Disturbed by the Dissonance:

A Phenomenological Study of Family, Friend, and Neighbor Care

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Submitted in partial fulfillment of the
requirements for the Degree of Doctor of Education in
Teachers College, Columbia University

2021

Abstract

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In the United States, most of the Family, Friend, and Neighbor providers are the grandmothers of the child in care. Parental preference for Family, Friend, and Neighbor (FFN) care for infants and toddlers is consistent across race, class, and ethnicity. Although FFN providers care for the largest number of infants and toddlers in the United States, they are not considered part of the childcare milieu. This exclusion means FFN providers are not, typically, the recipient of important childcare information and resources as formal childcare providers who provide care to the smallest number of infants and toddlers.

The small number of studies on FFN care often refers to these providers as "invisible." It is in direct response to this sense of invisibility that this study is presented. Using a phenomenological methodology to bring forward the essence of FFN care, this study hopes to broaden the field of Early Care and Education to include this group of diverse providers of care to young children. Instead of policymakers, funders, and early childhood professional development systems viewing "childcare" exclusively as formal and regulated this study serves to challenge this limited perspective by offering a richer perspective.

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Dedication

I dedicate this work to the loving memory of my parents,

Reverend Dr. Albert J. White and Mrs. Carrie T. White,

lovingly known to some as Poppi and Nene.

I can still feel you cheering me on beyond the veil.

PREFACE

As an administrator in a large early care and education program serving infants to 4-year-old children, I knew most Center-based programs did not have the space or funding to serve infants and toddlers. This meant very few programs could serve children birth to 2 years old. However, I never considered where the unserved infants and toddlers were or the quality of care these children were receiving. It was not until I conducted a community assessment, as part of a funding proposal, that I became aware of the incongruence between the number of childcare centers that served infants and toddlers and the number of infants and toddlers with working mothers, specifically in the City of Paterson, New Jersey, where the program was located.

Infinitely aware that all parents did not want or need outside care for their infants and toddlers, by allowing for a healthy hypothetical percentage of parents who would be in this group, there would still be over 200 infants and toddlers without formal childcare slots. I knew there was a need for infant and toddler care as the program I worked for maintained a waiting list of no less than 100 children. As a result, we did not advertise our infant and toddler slots because we had so few in comparison to our PreK slots, 48 (infant and toddler) vs. 1,000 (preschool), respectively.

Disturbed by this dissonance, I began to investigate where these infants and toddlers might be. My investigation revealed that most of these children were in Family, Friend, and Neighbor (FFN) settings. As I continued my informal inquiry into informal care or Family, Friend, and Neighbor care, I realized there was an entire area of childcare that I knew little about. This realization led me to further explore this aspect of childcare as a formal inquiry.

Chapter I

INTRODUCTION

Vignette: Passing of Blankets

In the early morning hours before sunrise, a young woman leaves her apartment and walks down a poorly lit and smelly corridor. As she quietly moves down the corridor, passing many doors along the windowless hallway, she has several bags hanging on both arms…and what looks like a mound of blankets thrown over her shoulder. She stops at one of the doors and knocks softly. In a few moments, the door slowly yawns open into a darkened space with a soft light illuminating somewhere in the darkened apartment. A woman's form slowly appears from behind the door. The young woman slowly moves the blankets from her shoulder and towards this shadowy figure who extends her hands to receive the blankets. The women talk in hushed voices as the blankets are passed from one to the other. As the blankets transition from one woman to another, they begin to move, and the woman now holding the blankets pulls them back to reveal a sleeping baby who is slowly stretching out an arm while balling up everything else. The women continue their low murmurs as the young woman places the bags from one arm on the floor inside the door. She then turns to leave, and the door slowly and quietly closes behind her.

This is a typical scenario for many babies, families, and childcare providers across the country. The mom in the vignette uses an informal childcare provider who is conveniently located down the hall from her apartment. This provider could be her mother, sister, friend, or neighbor. Maybe the young mom has chosen this provider because she is conveniently located or because she is a relative or they share the same culture, language, or religion. Whatever her reason, this mom has chosen a Family, Friend, and Neighbor (FFN) provider to care for her infant.

Background of the Problem

Family, Friend, and Neighbor care (FFN) is the preferred childcare by parents for their youngest children (Paulsell et al., 2010). Historically, this form of care was primarily used by poor and low-income Black and Brown families (Brown-Lyons et al., 2001; Office of Planning, Research, and Education [OPRE], 2010). However, in the last 10 years, the number of families using FFN care for young children has grown tremendously across race and class within the United States (National Women's Law Center [NWLC], 2018; OPRE, 2010). In 2016, relative and home-based childcare was comprised of 24% relative providers and 13% nonrelative providers (NWLC, 2018). Of the relative providers, 79% were grandparents, 13% were relative aunts, and 9% were related in a capacity other than grandmother or aunt (NWLC, 2016). The high number of grandparents in FFN care contributes to its reputation as the most trusted childcare for children birth to 3 years old by families across race, class, or ethnicity (NWLC, 2016; OPRE, 2010).

Historical Perspective

In the last 15 or 20 years, there has been a shift to formally include infants and toddlers as part of the field of Early Childhood (Couse & Recchia, 2016). Previously, most higher education settings and many research studies considered "early childhood" to be comprised primarily of preschool children. This shift to a broader and more inclusive population within early childhood became more prevalent with the reform of the child and family welfare system, Aid to Families with Dependent Children, which became Temporary Assistance to Needy Families (TANF) (Brown-Lyons et al., 2001). As TANF required mothers with very young children to "get a job," this created attention and tension around childcare for infants and toddlers. Prior to TANF's requirement, Zero to Three, which is a national leader on advocacy and policy for children aged

birth to 3 years old, had identified compelling, safe health and learning environment concerns in infant and toddler care across the country.

The strict enforcement of TANF and the research-based findings of Zero to Three ignited an aggressive campaign by early childhood advocates around the poor quality in most infant and toddler childcare programs (Lally et al., 2006). This campaign quickly rolled to the front door of the federal government, which was supporting these settings for young children through childcare subsidies that paid for or supplemented childcare cost for TANF clients to be in compliance with the law (Lally et al., 2006; Porter, 1998).

Childcare advocates were not the only ones engaged in this campaign. Organizations such as the National American Academy of Pediatrics, the American Psychological Association, the National Organization for Women, and the Civil Rights Commission, to name only a few (Rena, 2005), were actively working for change. The collective focus around this issue resulted in new studies being commissioned by the federal government as well as private funders to ascertain the quality of infant and toddler childcare (Porter & Paulsell, 2011). Findings from these new studies resulted in the development and editing of numerous policies with regard to families with infants and toddlers (Porter et al., 2003). Specifically, some of the changes resulted in the reallocation of federal and state funding to support quality initiatives that impact infants and toddlers as well as opportunities for states to review and revise their childcare regulations regarding health and safety standards that pertained to all children, especially infants and toddlers (Porter & Paulsell, 2011).

Other impacts of these findings were seen in the academic literature. For example, academic journal articles on early childhood or early childhood education (which typically included children 3 to 5 years old) changed to the field of Early Care and Education to include a

broader range of children—infants to children aged 5 years old (Couse & Recchia, 2016). During this time of landscape change, findings from the infant brain research were released which revealed that infants are born learning (Institute of Medicine & National Research Council [IOM & NRC], 2015; Shore, 1997). The infant brain research information caused quite a ripple in the early childhood literature because now there was evidence that young children were not Tabula Rasa or blank slates. Instead, babies were born with brains developed for and capable of learning (Shonkoff et al., 2000). Of course, there had always been studies on fetal competencies which showed intentional movements of the fetus to outside stimuli; such studies documented the ability of the fetus to hear in the womb and showed newborn infants' recognition and preference for the voices they frequently heard in the womb. While these studies demonstrated competence in the fetus before birth, they never seemed to cross the aisle from science to education (Andre et al., 2017; Lecanuet & Schaal, 1996).

Home-based or Home-based

This socially constructive qualitative study presents a perspective of FFN care not prominent in the research. What is evident from the few studies conducted on this population is the minimal understanding about FFN providers (OPRE, 2015; Porter, 1998). Initially, the few FFN studies focused on quantitative information about FFN providers, such as age, location, educational background, relative vs. non-relative, and so on (Powell, 2008). Later, research studies began to use environmental measurement tools designed for "home-based" childcare programs to identify the level of quality in FFN environments (Susman-Stillman & Banghart, 2011). The level of quality of a childcare environment became the new indicator of quality care in childcare settings with the release of the study *From Neurons to Neighborhoods* that showed a connection between childcare environmental quality and quality of care impacting child

development (Shonkoff et al., 2000). Prior to the development of evaluation tools for different childcare settings, the only indicators of childcare quality came from Center-based or formal childcare settings which did not adequately measure childcare in informal settings (Powell, 2011; Susman-Stillman & Banghart, 2011).

