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## Kinship care connection: A school-based intervention for kinship caregivers and the children in their care

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### Abstract

Whereas child welfare has championed efforts in kinship care practice, policy, and research, there is a growing need for other systems of care, specifically the school system, to improve the ways in which kinship care families are supported. This study highlights outcomes from the Kinship Care Connection (KCC), an innovative school-based intervention designed to increase children's self-esteem and to mediate kin caregiver burden. Current issues regarding the status of kinship caregiving families involved in the school system are highlighted using quantitative data and case studies based on: (1) 34 caregivers participating in support groups and case management services, including counseling, advocacy, and resource procurement, and (2) 63 children participating in tutoring, mentoring and counseling, advocacy, and resource procurement. Two case studies describing the familial experience in KCC will detail the process evaluation related to this intergenerational intervention. Results indicate increased self-esteem in children and mediated kin caregiver burden for families participating in the KCC. Implications for social work practice include suggestions for ways social workers and the school system can better support kinship caregiving families.

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*Keywords:* Kinship Care Connection; Caregiver; Family

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## 1. Introduction

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Kinship care is defined as “the full time nurturing and protection of children who must be separated from their parents by relatives, members of their tribes or clans, god-parents, step-parents, or other adults who have a kinship bond with the child” (Child Welfare League of America, 2002). A variety of social factors contribute to children requiring substitute caregivers, including neglect, abuse, abandonment, substance abuse, non-marital childbearing, mental illness, HIV/AIDS, emotional difficulties, teen pregnancy, incarceration, parental death, divorce, unemployment, and general familial dysfunction (Caputo, 2001; Flint & Perez-Porter, 1997; Landry-Meyer, 1999; Minkler & Roe, 1996; Smith & Beltran, 2000).

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The rates of children being raised in kinship family homes have risen markedly in recent years. In 1997, it was estimated that 1.8 million children lived with relatives, with neither of their parents present in the home, according to analyses of the 1997 National Survey of America’s Families (NSAF) (Ehrle & Geen, 2002). The 2000 U.S. Census presented higher national figures, including reports of 4.5 million children under the age of 18 living in grandparent-maintained households, and another 1.5 million children under 18 living in other relative-maintained households (Generations United, 2001).

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Child welfare practice, policy, and research have championed efforts designed to meet the unique needs of kinship care families. However, most kinship care is informal and unaccounted for by any agency, making it difficult to accurately assess the number of families affected and services needed. Many of the families involved in kinship care are not involved in the child welfare system and do not receive the amount or quality of support available to those families with differential child welfare oversight. Other systems of care, specifically the school system, must increase their knowledge about the special needs of kinship care families to ensure that children are receiving adequate support to meet school outcomes.

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Kinship care is usually the first choice for placement of a child when the parent is unable to continue parenting because this kind of care preserves family ties, provides community and ethnic/cultural consistency, and reduces the trauma of separation from the parents. Hand in hand with the strengths of kinship care, however, come a number of stressors and challenges (Burton, 1992; Kelley, 1993; Kelley, Whitley, Sipe, & Crofts Yorker, 2000; McGrew, 2000). Common sources of stress are finances, loss of personal time and “freedom” (Burton, 1992), concerns about children’s anger or emotional problems (McGrew, 2000), lack of social support (Kelley et al., 2000), and concerns about the caregiver living long enough to take care of the grandchildren (Kelley, 1993).

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### 1.1. Kinship caregiver burden

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In the past decade research has emerged focusing on the burden of caring for family members. Since family caregiving can include the helping of a child, sibling, spouse or parent with physical or emotional impairments, or an elderly parent with diminishing facilities, there is a great deal of variation in the conceptual definitions and measurement of burden in caregiving. Montgomery, Borgatta, and Borgatta (2000) provide a clear explanation of caregiving burden differentiation. Objective burden is defined as perceived

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infringement or disruption of tangible aspects of a caregiver's life. Subjective demand 69  
burden is defined as the extent to which the caregiver perceives care responsibilities to be 70  
overly demanding. Third, subjective stress burden is the emotional impact of caregiving 71  
responsibilities on the caregiver. 72

The concept of caregiver burden as it relates specifically to kinship care is relatively 73  
new. [Cimmarusti \(2000\)](#) links kinship caregiver burden to perceived social support and 74  
amount of emotional distress in the caregiver's experience. Cimmarusti uses the metaphor 75  
of "an alliance of tears" to illustrate the relationships between individuals within the family 76  
(both immediate and extended), the amounts of stress and strain associated with these 77  
relationships, and the communication breakdown between family members. [Cuddeback's](#) 78  
(2004) review of the literature, reports evidence that grandparent kin caregivers have more 79  
burdens than grandparents not caring for grandchildren (e.g. limitations of daily activities, 80  
increased depression, lower levels of marital satisfaction, and poorer health). To date, 81  
however, no studies have specifically measured kinship caregiver burden as it relates to 82  
raising school-aged grandchildren. 83

### 1.2. *Children and self-esteem* 84

Some of the stressors children in kinship care commonly experience are due to 85  
circumstances associated with the removal from their parents. Research conducted with 86  
children in kinship care found a high rate of behavioral problems among these children, 87  
similar to that found in foster children ([Dubowitz, Zuravin, Starr, Feigelman, &](#) 88  
[Harrington, 1993](#)). [Sawyer and Dubowitz \(1994\)](#) reported that children in kinship care 89  
have problems with work study habits, attention, and concentration skills and they exhibit 90  
higher than average rates of acting-out behaviors. The researchers further reported that 91  
teacher responses regarding children's school performance differed significantly from 92  
caregiver responses, indicating a lack of communication between these two groups. In 93  
addition, many of the children suffered from learning disorders, poor academic 94  
performance, low self-esteem, and depression. 95

