus groups reported having been trained and were currently assessing for trauma as part of their intake assessments. Thus, perhaps one strategy to not only increase the number of TIC-trained providers in the area, but also influence the number of specialized service providers is to offer an introductory training so formal service providers can consider pursuing specialized certifications. Another clinical
implication is for formal service providers to pair assessment and intervention together by not only gathering information about the grandchild’s situation and background, but also providing education on grandchild ACEs, where ACEs are applicable, as an intervention to grandparents as part of the assessment process.

The findings from my study offer a contrasting view of TIC, in that this approach to service provision is effective for grandparents raising a grandchild with an ACE history. One of the ways that TIC is helpful for grandfamilies is the focus on resilience, of shifting from the ACE to empowering the grandparent to change their behavior and understand the grandchild’s experience better. My study, through both focus group and interview data, highlight the importance of building a relationship with grandparents raising their grandchild with an ACE history. In the interview data, this was described as Creating a Working Relationship with the Service Provider, while in the focus group, this came through as building a relationship of trust through using TIC, which is more nuanced than the interview data, as it highlights one component of the relationship. Nevertheless, both data sources highlighted a commonality of the importance of a relationship.

Education may be especially important because grandparents may experience challenges in not knowing how to understand grandchild needs or interpret grandchild behaviors. This lack of understanding about the grandchild’s behavior may further exacerbate grandparent symptoms and place the GC at risk for additional ACEs. For example, in a study comparing the distress levels of 157 foster parents and 102 kin foster parents, Timer et al. (2004) found that “kin foster parents showed moderately higher levels of depressive symptoms, parental distress, and abuse potential than non-kin caregivers” (p. 259). Gerald et al. (2006) also highlighted the abuse potential that grandparents may utilize, should their stress levels become too high. Grandparents
may also experience not receiving sufficient support needed to mitigate the possible effects of grandchild ACEs, which likely occurs when grandparents raising a grandchild with an ACE history have formal service providers who are unprofessional, inconsistent, or a poor fit to provide needed services to the grandfamily.

Another key finding from the focus groups was that formal service providers who work with grandparents raising a grandchild with an ACE history are consistently using TIC as part of their approach to treatment. Interestingly, several participants noted that TIC is a mechanism to focus on the therapeutic relationship. Another unique finding in my study was that, when working with grandparents raising a grandchild with an ACE history in Central, North Central, and South Central Appalachia, formal service providers believe that a TIC approach is not only commonly used, but is also helpful in building trust as part of their relationship with grandparents.

In fact, focus group participants also highlighted that TIC is a tool they used to build resilience with grandparents. Focus group participants first assessed for an ACE history, and when it was present, focus group participants acknowledged that the ACE history occurred and then use a strengths-based perspective of what to do with that knowledge of trauma. Focus group participants noted how assessing ACEs is not enough and education is needed. Focus group participants commented that the next step was to not only teach grandparents raising a grandchild with an ACE history about how their grandchild’s body is affected by trauma, but also how to respond to the grandchild’s behaviors. This finding supported Leitch’s (2017) recommendation in the criminal justice literature to make TIC an action-focused lens, rather than an educational one.
Yet, what was interesting in this study is that a couple of formal services providers commented on how they actively worked to grow or build resilience after the trauma, which goes beyond the standard TIC approach. Leitch (2017) echoes this way of working with individuals stating that, while an awareness of trauma in an individual’s life was helpful, more needed to be done to build resilience, of making TIC an active approach towards resilience rather than a passive one. It is hopeful that service providers in this study are choosing to be forward focused, rather than past dwelling when it comes to traumatic experiences grandfamilies have experienced. This study offers emerging evidence of how service providers are using TIC to promote resilience within grandfamilies. This study also offers the perspective that using TIC can be an effective strategy to building a relationship with grandfamilies in North Central, Central, and South Central.

**Study Limitations**

One limitation of the interview portion of the study is the small sample size of predominantly White grandparents ($n=10$), which makes extending the findings to other grandparents raising a grandchild with an ACE history difficult. A second limitation of this study is its geographic focus. Grandparents in this study were recruited from three regions of Appalachia (Central, North Central, and South Central), which makes generalization difficult due the possibility that these findings are specific to this region, compared to another region in the United States such as the South or the Western United States. Another limitation is that all the grandparents were sampled via convenience or snowball sampling, which may have introduced bias in the results of the study, due to the lack of diversity among interview participants. Another limitation of this study is that grandparents had difficulty separating grandchild ACEs
from custodial grandparenting in general, making it hard to discern what was most specific to ACEs.

One limitation of the focus group sample was that it was all White and female, which introduced bias due to the lack of diverse perspectives. In addition, another limitation in the focus group sample was the low number of providers in the first group \((n = 3)\) and the high number in the second group \((n = 7)\), which affected the number of times individuals could comment on focus group questions.

**Recommendations for Future Research**

As demonstrated by the findings of this study, some grandfamilies have intergenerational patterns of ACEs. Future research on intergenerational ACEs could explore how grandparents conceptualize their personal ACE histories and in what ways grandparents believe their ACE histories influence how they raise their grandchildren with ACE histories. Additionally, in this study, grandparents reported that formal services can help their grandchild with the grandchild’s ACE histories; however, what was not explored was whether grandparents think they could also benefit from trauma-focused services for their ACE histories. As such, future research should explore how grandparents receiving trauma-focused services impacts the grandchild behavior outcomes, grandparent parenting stress, as well as the grandparent depression and anxiety symptoms.

Remarkably, despite grandfamilies’ origins commonly coming from ACEs, grandfamily ACE exposure has been researched very minimally. Grandfamily researchers could explore how the different ACE categories (e.g., abuse, neglect, household dysfunction), ACE type, ACE count, or protective factors affect grandchild behaviors as well as grandparent stress levels.
differentially, which would provide a more nuanced understanding of how the ACEs may affect a grandparent and grandchild.

From a trauma-informed lens, the type of traditional parenting (e.g., spanking, lecturing, sending to time out; Brunissen et al., 2020) that grandparents may use, by nature of only knowing this type of parenting approach, may further exacerbate ACE-related grandchild behavior, when grandchildren need a more trauma-informed approach to parenting (Kaminski et al., 2008; Li et al., 2019). Future research can develop or adapt trauma-informed materials that focus on strategies to help grandparents attend to a grandchild’s trauma as well as learn new ways to support a grandchild.

Future research related to my second research question could explore the process by which grandparents raising grandchildren with an ACE history take the psychoeducation that formal service providers give to them about their grandchild’s trauma and apply it to their parenting of that grandchild. This research could measure whether child behaviors and parenting stress shift over time.

In the focus group findings, formal service providers emphasized the importance of ACEs education in helping grandparents develop insight into their parenting choices as well as better understanding their grandchild’s experiences. The trauma literature highlights two attachment- and evidence-based therapeutic models, as well as parenting strategies: Trust-Based Relational Intervention (TBRI) (Purvis et al., 2013) and Theraplay (Booth & Jernberg, 2010). The approaches promote attachment and change in the homes of families that use them. In the context of grandfamilies, future research could explore the efficacy of attachment-based therapeutic models (e.g., Theraplay; TBRI) in improving the grandparent-grandchild relationship. This research could also explore three parenting conditions (e.g., therapeutic- and
attachment-based parenting; parenting intervention; and information control) and measure
grandchild behavioral outcomes and grandparent stress after the study period to measure what
changes, if any, occur in grandfamilies assigned to each condition.

**Clinical Implications**

This study has numerous implications for clinical practice. First, it is important for
service providers to recognize that grandfamilies can experience contextual stressors such as
financial concerns, a grandchild’s ACE history, and associated grandchild behavior challenges.
Grandparents can also experience stressors such as difficult parent involvement, identifying
grandchildren’s ACE-related needs, and managing grandchild ACE-related, needs and behavior.
The arrows in the conceptual model (Figure 2) demonstrated an ongoing back-and-forth
experience between identifying grandchild needs and managing grandchild ACEs, needs, and
behavior. This was particularly evident for grandchildren who would experience a pendulum
effect in making behavioral changes depending on the presence or absence of their parent.

Because of grandchild trauma and the difficulties of raising a grandchild with a trauma
history, education on grandchild trauma was piloted as an intervention with rural grandparents in
Foli et al.’s (2018) study on a trauma-informed parenting class for rural kinship parents living in
Appalachia. Foli et al. found improvement in parent responsiveness, meaning making of
grandchild abilities and deficits, as well as family environment. The improvements in kin parent
responsiveness as well as family environment changes, can be protective factors that can off-set
the negative impact of risk factors for grandchildren. Formal service providers can assist
grandparents raising a grandchild with an ACE history by acquiring and sharing information
with the grandparent on grandchild ACE histories on what to expect and how to react as the
grandparent attempts to *Manage the GC’s ACE-related Needs and Behavior*. Formal service
providers, in addition to providing education, can also look for diagnostic or assessment questionnaires that align with a grandchild’s symptoms, to assist the grandparent in identifying the grandchild’s ACE-related needs. For example, in the grandparent interviews, one grandparent reflected on how their formal service providers gave her a diagnostical questionnaire that reflected the diagnosis of Reactive Attachment Disorder, which is linked with childhood trauma, which mapped on nearly perfectly with her grandchild’s behaviors (Hanson & Spratt, 2000). In this case, the grandparent then joined support groups to acquire greater understanding about her grandchild’s diagnosis.

Many service providers are in a unique position to assist grandparents raising a grandchild with an ACE history manage their grandchild’s needs, primarily via the professional networks that some providers have created. This does not only benefit service providers by having a strong referral network, but also grandparents in this unique situation, which would reduce the availability barrier that grandparents in this study reported experiencing. For example, service providers can benefit grandparents by having a list of available resources that pertain to grandparents and grandchildren in their area, such as respite providers, the local Department of Social Services, childcare options, adoption agencies, ACE-specific parent education programs, local health department, organizations that offer assessment and evaluation, schools, as well as medical and behavioral health specialists. This strategy reinforces not only removing barriers for grandparents, but also contribute to building a relationship of trust with the grandparent. King et al. (2009) similarly recommended that professionals create bridges between grandparents and professional services to reduce grandparent isolation and societal judgement, for rural living Georgian grandparents.
Trauma Informed Care – A Strategy for Creating a Working Relationship

While ACEs have been categorized into three distinct categories (e.g., abuse, neglect, and household dysfunction) within the trauma literature, formal service providers would benefit from remembering that grandparents and grandchildren may have their own definitions of trauma and may categorize something outside of the typical ACE categories as traumatic. Formal service providers who are flexible in the definition of a grandparent or grandchild’s trauma may be better able to connect with that individual and build a working relationship, which according to the model, is an important step towards creating change.

Grandparents may have difficulty with shifting from their role as a grandparent to their new role as both a grandparent and a parent to their grandchild as they raise a grandchild with an ACE history. This difficulty can be addressed by using TIC, and many focus group participants identified that practicing TIC was the best way to form a relationship of trust with grandparents, whose grandchildren were receiving professional services. Having a working relationship with a grandparent also emerged as an important factor in my conceptual model, which confirms Leach’s (2005) point that rapport, or trust, is at the crux of any therapeutic relationship and is highlighted in the grandparents raising grandchildren literature (Maiden & Zuckerman, 2008). When ACEs occur, trust can be one of the first victims. As a result, TIC provides an avenue wherein service providers communicate to grandparents as well as grandchildren, “I understand you”; “What happened to you?”; and invite the client for greater connection for closeness and change. Examples of how formal services providers can do this include: (a) being compassionate while attending to client needs, (b) being aware of how treatment approaches may retraumatize individuals, and (c) building on individual strengths in their familial and community contexts (The Substance Abuse and Mental Health Services Association, 2014). In addition, Leitch (2017)
emphasized that formal service providers can strengthen their use of TIC by (a) exploring the strengths of the individuals to whom they provide services and (b) deepening an individual’s understanding of how trauma affects them (e.g., emotion regulation and reactivity) using neuroscience-based information, which encourages action, rather than only insight.

Knowing that grandparents may have their own ACE histories makes it even more imperative that additional research be conducted to assist grandparents, as well as grandchildren, in developing the empowerment and confidence in understanding their distress and how to heal from that. For example, Purvis et al. (2013) identified that children with past complex trauma (e.g., multiple instances of sexual or physical abuse) require a different approach to treatment, one that is focused on physical, emotional, and behavioral needs, respectively, due to the breaks in attachment that commonly accompany past trauma. Given that both grandparents and grandchildren may have service needs as they come into a grandfamily situation and after thorough assessment, having a treatment approach that supports the entire grandfamily through attending to family relationships may be helpful, particularly in assisting grandparents in *Managing their GC’s ACE-related Needs and Behaviors*. For example, in the foster care literature, Dozier et al., (2002) proposed ten strategies on how to enhance foster parent-infant connection. These strategies included offering acceptance and love, developing parent self-awareness, giving the child voice and choice in play, developing awareness of how the child communicates, and helping parents respond to infant foster children with empathy and support, which grandfamilies may also benefit from.

In addition, providers would do well to utilize attachment- and evidence-based clinical modalities such as Trust-based Relational Intervention (TBRI; Purvis) or Theraplay (Booth & Jernberg, 2010). TBRI seeks to provide healing of the breaks in attachment, while Theraplay
provides assistance with attachment challenges—particularly for children of trauma, foster care, or adoption, as well as other relationship or trauma-related behavioral challenges (Tucker & Smith-Adcock, 2017). These recommendations echo Strong et al.’s (2010) attachment approach to working with grandparents raising grandchildren. In sum, grandfamilies may also benefit from this type of treatment approach, given that it focuses on the relationship.