Findings from these early and ill-fitting evaluation tools and subsequent standards rendered FFN care as very poor in quality (Porter, 2007; Susman-Stillman & Banghart, 2008). However, the stigma of FFN care did not dissipate with the design of these newer tools because these tools were designed for a different "home-based" setting which was Family Child Care (FCC). Different but similar in setting, FCC is provided in a home-based setting, but this type of care has regulated standards. Although the standards of care for FCC providers are not at the level of Center-based care, there are regulations around health, safety, early learning requirements, and mandatory professional development requirements. This is not the case for FFN care. FFN care is typically not regulated in most states; therefore, these providers do not receive professional development opportunities or information to ensure the care provided in these settings is, at the very least, minimally safe and healthy. For example, FFN providers might not understand the broader concept of wearing gloves during diaper changes or potty training to protect them as well as the child; rather, they might see it as a cold and detached practice.

Many FFN providers have never been formally or informally trained in child development (Powell, 2008; Porter & Rice, 2004). This is a concern in several research studies where researchers have associated poorly rated environments with providers who are minimally trained or not trained at all, particularly in the areas of developmental support and appropriate developmental stimulation in young children (Alexandre et al., 2013; OPRE, 2010). Specifically, these studies which used environmental assessment tools found FFN settings to be harmful to the

children in care, especially in the areas of safety, health, and learning environments (Alexandre et al., 2013; Harms, et al, 2006). For example, many FFN providers had no process or consistent schedule for disinfecting surfaces and toys or consistent handwashing practices associated with diaper changing and toileting by providers and children, which could contribute to serious public health issues. In the case of a preterm infant, where the FFN provider is not aware of National Handwashing Procedures in Diapering, something as seemingly benign as frequent ear infections or upper respiratory illness could result in dire health outcomes (American Academy of Pediatrics [AAP] et al., 2016).

These studies also identified that most FFN settings were found to provide few opportunities for cognitive stimulation or experiences that encouraged the use of varied investigation skills to develop deeper inquiry, otherwise known as meaningful play. As mentioned previously, most of the environmental assessment tools used in the small number of studies were not designed for FFN settings. These tools were designed to identify safe and healthy practices in a different setting. For example, they assess safe and healthy practices in Center-based settings where two sinks are required—one sink for food and the other for everything else. In an FFN setting, identifying a sink for handwashing only would not be realistic. However, on a tool designed for Center-based, any environment that does not have "clean" and "dirty" sinks would be negatively scored. In another example, a non-porous surface with a disposable covering is required for diaper changing. In most FFN settings, there would not be an area in the home designated for diapering only. However, many of these environmental assessment tools designed for formal childcare settings would negatively score a setting that does not reflect these spaces and practices. Current diaper changing practices in some FFN settings might need to be enhanced to ensure heightened safety and healthy practices, especially given

the pandemic, but these practices will not look like those in formal childcare settings nor should they because they are not formal childcare settings. Although these heightened safety and health practices might present or look differently in FFN settings, they fulfill the intended outcome. The continued use of tools not designed for informal childcare settings such as FFN care will rarely result in the identification of any strengths in these childcare settings which presents a biased and unbalanced perspective of this type of care in the literature (O'Donnell et al., 2006; Susman-Stillman & Banghart, 2011).

Mixed Results in Research Findings

To further complicate the issue of quality in FFN care, several studies did not differentiate between FCC and FFN care (Bromer & Korfmacher, 2016; Powell, 2011; Susman-Stillman et al., 2011). FCC is a formal type of childcare provided in a home-based setting, while FFN care is an informal type of childcare provided in a home-based setting (Powell, 2011). This confusion between formal and informal childcare settings points to a lack of understanding of these two different types of childcare settings by those evaluating and interpreting their services. Specifically, several studies in this small collection of research discussed FCC and FFN as though they were interchangeable (Bromer & Korfmacher, 2016; Powell, 2011; Susman-Stillman, 2011). To really understand the seriousness of this faux pas in the literature, one would have to consider the number of people involved in bringing the study to fruition who did not know the difference between the two programs, such as one is regulated (FCC) and the other is not (FFN)—a significant difference. This suggests that the funders and the researchers who were commissioning, funding, and implementing these studies were not aware of the differences between these childcare approaches since these studies were approved and released with erroneous information to the public. Intellectually, this is great fodder for colorful and animated

discourse between those who know the difference and those who do not, but this discourse has done little to change the reality that FFN care is not considered part of the childcare system and, therefore, does not receive support and information to provide a richer early learning experience for the children in this care.

Childcare providers who work in licensed centers and licensed or registered FCC settings are provided professional development opportunities that directly address the quality indicators in these environmental assessment tool (Powell, 2008). Topics covered in these training opportunities keep the providers informed of current research-based information on practices that are pertinent to young children (AAP et al., 2016; IOM & NRC, 2015). However, FFN providers are rarely included in these offerings because they are not licensed or registered, at least in most states, and therefore are not considered part of their state's childcare system (Bruner & Chase, 2012; Powell, 2008). To have one system of care that provides "informed" care to 751,000 children aged 0-5 years old and another that provides "uninformed" care to 4,060,000 children aged 0-5 years old is an example of an inequitable childcare system (OPRE, 2015). This inequity could be contributing to a segment of the population, specifically Black, Brown, and poor children who stay in FFN care the longest, arriving at their first formal learning experience with limited or no preschool/kindergarten readiness skills (Burkham & Lee, 2002; OPRE, 2010; Powell, 2008). This might not be the case for all children in FFN care, but it is certainly the case for many (Shivers, Farago et al., 2016; Thomas et al., 2017).

As FFN care comprises the largest group of providers who care for infants and toddlers, it is critical for them to have access to information and support to provide care that is safe, responsive, and appropriately stimulating (NWLC, 2018). Although a few children might be receiving care from an informed grandmother or "grandmother-like" FFN provider, this inquiry

is being presented to contribute to the small pool of literature on FFN care and to create attention around the inequitable systems in childcare that might be inhibiting FFN providers from providing higher-quality care to young children. For example, every provider of care for an infant should receive information on Safe Sleep to prevent incidents of SIDS, in addition to information on Shaken Baby Syndrome, in a responsive manner to the provider. This information is mandatory for providers in formal care, where a much smaller number of infants and toddlers receive care, but this information is not marketed to grandmothers and "grandmother-like" providers who care for the largest number of infants and toddlers. In some of the studies where FFN providers were observed placing babies to sleep on the stomach instead of in a safe sleep position, these providers probably never received this information on Safe Sleep practices.

The field of Early Care and Education must become better acquainted with this informal childcare modality to make certain that all children in non-parental care, aged 0-5 years old, have the same opportunity to receive informed care or care that is increasingly knowledgeable. Providing information on such topics as safe sleep practices, creating richer early learning experiences in everyday interactions, strategies to guard against lead exposure, understanding the characteristics and impact of stress and resilience in young children, intentionally using strategies such as "Serve & Return" to enhance brain development, among other early childhood research-based strategies, could influence child outcomes (Lally et al., 2008; National Scientific Council on the Developing Child, 2018). These value-added suggestions are not made to insinuate that FFN care does not provide quality care; instead, they are meant to ensure that quality improvement efforts are equitable across all childcare settings and modalities.

Theoretical/Conceptual Framework

Using a social constructivism framework and a phenomenological methodology, this study presents FFN care through the FFN providers' voice as it pertains to the care they provide young children (Creswell, 2013; Groenewald, 2004). To create an experiential opportunity to deepen understanding in FFN care, vignettes are provided to give the reader a glimpse into an FFN care setting. The vignettes are contrived from numerous experiences acquired through the researcher's professional experience in Early Care and Education.

Statement of the Problem

Infants and toddlers from poor and low-income families are significantly more impacted by an untrained childcare provider, no matter how loving (Child Trends, 2016). Young children who experience poverty are at a heightened risk for low birth weight, preterm birth, higher infant mortality rates, language delays, chronic illness, SIDS, and poor nutrition, to name a few factors (Brooks-Gunn et al., 1997; Brown-Lyon et al., 2001; Child Trends, 2016). Using infant brain research as an example, if an FFN provider is not aware that infants are capable and ready to learn, they might not know the importance of engaging the infant verbally even if the infant has no discernable language (National Scientific Council on the Developing Child, 2007). However, an informed childcare provider would know that talking with the infant not only using pauses and intonation but also verbally labeling meaningful items in the child's environment, i.e., bottle, diaper, mommy/daddy, and so on, is stimulating cognitive and language development (Parlakian, 2003). Although some FFN providers might know to provide some of these experiences instinctively, it is important for them to understand why these experiences are important and how they impact the child's later school success.