Self-esteem appears to be an important concept to measure in school-aged children. 96  
Self-esteem is generally considered to be dependent on interactions with the environment 97  
and accomplishments in one's life. Many researchers have found that self-esteem is a good 98  
predictor of academic performance ([Brookover, Thomas, & Patterson, 1964](#); [Covington,](#) 99  
[1989](#); [Holly, 1987](#); [Scheirer & Kant, 1979](#); [Walz & Bleuer, 1992](#)). For example, in 100  
[Covington's \(1989\)](#) study, findings indicated that as the level of self-esteem increased, so 101  
did achievement scores. [Franken \(1994\)](#) states: "people who have good self-esteem have a 102  
clearly differentiated self-concept...When people know themselves they can maximize 103  
outcomes because they know what they can and cannot do" (p. 439). 104

### 1.3. *Kinship care and education* 105

Literature suggests that children in kin families need support and special services in 106  
their schools ([Lawrence-Webb, Okundaye, & Hafner, 2003](#); [Smith, Strozier, & Chaffin,](#) 107  
[2000](#)). Grandparent caregivers often find that one of the most difficult areas for them 108  
in raising grandchildren is helping their grandchildren be successful in school, because 109

they themselves do not feel skillful in working with the schools. Cuddeback, Franck, Buehler, and Orme (submitted for publication) controlled for demographic variables such as race and socioeconomic well-being when investigating differences in problem behaviors for children in the general school population and in children living in kinship care. The study examined self-reports from 86 sixth-graders from 13 diverse middle schools in a southeastern state. Franck et al. (2003) found that children in kinship care experienced more borderline delinquent behavior and more severe attention problems than those children in the general school population. The researchers recommended that teachers and other professionals who work with kinship care families be aware of special emotional and behavioral issues and develop strategies to help children in kinship care overcome these barriers. Rothenberg (2000) recommended that schools provide better experiences for kinship caregivers such as offering information, referrals, and using “family-friendly” interventions. The school setting has the potential to significantly contribute to the successful development of these kinship children.

The present study examined a school-based intervention designed to improve child self-esteem and mediate caregiver burden for kinship care families. The hypotheses for this study were: (1) involvement in tutoring, mentoring, support groups, counseling, advocacy, and case management services will increase the self-esteem of children in kinship care; and (2) group participation, counseling, advocacy, and case management services will mediate kinship caregiver burden.

## 2. Intervention design 131

There are many interventions aimed at assisting children who have difficulties in school. Interventions for this study were selected based upon previous research studies (Dore, Nelson-Zlupko, & Kaufmann, 1999; Gonyea & Silverstein, 1991; Maslow, 1954; Private/Public Ventures, 2002; Reinhard, Gubman, Horowitz, & Minsky, 1994; Solomon & Draine, 1995; Wood, 1986) and the recommendations from caregivers in a study by Lawrence-Webb et al. (2003). Lawrence-Webb et al. (2003) examined current issues regarding education of children who are placed with kinship caregivers. While only nineteen kin caregivers participated in two focus groups, the research highlighted tangible recommendations offered by the caregivers who expressed strong interest in improving the relationship between the school and their grandchildren.

### 2.1. Mentoring and tutoring 142

Evaluations of mentoring programs have shown that a youth’s one-to-one relationship with a supportive adult can lead to higher self-esteem and a number of positive outcomes, such as improved academic achievement, improved relationships with families, and decreased drug and alcohol use (Private/Public Ventures, 2002). Developing a bond with an unrelated adult can provide children in kinship care with more stability in their lives, as well as another supportive influence to turn to in times of family crises or stress.

Subsequent to No Child Left Behind (NCLB) that encourages evidenced-based practice, tutoring programs have been more rigorously evaluated for their effectiveness on improving outcomes. As a sanction for NCLB, schools are mandated to provide tutoring to children. Tutoring has been included in many school improvement programs to better meet children's educational needs. While there is a lack of empirical studies that test the effectiveness of tutoring, there are many theoretical explanations rooted in developmental theory which would support such an intervention. For example, Wood (1986) emphasizes the role played by adult tutors in "scaffolding" children's performance on concrete tasks (and hence their acquisition of relevant skills).

### 2.2. Mutual support groups

Literature on support groups has examined their moderating effects on caregiver burden. Gonyea and Silverstein (1991) explored the relationship between support group participation and an improved sense of psychological well-being among 301 caregivers attending support groups and 75 control families. Caregivers who attended support groups experienced lower levels of objective and subjective burden (Gonyea & Silverstein, 1991). Solomon and Draine (1995) found self-efficacy and coping strategies to be effective mediators of burden. Reinhard et al. (1994) demonstrated that practical advice on managing disruptive behaviors also reduced caregiver burden.

Research shows that support groups offered at schools have improved children's self-esteem. Dore et al. (1999) conducted a school-based intervention for children living in a heavily drug-affected urban area. Their study lasted 2 years and had 206 elementary school-aged participants. Sixteen treatment groups each met for eight sessions of one and a half hours. Each group had a wait-list control group. The intervention was designed to educate children about substance abuse, to link children having similar experiences at home, and to help the children verbalize their feelings about those experiences. The measurements used to determine the intervention's effectiveness were the Teachers Report Form, the Children's Loneliness Questionnaire, and the Nowicki-Strickland Locus of Control Questionnaire. The researchers found that the students showed improvements in their sense of internal locus of control, feelings of social acceptance, self-esteem, and classroom behavior. The researchers concluded that the children had a "tremendous need... for someone to listen to their worries and fears" (p. 188).