This study found additional support for a recommendation by Ge and Adesman (2017), who suggested that pediatricians evaluate a grandparent’s knowledge about appropriate parenting practices, as well as connect them with other grandparents raising their grandchildren through local or online sources. In addition to pediatricians, this recommendation could also be applied to practitioners who work with grandparents raising a grandchild with an ACE history, in making sure that grandparents have a sufficient understanding of trauma-informed parenting or current knowledge of trauma-related behaviors for their grandchildren. The Administration for Children and Families (2014) warned that parents who do not understand their traumatized children’s behavior may harbor negative feelings directed at the child. After grandparents have been taught, they can then practice the skill with their formal service provider.

In addition to helping a grandfamily with their grandchild’s trauma history, another clinical implication was to use a strengths-, or resilience-based focus. Many providers in this study identified having a strengths-based and future-oriented focus for the grandfamily when learning about a grandchild’s ACE history. Alternatively, formal service providers can share information, and then use the principles of TIC to create a collaborative environment of sharing and discussion, rather than a hierarchical one, about how the ACEs education could be utilized within the grandfamily. Formal service providers can also facilitate opportunities during service
provision, where parents have the opportunity for grandparents to practice their skills. After all, practicing a skill can be more instrumental than just listening to a skill being taught.

Conclusion

The goal of this study was to address the following questions: 1) identifying the needs of grandchildren with ACE histories as well as the needs of the grandparents who are raising these grandchildren; 2) examining the process by which grandparents identify grandchild needs, seek, and receive services, and 3) articulating best practices for working with grandparents raising a grandchild with an ACE history. Findings suggested that grandchildren often have complex and nuanced ACE-related needs that grandparents must identify and learn how to manage. In comparison, grandparents also have needs for respite as well as managing the appointments and responsibilities of raising a grandchild, not to mention knowing how to parent a grandchild with challenging behaviors related to their ACE history. A conceptual model from interview data with ten grandparents raising a grandchild with an ACE history revealed that many grandparents experience an iterative process of identifying and then managing a grandchild’s needs, which was overshadowed by barriers to accessing services including personal and systemic barriers, as well as personnel and service availability barriers. Once the grandparent decided to enter services, grandparents illustrated how a relationship of trust helped the grandparent to create change or better manage the grandchild’s needs. Grandparents noted that formal service providers commonly created a working relationship with them through (a) when the grandparent has had the service before or knows someone in a similar formal service provider position and attending to grandfamily needs which included (a) removing barriers and (b) involving grandparents in services. In contrast, the lack of a working relationship with a formal service provider often resulted in the grandparent ending the formal service. As such, formal service
providers can be attentive to grandfamily needs by removing barriers and including grandparents in services to demonstrate a willingness to create a working relationship with the grandparent.

To supplement the grandparent interview data, ten formal service providers participated in two focus groups. Findings revealed that formal service providers assessed and intervened with ACEs, utilized TIC to both build a relationship of trust and promote a strengths-based perspective, provided ACEs education to grandparents, and observed intergenerational patterns in grandfamilies. Surely, additional research conducted on ACEs and their impact on grandfamilies will only enhance our understanding and knowledge on how to best cater professional services to this population.

In conclusion, this study depicted the intricacies of understanding unique grandfamily needs and highlighted the challenges grandparents experience as they seek and acquire services for their grandchild with an ACE history. This study also emphasized not only the need, but also the effectiveness for using TIC with grandfamilies in North Central, Central, and South Central Appalachia.
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Appendix A

IRB Approval

MEMORANDUM

DATE: August 13, 2021

TO: Megan Leigh Dolbin-MacNab, Bradford David Slucki, Pamela D Teaster

FROM: Virginia Tech Institutional Review Board (PWA00000072)

PROTOCOL TITLE: Grandfamilies, Grandchild Averse Childhood Experiences and Formal Services: An Examination of Needs, Experiences and Best Practices

IRB NUMBER: 20-444

Effective August 12, 2021, the Virginia Tech Human Research Protection Program (HRPP) determined that this protocol meets the criteria for exemption from IRB review under 45 CFR 46.104(d) category (ies) 2(f).

Ongoing IRB review and approval by this organization is not required. This determination applies only to the activities described in the IRB submission and does not apply should any changes be made. If changes are made and there are questions about whether these activities impact the exempt determination, please submit an amendment to the IRB for a determination.

This exempt determination does not apply to any collaborating institution(s). The Virginia Tech HRPP and IRB cannot provide an exemption that overrides the jurisdiction of a local IRB or other institutional mechanism for determining exemptions.

All investigators (listed above) are required to comply with the researcher requirements outlined at: https://secure.research.vt.edu/external/responsibilities.htm

(please review responsibilities before beginning your research.)

PROTOCOL INFORMATION:

Determined As: Exempt, under 45 CFR 46.104(d) category(ies) 2(f)

Protocol Determination Date: July 31, 2020

ASSOCIATED FUNDING:

The table on the following page indicates whether grant proposals are related to this protocol, and which of the listed proposals, if any, have been compared to this protocol, if required.
SPECIAL INSTRUCTIONS:

This amendment, submitted August 11, 2021, updates research protocol, recruitment materials, consent forms, and data collection instruments.

***Please note: The HRPP office has stopped stamping documents for Exempt protocols. It is your responsibility to maintain these documents and make current versions available on request.

<table>
<thead>
<tr>
<th>Date*</th>
<th>OSP Number</th>
<th>Sponsor</th>
<th>Grant Comparison Conducted?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

* Date this proposal number was compared, assessed as not requiring comparison, or comparison information was revised.

If this protocol is to cover any other grant proposals, please contact the HRPP office (irb@vt.edu) immediately.
Appendix B

Grandparent Flyer

ARE YOU A GRANDPARENT RAISING A GRANDCHILD?

SHARE YOUR EXPERIENCE!

We are seeking volunteers from Central/Eastern Kentucky, Central/Eastern Tennessee, Western North Carolina, Southwest/Western Virginia, Southeast/Southwest Ohio, or West Virginia (except for Marshall, Ohio, Brooke, & Hancock counties) for a research study.

You must be 1) over age 18; 2) currently raising a grandchild under 18 years old full-time; 3) grandchild has a history of abuse, neglect, or household challenges, like parent substance misuse; 4) grandchild has received professional services in one of the above areas; and 5) the grandchild’s parent does not live in the home.

Survey
20-minute online survey

Interview
60-90 minute phone interview

Compensation
$20 Amazon gift card

Ready to share?

Contact Bradford Stickel, M.MFT, Doctoral Candidate in Marriage and Family Therapy, Primary Researcher, Department of Human Development and Family Science, Virginia Tech, at grandfamilies.study@vt.edu or (540) 358-0064.

Risks are minimal and may include discomfort in sharing past experiences. Study results may be published or presented. (Study was reviewed by Virginia Tech HRPP; irb@vt.edu; 540-231-3732).
Appendix C

Email to Formal Service Provider for Grandparent Recruitment

Subject Line: Know a Grandparent Raising a Grandchild? Have them share their experiences and receive a $20 Amazon gift card

Dear [Professional Name],

My name is Bradford Stucki, and I am a doctoral candidate at Virginia Tech. I am doing a research study on grandparents who are raising a grandchild with past abuse, neglect, or household instability, also known as adverse childhood experiences or ACEs. These grandparents are needed for a Virginia Tech Human Development and Family Science research study (Study was reviewed by Virginia Tech Human Research Protection Program (HRPP) (#20-444)).

Grandchildren need to have received or currently receive professional services in Central or Eastern Kentucky, Central or Eastern Tennessee, Western North Carolina, Southwest or Western Virginia, West Virginia (except for Marshall, Ohio, Brooke, & Hancock counties), Southeast or Southwest Ohio and currently live in one of these areas. Grandparents will complete a 20-minute survey as well as complete an audio-recorded 60-90-minute phone interview sharing their experiences seeking services for their grandchild as well as themselves, if applicable. Grandparents will be compensated for their time with a $20 Amazon gift card, delivered via email. See attached flyer for additional information.

Ready to share? Please contact Bradford Stucki at grandfamilies-study@vt.edu or (540) 358-0064. Please share this information and the research flyer with listservs you may be on, your colleagues or grandparents raising grandchildren whom you may know—except for colleagues in school districts, as we are not currently recruiting from schools at this time—or hang the flyer publicly in your office.

Sincerely,

Bradford Stucki, M.MFT
Doctoral Candidate in Marriage and Family Therapy
Primary Researcher
Virginia Tech
Appendix D
IRB-Approved Facebook Posts for Service Provider Recruitment

Post 1
Are you a grandparent raising a grandchild? Have you sought professional help for your
grandchild? We are looking for grandparents who live in one of the yellow, purple, or red
counties in the picture below to participate in a Virginia Tech research study. Grandparents will
complete an online survey, and if eligible, share their story via a recorded phone interview and
then receive a $20 Amazon gift card. To share your story, please contact us at grandfamilies-
study@vt.edu or 540-358-0064!

Post 2
Do you know someone who is raising their grandchildren? We want to hear their story of seeking
professional help for their grandchild. We are seeking participants from Central/Eastern
Kentucky, Central/Eastern Tennessee, Western North Carolina, Southwest/Western Virginia,
Southeast/Southwest Ohio, or West Virginia for a research study.

Grandparents will complete an online survey, and if eligible, share their story via a recorded
phone interview and then receive a $20 Amazon gift card. Have them contact us at
grandfamilies-study@vt.edu [or alternative email as proposed in Facebook page file] or 540-358-
0064 to share their story!

Post 3
Are you a grandparent raising a grandchild? Share your story for a $20 Amazon gift card!

Grandparents who are raising a grandchild with past abuse, neglect, or household instability, also
known as adverse childhood experiences or ACEs, are needed for a Virginia Tech Human
Development and Family Science research study (Study was reviewed by Virginia Tech Human
Research Protection Program (HRPP) (#20-444).

Grandchildren need to have received or currently receive professional services in Central or
Eastern Kentucky, Central or Eastern Tennessee, Western North Carolina, Southwest or Western
Virginia, West Virginia, Southeast or Southwest Ohio and currently live in one of these areas.
Grandparents will complete a 20-minute survey as well as complete an audio-recorded 60-90-
minute phone interview sharing their experiences seeking services for their grandchild as well as
themselves, if applicable. Grandparents will be compensated for their time with a $20 Amazon
gift card, delivered via email. See attached flyer for additional information.
Ready to share? Please contact Bradford Stucki at grandfamilies-study@vt.edu [or alternative
email as proposed in Facebook page file] or (540) 358-0064.
Appendix E:

Facebook Recruitment Statistics

Table 18
Facebook Recruitment Statistics – Grandparents Raising a Grandchild with an ACE History

<table>
<thead>
<tr>
<th>Grandparent Recruitment</th>
<th>Caption</th>
<th>Post date and time</th>
<th>Reach</th>
<th>Likes and reactions</th>
<th>Link Clicks</th>
<th>Comments; Shares</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Update Cover photo</td>
<td>4/24/21; 4:49 pm</td>
<td>33</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Update profile picture</td>
<td>4/24/21; 4:49 pm</td>
<td>7</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>GP recruitment post</td>
<td>4/24/21; 4:54 pm</td>
<td>40</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4/24/21; 4:58 pm</td>
<td>42</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4/24/21; 4:58 pm</td>
<td>55</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4/24/21; 4:59 pm</td>
<td>61</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4/24/21; 5:00 pm</td>
<td>68</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4/24/21; 5:15 pm</td>
<td>32,258</td>
<td>173</td>
<td>911</td>
<td>39; 274</td>
</tr>
<tr>
<td>Phone Number Update</td>
<td></td>
<td>4/24/21; 5:48 pm</td>
<td>79</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<tr>
<td>Status update</td>
<td></td>
<td>5/8/21; 7:33 am</td>
<td>89</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Phone Number Update</td>
<td></td>
<td>5/8/21; 7:34 am</td>
<td>102</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>

Table 19
Facebook Recruitment Statistics – Formal Service Providers

<table>
<thead>
<tr>
<th>Formal Service Provider Recruitment</th>
<th>Caption</th>
<th>Post-time</th>
<th>Reach</th>
<th>Likes and reactions</th>
<th>Link Clicks</th>
<th>Shares</th>
</tr>
</thead>
<tbody>
<tr>
<td>Updated information for SP</td>
<td>8/13/21; 6:23 am</td>
<td>22</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>SP Recruitment Message</td>
<td>8/13/21; 6:37 am</td>
<td>315</td>
<td>2</td>
<td>5</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Thank you, study now closed</td>
<td>9/20/21; 10:11 am</td>
<td>30</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>
Appendix F

Grandparent Screening Tool and Demographic Questionnaire

Confidential

**Grandparent Eligibility Form**

Thank you for being interested in this research study. To determine whether you are eligible to participate, you are going to answer some questions.

1. Are you able to speak and understand English?  
   - [ ] Yes  
   - [ ] No

2. Central Appalachia is a region with many counties and independent cities. Please review the states below and select which state you reside in.

   I am requesting this information so that I can provide you with a list of grandparent-related local resources, general health, and mental health resources to give you at the end of the interview via email. This information will also assist me in reporting any abuse or neglect that you may share with me during the interview so that I can report it to the appropriate authorities.