A trained caregiver would also know that erratic hand movements, kicking of the feet, quickening of the breath, widening of the eyes, and other facial expressions are all communication strategies that infants possess at birth. These instinctual, nonverbal communication strategies become early language skills in young children (Lally et al., 2008). However, if a caregiver is not aware of these early communication opportunities, they may not see their importance or feel compelled to engage the baby verbally, instead allowing the baby to sit and sleep without appropriate interaction. In some cases, these might be the babies that some providers consider as "good" babies because they are considered quiet, not developmentally shut down. However, young children in informal care settings should receive informed early learning experiences just as those in formal care settings (Brown-Lyons et al., 2001; Lareau, 2011). Although some FFN providers might intuitively understand the difference between a quiet baby and an understimulated baby, this information is not intentionally or consistently provided to grandmother and "grandmother-like" providers who care for the largest number of infants and toddlers.

The quality of care a child receives in non-parental care should not be dependent on the childcare setting. Parents who prefer an informal care setting with a familiar provider should be assured that their childcare provider has access to the same information that providers in formal childcare settings have in a way that is responsive to them. Specifically, if developmental support and stimulation are offered to formal childcare providers, these same offerings which might look different in an informal setting should also be given in a responsive manner to informal childcare providers.

Rationale for the Study

This inquiry seeks to better understand FFN providers from the providers of this care themselves. Providing space for the FFN providers to come forward and share their perspectives on caregiving and young children will hopefully encourage existing early care and education systems to think more broadly when designing and creating strategies that are responsive to a browner and older group of childcare providers.

Currently, existing systems that offer information designed to create rich, developmentally appropriate early learning experiences are designed for younger, White, and dominantly English-speaking providers who are, mostly, looking to advance their early childhood career. However, most FFN providers are not being paid or looking to attain a degree or certification (OPRE, 2015; Powell, 2008). These more mature providers might not be attracted to quality improvement efforts designed for younger and career-motivated caregivers, but they are interested in receiving information that will support the growth and development of the children in their care.

Statement of Purpose and Research Questions

Creating responsive opportunities for FFN providers to increase their knowledge in child development and to provide richer early learning strategies through everyday interactions will enhance child outcomes in this childcare setting. As the majority of FFN providers are grandmothers or "grandmother-like" caregivers, learning how this population perceives its role as a caregiver will provide guidance on their possible preference for information on book reading to young children or intentionally stimulating language development through everyday routines. For example, this inquiry might reveal that most FFN providers do not perceive their role as influential in preparing the child for the formal learning experience because they are just helping

the parents by providing loving and safe care to the child while the parent/family works, or they may feel that preparing the child for kindergarten means the child has manners and can self-toilet independently.

Questions guiding this study pertained to the FFN providers' beliefs and ideas about caring for young children. Specifically:

1. How do Family, Friend, and Neighbor providers understand their role as a caregiver? Does this differ by race?
2. What caregiving experiences do Family, Friend, and Neighbor providers provide? Do these experiences differ by race?

Significance of the Study

This study will contribute to the small but slowly growing research on FFN providers. FFN providers are vital to the families and communities they serve (NWLC, 2018). According to the National Survey of Early Care and Education Project Team (NSECEPT, 2015), the number of children served in "listed and paid" childcare settings or formal childcare settings that are listed with the state as a childcare program was 751,000 nationally. The number of children served in "unlisted and unpaid" childcare settings by an FFN provider was 4,060,000 (NSECEPT, 2015). This is a significant difference and shows where most young children are receiving their childcare experiences. Additionally, contrary to popular belief, children in FFN care are not all Black or Brown and from poor families (NWLC, 2018; Oser & Cohen, 2003). The diversity represented by the FFN providers is mirrored in the children and families who prefer this childcare modality. It is imperative for FFN providers who are considered invisible in the childcare system to have a stronger voice and be recognized as respected contributors of care in the childcare system (Paulsell et al., 2010; Powell, 2008).

We cannot continue to ignore any early care system that might be consciously or unconsciously contributing to the achievement gap. As Black and Brown children stay in informal care longer than their White peers, continuing to disregard this population of care providers robs them of offering continuously informed early learning experiences that include manners, self-help skills, and the ability to communicate with adults. Moreover, it would also support them in offering early literacy, early math, and other Kindergarten Readiness experiences (Isaacs, 2012; Rathbun & Zhang, 2016). Quality early learning experiences must be available to all children, regardless of the childcare setting. Families should not have to choose between a provider of care who receives ongoing early learning training but is a stranger and a familiar provider who is loved and trusted but does not have access to early learning information. A rich early learning experience should be a human right.

Chapter II

REVIEW OF THE LITERATURE

Vignette: "Chantelle? Is that you, baby?"

A soft knocking followed as the front door slowly opening. The creaking of the floor indicated that someone was walking across the closed-in porch through another door which led into the living room. These familiar sounds were better than a doorbell in announcing the arrival of someone. Ms. Lucille's voice, clear and strong, calls through the house. "Chantelle? Is that you, baby?" Chantelle laughs and thinks: How can Ms. Lucille, who is at least 40 years older than her, have such a strong voice? Chantelle walks further into the house and strains to yell back in response, "Yes, ma'am, it's me." Chantelle notices that her voice sounds thinner and doesn't carry like Ms. Lucille's, but her thoughts are quickly subsided. "Baby, come on down here. We had a busy day, and my knees are telling me about it," laughs Ms. Lucille. Chantelle begins to descend the stairs. Ms. Lucille says, "Mykel, go meet your momma at the steps and show her how happy you are to see her." Mykel toddles to the steps. He looks up and sees his mother and starts to laugh and stomp in a circle. Ms. Lucille and Chantelle laugh at Mykel's excitement. Chantelle reaches down to pick him up. Mykel begins to cry and tries to wiggle out of Chantelle's arms. Chantelle releases a loud exhale and says, "I really can't deal with this today, Mykel." Ms. Lucille pushes herself up and out of the chair, saying, "You hear your momma, Mykel. She had a hard day. Tell her that you just get so excited when you see her. You don't know how to slow your roll." Ms. Lucille motions for Chantelle to sit down. She takes Mykel from Chantelle and gives him a bottle that she picked up from somewhere on her way towards Chantelle. She takes Mykel and gives him the bottle, and he immediately calms down.

Chantelle drops into the chair and kicks off her high heels. Ms. Lucille says, "Mykel, let's me and you get momma something to drink. Baby, what you want?"

This vignette reflects an interaction between a Family, Friend, and Neighbor (FFN) provider, parent, and child. There is a lot happening in this vignette. The FFN provider greets the parent in a familiar manner ("Is that you, baby?"). The FFN provider, either consciously or unconsciously, is training the toddler to acknowledge his mother's arrival when she comes to pick him up (*"Mykel, go meet your momma at the steps and show her how happy you are to see her"*). The FFN provider models for the parent how to deal with the child's reaction to his mom's arrival. She does not chastise the toddler for his behavior, but instead provides the parent with another perspective on the behavior (*"You hear your momma, Mykel. She had a hard day. Tell her that you get excited when you see her. You don't know how to slow your roll."*). As the vignette continues, the FFN provider smoothly inserts herself into and out of the parent-child interaction (*Ms. Lucille motions for Chantelle to sit down as she takes Mykel from Chantelle and gives him a bottle that she picked up from somewhere on her way towards Chantelle. She takes Mykel and gives him the bottle, and he immediately calms down.*). The FFN provider and the child now shift their focus to caring for the parent (*"Mykel, lets me and you get momma something to drink. Baby, what you want?"*). The vignette presented in this section allows the reader a glance into the intimate dance of FFN childcare.

Introduction

Family, Friend, and Neighbor is the oldest form of childcare (Susman-Stillman & Banghart, 2011). It is also the preferred childcare by families for their youngest children (NSECEPT, 2015; OPRE, 2010). This preference holds true regardless of family race, culture, or class (Porter et al., 2010). This trend in childcare preference is interesting as a decade ago, FFN

care was mostly utilized by poor and low-income families (Child Care Aware of America, 2014; Krutsinger & Tarr, 2011). Studies seem to base this trend towards informal care on the U.S. economy and families wanting a childcare setting and provider who are more familiar (Saltzman & Miller, 2020).