### 2.3. Case management services

Case management for kinship caregivers is based on Maslow's Hierarchy of Needs (1954). Maslow explained human needs based on two groupings: deficiency needs and growth needs. Each lower need must be met before moving to the next higher level. This theory applies to the current kinship care intervention because caregivers need assistance with the very basic physical needs of their family (e.g. housing, food, clothing), before they can address psychological/emotional needs. Lawrence-Webb et al. (2003) described the importance of procuring services that assist caregivers in addressing their unique family situations, such as finances and housing, by connecting families to community resources.

<b>3. Method</b>	191
3.1. Measures	192
3.1.1. Child self-esteem	193
The Hare Self-esteem Scale (HSS) (Hare, 1980) is a 30-item rapid assessment instrument developed to measure self-esteem in school-aged children. Items are scored on a four-point Likert scale and higher scores indicate higher self-esteem. The HSS identifies three important sources of self-esteem in children through the structure of three 10-item subscales that measure home, peer, and school related self-esteem.	194 195 196 197 198
The HSS is sensitive to the contextual source of self-esteem, unlike many other assessment measures on child self-esteem. The HSS is suitable for the varying backgrounds of children in this study. Hare (1980) indicated no significant racial differences on any of the general or area-specific esteem measures when SES was controlled.	199 200 201 202 203
This instrument was used by Springer, Lynch, and Rubin (2000) to study the impact of an intervention on trauma-reactive behaviors (depression, aggressiveness, withdrawal, etc.) of elementary school Hispanic children whose parents had been incarcerated. A number of these children of incarcerated parents lived with relatives. In Springer et al.'s study, subjects made significant pre–post improvement on the HSS, whereas the comparison groups' scores were unchanged. Even though a covariance analysis of the posttest scores found no significance between group differences, the effect size for this study (0.57) demonstrated a moderate effect.	204 205 206 207 208 209 210 211
The HSS test–retest correlation is reasonable at 0.74 and a range of 0.56 to 0.65 for the three subscales. The HSS correlates (0.83) with other scales of self-esteem, such as the Coopersmith Self-esteem Inventory and the Rosenberg Self-esteem Scale, indicating adequate concurrent validity.	212 213 214 215
3.1.2. Caregiver measure	216
The Caregiver Self-Efficacy Scale (CSE) (Boothroyd, 1997) was selected for measuring the construct of caregiver burden in kinship caregiving participants who are raising a relative's school-aged child. The CSE is a self-report measure comprised of twenty-five Likert-type items intended to measure the extent of self-efficacy caregivers perceive when raising school-aged children.	217 218 219 220 221
The CSE is comprised of five subscales: behavior management, school issues, advocacy, emotional support, and service provision. These subscales fit conceptually with the literature on possible sources of caregiver burden for kin. For example, children in kinship care experience a high rate of behavioral problems, similar to that found in foster children (Dubowitz et al., 1993). Improving caregiver perceived self-efficacy on behavior management of the children in care could mediate caregiver burden. Similarly, Yu, Day, and Williams (2002) explain how kinship caregiving families tend to fall between the cracks of the school system regarding many issues such as advocacy, emotional support, and service provision. Communication breakdown can occur when one system (i.e. the school) believes the family is receiving adequate support from the other system (i.e. the child welfare system) which thinks the same of the other system, and vice versa. In	222 223 224 225 226 227 228 229 230 231 232

actuality, the family is often not receiving adequate support from any system of care. The CSE subscales differentiate among these potential sources of caregiver burden and measure the perceived self-efficacy in specific areas. No other scale makes a distinction among various sources of burden for caregivers.

Internal consistency reliability is estimated at 0.86. The subscales containing only four items, school issues and advocacy, have lower alphas at 0.61 and 0.62, respectively, while the subscales containing five or six items (behavior, emotional support, and provider issues) have alphas ranging from 0.64 to 0.78 (Boothroyd, 1997). Boothroyd (1997) used the CSE to compare fundamental differences in several program models that provide support to caregivers ( $N=354$ ). Boothroyd reported that all ten interscale correlations assess a similar construct relating to self-efficacy, while the five subscales possess a reasonable amount of independence and assess different aspects of self-efficacy (interscale correlations=0.28 to 0.52).

### 3.2. Participants

All participants in this study were voluntary. Participants were recruited by the school-based social worker at elementary schools in a large Southern metropolis and identified as being eligible for services from the Kinship Care Connection program. To be eligible for the KCC, children at participating elementary schools were self-reported or teacher reported as living with a grandparent or other relative. Children were required to assent to participate, while the relative caregiver provided permission for child services and volunteered to participate for their own services. Once potential participants were identified and provided necessary informed consent, a school-based social worker and the KCC program coordinator administered an intake assessment to gather demographic information and to identify and prioritize basic familial needs.

Table 1 summarizes the demographic characteristics collected from all of the caregivers ( $N=72$ ) and children ( $N=235$ ) who completed an intake assessment before deciding to participate or not participate in KCC. The mean age for kin caregivers is 52 years of age, while 63% ( $n=45$ ) of all caregivers were 50 years and older and 7% ( $n=5$ ) of caregivers were under the age of 30. Most ( $n=49$ , 68%) caregivers were African American, which is consistent with much of the literature describing African American family helping traditions. The most common caregiver relationship to the child was that of a grandmother ( $n=45$ , 63%), while great aunts, great grandmothers, cousins, grandfathers, aunts, and sisters also provided kinship care. Caregivers reported the range in the number of children in their care as one to ten children. Many caregivers ( $n=24$ , 33%) were caring for four or more children.