   - [ ] Central or Eastern Kentucky  
   - [ ] Western North Carolina  
   - [ ] Southeast or Southwest Ohio  
   - [ ] Central or Eastern Tennessee  
   - [ ] Southwest or Western Virginia  
   - [ ] I don't live in any of these places.

2.1 What part of Central or Eastern Kentucky do you live in?  
   - [ ] Cumberland Plateau (Bell, Boyd, Breathitt, Carter, Clay, Estill, Elliott, Fleming, Johnson, Knott, Laurel, Lawrence, Leslie, Lee, Letcher, Magoffin, Martin, McCreary, Menifee, Morgan, Owsley, Perry, Pike, Powell, Rowan, Scott, Ballard, Bath, Fayette, Bourbon, Harrison)  
   - [ ] Bluegrass Region (Boone, Bourbon, Bracken, Garrard, Jessamine, Kenton, Madison, Montgomery, Nicholas, Robertson, Rowan, Clark, Estill, Floyd, Franklin, Garrard, Harlan, Jackson, Johnson, Knott, Knox, Laurel, Lawrence, Lee, Leslie, Letcher, Magoffin, Martin, McCreary, Menifee, Morgan, Owsley, Perry, Pike, Powell, Rowan, Scott, Ballard, Bath)  
   - [ ] Pennyrile, Pennyrile, or Mississippi Plateau (Clinton, Cumberland, Edmonson, Hart, Meade, Monroe, Pulaski, or Wayne County)  
   - [ ] Western Coal Fields (Adair, Casey, Green, Rockcastle, Russell, or Somerset County)  
   - [ ] I don't live in any of these counties.

2.2 What part of Western North Carolina do you live in?  
   - [ ] Mountains (Alleghany, Ashe, Avery, Buncombe, Burke, Caldwell, Cherokee, Clay, Graham, Haywood, Henderson, Jackson, Macon, Madison, McDowell, Mitchell, Polk, Rutherford, Swain, Transylvania, Watauga, Wilkes, or Watauga County)  
   - [ ] Piedmont (Alexander, Alleghany, Forsyth, Stokes, Surry, or Yadkin County)  
   - [ ] I don't live in any of these counties.

2.3 What part of Southeast or Southwest Ohio do you live in?  
   - [ ] Southeast Ohio (Adams, Gallia, Hocking, Jackson, Lawrence, Meigs, Morgan, Noble, Perry, Vinton, or Washington County)  
   - [ ] Southwest Ohio (Adams, Brown, Clermont, Highland, Pike, Ross, or Scioto County)  
   - [ ] I don't live in any of these counties.
### 2.4 What part of Central or Eastern Tennessee do you live in?
- **East Tennessee** (Anderson, Bledsoe, Blount, Bradley, Campbell, Carter, Claiborne, Cocke, Cumberland, Grainger, Greene, Hamblen, Hamilton, Hancock, Hawkins, Jefferson, Johnson, Knox, Loudon, Marion, McMinn, Meigs, Monroe, Morgan, Polk, Rhea, Roane, Scott, Sevier, Sullivan, Unicoi, Union, or Washington County)
- **Middle Tennessee** (Cannon, Clay, Coffee, Dekalb, Fentress, Franklin, Grundy, Jackson, Lawrence and Lewis, Macon, Marion, Overton, Pike, Putnam, Sequatchie, Smith, Van Buren, Warren, or White County)
- I don't live in any of these counties.

### 2.5 What part of Southwest or Western Virginia do you live in?
- **Southwest Virginia** (Cumberland, Lenawisco, Mount Rogers, New River Valley, or West Piedmont Health Districts)
- **Western Virginia** (Shenandoah Valley: Rockbridge County, Buena Vista City, or Lexington City) or Virginia Mountains (Alleghany, Bath, Botetourt, Craig, Highland County, or Clifton Forge City, or Covington City)
- I don't live in any of these areas.

### 2.51 What part of Southwest Virginia do you live?
- **Cumberland** (Buchanan, Dickenson, Grayson, Russell, or Tazewell County)
- **Lenawisco** (Lee, Scott, Wise County, or City of Norton)
- **Mount Rogers** (Bland, Carroll, Smyth, Washington, or Wythe County: City of Bristol or City of Galax)
- **New River** (Floyd, Giles, Montgomery, Pulaski County, or City of Radford)
- **West Piedmont** (Henry County, Patrick County, or City of Martinsville)
- I don't live in any of these areas.

### 2.52 What part of Western Virginia do you live in?
- **Shenandoah Valley** (Rockbridge County, Buena Vista City, Lexington City)
- **Virginia Mountains** (Alleghany, Bath, Botetourt, Craig, Highland County, Clifton Forge City, or Covington City)
- I don't live in any of these areas.
2.6 What part of West Virginia do you live in?

- Eastern Panhandle (Berkeley, Jefferson, or Morgan County)
- Hatallic-McCoy Mountains (Boone, Lincoln, Logan, Mingo, or Wayne County)
- Metro Valley (Cabell, Kanawha, Mason, or Putnam County)
- Mid-Ohio (Calhoun, Jackson, Pleasants, Ritchie, Roane, Web, or Wood County)
- Mountain Lakes (Braxton, Clay, Gilmer, Lewis, Nicholas, Upshur, or Webster County)
- Mountaineer Country (Barbour, Doddridge, Harrison, Marion, Monroe, Preston, or Taylor County)
- New River/Greenbrier Valley (Fayette, Greenbrier, McDowell, Mercer, Monroe, Raleigh, Summers, or Wyoming County)
- Northern Panhandle (Tyler or Wetzel County)
- Potomac Highlands (Grant, Hampshire, Hardy, Mineral, Pendleton, Pocahontas, Randolph, or Tucker County)
- I don't live in any of these counties.

3 Are you currently raising (e.g., providing basic needs, parenting, full-time care) to at least one grandchild under the age of 18?

- Yes
- No

4 Are either of the grandchild's parents living in your home?

- Yes
- No

5 The Centers for Disease Control (CDC) (2013) define adverse childhood experiences as "potentially traumatic events that occur in childhood (0-17 years)" (para. 1) and includes events such as parent death, parent separation or divorce, abandonment, family member mental health condition, family member substance use, emotional abuse, physical abuse, sexual abuse, physical neglect, domestic violence, emotional abuse to another adult, or parent incarceration.

Has a GRANDCHILD you are currently raising experienced at least one of these events?

If you are raising more than one grandchild, please select the grandchild with the next upcoming birthday and think of that grandchild throughout the entire survey.

6 Has your grandchild received or does your grandchild currently receive services provided by a professional in Central or Eastern Kentucky, Central or Eastern Tennessee, Western North Carolina, Southwest or Western Virginia, West Virginia, Southeast or Southwest Ohio?

- Yes
- No
7. The Centers for Disease Control (CDC) (2019) define adverse childhood experiences as "potentially traumatic events that occur in childhood (0-17 years)" (para. 1) and includes events such as parent death, parent separation or divorce, abandonment, family member mental health condition, family member substance use, emotional abuse, physical abuse, sexual abuse, physical neglect, domestic violence, emotional abuse to another adult, or parent incarceration.

Have YOU experienced one of these events?

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are you willing to have your interview audio recorded?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are you willing to complete the interview over the phone?</td>
<td></td>
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</tr>
</tbody>
</table>

Based on your answers above, you are eligible to be part of this study!

Please carefully review the consent form below. If you have any questions, please email the primary researcher, Bradford Stucki at stuckib@vt.edu before you select to consent to this research study.
Consent to Take Part in a Research Study

Title of research study: Grandfamilies, Grandchild Adverse Childhood Experiences, and Formal Services: An Examination of Needs, Experiences and Best Practices

Virginia Tech IRB#: 20-444

Principal Investigator: Dr. Megan Dolbin-MacNab, Ph.D., Associate Professor,
Department of Human Development and Family Science/Center for Gerontology, Virginia Tech.
Email: mdolbinm@vt.edu

Co-investigator: Dr. Pamela Teaster, Ph.D., Professor, Director, Center for Gerontology, Virginia Tech.
Email: pteaster@vt.edu

Email: stucki04@vt.edu

Key Information: Here is a short summary about this study to help you decide whether you would want to be a part of this study. More detailed information is listed later in this form.

My name is Bradford Stucki. I am a doctoral candidate at Virginia Tech in the Human Development and Family Science Department. I am conducting research that will be used in my dissertation for the purposes of my doctoral degree. Since starting my doctoral program, I have been interested in how grandparents who raise their grandchild experience the process of seeking and receiving services provided by a professional, or formal services.

The current research does not talk very much about adverse childhood experiences, or ACEs, and their relationship to the grandfamily. Some examples of ACEs include parent death, parent separation or divorce, abandonment, family member mental health condition, family member substance use, emotional abuse, physical abuse, sexual abuse, physical neglect, parent incarceration. ACEs are often crucial to grandfamilies, where a grandparent is raising a grandchild with this type of past. In addition, there is not very much information available about how ACEs influence grandparents and their grandchildren during service seeking and service use. I hope to explore that in this study. Thank you so much for your interest, time, and consideration to participate in this study. Please remember that participation in this study is entirely voluntary.

Detailed Information: The following is more detailed information about this study in addition to the information listed above.

Who can I talk to?

If you have questions, concerns, or complaints, or think the research has hurt you, contact the primary researcher, Bradford Stucki at stucki04@vt.edu or by phone at: (540) 358-6064. You can also email the principal investigator of the study, Dr. Megan Dolbin-MacNab at mdolbinm@vt.edu or the co-investigator of the study, Dr. Pamela Teaster at pteaster@vt.edu.

This research has been reviewed by the Virginia Tech HRPP.

You may communicate with them at 540-231-3732 or irb@vt.edu if:

You have questions about your rights as a research subject
Your questions, concerns, or complaints are not being answered by the research team
You cannot reach the research team
You want to talk to someone besides the research team to provide feedback about this research

How many people will be studied?

We plan to include approximately 20 people like you in this study. All interviews are conducted via phone.

What happens if I say yes, I want to be in this research?

If you decide to participate in the research, you will first consent to the study. Next, you will complete a survey with questions about yourself, your grandchild, and the formal services you are receiving in the past.
currently using. After the survey, the primary researcher will call you and schedule a day and time for an interview, over the phone. The primary researcher will ask you how you would like to be contacted for the appointment for a reminder, either by phone or email. The primary researcher will then call or email, based on your preference, the day before the appointment to remind you of the appointment. Your interview will last approximately 60-90 minutes. Once the interview is over, you will receive a $20 Amazon gift card via email or text message as a token of gratitude for your participation.

Your participation in this study is voluntary. If you have any questions about the research, you should ask before you decide to consent. Please refer below for additional information about the study.

-It is your choice to participate in this research.
-You will first answer some questions to determine if you are eligible for the study. If you are, you will then read through the consent form. After consenting to the research, you will enter in the research identifier number you received (e.g., 008-1) in a box so your responses can be paired with your consent. You will then complete a survey about yourself and your grandchild. You will also answer questions about services you have used in the past or which you are currently using. This entire process will take you approximately 20 minutes to complete.

-After you complete the survey, you will be contacted by the primary researcher.
-You will schedule your interview and be interviewed by Bradford Stucki, the primary researcher of the study.
-You will be interviewed only one time.
-The interview is anticipated to last between 60 to 90 minutes.
-The interview will be conducted over the phone. The researcher will be in a private location when conducting your interview.
-The study requires recording of the interviews. Phone calls will be recorded on an audio recorder. All recordings will be deleted after transcription. More information about recording is provided at the end of this document.
-The researcher will ask you 14 open-ended questions with follow-up probes about your experiences. You can choose to not answer a specific question or to skip a question. You can choose to skip any question. It will not be held against you.
-You can choose to take a break during a question if you feel the need to. It will not be held against you.
-Although there are no current plans to conduct a secondary research study with the interview data from this study, it is a possibility that the transcripts from the interviews will be used for a second study. More information about using transcript data for a secondary project is provided at the end of this document.

What happens if I say yes, but I change my mind later?

You can leave the research at any time, for any reason. Doing so will not be held against you. If you decide to leave the research, contact the investigator. The investigator will then remove you from the pool of participants. If you decided to cease participation during the interview process or after it, none of the data you provided will be utilized for the purposes of the study.

Is there any way being in this study could be bad for me? (Detailed Risks)

-You may experience physical discomfort during the interview if you are sitting for 60-90 minutes.
-Sometimes talking about some service delivery experiences can be hard. You may experience some emotional discomfort in discussing difficult experiences while seeking services or while remembering negative grandchild behavior. You may become stressed during the remembering or sharing of their experiences. Please take the time you need to respond. If you need a break, at any point during the interview, please let me know and we can pause. You can also choose to not respond to any question. At the end of the interview, I will provide you with a list of resources in your community that you can contact in case you want to seek professional help.
-To ensure confidentiality of the information you are sharing, no names will be used in the transcript of your interview. During transcription, we are also de-identifying the recordings. What this means is that, after I transcribe, or type out, the recording, all identifiers (names of family members, county or other locations, unique identifying characteristics about a location (e.g., X building with the purple car in front of it) names and places of providers) will be removed, if they do come up. After your interview has been transcribed, the audio recording will be deleted.
-At any time during the interview, you disclose current abuse, exploitation, or neglect that you or your grandchild are experiencing, I have an ethical obligation to report this to the appropriate social services authorities in your specific geographic area. This could be any form of abuse, including but not limited to physical, verbal, emotional, psychological, and/or sexual as well as any form of emotional or physical neglect. If a report is made, you will have your shared personal information with the primary researcher shared with your state-specific County Department of Social Services or state hotline without your consent. In the case that the reporting does need to occur, I will stop the interview, tell you I will need to report your information, and give you the choice on whether you want to continue to participate in this study. The abuse or neglect report and the reporting instance will not be included in the final transcript, and therefore will not be used for the purposes of this study. Your $20 Amazon gift card compensation will not be impacted, nor will you be negatively impacted in any other way in the context of the research process.
-If a report is made or founded, you may experience a disruption in personal and family relationships, depending on the circumstances of your personal and family relationships, your personal and family's awareness of your day-to-day happenings, and the closeness of their relationship with you.
-The research team does not anticipate any loss of economic risk of participants to this study, such as loss of insurance or employment.