Although FFN providers care for the largest group of infants and toddlers in the United States, compared to Center-based and Family Child Care (FCC), they are rarely seen in the early care and education research literature (Powell, 2011). Whether FFN care is not reflective in the literature and therefore not considered part of the field of Early Care and Education, or whether FFN care is not considered part of the field of Early Care and Education and therefore not reflected in the childcare research literature, is a proverbial chicken-egg conundrum. However, the fact remains that FFN care is considered "invisible" in the childcare milieu (Saltzman & Miller, 2020; Susman-Stillman & Banghart, 2011).

The purpose of this inquiry is to contribute to the small but growing literature on FFN care. Very few studies on FFN care have provided space for FFN providers to share their caregiver story (Susman-Stillman & Banghart, 2011). Most studies on FFN tend to focus on narrow structural care information, such as the number of children served, primary language spoken, education background, racial background, motivation to provide care, and environmental assessment findings, to name a few (Powell, 2008). Although the research on FFN has been smaller than studies on Center-based settings and FCC settings, the limited studies have provided more information than previously known on this type of childcare.

This literature review explored the phenomenon known as FFN care. Highlights from the limited research on this approach to the care of young children were used to organize this chapter. The chapter begins with an overview of FFN care, moves through the exploration of

those things that both invalidate its service in childcare from the perspective of the childcare universe, identifies it as a vital support to families with young children, and discusses areas of perceived or real bias. Although this form of care to young children has been identified in the research as "invisible" within the larger universe of childcare as well as within given communities, its significant connections to families who use this form of care are intense and intimate (Porter et al., 2008).

Who Are Family, Friend, and Neighbor Providers?

FFN childcare is defined by the U.S. Office of Research and Evaluation (OPRE, 2010) as "non-parental care provided to a child or group of children in the caregiver's home." FFN providers are typically grandmothers, aunts, friends, or neighbors. Specifically, the percentages of FFN providers by designation is 42% relatives, 22% friends, and 35% neighbors (OPRE, 2016). Of relative providers or providers who are related to the child in care, the majority (46%) are grandmothers and "grandmother-like," as captured in the opening vignette (OPRE, 2016).

The familial and familiar relationship between FFN providers and parents allows parents to feel more secure and comfortable about leaving their youngest children in the care of another (Thomas et al., 2017). As most FFNs typically share the same or similar culture, language, geographical location, and beliefs in childrearing as the parent, this makes for a shared feeling of trust between the FFN provider and the parent (Susman-Stillman & Banghart, 2011). Most parents would feel strongly that their mothers would never intentionally harm their grandchildren but would protect and love them. In many cases, the parents' feelings of trust and love towards the FFN grandparent also extends to their girlfriend (friend), aunt (family), sister (family), and "grandmother-like" (neighbor) providers in the community.

In some communities, the "grandmother-like" provider who typically is not a blood relation has a strong connection with many families in the neighborhood (Shivers, 2012). These providers are considered extensions of the families they serve. FFN providers who are "grandmother-like" are typically older women who would not be considered a "friend" to the parent but also not a relative. However, these majority women are typically called and referred to as "grandma" or "auntie" by the children as well as the parents. Some of these "more than friends, but not family" type of providers cared for generations of children within families (OPRE, 2015; Powell, 2011). In some instances, the FFN provider who is now caring for an infant might have provided childcare to the infant's parent. In this regard, the FFN provider could very well have a trusted and endeared relationship with the infant's grandmother as well as the infant's mother and, quite possibly, the aunts and uncles of this same infant (Thomas et al., 2017).

Family, Friend, and Neighbor and Pilot Study

In the pilot study conducted in 2017 that served as the catalyst for this inquiry, there were initially three FFN providers. This study was actively implemented across 3 months. Two of the FFN providers were African American and one was West Indian/African American. They each had differing cultural beliefs and practiced different religious beliefs. One provider was the maternal grandmother of the child in care, and the other two providers were providing care to young children who were the childhood friends of the FFN providers' children. Across all these providers, the children and the parents referred to the FFN provider as "grandma."

The interactions between the parents and the FFN providers in the non-relative settings looked very much like the interactions in the relative FFN provider setting—for example, the verbal and nonverbal interactions between FFN provider and parent were familiar. In one

example, the parent arrived to pick up the baby and the FFN provider came to the door carrying the baby on her hip. The baby made all kinds of giggles and squeals upon seeing the parent, and the FFN provider, who was verbally greeting the parent at the same time, tilted the baby towards the parent as the parent put out her hands to take the child. The FFN provider turned and walked away as the parent entered, alternately talking baby talk to the baby and sharing the events of her workday as she closed the door with her free arm. The FFN provider who had walked to another room yelled out, *"I hear you honey, keep talking."* The FFN provider walked back into the room with a glass of water and handed it to the parent. As the parent took the glass, the FFN provider took the baby from the parent with her other arm and magically produced a bottle when the baby started to whimper from leaving the mother. The baby immediately reached for the bottle and popped it into her own mouth as the FFN provider sat down and told the parent, *"Sit a minute. Did you take your medication today?"* The parent laughed as she sat down. The parent looked over at the researcher and said, *"She always knows when I don't take my medicine."* Looking back at the FFN provider, the parent laughingly said, *"How do you know this?"* The FFN provider, in a joking tone, responded, *"Don't you worry about it. Take your medicine."*

In this exchange, there was no verbal discussion about the mother taking the baby or taking her medication. The shifting of the baby from one to another occurred like a choreographed dance. These nonverbal interactions reflected the level of familiarity in the relationship between the FFN provider and the parent. As FFN providers care for only one or two children, this allows them to become very familiar with the children and the families.

Family, Friend, and Neighbor Care and Fee for Service

In the childcare milieu, FFN care is considered informal childcare (Powell, 2008). This typically familial and familiar type of childcare is not always a fee-for-service arrangement

(Thomas et al., 2017). In a few cases, parents and the FFN providers barter their services (Porter, 1998; Powell, 2011; Thomas et al., 2017). For example, a parent might be a manicurist who provides weekly manicures and pedicures to the FFN provider in lieu of caring for her baby. In the case of the child in care being the grandchild of the FFN provider, there is typically no fee because the FFN provider is providing care to support the parents (Siddiqui et al., 2017; Thomas et al., 2017). This is one difference between FFN care and formal childcare, e.g., Center-based and FCC. In formal care, fees are always paid directly to the childcare program or indirectly as the parent might qualify for a childcare subsidy or a voucher of some kind whereby the state pays for all or a portion, depending on parent income. Most FFN grandparents would not charge even if the parent could apply for a subsidy or voucher (Siddiqui et al., 2017; Thomas et al., 2017). Many FFN providers who are the grandparents feel that providing care to the child is one way they can support their own children (Porter et al., 2005; Powell, 2008; Siddiqui et al., 2017).

This difference in perspective and motivation around the care of young children is another area where Center-based providers or FCC providers differ from FFN providers. As the FFN providers are either familial or familiar with the families they serve, they might have a deeper or more intimate understanding of the families' story (Powell, 2011; Thomas et al., 2017). This might contribute to FFN providers possibly being more empathetic about the family's situation. In one study, the grandparent kept the child overnight, Monday through Friday, during the winter to keep the parent from having to take public transportation so early in the morning, especially in "bad weather," to bring the child to her home (Porter, 2018). In this scenario, the parents picked up the child on Friday after work and kept the child over the weekend, returning the child to the FFN grandparent on Monday morning. Regardless of how great a need or how

bad the weather, this would not be a service most formal childcare programs would offer families.

Family, Friend, and Neighbor and Caregiver Motivation

For some FFN providers, becoming a grandparent was their entry into becoming a provider of care to a young child. As their children were looking for childcare options, the grandparent who was available would volunteer this service of love to alleviate some of the family's financial challenges by providing care to their grandchild and sparing the parents the cost of childcare (Siddiqui et al., 2017; Susman-Stillman & Banghart, 2011). However, many FFN providers have found themselves years later continuing to provide care to children in the neighborhood, the children and grandchildren of other family members, and the infants of their children's friends (Porter & Rice, 2000; Susman-Stillman et al., 2011). This acknowledges unseen networks of communication in communities and the effectiveness of "word of mouth." FFN providers do not advertise their services as formal childcare providers might in newspapers, on cable stations, or through flyers posted in places frequented by young families (Susman-Stillman & Banghart, 2011). In several studies, finding and identifying FFN providers was a major challenge because they did not advertise their services; making money or filling empty slots was not their motivation to provide care (Powell, 2011). Families came to them through personal connections such as prior families, the FFNs' own adult children, or families in the neighborhood (Powell, 2011; Shivers et al., 2016). These connections also served as an extension of trust to the caregiver. There is rarely a request for a formal reference as the love and respect or familiarity in connection between the person who is recommending the caregiver and the potential parent/family transfers to or assumingly includes the FFN provider (Powell, 2011).