The primary concern for most caregivers ( $n=37$ , 51%) was finances. This is not surprising given that taking care of additional children can be expensive and that elderly caregivers are often living on a fixed income. Caregivers also reported primary concerns about the social and emotional well-being of the children in their care. Interestingly, only two caregivers (3%) reported primary concerns with their own health and well-being. This supports the notion that caregivers often overlook their own needs when providing care to relative children. The most common secondary concern ( $n=16$ , 25.4%) for these caregivers was the social and emotional well-being of the children in their care. Many of the

t1.1 Table 1  
t1.2 Demographic information for kinship care connection assessment

t1.3			Frequency	Percent	
t1.4	Caregiver ( <i>N</i> =72)	Age (in years)	19–29	5	6.9
t1.5			30–39	7	9.8
t1.6			40–49	15	20.8
t1.7			50–59	23	31.9
t1.8			60–69	18	25.0
t1.9		70 and over	4	5.6	
t1.10	Race	African American	49	68.0	
t1.11		Caucasian	15	20.8	
t1.12		Hispanic	6	8.5	
t1.13		Other	2	2.7	
t1.14	Relationship to child	Grandmother	46	63.9	
t1.15		Aunt	12	16.6	
t1.16		Great aunt	5	6.9	
t1.17		Great grandmother	3	4.2	
t1.18		Cousin	3	4.2	
t1.19		Grandfather	2	2.8	
t1.20		Sister	1	1.4	
t1.21	Number of relative children in care	1–2	35	48.6	
t1.22		3–4	22	30.6	
t1.23		5–6	9	25	
t1.24		>6	6	8.4	
t1.25	Primary concern	Financial	37	51.4	
t1.26		Social/emotional well-being of children	14	19.4	
t1.27		Children's behavior	6	8.3	
t1.28		Children's mental health	6	8.3	
t1.29		Children's academics	5	7.0	
t1.30		Relationship with biological parent	2	2.8	
t1.31		Caregivers own health and well-being	2	2.8	
t1.32	Secondary concern ( <i>n</i> =63)	Financial	13	20.6	
t1.33		Social/emotional		25.4	
t1.34		Well-being of children	16		
t1.35		Children's behavior	10	15.9	
t1.36		Children's academics	10	15.9	
t1.37		Relationship with biological parent	7	11.0	
t1.38		Caregivers own health and well-being	3	4.8	
t1.39		Housing	3	4.8	
t1.40		Basic needs	1	1.6	
t1.41	Child welfare involvement ( <i>n</i> =62)	Yes	34	47.2	
t1.42		No	38	52.8	
t1.43	Reason for placement ( <i>n</i> =63)	Substance abuse	47	65.3	
t1.44		Incarceration	8	11.1	
t1.45		Maltreatment	7	9.7	
t1.46		Domestic violence	5	6.9	
t1.47		Death	2	2.8	
t1.48		Mental illness	2	2.8	
t1.49		Teenage pregnancy	1	1.4	
t1.50	Children ( <i>N</i> =235)	Age (range in years)	1–5	44	18.8
t1.51			6–10	106	45
t1.52			11–14	63	26.9
t1.53			15+	22	9.3

caregivers ( $n=38$ , 53%) were providing informal kinship care, the kind of care occurring without child welfare system involvement. More than half of the children (65.3%) were living with a relative due to their biological parent(s)' substance abuse. It is difficult to determine if substance abuse was related to the other reasons for kinship care placement such as parental incarceration, child maltreatment, or domestic violence.

The mean age for children enrolled in the KCC was 8.96 years old ( $n=235$ ). Forty-six percent ( $n=108$ ) of the children were eight years old or younger. Twenty percent ( $n=48$ ) of the children were teenagers.

#### 4. Procedure

##### 4.1. Caregivers

Once kinship families were identified by the school-based social worker at the elementary schools, caregivers were invited to participate in the study. Those who agreed were given an informed consent form to sign. Caregivers in the KCC were provided with support groups and individualized interventions to mediate kinship caregiving burden. These interventions were provided for 18 weeks (the approximate length of one school semester).

The adult participants attended an eight-session school-based support meeting every other week, facilitated by the KCC program coordinator. Transportation and childcare were offered and dinner was served before each meeting. The support group consisted of group discussion and support, using the following subjects: Anger Management, Taking Care of Yourself, Long-term Planning for Children, Tools for Forgiveness, Academic Expectations, Coping Strategies and Tools, and Termination.

In addition to the support group, caregivers were provided personalized interventions, including counseling, advocacy, and case management services approximately once a week. Case management services included utility assistance, emergency food and clothing, household support, holiday assistance, and additional assistance to alleviate the burden associated with kin caregiving. Services for both caregivers and children were provided by the KCC program coordinator and the school-based social worker, as well as MSW and BSW student interns from the local university. The outcomes of the intervention were designed to mediate caregiver burden in the following areas: (a) child behavior management, (b) self-advocacy, (c) emotional support, (d) school issues, and (e) provider issues.

##### 4.2. Children

Children in the KCC were provided with several interventions designed to improve self-esteem. Mentoring and tutoring services were offered to students one to two times per week. The mentoring interventions included problem-solving skills, goal setting, character building, social skills training, and other activities that build self-esteem. Behavior contracts were utilized to modify classroom behavior. These contracts could focus on simple behaviors such as staying in line to not hitting or kicking fellow students. The

tutoring interventions were developed with the guidance of each child’s teacher. Tutoring interventions provided academic remediation and enhancement. Classroom assignments as well as adjunctive curriculum materials were used in this process.