What happens to the information collected for the research?
We will make every effort to limit the use and disclosure of your personal information, including research study records, only to people who have a need to review this information. We cannot promise complete confidentiality. Organizations that may inspect and copy your information include the IRB, Human Research Protection Program, and other authorized representatives of Virginia Tech.

If the research team uncovers abuse or neglect, this information will be disclosed to appropriate social services authorities in your specific geographic area.

Although there are no specific plans currently for a secondary project with the data collected for this study, there is a possibility that the same data will be used for future research. Since all recordings will be deleted right after transcription, any secondary project will only use transcripts that contain no identifiers (e.g., name, location, email addresses, work location, etc.). The transcripts will be stored in a secure drive on a password-protected computer, to which only members of the research team at Virginia Tech will have access.

Once all identifiers (e.g., name, location, email addresses, work location, etc.) are removed from your private information that is collected during this research, the remaining deidentified information could be used for future research studies or distributed to another investigator for future research studies without your additional informed consent. Deidentified data (e.g., survey and interview) will be stored indefinitely at Virginia Tech and preserved for future use. Audio recordings will be destroyed after transcription is completed for focus group data. The identifier link linking participant names to research numbers will be destroyed following project completion.

The results of this research study will be used primarily for dissertation purposes to meet requirements for the primary researcher’s doctoral degree. The study may also be published in one or more journals. It may be presented in summary form at conferences, in presentations, and in academic papers.

Members of the research team (e.g., the PI, the primary researcher, and a collaborator) will have access to all study data. Data will be shared only with additional research team members with an approved IRB and who have completed Virginia Tech’s approved IRB training and have a time-sensitive and specific purpose will have access to study data. Raw data is only accessible by members of the IRB-approved research team. No email addresses of research participants will be shared with any team members outside of the Virginia Tech team. Research data will not be disclosed to anyone outside of the research team unless required by law. Anyone outside the research intending to use the de-identified data must first request permission from the PI and once permission is obtained, the individual(s) must receive IRB approval before data will be shared with the requesting individual. De-identified data will be stored on Virginia Tech’s Google Drive system until the final report (e.g., dissertation) is officially completed. Upon completion of that document, data will be moved to Virginia Tech storage.

Can I be removed from the research without my OK?

The primary researcher, or the PI, can remove you from the research study without your approval. Possible reasons for removal include discovering during the research process that you do not meet the eligibility criteria you had disclosed earlier or any conflict of interest that might arise. However, a member of the research team will talk with you about this decision before your removal.

What else do I need to know?

A portion of this research is being funded by the Center for Gerontology at Virginia Tech. Any expenses accrued for seeking or receiving medical or mental health treatment will be your responsibility and not that of the research project, research team, or Virginia Tech.

If you agree to take part in and complete this research study, we will compensate you with a $20 Amazon gift card for your time and effort. This $20 Amazon gift card will be sent to you after the completion of the interview, via email or text message. At the end of the study, the primary researcher will create a one-page summary of study findings that will be emailed to you, unless you choose to not receive this information.

Study was reviewed by Virginia Tech Human Research Protection Program (HRPP). If the individual has questions or concerns about their rights as a research participant, they can contact our office at 540-231-3732 or irb@vt.edu.

Contact Information:

Researcher/Co-Investigator: Bradford Stucki, Doctoral Candidate,
Human Development and Family Science, Virginia Tech.

Email: stuckib@vt.edu
Phone: (540) 358-0084

Principal Investigator: Dr. Megan Dolbin-MacNab, Ph.D, Associate Professor
Human Development & Family Science/Center for Gerontology, Virginia Tech
Email: mdolbinm@vt.edu

Study was reviewed by Virginia Tech HRPP.

Your selecting the affirmative consent documents your permission to take part in this research.

10 Do you consent to participate in this research study?
   ○ I understand the risks and benefits involved in this study and CONSENT to participate in this research study.
   ○ I DO NOT consent to the study.

11 Please enter the participant study number assigned to you. (This number came with the email that had the link to this survey).

12 How would you like to receive your $20 Amazon gift card compensation for completing the survey and interview?
   ○ You can send it to my email address.
   ○ I don't want want to be compensated.

12 Would you like to be emailed a one-page summary of study results?
   ○ Yes
   ○ No

Thank you for choosing to be part of this study. First, you will answer questions about yourself. Next, you will answer questions about your grandchild. Last, you will mark which services your grandchild has used since coming to live with you and what services you have used since your grandchild has come to live with you.

What is your gender?
   ○ Male
   ○ Female

What is your marital status?
   ○ Single
   ○ In a committed relationship
   ○ Married
   ○ Separated
   ○ Divorced

What is your race?
   ○ American Indian/Alaskan Native
   ○ Asian
   ○ Black or African American
   ○ Multi-racial
   ○ Native Hawaiian/Pacific Islander
   ○ White
   ○ Other

Please type in the race that you identify with.

Do you consider yourself to be Hispanic?
   ○ Yes
   ○ No

What is your age? (in years)
What is your annual income before taxes?
- $0 to $10,000
- $10,001 to $20,000
- $20,001 to $30,000
- $30,001 to $40,000
- $40,001 to $50,000
- $50,001 to $60,000
- $60,001 to $70,000
- $70,001 to $80,000
- $80,001 to $90,000
- $90,001 to $100,000
- Over $100,000
- Prefer not to answer

What is your highest level of education?
- Less than High School
- High school graduate (or GED)
- Technical school
- Some college
- Associate degree
- Bachelor's degree
- Some graduate school
- Master's degree
- Doctorate (JD, PhD, PsyD)
- Medical Degree (DO, MD, NP)

How many grandchildren are you raising?

How many grandchildren have you ever raised?

Do you have a legal responsibility for your grandchild?
- Yes
- No

Have you ever worked with the Department of Social Services while raising your grandchild?
- Yes
- No

Are you currently working with the Department of Social Services?
- Yes
- No

The Centers for Disease Control (CDC) (2013) define adverse childhood experiences as "potentially traumatic events that occur in childhood (0-17 years)" (para. 1).

Of the examples listed above, please select which potentially traumatic events YOU experienced before you turned 18.

- Parent death
- Parent separation or divorce
- Abandoned by your parents
- Family member mental health condition
- Family member substance use
- Emotional abuse
- Physical abuse
- Sexual abuse
- Physical neglect
- Emotional neglect
- Domestic violence
- Seeing another adult be emotionally abused
- Having a parent in jail or prison

Since you have been raising your grandchild, have YOU participated in any of the following programs or services? (Mark all that apply.)
<table>
<thead>
<tr>
<th>Service</th>
<th>Current</th>
<th>Past</th>
</tr>
</thead>
<tbody>
<tr>
<td>Food pantries</td>
<td></td>
<td></td>
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<tr>
<td>Medicare</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social Security</td>
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<td></td>
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<tr>
<td>Housing Assistance</td>
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<tr>
<td>Legal Aid/Assistance</td>
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<tr>
<td>Support Group</td>
<td></td>
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<tr>
<td>Counseling</td>
<td></td>
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<tr>
<td>Crisis Management (e.g., crisis counselor)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parent Coach (e.g., one-on-one provider, classes, workshops)</td>
<td></td>
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<tr>
<td>Case Management (e.g., social worker, being linked to resources, about monthly appointments)</td>
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<td></td>
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<tr>
<td>Medical Services (e.g., doctor visits, health clinics)</td>
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<td></td>
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<tr>
<td>Emergency Services (e.g., going to the hospital for medical reasons)</td>
<td></td>
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<tr>
<td>Psychiatric (e.g., medication, appointments)</td>
<td></td>
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<tr>
<td>Psychiatric hospitalization (e.g., going to the hospital for mental health reasons)</td>
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<tr>
<td>Comprehensive Health Investment Program (CHIP)</td>
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<tr>
<td>Food Stamps/Supplemental Nutrition Assistance Program (SNAP)</td>
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<tr>
<td>Temporary Assistance to Needy Families (TANF)</td>
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<tr>
<td>Temporary Assistance to Needy Families (TANF) Child Only Grants Supplemental Security Income (SSI)</td>
<td></td>
<td></td>
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<tr>
<td>Women, Infants, and Children (WIC)</td>
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</tr>
<tr>
<td>Court Services (e.g., going to court)</td>
<td></td>
<td></td>
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<tr>
<td>Other</td>
<td></td>
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</tr>
</tbody>
</table>

What other professional services do you currently receive?
What other services have you received in the past?

Please answer the following questions for the grandchild that you answered questions about regarding their ACE history.

The Centers for Disease Control (CDC) (2019) define adverse childhood experiences as "potentially traumatic events that occur in childhood (0-17 years)" (para. 1).

Please select which "potentially traumatic events" your grandchild has experienced before coming to live with you.

- Parent death
- Parent separation or divorce
- Abandoned by parents
- Family member mental health condition
- Family member substance use
- Emotional abuse
- Physical abuse
- Sexual abuse
- Physical neglect
- Emotional neglect
- Domestic violence
- Seeing another adult be emotionally abused
- Having a parent in jail or prison

How long (in years) you have been raising your grandchild?

How old is your grandchild?

What is your grandchild's gender?

- Male
- Female

What is your grandchild's race?

- American Indian/Alaskan Native
- Asian
- Black or African American
- Multiracial
- Native Hawaiian/Pacific Islander
- White
- Other

Please type in what other race your grandchild is:

Do you consider your grandchild to be Hispanic?

- Yes
- No

Once you became the person primarily responsible for your grandchild, when did you first look for services due to the ACE-related behaviors or symptoms you were seeing?

- 0 to 6 months
- 6 to 12 months
- 1-2 years
- 3-4 years
- 5+ years
- Not Applicable, my grandchild was already receiving services
Once you became the person primarily responsible for your grandchild, when did your grandchild first begin professional services for the ACE-related behaviors or symptoms you were seeing?

- 0 to 6 months
- 6 to 12 months
- 1-2 years
- 2-4 years
- 5+ years
- Not Applicable, my grandchild was already receiving services

What was the earliest service you sought related to your grandchild’s ACE history?

Since you have been raising your grandchild, has your grandchild participated in or been the recipient of any of the following programs or services? (Mark all that apply.)

<table>
<thead>
<tr>
<th>Service</th>
<th>Current</th>
<th>Past</th>
</tr>
</thead>
<tbody>
<tr>
<td>Head Start</td>
<td></td>
<td></td>
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<tr>
<td>Free/Reduced School</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breakfast/Lunch</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicaid</td>
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<tr>
<td>Foster Care</td>
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<tr>
<td>Kinship Care</td>
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<tr>
<td>Individual Counseling</td>
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<tr>
<td>Family Counseling</td>
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<tr>
<td>Crisis Management (e.g., crisis counselor)</td>
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<td></td>
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<tr>
<td>Case Management (e.g., social worker)</td>
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<tr>
<td>Support Group</td>
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<tr>
<td>Mental Health Skill Building</td>
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<tr>
<td>Mentoring</td>
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<tr>
<td>Developmental Clinic</td>
<td></td>
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<tr>
<td>Physical Therapist</td>
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<tr>
<td>Occupational Therapist</td>
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<tr>
<td>Speech Therapist</td>
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<tr>
<td>Court Services (e.g., probation officer)</td>
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</tr>
<tr>
<td>Psychiatric Services (e.g., medication, appointments)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychiatric Emergency Services (e.g., hospital visit for mental health reasons)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Services (e.g., doctor visits, health clinics)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency Services (e.g., hospital visit for medical reasons)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
What other services does your grandchild currently receive?

What other services has your grandchild received in the past?

You have now completed the survey. Thank you for taking the time to complete these questions!

I, Bradford Stucki, will be reaching out to you by phone (540-358-9064) or email (stuckiba@vt.edu) within the next business day to schedule a day and time for your interview. I look forward to talking with you!

Thank you, your answers have been recorded. Thank you for sharing your time. Based on your answers, you are not eligible for the study.

Please consider sharing this information about this study with other grandparents raising their grandchildren.
Appendix G

Grandparent Interview Protocol

**Interviewer:** Bradford Stucki  
**Participant Number:**  
**Date of Interview:**

**Introduction:** Hello, my name is Bradford Stucki, and I am a doctoral candidate at Virginia Tech. I am in the Department of Human Development and Family Science. I am doing this study to better grasp what it is like for grandparents raising a grandchild with a history of abuse, neglect, or household challenges—or adverse childhood experiences (ACEs)—to seek and use professional services. You were picked for the interview because you meet study criteria. You are raising a grandchild with an ACE history, have used, or are using services in Central or Eastern Kentucky, Central or Eastern Tennessee, Western North Carolina, Southwest or Western Virginia, West Virginia, Southeast or Southwest Ohio, that you live in one of the above listed areas, I look forward to hearing about your experiences.