In instances where parents pay an FFN provider, the cost is significantly less than they would pay for Center-based or FCC (Thomas et al., 2017). Fee for service is rare among FFN grandparent providers and typically only occurs among non-family members (Thomas et al., 2017). In these instances, the FFN providers' motivation to provide care is to supplement their income rather than provide a sole source of income, which allows the provider to charge much less than a provider who offers care for the sole purpose of supporting themselves. For many working-poor and low-wage-earning parents, the expense of Center-based and FCC would impact their ability to buy food or pay rent (Child Care Aware, 2014; Gould & Cooke, 2015). For these economically vulnerable families, using 10%-20% of their minimal income on childcare is not realistic (Advocates for Children of New Jersey [ACNJ], 2014; Child Care Aware, 2014).

FFN providers are important to the families and communities they serve (NWLC, 2018). They fill a gap that is not being covered by formal childcare (NWLC, 2018; Powell, 2008). FFN providers intimately understand the needs of their community and provide a service to fill the gap in a way that supports the family and, in some cases, the provider (Paulsell et al., 2010; Siddiqui et al., 2017; Susman-Stillman & Banghart, 2011). For example, caregiving is inclusive of doctor visits (e.g., Well Baby appointments as well as Sick Baby appointments) and errands. These efforts are perceived by the parent and the FFN provider as expressions of "loving care" to the parent as well as the child (Brown-Lyons et al., 2001; Powell, 2008). In addition, most FFN providers typically have one to two children versus formal care where there could be four or more young children. This is another factor that parents prefer because they feel their child will be attended to and not left to cry as they might in a formal childcare setting where there are many children (Porter & Vuong, 2008).

Family, Friend, and Neighbor and the Missing First Year

According to a national parent survey on the thoughts, feelings and understanding of parents regarding the care of young children, the majority of parents, at least those engaged by this survey, believed the two most important components of care for infants and young toddlers was love and safety (Zero to Three, 2015). This study was conducted by the country's most influential authority on infants and toddlers, Zero to Three (2015). The findings revealed that a large number of parents believe "loving care" which is also considered "custodial care" is the most important care for children under 3 years old (Zero to Three, 2015). Interestingly, these findings reflect very strongly with beliefs and attitudes of the FFN grandparent or "grandparent-like" provider in the pilot study.

As stated previously, the majority of FFN providers are the grandparent to the child in care and these grandparents are approximately 60-plus years old which would have made them a parent of a young child approximately 30-35 years ago. During a period when research on infant brain development would not have been available (Shonkoff et al., 2000) and making the FFN grandparent or "grandparent-like" providers reliant on mostly experiential information or default information on the care of young children. Relying only on their default information for many FFN providers who are grandparents and "grandparent-like" providers could mean the provision of only custodial care which was considered adequate care for infants and toddlers prior to the research findings on infant brain development. For many, infants and toddlers were considered Tabula Rasa or "blank slates" prior to the infant brain research findings (Shonkoff et al., 2000).

Custodial care is considered adequate childcare for young children from an old paradigm of infant care. This care includes adult supervision, mostly scheduled feeding (breakfast, lunch, dinner), physical safety of the child, keeping the child clean, diaper changing, and attention to

minor hurts (Uttal, 1996). Of course, feeding, diapering, and basic safe and healthy practices are important; however, research has revealed that without responsive adult-child interaction, developmentally appropriate practices, and culturally and linguistically appropriate engagement, to name a few of the larger components identified in high-quality care, strong developmental trajectories might not be realized (Parlakian, 2003). Zero to Three refers to this period of infancy as the "missing first year." The "missing first year" refers to the continued belief and practice of custodial care being considered appropriate care for infants and young toddlers. Although parents who participated in the survey created by Zero to Three felt quality early care was important, they did not feel this level of developmental support and stimulation was important until the child was approximately 2 years old (Zero to Three, 2015).

The Zero to Three (2015) survey findings revealed a deeper truth, which is that many parents and families are still not aware of fetal competencies or infant competencies because they do not feel that infants come into the world ready to learn. Instead, they believe that babies start "learning" around 20 to 24 months of age. Specifically, many parents and families are not aware that the fetus can hear at 8 months of gestation, infants can recognize familiar voices heard in the womb up to 3 months after birth, or babies are born actively taking in information through their senses (Lecanuet & Schaal, 1996; Shore, 1997). This lack of awareness might also hold true for many FFN providers, especially those who are grandmothers and "grandmother-like," as fetal competencies might not have been common information when they were young parents. As this population of caregivers is considered "invisible" and not part of the formal childcare milieu, they may not receive information on the capabilities of the fetus or the competencies of the infant; as a result, they rely on their own beliefs about the abilities of young children (Powell, 2008; Shonkoff et al., 2000). This scenario may result in quite a few FFN providers working

with out-of-date information and not really understanding the importance of singing, experiencing picture books, or talking to babies and expecting a response (Parlakian, 2003). However, providing this information to FFN providers in a manner responsive to them would require them to, at least, think differently about the infant in their care.

Family, Friend, and Neighbor and Quality

The field of Early Care and Education is consumed with the concept of "quality." The quality of child learning and outcomes, the quality of early learning environments, and the quality of adult-child interactions in early care and education settings are all significant factors in high-quality early learning outcomes (Gonzalez-Mena & Widmeyer-Eyer, 2018; Harms et al., 2006; Jamison et al., 2015). In recent studies, the quality of the early childhood environment has been found to be reflective of the early learning experience provided in that setting (Gonzalez-Mena & Widmeyer-Eyer, 2018; Harms et al., 2006; Jamison et al., 2015).

The heightened focus on quality in early care and education is interesting as these conversations, with regards to the birth to 3-year-old population, seem to apply mainly to a particular setting—formal childcare settings. Early childhood programs funded by state and federal sources are providing numerous professional development opportunities on curricula, developmental screening and assessment tools, and so on, for caregivers and teachers in formal childcare spaces to increase quality child outcomes (OPRE, 2015; Pittard et al., 2006).

The requirement and successive support for programs to implement formative child assessment, developmental screening, early learning environmental rating scales, and measures of adult-child interaction, to name a few, is commendable. However, programs connected to funding sources that support the implementation of these quality indicators are limited in their impact due to the small number of children served in Center-based or formal childcare settings

(Mohan, 2017; NSECEPT, 2015). The majority of infants and young toddlers who are served in relative care or FFN care have less access to these sources of support because their providers have no connection to these quality improvement opportunities as they are not considered part of the childcare universe or formal childcare (Altamirano & Leidy, 2012; Powell, 2008). This uneven allocation of resources, whether intentional or not, creates a system of inequity regarding young children and their families.

In several studies, FFN care has been shown to provide poor- and low-quality care when compared to Center-based and FCC settings. In some studies, FFN care has been shown to be detrimental to the children's safety, health, and development (Alexandre et al., 2013; Rathbun & Zhang, 2016). For example, the FFN providers were observed to not follow national diaper changing procedures (AAP, 2016) or have a procedure for disinfecting toys and other surfaces accessible to the child (Alexandre et al., 2013). These health and safety concerns should be corrected, although the expectation for these corrections can be problematic because they are based on formal or regulated childcare settings. For example, the CDC's recommended policies and procedures on diaper changing are written broadly to ensure that the procedures can be implemented successfully in all types of childcare settings (AAP, 2016). However, in many settings, the standard for diaper changing is interpreted by a widely used tool used in most states' Quality Rating and Improvement Systems (QRIS) and is based on the Early Childhood Environmental Rating Scale (Harms et al., 2014). The Early Childhood Environmental Rating Scale (ECERS) has incorporated within its protocol the CDC's recommendations with interpretation (AAP, 2011; Harms et al., 2014). Although the preschool version of this tool is the most widely implemented, there are other versions of this environmental rating scale such as the Family Child Care Environmental Rating Scale (FCERS) and the Infant and Toddler

Environmental Rating Scale (ITERS) (Harms et al., 2006; Harms et al., 2007). These early childhood environmental rating tools were created for formal childcare settings. The FCERS and the ITERS require a child to be placed on a "table" for diaper changing. The CDC recommendations call for the use of a "non-absorbent paper liner" to be placed on the diapering "surface" (AAP, 2016). The ECERS and FCERS tools which most states use to determine quality care in a childcare setting have created bias by determining that the quality standard for diaper changing in a childcare setting must include a "table." In the reliability training for someone to formally use these tools, one cannot substitute or "allow" for anything to be used in place of what is stated in the rating protocol. For example, an FFN provider changing a baby on her bed using a non-absorbent paper liner would not be given credit but would be negatively marked in the area of diapering and toileting.