In addition, support groups and individual counseling were provided to children to improve relationships with peers, self-esteem, and behaviors. All children in the KCC were assessed and offered these services for 18 weeks.

## 5. Analysis

This study used statistical procedures to determine if significant changes occurred for children and kinship caregivers who participated in the interventions. The Caregiver Self-Efficacy Scale was administered to caregivers prior to the start of the first support group and 18 weeks later at the completion of the last support group. The Hare Self-esteem Scale was administered to the children at the same two intervals as the caregivers. Once the data were collected, it was entered into a database and analyzed using SPSS version 11.0.

Q–Q plots were used to determine whether the distribution of the variables were normally distributed. When the selected variables are normally distributed, the points cluster around a straight line. After the normality assumption was met, regression analysis was used to determine the relative importance of each variable in the model. Table 2 summarizes the results of an analysis of variance for each model. Both models have a larger regression sum of squares in comparison with the residual sum of squares which indicates that the pretests account for most of the variation in the posttests. Additionally, because the significance value of the *F* statistic is small ( $p>0.001$ ), this preliminary analysis concludes that the pretest could do a good job explaining the variation in the posttest. Coefficient model summaries are provided in Table 3.

In each model, the *t* statistic is large and statistically significant. This provides initial evidence that the pretest scores could significantly predict change in the posttest scores for both children and caregiver measures.

Next, paired samples *t*-tests were conducted to determine if significant changes occurred between the participants’ pretest scores and posttest scores. The paired sample *t*-test compares the means of two variables by computing the difference between the two variables for each case, and tests to see if the average difference is significantly different

t2.1 Table 2

t2.2 Analysis of variance for the Hare Self-esteem and the Caregiver Self-Efficacy Scales

t2.3	Source		<i>df</i>	<i>F</i>	<i>SS</i>	<i>MS</i>	<i>F</i>	<i>p</i>
t2.4	Hare Self-esteem Scale (HSS) ( <i>N</i> =63)	Regression	1	71.876	049.483	2049.483	71.876	0.000***
t2.5		Error	61		1739.374	(28.514)		
t2.6		Total	62		3788.857			
t2.7	Caregiver Self-Efficacy (CSE) ( <i>N</i> =34)	Regression	1	36.899	1.184	1.184	36.899	0.000***
t2.8		Error	32		1.027	(0.032)		
t2.9		Total	33		2.221			

t2.10 \* $p<0.05$ , \*\* $p<0.01$ .

t2.11 \*\*\*  $p<0.001$  (one-tail test).

t3.1 Table 3  
t3.2 Regression analyses coefficients for HSS and CSE

t3.3	Model		<i>B</i>	S.E.	$\beta$	<i>t</i>	<i>p</i>
t3.4	Hare Self-esteem Scale (HSS) ( <i>N</i> =63)	(Constant)	26.232	7.155		3.667	0.001**
t3.5		CPRETEST	0.721	0.085	0.735	8.478	0.000***
t3.6	Caregiver Self-Efficacy Scale (CSE) ( <i>N</i> =34)	(Constant)	1.448	0.370		3.916	0.000***
t3.7		GPRETEST	0.633	0.104	0.732	6.074	0.000***

t3.8 Dependent variable: posttest scores.

t3.9 \* $p < 0.05$ .

t3.10 \*\*  $p < 0.01$ .

t3.11 \*\*\*  $p < 0.001$  (one-tail test).

from zero. A one-tailed probability test was used because the hypotheses for this study stated a positive directional change in outcomes for the children and caregivers.

## 6. Results

The results are presented in two sections: first, the quantitative results, and second, the two case studies.

### 6.1. Quantitative results

Tables 4 and 5 summarize the caregivers' and the children's pretest scores and posttest scores. A paired samples *t*-test was conducted to determine if there was a significant difference between participants' overall pretest and posttest scores on the Caregiver Self-Efficacy Scale and the Hare Self-esteem Scale. Each subscale result is also included in the analyses.

Paired sample correlations were reported to determine that each pre and posttest variables represented the same group at different times. All correlations were fairly high and the significance values were low in both the Caregiver Self-Efficacy results and the Hare Self-esteem results. All correlation significance value levels were at or below  $p = 0.01$ .

t4.1 Table 4  
t4.2 Caregiver Self-Efficacy pre–postpaired sample *t*-test (*N*=34)

t4.3		Pretest mean	Posttest mean	S.D.	Paired samples correlation	Correlation sig.	<i>t</i>	<i>p</i>
t4.4	Behavior	3.6226	3.6915	0.40113	0.588	0.000	−1.047	0.1515
t4.5	School	3.47	3.625	0.53243	0.549	0.001	−1.916	0.032***
t4.6	Advocacy	3.5441	3.7868	0.44582	0.434	0.010	−3.372	0.001***
t4.7	Emotional	3.1138	3.4241	0.72213	0.574	0.000	−2.943	0.003***
t4.8	Service Provision	3.9165	3.9071	0.16551	0.533	0.001	0.245	0.404
t4.9	Overall	3.5346	3.6868	0.29908	0.732	0.000	−4.270	0.000***

t4.10 \* $p < 0.05$ , \*\* $p < 0.01$ .

t4.11 \*\*\*  $p < 0.001$  (one-tail test).

t5.1 Table 5  
 t5.2 Children Self-esteem pre–postpaired sample *t*-test (*n*=63)

t5.3		Pretest mean	Posttest mean	S.D.	Paired samples correlations	Correlation sig.	<i>t</i>	<i>p</i>
t5.4	Peer relations	26.9365	27.619	3.45885	0.556	0.000	−1.711	0.046***
t5.5	Home	29.4127	30.4921	3.14507	0.558	0.000	−2.712	0.0045***
t5.6	School	27.4603	28.4127	3.50035	0.534	0.000	−2.255	0.014***
t5.7	Overall	27.9365	28.8723	3.36809	0.735	0.000	−3.880	0.000***

t5.8 \**p*<0.05, \*\**p*<0.01.  
 t5.9 \*\*\* *p*<0.001 (one-tail test).