**Purpose:** The goal of this study is to better grasp how grandparents seek and use professional services. Another goal of the study is to better know how grandparents figure out their grandchild needs professional help. I also want to better understand what it is like for grandparents to seek and use professional services.

**Confidentiality Script:** Before we begin the interview, I would like to remind you of a few things. Because of required reporting, when I ask you a question, please answer just the question being asked. Please do not include your grandchild’s name or other details that may identify him or her. Also, this interview is based on only your experience. Also, if you disclose any abuse, exploitation, or neglect of either yourself or your grandchild, or if I have reason to suspect abuse, exploitation or neglect is currently occurring, I am required to report this to the authorities. If this occurs, I will stop the interview and tell you such. You will then have a choice to stop the interview completely or to continue. Finally, if the interview becomes too difficult for any reason and you need a break, please let me know. We can pause the interview to give you the time you need or stop entirely.

**Instructions:** Also, when I say, “your grandchild’s background or history,” I mean your grandchild’s life before he or she came to live with you. Some grandparents are raising more than one grandchild. When I say, “your grandchild,” during this interview, I am referring to the grandchild you were thinking of when you completed the questions on the survey.

The interview has 18 questions and takes between 60 and 90 minutes. I may ask you more questions to clarify or further explore your answers. At the beginning of the interview, I will turn on my recorder and I will turn it off at the end of the interview. I will also write down notes as we talk which will help with the analysis of your interview. After the interview, notes will be uploaded to a secure network and the hard copies will be destroyed. Audio recordings will be saved until the interview is transcribed, or completely written down. Then the audio recording will be destroyed.

Do you have any questions before we begin?

Record Response: ____________________________

Do I have your consent to participate in the interview?
Record Response: __________________________
Do I have your consent to record in the interview?
Record Response: __________________________
How would you like to be compensated for the interview? (e.g., email, text, no pref, no comp)
Record Response: __________________________
How did you find out about the study?
Record Response: __________________________

Interview

Context
Sometimes grandchildren, prior to coming to live with their grandparents, experience some things such as having a parent with a substance problem, have a family member in jail, or have a parent die.

1. How did you come to care for your grandchild?
2. How do you see your grandchild’s ACE history reflected in their life with you?
3. How much do you think you can help your grandchild with their ACE history?
   Probe
   Do you think the ACE history is just something that is part of their life that they just have to deal with?
   Can you do something about your grandchild’s ACE history affecting your grandchild?
   Do you think formal services will matter?
4. Do you think there is a connection between what happened to your grandchild prior to living with you (e.g., ACEs) and how your grandchild is doing now? (e.g., behaviors, sleeping patterns, attention) Why or why not?

Seeking Services
5. What are some of the needs and challenges your grandchild has?
6. Tell me of a time when you realized your grandchild needed additional help from a professional.
   Probes
   a. How did you come to this realization? (e.g., was it something someone said or told you, your grandchild’s behavior, something you read, etc.?)
   b. Before realizing that your grandchild needed additional help, how did you manage your grandchild’s needs or challenges? How well did that work for you?
7. Would you share a time when you decided to get help for your grandchild with the ACE history?
   Probes
   a. How long ago was that and what happened for you to make the decision (e.g., to get help)?
   b. What are things that make it easy for you to get help?
   c. What are some of the things that made it hard for you to get help? (e.g., avoiding it, finding time)
   d. How did you find the service?
   e. When you decided to seek formal services, what thoughts or feelings did you have when you reached out for help?
8. How has the current Covid-19 pandemic impacted you in either seeking services for your
grandchild with an ACE history or receiving services, if at all?
   Probes
   a. Has the pandemic influenced the timing of when you seek or receive services?
   b. Has the pandemic influenced the types of services you can receive?
   c. What type of eligibility was required?
   d. How soon did you start services?

Grandparent Experience
9. Would you please share with me some of the needs and challenges you have experienced
   as you have raised your grandchild? (e.g., mental health, parenting stress, emotion
dysregulation, have trouble thinking about the future, have trouble getting things done,
get stressed more easily, lowered relationship quality with grandchild, family members,
lack of alone time; Arditti & Savla, 2013; Stover, Thomas, & Gewirtz, 2011)
   a. How did you come to this realization of having needs or challenges? (e.g., was it
      something someone said or told you, your behavior, something you read, etc.)
   b. Before realizing that you needed additional help, how did you manage your
      grandchild’s needs or challenges? How well did that work for you?
   c. What had to happen for you to make the decision (e.g., to get help)?
   d. How did you find the service?
   e. What are things that make it easy for you to get help?
   f. What are some of the things that made it hard for you to get help? (e.g., avoiding
      it, finding time)
   g. When you decided to seek formal services, what thoughts or feelings did you have
      when you reached out for help?
10. Is there anything in your history that impacts how you manage your grandchild’s needs?
    (If yes, will you tell me more about that? If no, what makes you think so?)
11. What do you do to get support for your needs and challenges you face? (e.g., personal
    resources; friends, family, formal services, informal services). Would you share an
    example of when you did this?

Receiving Services
Many grandparents raising grandchildren will seek out formal services (e.g., government
financial assistance programs, counseling, support groups, respite care, legal assistance, case
management, education workshops, parenting programs, social, human, or judicial services) to
help their grandchildren.
12. Think back to a time when your grandchild with an ACE history first started services.
    What service was that?
    a. At that time, did you think you or your grandchild would be treated differently by
       the provider based on your grandchild’s history or your family structure? What
       inclined/disinclined you to think that? If yes, would you please share an example
       of this?
    b. How did you think this service would help your grandchild? (e.g., reducing the
       impact of the challenge, relationship with the provider, symptom reduction)
    c. How did you build a relationship of trust with the service provider throughout the
       service process?
       i. What happened to help you build trust together? (e.g., what did you do,
          what did the provider do that helped you to build trust in them?)
ii. How would you describe your relationship with the provider? (e.g., collaborative, empowering, passive)

13. As you think about the services your grandchild has received, what would you say has been helpful for your grandchild?
   Probes
   a. How were the services helpful to you?
   b. What did you feel like your provider understood about your grandchild or your family?
   c. What would you say the provider did that made the service helpful for you? (e.g., provider knowledge or experience, listening, creating a safe space, collaborated with you, provider was transparent with you, provider was attentive to cultural, historical, or gender aspects of care, etc.)
   d. How would you describe your interactions with the provider?
      i. How would you describe their language, tone, demeanor, or attitude (e.g., hopefulness) towards you or your grandchild?

14. How would you describe the level of involvement you had in your grandchild’s formal service?
   a. What was your involvement? How did you feel about it? (e.g., comfortable, uncomfortable)
   b. How would you say that your grandchild’s services have affected you, if at all? (e.g., feelings of empowerment, new skills, a relationship with a provider). Would you please provide an example?
      i. Please share a time when you used something you learned from your involvement in your grandchild’s services to support your grandchild with their challenges
      ii. What was the outcome of your attempt?
      iii. How has your family situation changed since receiving services? (e.g., change in thinking about grandchild’s behavior, stress reduction)

15. Would you share a time when there was a conflict between you or your grandchild and the provider while your grandchild received formal services?
   a. What was your concern at the time?
   b. How did you do about your concern? Did you feel like the provider would listen to your concerns? Why or why not?
   c. Was the conflict resolved? How? Was it to your satisfaction?

16. Tell me about a time when you thought services for your grandchild were not helpful.
   Probes
   a. What do you think contributed to this situation?
   b. What did you feel like your provider did not understand about your grandchild or your family? (e.g., insufficient knowledge, provider negative perceptions, did not listen, saw you as part of the problem, non-transparent).
   c. How would you describe your interactions with this service provider?
      Probe
      i. Did you feel judged by the provider for raising your grandchild?
      ii. How would you describe their language, tone, demeanor, or attitude (e.g., hopefulness) towards you or your grandchild?
   d. What about the service wasn’t helpful?
e. How do you think the service provider treated your grandchild?
   i. How would you describe their language, tone, demeanor, or attitude (e.g., hopefulness) towards you or your grandchild?

17. Has there been a time where you ended formal services? If so, please tell me about that time when you ended formal services.
   Probes
   a. What happened to end the formal service? (e.g., did you have concerns; were those concerns addressed or resolved?)
   b. What was the outcome?
   c. Are you satisfied with the decision you made to end formal services?
   d. What did you do or who did you use to help you out now, other than formal services? (e.g., personal resources; friends, family, self)

18. What do you wish formal service providers knew about families like yours (e.g., grandparents raising grandchildren with ACE histories)?
   Probe
   a. What would you recommend to formal service providers to start or keep doing to help grandfamilies like yours?
   b. What would you recommend to formal service providers to stop doing to help grandfamilies like yours

**Closing Script:** We have reached the end of the interview. Thank you very much for your time. I am grateful for your willingness to share about raising your grandchild and seeking professional services. Before we end the call, do you have any questions and/or comments for me? (If no comments/questions): Okay, I am turning off the recorder.

**Post Interview Comments and/or Observations:**
Appendix H

Recruitment Email to Formal Service Provider

Subject line: Work with Grandparents Raising Grandchildren? Share your experience in a focus group!

Dear [Professional Name],

My name is Bradford Stucki. I am conducting a research study for my dissertation to better understand how service providers work with grandparents raising grandchildren with histories of adverse childhood experiences (abuse, neglect, household challenges such as substance use, parent being in jail, etc.) and to explore what providers consider as best practices for this unique population. Participants will complete a 15-minute online survey and participate in a 60-minute audio recorded focus group over Zoom during a lunch hour. The Virginia Tech Institutional Review Board approved this study (#20-444). Participant confidentiality will be protected. You qualify for this research if you:

- Are over 18 years old
- Have provided services for a minimum of a year with at least three grandchildren with histories of at least one past adverse childhood experience (ACE) who are being raised by their grandparents in Central or Eastern Kentucky, Central or Eastern Tennessee, Western North Carolina, Southwest or Western Virginia, West Virginia except for Marshall, Ohio, Brooke, & Hancock counties, Southeast or Southwest Ohio
- Speak and understand English

Participants will be provided with a summary of study findings from both the grandparent interviews and the focus groups at the conclusion of the study.

Please consider participating in this study. Also, please share study information with colleagues with whom you work with or know. A study flyer is attached. Thank you for your time and consideration. If you have any questions, please feel free to contact me by email at grandfamilies-study@vt.edu or by phone at (540) 358-0064.

Sincerely,

Bradford Stucki, M.MFT
Doctoral Candidate in Marriage and Family Therapy
Primary Researcher
Virginia Tech
Appendix I

Formal Service Provider Research Flyer

ARE YOU A PROFESSIONAL WHO HAS WORKED WITH A CHILD RAISED BY THEIR GRANDPARENT?

SHARE YOUR EXPERIENCE!

We are seeking volunteers from Central/Eastern Kentucky, Central/Eastern Tennessee, Western North Carolina, Southwest/Western Virginia, Southeast/Southwest Ohio, or West Virginia (except for Marshall, Ohio, Brooke, & Hancock counties) for a research study.

You must:

1) have at least a year of experience providing services to children with a history of abuse, neglect, or household challenges (parent substance use, parent incarceration, etc.) and who are being raised by their grandparent in one of the above areas
2) be over 18 years old, speak and understand English

Survey
15-minute online survey

Focus Group
60-minute audio-recorded
Zoom focus group during the lunch hour

Compensation
Resource sheets and study findings

Ready to share?

Contact: Bradford Stucki, M.MFT, Doctoral Candidate in Marriage and Family Therapy, Primary Researcher, Department of Human Development and Family Science, Virginia Tech, at grandfamilies.study@vt.edu or (540) 358-0064.

Risks are minimal and may include discomfort in sharing past experiences.
Study results may be published or presented.
(Study was reviewed by Virginia Tech HRPP; IRB@vt.edu; 540-231-3732).
Appendix J

IRB-Approved Facebook Posts for Service Provider Recruitment

Post 1
Are you a professional with at least a year of experience working with grandchildren who have histories of abuse, neglect, or household challenges and are being raised by a grandparent? Are you over 18, speak, and understand English? We are looking for professionals who work in one of the yellow, purple, or red counties in the picture below to participate in a Virginia Tech research study.

Professionals will complete an online survey, and if eligible, share their experiences in an audio recorded Zoom focus group during a lunch hour. Participants will then receive a list of national, state, and online resources after the focus group. To share your experiences, please contact us at grandfamilies-study@vt.edu or 540-358-0064!

Post 2
Do you know a professional who is working with grandchildren with a history of abuse, neglect, or household instability and the grandchild is being raised by a grandparent? We want to hear their story of working with this unique population. We are seeking participants from Central/Eastern Kentucky, Central/Eastern Tennessee, Western North Carolina, Southwest/Western Virginia, Southeast/Southwest Ohio, or West Virginia (except for Hancock, Marshall, Ohio, and Brooke counties) for a research study.

Professionals will complete an online survey, and if eligible, share their experiences via an audio recorded Zoom focus group during a lunch hour and then national, state, and online resources specific to grandparents raising grandchildren. Have them contact us at grandfamilies-study@vt.edu or 540-358-0064 to share their experiences!

Post 3
Post of Focus Group study flyer on Facebook page

End of Study Message
Thank you for visiting this page and your interest in this research study. Recruitment for grandparent interviews and focus groups for professionals have now ended. Information gathered will now be analyzed. If you are interested in future research studies involving grandparents raising grandchildren, please like the Facebook page. Thank you!
Appendix K

Formal Service Provider Screening Tool and Demographic Questionnaire

Service Provider Eligibility Form

Thank you for being interested in this research study. To determine whether you are eligible to participate, you are going to answer some questions.