In most formal care settings that serve young children, a standard piece of furniture in the environment is a diaper changing table. This is also true in FCC, which occurs in home-based settings but functions within a formal, regulatory process, as do Center-based childcare settings (Powell, 2008). Most FFN providers do not have space in their home for a changing table or might not be able to afford one. In most FFN environments, diaper changing occurs on the bed or coach. The concerns over diaper procedures and sanitation can be easily remedied in the FFN setting; however, these procedures may not look like they do in a formal setting, and this would still be a strike against the providers if the rating scale tools were used. These exclusive expectations regarding different procedures and strategies have contributed to the poor reputation that the formal childcare milieu has conferred on FFN providers.

Regardless of the poor fit of these assessment and evaluation tools used in several FFN studies, much of the field remains resolute that FFN care is believed to provide a lesser-quality

early learning experience compared to formal childcare settings. Interestingly, although this is the dominant narrative around FFN care in the childcare milieu, FFN care continues to be the preferred childcare arrangement by families with infants and toddlers and, as a result, provides care to the largest number of infants and toddlers in care (OPRE, 2015).

Recently, a small number of researchers have begun creating measurement tools to better capture the nuances of FFN care (Atkins-Burnett et al., 2015; Susman-Stillman & Banghart, 2011). As these more diverse tools are being implemented and refined, researchers are realizing that they need to use different approaches to create a more authentic evaluation process for FFN settings. These new approaches are beginning to include feedback from providers and parents to capture FFN care adequately (Bromer & Korfmacher, 2017; NWLC, 2017).

This inquiry is not presented to malign FFN care. To the contrary, this inquiry is designed to bring attention to the possibility that the current system of early care and education could be creating harm in the form of inequalities by setting up a particular group of young children. As poor and low-income young children remain in FFN care longer than their middle- and upper-middle-income peers, continuing to ignore FFN providers as part of the childcare milieu could have far-reaching implications for later school success for the children in these settings.

These impacts could include children who have not had the benefit of research-based early learning experiences created and supported by a caregiver who receives ongoing quality improvement opportunities in early childhood development. Although most children from FFN care possess strong self-confidence, “good” manners, comfort in communicating with adults, and typically impressive self-help skills, these children might not be as prepared to embrace the learning opportunities presented in kindergarten as their peers who were in formal care for which their caregivers received kindergarten readiness training (Lareau, 2011; Lee & Burkham, 2002;

Thomas et al., 2017). In the case of Black and Brown children, this could possibly be contributing negatively to later school success and, ultimately, the Cradle to Prison Pipeline (Brooks-Gunn & Duncan, 1997; CDF, 2009; Child Trends, 2016; Rathbun & Zhang, 2016).

Family, Friend, and Neighbor and Learning Opportunities

Early learning opportunities that could be provided to children during everyday routines might be missed if providers are not receiving information about appropriate support and stimulation for young children. For example, most FFN providers are aware of the importance of book reading; however, if FFN providers do not know the components of reading readiness—e.g., turning the pages from left to right, pointing and naming pictures on the page, relating information in the story to the child's world, allowing the child to respond (verbally or physically) to questions regarding the story, and so on—then the child might not be as strong in their emergent literacy as another child whose childcare provider has received this type of training or information (AAP, 2016; High & Klass, 2014). Although the FFN provider and child might enjoy their book reading interaction, the question is whether this interaction is entertaining or educational. Entertainment resources might be enjoyable, but they do not necessarily provide an early learning experience and knowing which to use for the intended outcome is important to discern. Similarly, if the FFN provider is utilizing entertainment DVDs because she thinks she is supporting early learning in the child, these attempts to provide an early learning opportunity might fall short of the intended outcome (Lally et al., 2008; Parlakian, 2003). All FFN providers should know how to create rich early learning experiences within everyday routines and interactions (e.g., diaper changing, feeding, etc.) to support and stimulate strong developmental trajectories in young children (High & Klass, 2014; Shonkoff et al., 2000).

The concern with uninformed care might be more significant for young children in poor or low-income families, as these children tend to remain in FFN care for a much longer period versus children and families in higher socioeconomic levels (OPRE, 2010; Powell, 2008). This might be where the significant differentiation between the two groups occurs. Families with higher socioeconomic status typically move their children out of FFN care when the child is around 2 years old and into a formal care setting (OPRE, 2010; Powell, 2011). However, families who are poor and low-income tend to keep their children in FFN care until preschool, if available at no cost, or kindergarten (OPRE, 2016).

This could mean children from higher socioeconomic families might have the benefit of 1 or 2 years with a childcare provider who has been trained to prepare children intentionally for their next formal learning experience or kindergarten. However, children in poor or low-income families may not be receiving this preparation because their FFN providers are not considered part of the formal childcare milieu. This is not to imply that the FFN providers are not interested in receiving this information, but rather they are not afforded this opportunity. In many instances, these providers do not know to ask or advocate for these opportunities because, in short, one does not know what one does not know.

This becomes an upsetting scenario when one considers that the highest percentage of children arriving at kindergarten, who are not prepared to engage in this learning experience or have limited early literacy skills, are from poor and low-income families and neighborhoods (Isaacs, 2012; Rathburn & Zhang, 2016). Whether there is a direct link between these children and the childcare setting they experienced prior to kindergarten, the fact remains that two distinct and inequitable systems are being perpetuated, consciously or unconsciously, based on the caregiving setting.

Creating opportunities for meaningful discourse with FFN providers will expand our understanding of this type of care to young children. FFN providers bring a broader dimension to childcare. These providers bring a more mature perspective to caregiving as well as a more diverse population in terms of ethnicity, culture, and language (OPRE, 2015; Porter et al., 2006; Powell, 2011). This group of mostly grandmothers and "grandmother-like" providers might not be easily convinced of flowery theories and fanciful practices, but if they are responsively informed of the "why" behind the importance of telling toddlers where they are going instead of "herding" them towards a particular direction, or the "why" behind verbally naming the bottle as they hand it to the child, they might come to understand that this wonderful time they spend with an infant or a toddler could better support the child's later school success. By adjusting a few routines and interactions, the FFN provider could be setting up the child for a more powerful trajectory towards their next developmental milestone.

Early in the FFN literature, researchers believed that FFN providers did not want to receive information on child development, but later studies revealed that this population is indeed interested in supporting the development of the children in their care (Porter et al., 2006; Thomas et al., 2017). However, most are not interested in securing a college degree or certification in early childhood education to receive this information. A few studies have evaluated programmatic attempts to inform FFN providers of early learning strategies, but these attempts have been inconsistent in their success (Powell, 2008; Susman-Stillman & Banghart, 2011). That is, many of these attempts were not well attended by the FFN provider community, which claimed that the information they were given was for a Center-based program and not relevant to the FFN setting (Powell, 2008; Susman-Stillman & Banghart, 2011). Other evaluations found programs surveying FFN providers which revealed their disinterest in a

college degree or certification program, but the resulting program design included the attainment of a college degree or certificate program in child development (Altamirano & Leidy, 2012; Powell, 2008; Rider & Atwater, 2009).

Although the field has learned more about the FFN population from these attempts, much of the learning has been through deficit-based experiences or a "rule-out" process. These deficit-based findings also send a message of distrust and disrespect to FFN providers when opportunities are offered that are clearly of no interest. These misaligned attempts also raise question of bias as the FFN provider population is mostly comprised of older women who are, largely, Black and Brown. Considered with a lens of intersectionality, biases of race, gender, and age cannot be ignored.

Offering quality improvement opportunities to FFN providers that are not relevant to their setting or packaged programs that result in attaining degrees or certificates that are not of interest continues to situate FFN providers as powerless and not of value. These efforts maintain the ideals that the standard of quality in caring for young children can only be found in a particular setting (formal childcare) and is provided by certain people (college degree/certified). This continues the perpetuation of unequal and biased systems in the care of young children.

As ill-fitting attempts are made to increase the quality of early learning opportunities in FFN care, young children continue to be set up to fail in their first formal learning experience, thus ultimately securing the status quo of the haves and the have-nots. Studies have already identified developmental lags, especially in poor children as young as 9 months of age (Brooks-Gunn et al., 1997; Krutsinger & Tarr, 2011). Do we continue to watch infants and toddlers tumble down the proverbial river of miasma and over the cliff into the abyss as growing numbers of children arrive at preschool and kindergarten without the necessary skills to embrace the

learning offered in these experiences? Or should we address and remedy these inequities and biased beliefs (Isaacs, 2012; Rathburn & Zhang, 2016)?