The results of the Caregiver Self-Efficacy Scale analyses indicate that a significant difference exists between participants’ overall pretest and posttest scores ( $t(34)=-4.270$ ;  $p<0.01$  (Fig. 1). Significant differences were also identified in the school ( $p=0.032$ ) and advocacy ( $p=0.001$ ) subscales. On the posttest, caregivers answered positively on the subscales to questions such as: “how comfortable are you with your ability to . . . advocate for your child’s rights, . . . discuss your child with school personnel, and . . . participate in school activities with your child.”

The largest pre to postchange was seen in the “emotional support” subscale ( $p=0.003$ ). The items the caregivers were most concerned with include: “How comfortable are you with your ability to . . . cope with frustrations about your child’s problems, . . . talk with friends and family about your child, and . . . deal with stress at home.” Behavior and provider issues subscales reported no significant differences, although by examining Fig. 2, one can see that scores on the provider issues subscale remained high throughout the study. Caregivers responded positively to the following items: “How comfortable are you with your ability to . . . meet your child’s medical needs, . . . provide a safe home environment for your child, and . . . provide food, clothing, and shelter for your child?”

Paired samples *t*-tests were also performed to determine if there were significant differences between children’s pretest scores and posttest scores on the Hare Self-esteem

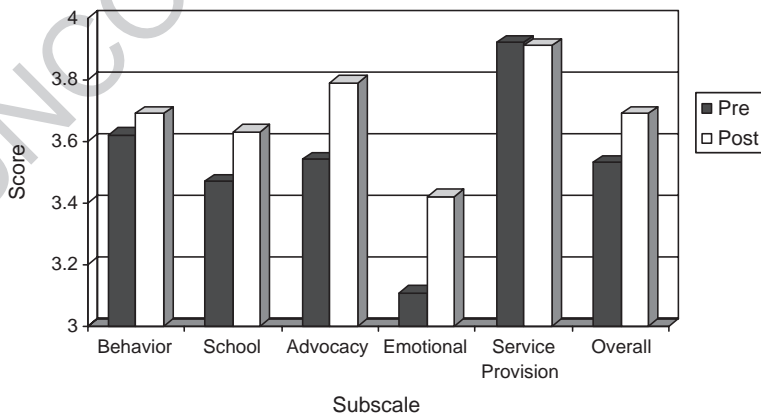


Fig. 1. Caregiver Self-Efficacy Scale pre and posttest change.

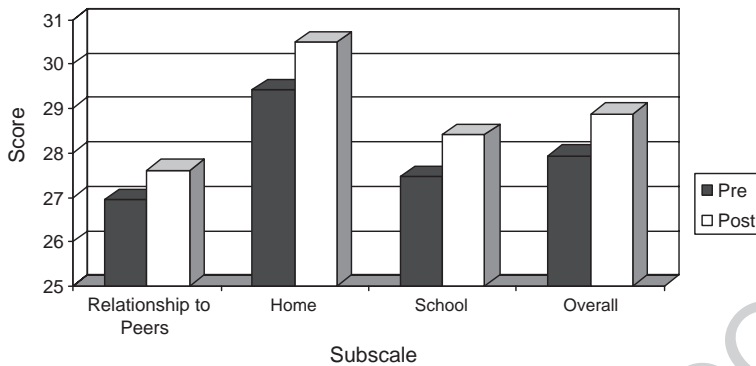


Fig. 2. Hare Self-esteem Scale pre and posttest change.

Scale ( $N=63$ ). The results of the analyses indicate significant positive differences in the total score ( $p=0.000$ ). Additionally, each subscale, peer relations ( $p=0.046$ ), home ( $p=0.0045$ ), and school ( $p=0.014$ ), reported significant changes over time.

## 6.2. Case studies

To gain a more complete understanding of the implementation of the KCC, this study provides case examples of participants' family experiences. The case studies of the KCC highlight some of the personalized interventions administered to these families in need.

### 6.2.1. The family of Mrs. C

Mrs. C. is a 56 year-old married African American grandmother raising seven children, ages 10 months to 21 years old. Mrs. C. has had custody of a 21 year-old grandson and his 18 year-old sister since birth, and the five younger children were placed with her 1 month ago. The family was referred to the Kinship Care Connection by the elementary school social worker because the 10 year-old grandson, Everest, needed school supplies. The most serious problem that this family faced was their financial plight. For the first 10 weeks that the KCC program coordinator worked with this family, they received no funds at all from the state to help support the five additional children. Another tremendous challenge for Mrs. C's family was housing. The family lived in a three-bedroom house where Mrs. C. had one bedroom, the 21 year-old grandson (who has Cerebral Palsy) had a bedroom, and the 18 year-old granddaughter had a bedroom. All of the five younger children slept in the living room, four on pallets on the floor and the baby in a playpen. Because of this housing arrangement, Mrs. C. could not apply for relative caregiver funds from the state (since a home study is required). In addition to these difficulties, Mrs. C. was disabled with severe arthritis. The school-aged children, Everest, age ten, Vanessa, age seven, and Ron, age six, had a variety of learning and behavior problems at school. Everest had an IQ of 68 and could not write his name. He was a drug-exposed child who struggled with schoolwork. Ron had pronounced behavior problems at school and at home as well as learning difficulties. Vanessa had mild learning difficulties.