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are you able to speak and understand English?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you worked with or do you work with grandfamilies where the grandchild has an ACE history in Central Appalachia (e.g., Central or Eastern Kentucky, Western North Carolina, Southeast or Southwest Ohio, Central or Eastern Tennessee, Southwest or Western Virginia, or West Virginia)?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Central Appalachia is a region with many counties and independent cities. Please review the states below and select which state you work in. I am requesting this information so that I can provide you with a list of grandparent-related local resources, general health, and mental health resources to give you at the end of the focus group via email. This information will also assist me in recording any abuse or neglect that you may share with me during the interview so that I can report it to the appropriate authorities.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Where do you work in Central or Eastern Kentucky?</td>
<td>Cumberland Plateau (Bell, Boyd, Breathitt, Carter, Clay, Eastern Lewis County, Elliott, Estill, Floyd, Greenup, Harlan, Jackson, Johnson, Knott, Knox, Laurel, Lawrence, Lee, Leslie, Letcher, Magoffin, Martin, McCreary, Menifee, Morgan, Owsley, Perry, Pike, Powell, Rowan, Southernmost Bath County, Whitley, or Wolfe County)</td>
<td></td>
</tr>
<tr>
<td>Where do you work in Western North Carolina?</td>
<td>Mountains (Alleghany, Ashe, Avery, Buncombe, Burke, Caldwell, Cherokee, Clay, Graham, Haywood, Henderson, Jackson, Macon, Madison, McDowell, Mitchell, Polk, Rutherford, Swain, Transylvania, Watauga, Wilkes, or Yancey County)</td>
<td></td>
</tr>
<tr>
<td>The Piedmont (Alexander, Alleghany, Ashe, Burke, Caldwell, Catawba, Cleveland, Davidson, Davidson, Davie, Forsyth,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surry, or Yadkin County)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I don't work or I haven't worked with a grandchild being raised by their grandparents in any of these counties.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Question</td>
<td>Options</td>
<td></td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------</td>
<td></td>
</tr>
</tbody>
</table>
| Where do you work in Southeast or Southwest Ohio?                      | ☐ Southeast Ohio (Athens, Gallia, Hocking, Jackson, Lawrence, Meigs, Monroe, Morgan, Noble, Perry, Vinton, or Washington County)  
  ☐ Southwest Ohio (Adams, Brown, Clermont, Highland, Pike, Ross, or Scioto County)  
  ☐ I don't work or I haven't worked with a grandchild being raised by their grandparents in any of these counties. |
| Where do you work in Central or Eastern Tennessee?                     | ☐ East Tennessee (Anderson, Blount, Bradley, Campbell, Carter, Claiborne, Cocke, Cumberland, Grainger, Greene, Hamblen, Hamilton, Hancock, Hawkins, Jefferson, Johnson, Knox, Loudon, Marion, McMinn, Meigs, Monroe, Morgan, Polk, Rhea, Roane, Scott, Sequatchie, Smith, Van Buren, Warren, or White County)  
  ☐ Middle Tennessee (Cannon, Clay, Coffee, DeKalb, Fentress, Franklin, Grundy, Jackson, Lawrence and Lewis, Marion, Overton, Pickett, Putnam, Sequatchie, Smith, Van Buren, Warren, or White County)  
  ☐ I don't work or I haven't worked with a grandchild being raised by their grandparents in any of these counties. |
| Where in Southwest or Western Virginia do you work?                    | ☐ Southwest Virginia (Cumberland, Lenawaso, Mount Rogers, New River Valley, or West Piedmont Health Districts)  
  ☐ Western Virginia (Shenandoah Valley, Rockbridge County, Buena Vista City, or Lexington City) or Virginia Mountains (Alleghany, Bath, Botetourt, Craig, Highland County, or Clifton Forge City, or Covington City)  
  ☐ I don't work or I haven't worked with a grandchild being raised by their grandparents in any of these counties. |
| Where do you work in Southwest Virginia?                               | ☐ Cumberland (Buchanan, Dickenson, Grayson, Russell, or Tazewell County)  
  ☐ Lenawaso (Lee, Scott, Wise County, or City of Norton)  
  ☐ Mount Rogers (Bland, Carroll, Smyth, Washington, or Wythe County, City of Bristol or City of Galax)  
  ☐ New River (Floyd, Giles, Montgomery, Pulaski County, or City of Radford)  
  ☐ West Piedmont (Henry County, Patrick County, or City of Martinsville)  
  ☐ I don't work or I haven't worked with a grandchild being raised by their grandparents in any of these counties. |
| Where do you work in Western Virginia?                                 | ☐ Shenandoah Valley (Rockbridge County, Buena Vista City, Lexington City)  
  ☐ Virginia Mountains (Alleghany, Bath, Botetourt, Craig, Highland County, Clifton Forge City, or Covington City)  
  ☐ I don't work or I haven't worked with a grandchild being raised by their grandparents in any of these counties. |
Where do you work in West Virginia?
- Eastern Panhandle (Berkeley, Jefferson, or Morgan County)
- Harford-McCoy Mountains (Boone, Lincoln, Logan, Mingo, or Wayne County)
- Metro Valley (Cabell, Kanawha, Mason, or Putnam County)
- Mid-Ohio (Clay, Calhoun, Jackson, Pleasants, Ritchie, Roane, Wet or Wood County)
- Mountain Lakes (Braxton, Clay, Gilmer, Lewis, Nicholas, Upshur, or Webster County)
- Mountaineer Country (Barbour, Doddridge, Harrison, Marion, Monongalia, Preston, or Taylor County)
- New River/Greenbrier Valley (Fayette, Greenbrier, McDowell, Mercer, Monroe, Raleigh, Summers, or Wyoming County)
- Northern Panhandle (Tyler or Wetzel County)
- Potomac Highlands (Grant, Hampshire, Hardy, Mineral, Pendleton, Pocahontas, Randolph, or Tucker County)
- I don't work or I haven't worked with a grandchild being raised by their grandparents in any of these counties.

Adverse childhood experiences (ACES) are potentially traumatic events that occur in childhood (0-17 years) which include events such as parent death, parental separation or divorce, abandonment, family member mental health condition, family member substance use, emotional abuse, physical abuse, sexual abuse, physical neglect, domestic violence, emotional abuse to another adult, and parent incarceration.

- None
- Less than 3
- 3 to 5
- 6 to 10
- More than 10

How many grandchildren with an adverse childhood experience (ACE) history, being raised by their grandparents, in Central Appalachia would you estimate you have ever worked with?

Adverse childhood experiences (ACES) are potentially traumatic events that occur in childhood (0-17 years) which include events such as parent death, parental separation or divorce, abandonment, family member mental health condition, family member substance use, emotional abuse, physical abuse, sexual abuse, physical neglect, domestic violence, emotional abuse to another adult, and parent incarceration.

- No experience
- Less than three months
- Less than six months
- Less than a year
- 1 to 3 years
- 3 to 5 years
- 5 to 10 years
- Over 10 years

In your career, how many experience would you say you have in working with grandchildren with an ACE history and who are being raised by their grandparents, in Central Appalachia?

This focus group will be an audio-only meeting, with no video.

- Yes
- No

Are you willing to be audio-recorded as part of your participation in a Zoom focus group?

Based on your answers above, you are eligible to be part of this study!

Please carefully review the consent form below. If you have any questions, please email the primary researcher, Bradford Stucki at stucki@wv.edu before you select to consent to this research study.
Title of research study: Grandfamilies, Grandchild Adverse Childhood Experiences, and Formal Services: An Examination of Needs, Experiences and Best Practices

VT IRB#: 20-444

Principal Investigator: Dr. Megan Dolbin-MacNab, Ph.D, Associate Professor,
Department of Human Development and Family Science/Center for Gerontology, Virginia Tech.
Email: mdolbin@vt.edu

Co-investigator: Dr. Pamela Teaster, Ph.D, Professor, Director, Center for Gerontology, Virginia Tech.
Email: pteaster@vt.edu

Email: stuckib@vt.edu

Key Information: The following is a short summary of this study to help you decide whether you would want to be a part of this study. More detailed information is listed later in this form.

My name is Bradford Stucki and I am a doctoral candidate at Virginia Tech in the Human Development and Family Science Department. I am conducting research that will be used in my dissertation for the purposes of my doctoral degree. Since starting my doctoral program, I have been interested in how grandparents who raise their grandchildren experience the process of seeking and receiving services provided by a professional, or formal services.

The current research does not talk very much about adverse childhood experiences, or ACEs, and their relationship to the grandfamily, or families where grandparents are raising their grandchildren. Some examples of ACEs include parent death, parent separation or divorce, abandonment, family member mental health condition, family member substance use, emotional abuse, physical abuse, sexual abuse, physical neglect, parent incarceration. ACEs are often crucial to grandfamilies, where a grandparent is raising a grandchild with this type of past. In addition, there is not very much information about how ACEs influence grandparents and their grandchildren during service seeking and service use. I hope to explore that in this study. Thank you so much for your interest, time, and consideration to participate in this study. Please remember that participation in this study is entirely voluntary.

Detailed Information: The following is more detailed information about this study in addition to the information listed above.

Who can I talk to?
If you have questions, concerns, or complaints, or think the research has hurt you, contact the primary researcher, Bradford Stucki at stuckib@vt.edu or by phone at (540) 358-0754. You can also email the principal investigator of the study, Dr. Megan Dolbin-MacNab at mdolbin@vt.edu or the co-investigator of the study, Dr. Pamela Teaster at pteaster@vt.edu.

This research has been reviewed by the Virginia Tech IRB.

You may communicate with them at 540-231-3732 or irc@vt.edu if:

- You have questions about your rights as a research subject
- Your questions, concerns, or complaints are not being answered by the research team
- You cannot reach the research team
- You want to talk to someone besides the research team to provide feedback about this research

How many people will be studied?

We plan to include approximately 8 to 12 people in this study. All focus groups are conducted via Zoom by audio only (no video), hosted by Virginia Tech. If you are available for one of the two focus group times, you will receive the Zoom meeting information after consenting to the study and completing this form as well as in each reminder you receive (e.g., two weeks and one week before the focus group date). If you are not available, you will have the opportunity to indicate such and indicate whether the researcher can reach out to you about future focus group times.

What happens if I say yes, I want to be in this research?

If you decide to participate in the research, you will first consent to the study. Next, you will indicate which focus group you will attend if one will work for you. If you are not available, you will have the opportunity to indicate whether the researcher can reach out to you about future focus group times.
indicate whether the researcher can reach out to you about future focus group times. Then you can consent to
two-week and one-week reminder emails or phone calls for the focus group. Then, you will complete a survey about
yourself, your work experience with grandfamilies where the grandchild has an ACE history, , and your self-rated
ranking of how well you do with addressing ACEs. This portion of the study (e.g., consent for study, consent for
reminders, and survey) is expected to take approximately 15 minutes. Finally, you will participate in an
audio-recorded focus group over Virginia Tech’s Zoom platform for approximately 60 minutes. Once the focus group
is over, you will receive a thank you email with receive a list of community, general medical, and/or psychological
resources for grandparents raising grandchildren in your health region.

Your participation in this study is voluntary. If you have any questions about the research, you should ask before you
decide to consent. Please refer below for additional information about the study.

It is your choice to participate in this research.

After consenting to the study, you will enter the research identifier number you received (e.g., 006 FG) in a box in the
survey so your answers can be paired with your consent. Then you will select the date and time that works for
your schedule for the focus group. If you are not available, you will have the opportunity to indicate such and indicate
whether the researcher can reach out to you about future focus group times.

- You will then complete a survey that asks demographic questions about you and your provision of services to
  grandfamilies. This, combined with the eligibility questions and consent form is anticipated to take approximately 15
  minutes.

- You will participate in a focus group only once. The focus group is anticipated to last between 60 minutes.

- The focus groups will be conducted on Virginia Tech’s Zoom platform. The focus group will be moderated by
  Bradford Stucki, the primary researcher of the study. The researcher will be in a private location when conducting the
  focus group.

- The study requires an audio recording of the focus group. The Zoom call will begin audio recording after reconsent
  has been acquired from participants. All recordings will be deleted after transcription. More information about
  recording is provided at the end of this document.

- The researcher will ask the focus group open-ended questions with follow up probes about your experiences
  providing services to grandfamilies where the grandchild has an ACE history. You can choose to not answer a
  specific question or a part of a question.

- You can choose to skip any question. It will not be held against you.

- You can choose to take a break during a question if you feel the need to. It will not be held against you.

- Although there are no current plans to conduct a secondary research study with the focus group data from this
  one, it is a possibility that the de-identified transcripts from the focus group will be used for a second study. More
  information about using transcript data for a secondary project is provided at the end of this document.

What happens if I say yes, but I change my mind later?

You can leave the research at any time, for any reason, and it will not be held against you. If you decide to leave the
research, contact the investigator so that the investigator can remove you from the pool of participants. If you
decided to cease participation during the focus group process or after it, none of the data you provided will be
utilized for the purposes of the study.