Although creating and successfully implementing quality improvement offerings that are responsive to the strengths and needs of FFN providers will certainly impact child development outcomes for the children in this setting, this strategy might not be the sole panacea for all concerns around inequity and bias in early childhood. Equally, creating more equitable opportunities for informal care providers to increase their impact on children and families may not result in the total eradication of a certain group of children entering kindergarten less prepared to embrace the experience. These efforts might not significantly reduce the swelling number of young Black boys being suspended and expelled from preschool and kindergarten. However, the potential that one contributing factor might have on reducing inequities and biases within the childcare system will certainly have some impact in moving the needle towards equitable early learning opportunities, regardless of the caregiving setting (Isaacs, 2012; Lareau, 2011).

Chapter III

METHODOLOGY

Vignette: Mama J, Alejandro, and Alessandra

It's 5:30pm on a Friday evening and Alejandro's mom, Alessandra, walks into the house through the unlocked side door. She is met with the delicious smell of spicy food cooking. Alejandro looks up from the highchair and starts wiggling his hands up into the air and kicking his feet at the sight of his mother. He has a huge smile on his face, which makes all the food his West Indian caregiver, Mama J, just put in his mouth slowly slide out the corners of his mouth, down onto his chest, and slowly pool onto the highchair tray. Mama J takes the cloth draped over one of her shoulders and attempts to catch the food falling from Alejandro's mouth. As she wipes, she says in a West Indian accent, "Oh my goodness…the beautiful mommy just walked in the door and my baby is so captivated that he forgets everything, even eating." Mama J and Alessandra laugh. Alessandra says, "Well, he certainly got that from his father!" The caregiver responds, "Alessandra…we are not going there. Been there, not going back. Remember?" Alessandra smiles as she drops her bags in a chair and takes off her jacket. Alejandro is trying to climb out of the highchair as he stares at his mother. Mama J says, "Hold on, little man. I'm working as fast as I can to get you out of this highchair." Alessandra walks over and helps Alejandro out of the highchair and says, "I can't keep him in anything anymore. I used to be able to put him in his crib while I put on my make up or clean, but I caught him with one leg over the rail of his crib the other morning!" Mama J responds as she tickles Alessandro who is sitting on his mom's hip, "Oh my goodness, Alessandro. Are you being cheeky with your mommy in the morning?" Alessandro laughs and squirms as he buries his head in his mommy's chest. "He's getting big ya know, Alessandra. You gonna have to be more careful with him. Ya won't know

what he can do until he does it. This is when a lot of little ones get hurt. When he's here with me, he goes where I go because he's always doing something new…even the bathroom if no one else is here," says Mama J. "I know, Mama…(sigh)…it's just hard. I can't get no time for nothing…not even to go to the bathroom. I guess I'm just frustrated." Mama J responds, "Baby, every mother been where you are. I know it don't seem like it now, but this won't last long. You gonna be just fine." Mama J motions to the chair and says, "Come child, eat before you go so you don't have to cook when you get home. Maybe that little man of yours will finish eating too."

Introduction

This study explored the perception of caregiving by Family, Friend, and Neighbor (FFN) providers using qualitative research methodologies within a phenomenological frame. FFN care is defined as

> informal care, relative care, kith and kin care, home-based care, legally unlicensed care, and license-exempt care. It is usually defined as any regular, non-parental childcare arrangement other than a center or licensed or regulated family childcare home. Unregulated childcare providers include relatives, friends, neighbors, nannies, and other adults caring for children in their homes. These childcare providers can be paid or unpaid. The National Survey of Early Care and Education Project Team describes these providers as "unlisted" because they do not appear on State lists as licensed, regulated, license-exempt, or registered home-based providers. According to the National Survey of Early Care and Education Project Team 6,400,000 children from birth through five years of age are cared for by unlisted providers compared to 2,340,000 cared for in listed, licensed, and regulated childcare. (Early Learning Challenge Technical Assistance, 2017)

The study included five racially diverse FFN providers who provided information about their perceptions as caregivers of young children and how they interpreted this care. Specifically, the following research questions were asked:

1. How do Family, Friend, and Neighbor providers understand their role as a caregiver? Does this differ by race?

2. What caregiving experiences do Family, Friend, and Neighbor providers offer? Do these experiences differ by race?

All the participants in the study were grandparents. This strongly correlated with the literature on FFN providers that identified 79% of FFN providers as grandparents (NWLC, 2018). These providers were all retired and had worked in various industries. Table 1 below reflects the study participants under an assigned pseudonym.

Table 1

Study Participants

Assigned Name	Age	Race	Background
Gayle (FFN)	70	White	Retired Educator
Helene (FFN)	69	African American	Retired Entrepreneur
Sofia (FFN)	64	Latina	Former Early Childhood Educator
Victoria (FFN)	71	White	Retired Educator
Julia (FFN)	60	African American	Former Aide for Children with Special Needs & Home Health Aide

Research in the Time of the COVID Pandemic

The study took place during the first summer of the COVID-19 pandemic. At this time, the participants were all caring for their grandchildren, exclusively, as childcare centers were closed, except those permitted to be open for the children of "essential workers." The entire country was in lockdown and many parents were working from home. Although these FFN providers were caring for their grandchildren, these caregiving experiences did not occur every day during the pandemic. Instead, the FFN providers cared for their grandchildren two or three times a week to allow the parents to have focused work time, or the providers would take the

children on a Saturday or Sunday to give the parents couple time. This allowed the FFN providers with space to think and reflect during the interviews.

Phenomenology and Family, Friend, and Neighbor Care

A co-investigator dynamic was created with the research participants. The co-investigator terminology was used to reflect "a trusting relationship, where both are committed to better understanding the experience being explored and allows for greater access to the richness of their experience" (Merriam, 2002). The FFN providers were just as interested in me understanding their responses as I was to understand the information being conveyed. In this context, we were all invested in the process. It was not unusual for the FFN providers to ask me if they were clear in their responses as it was a natural occurrence for me to ask questions regarding clarity.

In an effort to push against the dominant narrative in most childcare studies, it was imperative to bring the voices of the FFN providers forward (Azzarito & Kirk, 2013; Groenewald, 2004). Although more recent studies on FFN care include participatory methodologies such as focus groups and questionnaires, these studies were presented from the perspective of a norm or standard based on formal and regulated childcare settings, which continues to perpetuate bias against informal and unregulated childcare (Altamirano & Leidy, 2012; Thomas et al., 2017). As studies continue to use these exclusive norms and standards, they consciously or unconsciously maintain bias by either using these norms and standards to determine quality or to push against it.

Unlike the studies that present "murmuring voices" of FFN providers through the interpretation of focus group responses or an analysis of responses to questionnaires that were created from biased standards, this study served to make space for the resonant voice of the FFN providers. Through interviews and a Photo Novella experience, FFN providers directly shared

their understanding and beliefs about being a caregiver and what they understood to be important in the care of young children.

Data Collection and Data Explication Strategies

Data collection for this study took place during the Coronavirus pandemic. All engagement with the research participants was conducted over an online video platform, Zoom, and cell phones. Data explication strategies were as varied as the collection strategies used, e.g., puzzle, collage, mapping, journaling, profiles, and scribbling and doodling (Azzarito & Kirk, 2013; Bazeley, 2013; Seidman, 2013). However, not all strategies were used on each element of data. For example, the collage strategy was not used with the interview transcriptions but only with the Photo Novella transcriptions.

These creative strategies were employed to view the data from different perspectives. As this was a phenomenological study in which an understanding of the phenomenon was being studied, it was important not to break down ingredients in the data which might lead to misunderstanding. Rather, it was important to allow revelations to lift and reveal themselves through a variety of strategies to chunk and reposition the data (Ravitch & Carl, 2016). For example, in using the puzzle approach, I separated the interview questions, and the responses of each FFN provider for that question was listed below it (Bazeley, 2013). This allowed me to read and consider the responses collectively as well as individually. This format was used to read across the FFN providers and get a sense of their similarities and differences.

In another example, I reviewed the transcripts of each individual participant to identify “glows” and “wonders” that lifted from the data (MacLure, 2013). I marked these “glows” and “wonders” by a colored highlighter to identify interesting and revealing information (MacLure, 2013; Seidman, 2013). Each transcript was reviewed using scribbles and doodles in the margins

of the transcript about these "glows and wonders," especially regarding its content and connections to other parts of the transcript (MacLure, 2013; Seidman, 2013). This was done for each transcript individually, and then the highlights, scribbles, and doodles were captured across transcripts.