The KCC provided a number of interventions for this family. First, financial needs were addressed by purchasing basic items needed for the family such as diapers, baby food, and school supplies. Mattresses were purchased for the four children sleeping in the living room. Referrals were made to Head Start for the youngest children and home health care for the grandmother and the 21 year-old. The children were provided many services at school from the KCC. Everest received tutoring, social skills training, and support group services. His self-esteem and school performance increased a great deal during the program. Vanessa received the same services and made progress in the same areas. Success was not as easy to achieve with Ron, who had more learning challenges and behavior difficulties in class. The KCC program coordinator attended many school meetings to determine if Ron qualified for Exceptional Student Education (ESE) services. The program coordinator advocated for Ron and was able to get him tested for Attention-Deficit Hyperactivity Disorder (ADHD) and obtained services for him through the Specific Learning Disabilities (SLD) program at the school. In addition, the program coordinator encouraged Mrs. C. to contact Ron's teacher to talk with her about his difficulties in class. Initially Mrs. C. refused because of fears of the "new-fangled" school. The program coordinator encouraged Mrs. C., and eventually was able to arrange for Mrs. C. to meet and begin working with the teacher.

In addition to case management and advocacy services, Mrs. C. was provided with individual counseling and support group services. In individual counseling, Mrs. C. expressed worries about the children, especially Ron. Mrs. C. reported great relief that the KCC program coordinator was helping Ron in school and talking with his teacher and other staff about his difficulties. Mrs. C. had described, both to the program coordinator and to her support group, feeling very alone in her job as a parent the second time around. By the end of the semester, she reported feeling more accepting of her role as kinship caregiver and less isolated as a caregiver. She felt relieved to know that others were carrying the same burden, and encouraged about her abilities to handle the continuing challenges of raising her grandchildren.

### 6.2.2. *The family of Mrs. B*

Mrs. B. is a 63 year-old wheelchair-bound Caucasian woman who has been raising four grandchildren for the past 5 years. Also living in the home is a 47 year-old female friend. The children are twin boys, aged six, and two older girls, ages 16 and 17. A fifth child, a 13 year-old boy, currently living in a residential treatment center after trying to stab his 16 year-old sister. The children had been removed from their parents by the welfare department because of child abuse and neglect by chemically addicted parents.

The most pressing concern for this family also was financial. Mrs. B. received Social Security Disability but did not receive funds for the children. Mrs. B's live-in friend helped out occasionally with the children, but contributed nothing to the income of the household. In addition, the family was living under threat of eviction in a home that was dilapidated. School problems for the twin boys, Andy and Arthur, both drug-affected children, involved academic and behavior problems in the classroom. Arthur was in a special classroom for Severely Emotionally Disturbed (SED) children.

The Kinship Care Connection intervened by helping Mrs. B. apply for Relative Caregiver Funds for the children. The KCC program coordinator also provided case

management services by helping Mrs. B. get mortgage assistance, and securing an oversized wheelchair for Mrs. B, who weighed 350 pounds. Mrs. B. participated in individual counseling and attended support group sessions. Mrs. B. said she was not angry at having to care for her grandchildren because she felt that this was God's will. However, she expressed much sadness because of feeling not valued by anyone. Mrs. B. also worried about the twins' difficulties at school, especially Arthur's. Support group members proffered advice on these matters and, most importantly, communicated their support and caring for Mrs. B. She reported feeling valued for the first time in a long time by the end of the support group sessions. Mrs. B. worked with the program coordinator in individual sessions on parenting techniques, substance abuse education, advocacy training relating to the school, and emotional support.

School interventions included counseling, tutoring, and mentoring for the two boys. Since Arthur had been diagnosed SED, his difficulties were more extreme than Andy's. In his case, the program coordinator collaborated with the teacher to provide behavioral modification strategies to improve Arthur's behavior. His behavior did not improve sufficiently, however, and school administrators decided to move Arthur to a more restrictive school environment. This placement was ten miles from Mrs. B's home and she had no transportation to get to the school in order to work with the teacher when needed. Because the KCC program coordinator had developed a relationship with the teacher, she was able to advocate for the family and helped secure a placement that was more suitable for the family, closer to home and more accessible for wheelchair-bound Mrs. B. Both boys' behavior and academic achievement improved over the course of the semester and Mrs. B. felt valued and empowered.

## 7. Discussion

The families enrolled in the Kinship Care Connection appear to be committed to providing a nurturing environment for their kin children. Strengths of the caregivers included their efforts to maintain basic needs such as food and shelter and encourage regular school attendance for the children. Although the pre and posttest results were not significantly different on the "service provision" subscale of the Caregiver Self-Efficacy Scale (Boothroyd, 1997), consistently high scores on this subscale indicate the caregivers' beliefs that they are taking good care of the children. Their positive responses indicate affirmation of their beliefs that they are providing a safe and healthy environment for the children.

Caregivers requested assistance in developing strategies to work more closely with the school to ensure their children's academic success. In the beginning of the program, caregivers reported feeling intimidated by the school, and were afraid to ask questions of the teachers or school administrators. They also worried that any dissent on their part might cause the school to view them as uncooperative or disinterested and deem it necessary to call child welfare authorities. This lack of confidence on the caregiver's part sometimes caused school personnel to assume that the caregivers were not interested in their children and arrive at solutions that were in the best interest of the child and family. After participating in the KCC program, however, caregivers significantly improved in

their scores on the “school” and the “advocacy” subscales of the Caregiver Self-Efficacy Scale. With increased knowledge of school functioning and enhanced confidence, these caregivers felt more prepared to work with school personnel to increase their children’s learning potential.