Is there any way being in this study could be bad for me? (Detailed Risks)

You may experience physical discomfort during the focus group if you are sitting for 60 minutes. You may feel
stressed or embarrassed if you do not have an answer to a question posed to the focus group. Sometimes talking
about some service delivery experiences can be hard. You may experience some emotional discomfort in discussing
difficult experiences while seeking services or while remembering negative grandchild behavior. You may become
stressed during the remembering or sharing of their experiences. Please take the time you need to respond. You can
also choose to not respond to any question. To ensure confidentiality of the information you are sharing, no names
will be used in the transcript of your focus group. During transcription, we are also de-identifying the recordings.
After recordings are transcribed the recording, all identifiers (names, county or other locations, names and places of
providers or services used) will be removed, if they come up. After the focus group has been transcribed, the audio
recording will be deleted. The research team does not anticipate any loss of economic risk of participants to this
study, such as loss of insurance or employment. What happens to the information collected for the research?

We will make every effort to limit the use and disclosure of your personal information, including research study
records, only to people who have a need to review this information. We cannot promise complete confidentiality.
Organizations that may inspect and copy your information include the IRB, Human Research Protection Program, and
other authorized representatives of Virginia Tech.
Although there are no specific plans currently for a secondary project with the data collected for this study, there is a possibility that the same data will be used for future research. Since all recordings will be deleted right after transcription, any secondary project will only use transcripts that contain no identifiers (e.g., name, location, email addresses, work location, etc.). The transcripts will be stored in an online doubly password-protected drive, to which only members of the research team at Virginia Tech have access.

Once all identifiers (e.g., name, location, email addresses, work location, etc.) are removed from your private information that is collected during this research, the remaining de-identified information could be used for future research studies or distributed to another investigator for future research studies without your additional informed consent. De-identified data (e.g., surveys, focus group transcripts) will be stored indefinitely at Virginia Tech and preserved for future use. Audio recordings will be destroyed after transcription is completed for focus group data. The identifier link linking participant names to research numbers will be destroyed following project completion.

The results of this research study will be used primarily for dissertation purposes to meet requirements for the primary researcher's doctoral degree. The study may also be published in one or more journals. It may further be presented in summary form at conferences, in presentations, and in academic papers.

Members of the research team (e.g., the PI, the primary researcher, and a collaborator) will have access to all study data. Data will be shared only with additional research team members with an approved IRB and who have completed Virginia Tech's approved IRB training and have a time sensitive and specific purpose will have access to study data. Raw data is only accessible by members of the IRB-approved research team. No email addresses of research participants will be shared with any team members outside of the VT team. Research data will not be disclosed to anyone outside of the research team, unless required by law. Anyone outside the research intending to use the de-identified data must first request permission from the PI and once permission is obtained, the individual(s) must receive IRB approval before data will be shared with the requesting individual.

De-identified data will be stored on Virginia Tech's Google Drive system until the final report (e.g., dissertation) is officially completed. Upon completion of that document, data will be moved to Virginia Tech storage.

Can I be removed from the research without my OK?

The primary researcher, or the PI can remove you from the research study without your approval. Possible reasons for removal include: Participants will be removed from the research process that you do not meet the eligibility criteria you had disclosed earlier or any conflict of interest that might arise. However, a member of the research team will talk with you about this decision before your removal.

What else do I need to know?

Aside from the time research participants will need to participate in the study, research participants are responsible for any costs associated with their participation in the study, including but not limited to family care, as well as phone or internet use costs. There are no anticipated costs such as transportation, as participants will not be traveling to a specific location for the Zoom call. There are no anticipated costs such as missed work, due to the focus group occurring during the lunch break of focus group participants.

A portion of this research is being funded by the Center for Gerontology at Virginia Tech. Any expenses accrued for seeking or receiving medical or mental health treatment will be the participant's responsibility and not that of the research project, research team, or Virginia Tech.

If you agree to take part in and complete this research study, we will provide you with information sheets you may share. We believe these handouts can be helpful to grandparents raising grandchildren in your area. At the end of the study, as a token of my appreciation for your involvement, you will receive an emailed one-page summary with study findings, unless you choose not to receive study findings. After you have been sent grandparent information specific to your area and the one-page summary of study findings, if applicable, your email will be deleted from our records.

Study was reviewed by Virginia Tech Human Research Protection Program (HRPP). If the individual has questions or concerns about their rights as a research participant, they can contact the office at 540-231-3732 or irb@vt.edu. Please contact a member of the research team if they have any questions, before signing the consent form.

Contact Information:
Researcher/Co-Investigator: Bradford Stucki, Doctoral Candidate in Marriage and Family Therapy,
Human Development and Family Science, Virginia Tech.

Email: stucklb@vt.edu
Phone: (540) 358-0064

Principal Investigator: Dr. Megan Dolbin-MacNab, Ph.D, Associate Professor
Human Development & Family Science/Center for Gerontology, Virginia Tech
Email: mdolbinm@vt.edu

Do you give your consent to participate in this research study?  
☐ I understand the risks and benefits involved in this study and CONSENT to participate in this research study.  
☐ I DO NOT consent to the study.

Please enter the participant study number assigned to you. (This number came with the email that had the link to this survey.)

We are considering the following dates for the one-hour focus group.  
☐ Date and Time 1  
☐ Date and Time 2  
☐ Date and Time 3  
☐ I’m not available during any of these dates or times, but would like to be contacted if new times become available.

A member of the research team will be in touch to confirm the final date and time.

I would like to be reminded two weeks before the focus group.  
☐ Yes  
☐ No

How would you like to be reminded (e.g., phone call or email) two weeks prior to the focus group?  
☐ Email  
☐ Phone call

I would like to be reminded a week before the focus group.  
☐ Yes  
☐ No

How would you like to be reminded a week before the focus group?  
☐ Email  
☐ Phone call

As a token of appreciation for your time and effort with this study, we are providing you with a one-page summary of study results as well as a list of resources we believe are helpful for grandparents raising their grandchildren in your area.

Would you like a one-page summary of study results?

Would you like a list of resources we believe are helpful for grandparents raising their grandchildren in your area?  
☐ Yes  
☐ No

Thank you for choosing to be part of this study. First, you will answer questions about yourself. Next, you will answer questions about your work with grandchildren raised by their grandparents or grandparents raising grandchildren.

Then you will answer questions about resources available and barriers to grandparents and grandchildren, as well as what training professionals need who work with this family type. Last, you will self-rate your knowledge, comfort, and skill in addressing ACEs with grandchildren whom you work with.

What is your gender?

What is your age?
What is your race?  
- American Indian/Alaskan Native  
- Asian  
- Black or African American  
- Multi-racial  
- Native Hawaiian/Pacific Islander  
- White  
- Other  

Please share what you identify as your race:  

Do you consider yourself to be Hispanic?  
- Yes  
- No  

What is your highest level of education?  
- Less than high school  
- High school graduate (or GED)  
- Technical school  
- Some college  
- Associate's degree  
- Bachelor's degree  
- Some graduate school  
- Master's degree  
- Doctorate (e.g., JD, PhD, PsyD)  
- Medical Degree (e.g., DO, MD, NP)  

In a year's time, how many grandfamilies in Central Appalachia would you estimate that you work with?:  

What types of services do you provide to grandchildren with an ACE history, who are being raised by their grandparents?  
- General support  
- Counseling  
- Case management  
- Medical care  
- Medication management / Psychiatric Services  
- Support Group  
- Education  
- Early intervention (e.g., Head Start, Early Head Start, etc.)  
- Crisis intervention  
- Mental health skill-building  
- Childcare  
- Mentoring  
- Developmental clinic services  
- Physical therapy  
- Speech therapy  
- Occupational therapy  
- Probation services  
- Waiver services  
- Parent coaching  
- Emotional support  
- Other services  
- I don't provide services to grandchildren with an ACE history, who are being raised by their grandparents.  

Could you describe what you mean by providing general support to a grandchild with an ACE history?:  

In the question above, you marked "Other services." Could you describe what other service you provide to grandchildren with an ACE history, being raised by their grandparents?

<table>
<thead>
<tr>
<th>What types of services do you provide to GRANDPARENTS who are raising a grandchild with an ACE history?</th>
</tr>
</thead>
<tbody>
<tr>
<td>- General support</td>
</tr>
<tr>
<td>- Counseling</td>
</tr>
<tr>
<td>- Case management</td>
</tr>
<tr>
<td>- Medical care</td>
</tr>
<tr>
<td>- Medication management / Psychiatric Services</td>
</tr>
<tr>
<td>- Kinship Care</td>
</tr>
<tr>
<td>- Support Group</td>
</tr>
<tr>
<td>- Education</td>
</tr>
<tr>
<td>- Crisis intervention</td>
</tr>
<tr>
<td>- Mental health skill-building</td>
</tr>
<tr>
<td>- Physical therapy</td>
</tr>
<tr>
<td>- Speech therapy</td>
</tr>
<tr>
<td>- Occupational therapy</td>
</tr>
<tr>
<td>- Waiver services</td>
</tr>
<tr>
<td>- Parent coaching</td>
</tr>
<tr>
<td>- Emotional support</td>
</tr>
<tr>
<td>- Legal aid/assistance services</td>
</tr>
<tr>
<td>- Housing Assistance</td>
</tr>
<tr>
<td>- Financial Assistance</td>
</tr>
<tr>
<td>- Other services</td>
</tr>
<tr>
<td>- I don’t provide services to grandparents who are raising a grandchild with an ACE history</td>
</tr>
</tbody>
</table>

In the question above, you marked "Other services." Could you describe what other service you provide to grandchildren with an ACE history, being raised by their grandparents?

<table>
<thead>
<tr>
<th>Could you describe what you mean by providing general support to a grandchild with an ACE history?</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>What do you find rewarding when working with grandchildren with an ACE history and their grandparents, who are raising them?</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Helping families learn skills to manage their challenges</td>
</tr>
<tr>
<td>- Helping grandparents feel more empowered</td>
</tr>
<tr>
<td>- Helping grandchildren learn to manage their emotions</td>
</tr>
<tr>
<td>- Reducing stress in the family</td>
</tr>
<tr>
<td>- Providing information and resources</td>
</tr>
<tr>
<td>- Providing needed services</td>
</tr>
<tr>
<td>- Other reason</td>
</tr>
</tbody>
</table>

In the question above, you marked "Other reason." Could you describe what you find rewarding when working with grandchildren with an ACE history and their grandparents?

---

08/10/2021 11:45pm
<table>
<thead>
<tr>
<th>What parts of working with grandfamilies with an ACE history are challenging?</th>
</tr>
</thead>
</table>
| □ Time/Scheduling difficulties   □ Cancellations/No shows   □ Lack of understanding (e.g., techniques you are teaching, skills, depth of the problem, etc.)   □ Expecting the grandchild to change   □ Lack of engagement   □ Lack of motivation   □ Wanting a “quick fix”   □ Childcare   □ Transportation   □ Financial   □ Other reason

In the question above, you marked "Other reason." Could you describe what you find challenging when working with grandchildren with an ACE history and their grandparents?

What are some ways to reduce these barriers?

How do you assist in reducing barriers for services for grandfamilies with ACE histories, if at all?

How would you describe the availability of adequate services in your area for grandfamilies with ACE histories?

- Very Poor
- Below Average
- Average
- Above Average
- Excellent

Please help us understand why you chose the answer you did.

What do you think are training needs for professionals who work with grandchildren raised by their grandparents?

Or, put another way, what topics or trainings do you think are needed for professionals who work with grandchildren raised by their grandparents?

Based on your experience, what professional service needs do you think grandfamilies with an ACE history and grandparents who are raising the grandchild need? (e.g., physical, behavioral, emotional, psychological)

How familiar are you in working with trauma-informed care?

- Not at all familiar
- Not very familiar
- Somewhat familiar
- Very familiar
- Extremely familiar

Where did you learn about trauma-informed care?
To your knowledge, how often does working with a grandchild who has a history of ACEs occur in your line of work?

<table>
<thead>
<tr>
<th>Option</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td></td>
</tr>
<tr>
<td>Rarely</td>
<td></td>
</tr>
<tr>
<td>Sometimes</td>
<td></td>
</tr>
<tr>
<td>Often</td>
<td></td>
</tr>
<tr>
<td>Very Often</td>
<td></td>
</tr>
</tbody>
</table>

Note: ACEs, or adverse childhood experiences, are potentially traumatic events that occur in childhood (0-17 years) which include events such as parent death, parent separation or divorce, abandonment, family member mental health condition, family member substance use, emotional abuse, physical abuse, sexual abuse, physical neglect, domestic violence, emotional abuse to another adult, and parent incarceration.

How would you rate your knowledge of ACEs and their potential impacts on grandchildren being raised by their grandparents?

<table>
<thead>
<tr>
<th>Option</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very Poor</td>
<td></td>
</tr>
<tr>
<td>Below Average</td>
<td></td>
</tr>
<tr>
<td>Average</td>
<td></td>
</tr>
<tr>
<td>Above Average</td>
<td></td>
</tr>
<tr>
<td>Excellent</td>
<td></td>
</tr>
</tbody>
</table>

Note: ACEs, or adverse childhood experiences, are potentially traumatic events that occur in childhood (0-17 years) which include events such as parent death, parent separation or divorce, abandonment, family member mental health condition, family member substance use, emotional abuse, physical abuse, sexual abuse, physical neglect, domestic violence, emotional abuse to another adult, and parent incarceration.

How would you rate your comfort level in talking about a grandchild’s ACEs with their grandparent?

<table>
<thead>
<tr>
<th>Option</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not comfortable</td>
<td></td>
</tr>
<tr>
<td>Somewhat comfortable</td>
<td></td>
</tr>
<tr>
<td>Moderately comfortable</td>
<td></td>
</tr>
<tr>
<td>Very comfortable</td>
<td></td>
</tr>
</tbody>
</table>

Note: ACEs, or adverse childhood experiences, are potentially traumatic events that occur in childhood (0-17 years) which include events such as parent death, parent separation or divorce, abandonment, family member mental health condition, family member substance use, emotional abuse, physical abuse, sexual abuse, physical neglect, domestic violence, emotional abuse to another adult, and parent incarceration.

How would you rate your skill in talking about ACEs with grandparents raising their grandchildren?

<table>
<thead>
<tr>
<th>Option</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>No skill</td>
<td></td>
</tr>
<tr>
<td>Some skill</td>
<td></td>
</tr>
<tr>
<td>Moderate level of skill</td>
<td></td>
</tr>
<tr>
<td>Very skilled</td>
<td></td>
</tr>
</tbody>
</table>

Note: ACEs, or adverse childhood experiences, are potentially traumatic events that occur in childhood (0-17 years) which include events such as parent death, parent separation or divorce, abandonment, family member mental health condition, family member substance use, emotional abuse, physical abuse, sexual abuse, physical neglect, domestic violence, emotional abuse to another adult, and parent incarceration.

How did the COVID pandemic affect the grandfamilies with ACE histories that you work with?

How did COVID-19 affect your service provision? (e.g., visiting the home, virtual appointments)

How did the COVID-19 pandemic affect grandchild outcomes in your service provision?
You have now completed the survey. Thank you for taking the time to complete these questions!

I, Bradford Stucki, will be reaching out to you by phone (540-358-0064) or email (stuckib@vt.edu) once a focus group day and time have been selected.

If you are unable to make it at that time, please let me know if there is another person that represents your agency or line of work and I can reach out to them about the study.

Thank you, your answers have been recorded. Based on your answers, you are not eligible for the study. Thank you for sharing your time.

Please consider sharing this information about this study with other professionals who have worked with grandchildren raised by their grandparents, where the grandchild has a history of abuse, neglect, or household instability.

You may now close the tab on your browser.
Appendix L

Focus Group Protocol

Grandfamilies, Grandchild Adverse Childhood Experiences, and Formal Services: An Examination of Needs, Experiences and Best Practices

Focus Group Protocol

Interviewer: Bradford Stucki
Participant Numbers:
Date of Focus Group:
Introduction: Hello, my name is Bradford Stucki, and I am a doctoral candidate at Virginia Tech in the Department of Human Development and Family Science. I am conducting this research to explore what the process of seeking and using services is like for a grandparent raising a grandchild, where the grandchild has an ACE history and lives in one of the following areas in Central Appalachia, which includes Central or Eastern Kentucky, Central or Eastern Tennessee, Western North Carolina, Southwest or Western Virginia, West Virginia (except for Marshall, Ohio, Brooke and Hancock counties), and Southeast or Southwest Ohio. I first interviewed grandparents about their experiences and now I am conducting two focus groups to explore providers’ experiences working with grandparents raising grandchildren with ACE histories.

Purpose: The purpose of this research is to better understand how service providers work with grandfamilies where the grandchild has an ACE history and what each of you consider as best practices for working with this population.

Confidentiality Script: Before we begin, I need to remind you to avoid sharing identifying information such as name, age, ethnicity, or race about the grandparents or grandchild(ren) you are referring to. In addition, part of the confidentiality of the focus group is also maintaining the confidentiality of other focus group participants and what they say during the focus group.

Instructions: The focus group consists of 6 questions and takes approximately 60 minutes. I may ask additional questions to clarify or further explore your answers. At the beginning of the focus group, I will turn the recorder “on”, and I will turn it “off” at the end of the focus group. I will also write down notes as we talk. I will save audio recordings until the focus group is transcribed and reviewed for accuracy. Then the audio recordings will be destroyed. Does anyone have any questions?
Before we begin the focus group, I need everyone to send me a direct message to reconsent. Writing “I consent” is sufficient. The focus group will begin once everyone has reconsented. Zoom will tell you when the focus group begins recording. If you have decided to not consent to the focus group, you may leave the Zoom meeting.
After you have sent your direct message to me, please “mute” yourself by pressing the microphone button on the bottom left corner of your Zoom platform, until you are ready to share. Also, please do not turn on your video or use your computer camera during this focus group, as this group is audio only. Please do not use the chat box during the focus group.
As a reminder, you can take a break or skip any questions at any time. You may also withdraw from the study at any time. Finally, there are no correct answers, but rather ones that reflect your experience.

The following rules are in effect for today’s focus group:

1. Everything that is discussed during the focus group should remain confidential.
2. The identities of the focus group participants should remain confidential.
3. Respect the opinions of others, even if they differ from your own.
4. Participate in the focus group discussion.
5. Listen to the contributions of others in the focus group.
6. When talking about clients/patients, please do not share any identifying information (e.g., name, county, etc.)

Record Response: ___________________________

Research in the last 30 years has drawn a link between having a history of multiple adverse childhood experiences, or ACEs, where the higher the ACE history for a child, the more negative outcomes that child is likely to experience. ACEs include three categories: (1) abuse (e.g., physical, emotional, and sexual); (2) neglect (e.g., physical and emotional); and (3) household dysfunction (e.g., parental mental illness, incarcerated relative, mother treated violently, household substance abuse, and not being raised by both parents). Emerging research is finding that ACEs are intergenerational, and grandparents may have their own ACE histories as well. Many grandchildren who are raised by their grandparents have a history of one or multiple adverse childhood experiences, or ACEs.

**Grandfamily ACE Histories**

1. Do you assess or find out about the grandparent or grandchild ACE history?
   a. What do you ask about?
   b. When you find out about a grandparent or grandchild’s ACE history, how does this information influence your approach to service provision?
      i. Would you share an example of this?

**Grandfamily Service Utilization**

2. What do you think grandparents could do to better engage or get more out of your services??

3. The following situations reflect key points from grandparent interviews from their experience seeking professional services.
   How does this fit with your experience/do you share/have you observe some of these issues / what do you think about that
   a. Areas of Benefit
      i. Providers keeping the grandparent informed of services and inquiring about grandparent feedback
      ii. Providers explaining service before providing it (e.g., I’m going todo this or I’m doing this because…)
iii. Grandparents and grandchild benefitting from between appointment homework assignments
iv. Grandparents being transparent with service providers about grandchild behavior
   1. Building a relationship of trust
v. Grandparents knowing how to find services
b. Do these situations fit with your experience working with grandchildren or grandfamilies?
c. What other common situations have you experienced that you would add to your/this list
d. Areas of Confusion
   i. Grandparents not understanding what treatment looks like or communicating their expectations
   ii. Grandparents not understanding why mandated reporting should happen
   iii. Grandparents not addressing or handling conflicts so it is difficult for provider to address problems
   iv. Provider/Grandfamily fit
e. Providers providing resources to grandfamily or helping alleviate challenges
   Do these situations fit with your experience working with grandchildren or grandfamilies?
f. What other common situations have you experienced that you would add to your/this list

Intervention

4. What do you consider as best practices for working with grandfamilies where the grandchild has an ACE history?
   a. What do you consider as best practices or effective strategies for working with grandfamilies? (e.g., theoretical lens, strategies for communicating, interventions)
      i. One recommendation is “Trauma-informed care”
         1. A “trauma-informed approach incorporates three key elements: (1) realizing the prevalence of trauma; (2) recognizing how trauma affects all individuals involved with the program, organization, or system, including its own workforce; and (3) responding by putting this knowledge into practice” (SAMHSA, 2012, p. 4). In addition, “trauma-informed care embraces a perspective that highlights adaptation over symptoms and resilience over pathology” (Elliot, Bjelajac, Fallot, Markoff, & Reed, 2005, p. 467).
      ii. If you have heard of trauma-informed care, how might this approach help grandfamilies you work with?
      iii. If you use trauma-informed treatment, how do you incorporate the Substance and Mental Health Services Administration’s (SAMHSA) six principles of trauma-informed care (e.g., safety; trustworthiness and
transparency; peer support; collaboration and mutuality; empowerment, voice, and choice; cultural, historical, and gender issues) in your work?

5. What do you consider as best practices when someone has an ACE history?
   a. Will you please describe these best practices?
      i. Who do you include, what approaches do you use, how do you approach your relationship with them, approach to explaining and engaging with services, etc.
      ii. In your experience, have you noticed that these families tend to have intergenerational trauma (grandparents have trauma, grandchildren and parents have trauma)?

6. How did you see the COVID pandemic affect the grandfamilies with ACE histories?
   a. How did it affect your service provision?
      i. (e.g., Visiting the home, Virtual appointments
   b. How did the COVID pandemic affect the grandchild outcomes in your service provision?
      i. How did grandparents respond to your provision of services during COVID compared to before COVID?

Closing Script: Thank you very much for your time. I truly appreciate your willingness to share your experiences working with grandparents raising a grandchild with an ACE history. Before we end the Zoom call, does anyone have any questions and/or comments for me?

Post Interview Comments and/or Observations:
Appendix M

Service Provider Perspective on Grandchild Needs

Table 20

*Service Provider Perspective on Grandchild Needs*

<table>
<thead>
<tr>
<th>Type of Need</th>
<th>n (%)^a</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral</td>
<td>5 (50)</td>
</tr>
<tr>
<td>Emotional</td>
<td>5 (50)</td>
</tr>
<tr>
<td>Psychological</td>
<td>5 (50)</td>
</tr>
<tr>
<td>Physical</td>
<td>4 (40)</td>
</tr>
<tr>
<td>Financial aid</td>
<td>3 (30)</td>
</tr>
<tr>
<td>Education</td>
<td>2 (20)</td>
</tr>
<tr>
<td>Counseling</td>
<td>1 (10)</td>
</tr>
<tr>
<td>Family engagement</td>
<td>1 (10)</td>
</tr>
<tr>
<td>Group therapies for kids</td>
<td>1 (10)</td>
</tr>
<tr>
<td>Legal</td>
<td>1 (10)</td>
</tr>
<tr>
<td>Mental health services in the home</td>
<td>1 (10)</td>
</tr>
<tr>
<td>Mentorships</td>
<td>1 (10)</td>
</tr>
<tr>
<td>Parent coaching</td>
<td>1 (10)</td>
</tr>
<tr>
<td>Primary Care Provider</td>
<td>1 (10)</td>
</tr>
<tr>
<td>Referrals when needed</td>
<td>1 (10)</td>
</tr>
<tr>
<td>Respite</td>
<td>1 (10)</td>
</tr>
<tr>
<td>School personnel</td>
<td>1 (10)</td>
</tr>
<tr>
<td>School social workers</td>
<td>1 (10)</td>
</tr>
<tr>
<td>Substance abuse prevention</td>
<td>1 (10)</td>
</tr>
<tr>
<td>Transportation</td>
<td>1 (10)</td>
</tr>
</tbody>
</table>

^a Numbers will not equal 100% due to overlap in response
Appendix N

Provider Assessment of Service Availability and Barriers

Table 21

*Provider Assessment of Service Availability and Barriers*

<table>
<thead>
<tr>
<th>Service availability and barriers</th>
<th>n (%)^a</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment of services available to grandfamilies in their area</td>
<td></td>
</tr>
<tr>
<td>Below average</td>
<td>4 (40)</td>
</tr>
<tr>
<td>Average</td>
<td>6 (60)</td>
</tr>
<tr>
<td>Explanation of service availability rating^b</td>
<td></td>
</tr>
<tr>
<td>Rural area creates service limitations</td>
<td>4 (40)</td>
</tr>
<tr>
<td>Resources and services dependent on legal custody</td>
<td>4 (40)</td>
</tr>
<tr>
<td>GP not recognized by school</td>
<td>1 (10)</td>
</tr>
<tr>
<td>Transportation</td>
<td>1 (10)</td>
</tr>
<tr>
<td>Deterioration of community groups</td>
<td>1 (10)</td>
</tr>
<tr>
<td>Lack of grandparent-specific education</td>
<td>1 (10)</td>
</tr>
<tr>
<td>Need for respite and group therapies</td>
<td>1 (10)</td>
</tr>
</tbody>
</table>

^a For an explanation, see below

^b Numbers will not equal 100% due to overlap in response
Appendix O

Training Needs for Service Providers, Identified by Service Providers

Table 22

*Training Needs for Service Providers, Identified by Service Providers*

<table>
<thead>
<tr>
<th>Type of Training Need</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adverse Childhood Experiences Education</td>
<td>5 (50)</td>
</tr>
<tr>
<td>• Intergenerational trauma</td>
<td></td>
</tr>
<tr>
<td>• Understanding trauma</td>
<td></td>
</tr>
<tr>
<td>• Recognizing childhood trauma symptoms</td>
<td></td>
</tr>
<tr>
<td>• Trauma-informed parenting</td>
<td></td>
</tr>
<tr>
<td>• Awareness of guilt and shame for GP</td>
<td></td>
</tr>
<tr>
<td>Cultural Diversity</td>
<td>3 (30)</td>
</tr>
<tr>
<td>• Role conflict for GP</td>
<td></td>
</tr>
<tr>
<td>• Family engagement</td>
<td></td>
</tr>
<tr>
<td>Creating trauma-informed policies and procedures</td>
<td>1 (10)</td>
</tr>
<tr>
<td>Emotion Awareness and Management for GC</td>
<td>1 (10)</td>
</tr>
<tr>
<td>Family therapy</td>
<td>1 (10)</td>
</tr>
<tr>
<td>Safe technology practices</td>
<td>1 (10)</td>
</tr>
</tbody>
</table>

*a Numbers will not equal 100% due to overlap in response*