The largest pre to posttest change was seen in the “emotional support” subscale of the Caregiver Self-Efficacy Scale. Caregivers who began the program feeling very much alone and burdened ended the program by feeling less stressed and more connected with other people. Even though the improvement in this area was large, it is important to note that scores on this subscale remained the lowest of the entire scale. The emotional burdens of kinship caregiving are great.

The low scores on the emotional subscale, combined with the case study results, remind us of the severity of problems the families in this program faced. The families were often tremendously pressed for money and resources, overwhelmed at having to raise these children, intimidated by the schools and fearful of the child welfare system. Over 50% of the caregivers in this study told us that their primary concern was finances, a finding supported by Ehrle and Geen (2002). The educational demands of the children could not be addressed by the KCC without simultaneously assisting the families with the most basic needs of housing, food, and clothing (Maslow, 1954).

The second most frequently endorsed concern was the caregivers’ worry about the well-being of the children. These children, as is true of many children living in kinship care, have extra hurdles to jump. Children in this program were placed with caregivers due to problems such as parental substance abuse, incarceration of a parent, maltreatment, domestic violence, and parental mental illness. In addition, many of the children had learning and behavior problems in school, a finding supported by Dubowitz et al. (1993) and Franck et al. (2003). Almost 65% of the children in the Kinship Care Connection were receiving exceptional educational services, including children who were Severely Emotionally Disturbed (SED), Educable Mentally Handicapped (EMH), Emotionally Handicapped (EH), children with Specific Learning Disabilities (SLD), and Language Disorders. The KCC program, providing a number of services for the children, made a difference in their lives. All subscales and the total score on the Hare Self-esteem scale showed significant improvement pre and posttreatment for these children. The tutoring, mentoring, and support groups of the KCC appear to benefit these children’s self-esteem, which in turn should improve their academic performance (Brookover, Thomas, & Patterson, 1985; Covington, 1989; Holly, 1987; Scheirer & Kant, 1979; Walz & Bleuer, 1992).

In sum, this study demonstrated the effectiveness of school-based services that not only increased caregivers’ sense of self-efficacy in relation to dealing with their children’s school related issues and needs, but also provided a valuable source of self-esteem for the children themselves. Both hypotheses for this study were therefore upheld. These findings also indicate the value of support groups, as indicated previously by Burnette (1998) and Dore et al. (1999).

This study emphasizes the importance of initiating and evaluating a kinship care program based in the school system. To date, much of kinship care programming reported in the literature has focused on families that are part of the child welfare system. However, a majority (59%) of kinship care children live in informal placements where the child

welfare system has not been involved. Little (1998) estimated that the number of children living in informal kinship care is as high as four out of every five of these children.

Service provision through the school system differs in several ways from service delivery in the child welfare system. First, these two systems work toward different goals. For instance, the child welfare system's goals are to keep children physically safe, while the school system is designed to provide children with knowledge and skills needed to achieve academic success. In regard to service delivery, the schools use a developmental and educational model, while the child welfare system often employs a crisis intervention model of service delivery. Lastly, the school system offers participants a less stigmatized service delivery. As seen in this study, and reported in the literature (Generations United, 2001), kin caregivers often are fearful that their children will have to enter the foster care system when the child welfare system becomes involved with their family. One advantage of the Kinship Care Connection is that it operates within the relatively safe educational environment of the school, where it emphasizes support and empowerment of kinship children and their caregivers.

## 8. Limitations and directions for future research

An experimental design with control group would strengthen the results of this analysis; however, several factors encumbered this type of design. First, there are many barriers associated with implementing an intervention in the school-system. Withholding treatment, either by waiting list or other methods, was not a viable option for the school system. Second, the KCC program could not secure the resources needed to adequately undertake this type of evaluation. Future evaluation of the KCC will use a quasi-experimental design with a comparison group.

A further design limitation is the use of point-in-time data collection. A longitudinal design could have strengthened this study by more adequately describing the experiences for these families throughout the semester and across time. Although this study used self-report measures, KCC program coordinator's case notes were also analyzed to increase the validity of the results. Because of the small sample size and study design, it was difficult to determine the effects of individual interventions within the service provided. Cluster analyses and other analytic techniques could be used in future studies to determine the individual effects of services provided to kinship caregivers and their children. A last limitation is that the KCC staff could not gain access to students' records because of bureaucratic procedures of the school system. Since KCC could not ascertain grades for students in the program, we could not directly measure academic progress for kinship children.

## 9. Implications for social work

It is imperative that the social work profession finds strategies and interventions that enhance kinship caregivers' strengths and reduce their needs. Social workers are well versed in the use of school-based interventions. This study illustrates how interventions for

kinship caregivers who are rearing school-aged children can be effective, a finding which the researchers hope will lead to replications in other communities. It is anticipated that this study will provide a foundation for social workers conducting future research and practice.

Although school-based interventions will not alleviate all of the stressors of kinship care children and caregivers, these interventions offer the families a valuable source of emotional support and empowerment in the relatively safe environment of the school system. The reduced stress and increased self-esteem that caregivers and their children gained in this study should help build healthier family units. This is good news for all kinship families, including those informal kinship families who do not actively participate in the child welfare system. The Kinship Care Connection is an innovative program that was effective in improving the lives of kinship caregivers and the children they raise in the important arena for all families with children, the school.

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