A similar process was used with the data collected from the Photo Novella transcripts. However, I used these responses to create several collages (Bazeley, 2013; Seidman, 2013). Specifically, the highlighted text as well as the scribbles and doodles were cut out and placed around the picture that elicited the responses. Colorful lines were drawn between the same and/or similar text to color-code them. These different ways of presenting and positioning the data allowed for different perspectives not seen before to lift from the data (Ravitch & Carl, 2016).

Characteristics of the Study

This section describes the research design for this study, including recruitment, data collection and analysis, recruitment of FFN providers, Photo Novella, as well as real or imagined limitations of the study.

Recruitment

This study included five FFN providers, which is the minimum suggested for a phenomenological study (Creswell, 2013). Challenges in recruiting this population seem to be one common experience found throughout the FFN literature (Bruner & Chase, 2012; Powell, 2011; Susman-Stillman & Banghart, 2011). The recruitment for participants in this study was no different. FFN providers do not advertise their services but rather receive parents and children through "word of mouth" or from one parent telling another (Shivers et al., 2016). Several strategies were used to attain the five participants. I first started by contacting friends and asking who among their neighbors, family, and friends knew of a FFN provider. This resulted in

identifying one participant. I then expanded my recruitment base to co-workers and past co-workers to see if they knew of someone or could guide me to a source. This resulted in one more participant. I was reluctant to contact the FFN providers who participated in the pilot study because I wanted to create connections with a broader group. I then expanded my recruitment to church members (mine and those of friends and colleagues), which was difficult as we were in quarantine due to the pandemic and churches were closed. I physically visited one church member who did not have access to a computer to acquire contact information for a friend of theirs who was acting as the FFN for their grandchild. As I was leaving, a woman walked down the street pushing a stroller with an infant in it. The church member whom I visited was standing in the door as I left. The two women were neighbors and greeted each other. The woman pushing the stroller was a mature woman and the church member asked, "Hey Helene, aren't you keeping your grandbaby for your daughter?" The neighbor responded, "Yes, I am." The church member responded, "Gambi's trying to finish her schooling and she needs to interview people like you. Can't you help her?" I thought I would die of embarrassment on the spot! However, I quickly shifted my thinking from being made to feel desperate to successful recruitment. Ms. Helene looked at me with a broad smile and said, "Absolutely! What do you need me to do, Bambi?" I did not correct Ms. Helene for mispronouncing my name. I was grateful to have her participation.

Overview of the Research Design

Phenomenology is the study of a phenomenon through the people who experienced the phenomenon (Creswell, 2013). In this way, those who are living and breathing or who have lived and breathed the phenomenon have space to share and reflect on their experience. This approach also reduced the incidence of misinterpretation as the FFN providers who were the ones

experiencing or have experienced the phenomenon were actively engaged. In the role of co-investigator, the FFN providers were not agreeable to reading their transcripts, but they were all open to having dialog about things "I" needed to discuss for clarity. I was not successful in getting the FFN providers to be less concerned that "I" receive what I needed to further my education pursuits and more with ensuring that what I understood as their caregiving was correct. However, the interest they had in "helping me" fit with the type of caregiver I found them to be in the study, which was a deep and genuine interest in helping others. As trust and respect are important aspects of the FFN provider, I released my need for this co-investigator relationship to look a certain way and focused on allowing the co-creating process to occur naturally between us.

Specific phenomenological components used in this study included interview, epoche, phenomenon reduction, and researcher memos (Creswell, 2013; Marshall & Rossman, 2006).

Interviews

Two interviews were conducted over Zoom with each FFN provider individually. The interviews were scheduled for 45 minutes, but most lasted 1 hour. The first contact with the FFN providers varied. As mentioned above, one initial contact happened on the sidewalk. However, all participants received a formal initial contact via phone to discuss the study and what participation in the study involved. Specifically, during the initial contact, I introduced myself again, sharing information about my educational and work background and my reason for engaging in the study. I then gave a brief description of the study, where I also shared their anonymity in the study, including their right not to answer questions that made them feel uncomfortable, and then scheduled the first interview (Bogdan & Biklen, 2007; Creswell, 2013).

It was during this "getting acquainted" conversation that I inquired as to their level of comfort using Zoom before scheduling the first interview. Since we had been in a pandemic for 5 months, all the FFN providers had experience using some video-based program for business or pleasure. This was different from the pilot study participants, who refused to be videotaped because they did not want anyone to see how fat they were and especially did not want this image of themselves to exist into perpetuity.

In the pilot study, I purposefully held back any personal information because I wanted to maintain a professional barrier with the FFN providers as I was in their home conducting these observations and sought to uphold boundaries. During this study, I was able to conduct two onsite observations. By the second observations, the FFN providers were comfortable enough to ask me personal questions, which I answered without hesitation as I was also more comfortable. This sharing ignited a connection with the FFN provider that relaxed all formality in their interactions and resulted in very deep and reflective conversations. From this experience, I knew that personal connections were important to this population of caregivers, and I was more comfortable sharing some of my personal information with them when introducing myself.

The first interview focused on the FFN providers' caregiving story. Gayle, Victoria, Helene, and Julia talked freely about their experiences. Sophia, the Latina FFN, was more hesitant. I later realized that she was a bit ambivalent about talking with me alone in English. She worried about being able to answer my questions correctly in English and did not want me to think badly of her. Sophia shared her ambivalence with the contact (a colleague of a colleague) who put us together. The two colleagues discussed this dilemma, and it was decided that I should be pulled into the conversation. This allowed me to alleviate Sophia's worries by assuring her

that I was more than comfortable with her asking me to explain questions or say them differently as this helped me identify where I might need to clarify for others in the study who might not ask clarifying questions. My relationship with Sophia changed tremendously after this conversation. I noticed that she was more relaxed in her body language, and she frequently asked me questions or took the initiative to explain things to me that were culture-based or intuitive to her.

The second interview with the FFN providers was focused on their current caregiving philosophy and how, if at all, anything changed for them regarding being a provider of care. This interview also inquired into their differentiation in caring for young infants, toddlers, and preschoolers. This interview included their thoughts on engaging parents. The second interviews lasted over an hour as the sharing was so rich, I did not want to stop them. The interviews began with semi-structured questions, but once the participants became comfortable, each interview transitioned into a conversation (Creswell, 2013; Groenewald, 2004; Marshall & Rossman, 2006).

Epoche

Epoche or bracketing, as it is sometimes referred, is a process used to create space for the researcher's feelings and thoughts as it relates to the phenomenon being studied. The purpose of this process is to reduce the incidence of projecting the researcher's feelings and thoughts in the study (Creswell, 2013; Groenewald, 2004; Marshall & Rossman, 2006). I used this space differently than described. Typically, the epoche process is used before or after interviews or observations, but I used this process before and after interviews as well as the Photo Novella sessions (Azzarito & Kirk, 2013; Pink, 2007; Rose, 2016). Specifically, I used the process of epoche to explore any ambivalent feelings, biases, or emotional triggers I had about preparing and conducting the interviews.

In the case of the pilot study, using the process of epoche before and after interviews and observations allowed me to explore my conscious and unconscious expectations about the interviews, but it also served as a reflective space for me to explore the attitudes and judgments of the FFN providers that were different from mine. Epoche was not shared with the FFN providers as it was my private space as the researcher to reflect, react, and resolve feelings and thoughts about unexpected triggers or unconscious bias that needed to be identified as such and not allowed to influence the study unconsciously.

Phenomenological Reduction

Phenomenological reduction is the data analysis or data extrapolation process. The way phenomenological reduction occurred in this study was under the frames of puzzles, collages, and so on. I reviewed these data sources for sentences or phrases that clearly and succinctly provided an understanding of the FFNs' experiences and beliefs as caregivers of young children. These sentences and phrases or "significant statements" were highlighted, initially, within the participants' interviews or Photo Novella experience; then later, the mirroring data pieces in the interviews or Photo Novellas were examined together and against each other as well as across each other (Azzarito & Kirk, 2013; LeCompte, 2000; Pink, 2007; Rose, 2016). For example, the interviews were first observed individually for significant statements. These significant statements were compared and contrasted across participants. This process was done using strategies like puzzling, mapping, collaging, and so on. Statements found to be common across FFN providers were grouped together to identify a cluster. These clusters yielded to themes in the data:

> We listen to or read a text several times and ask, "What statement(s) or phrase(s) seem particularly essential or revealing about the phenomenon or experience being described? These statements we then circle, underline, or highlight. Next, we try to capture the phenomenological meanings in the thematic expressions. (Van Manen, 2014)

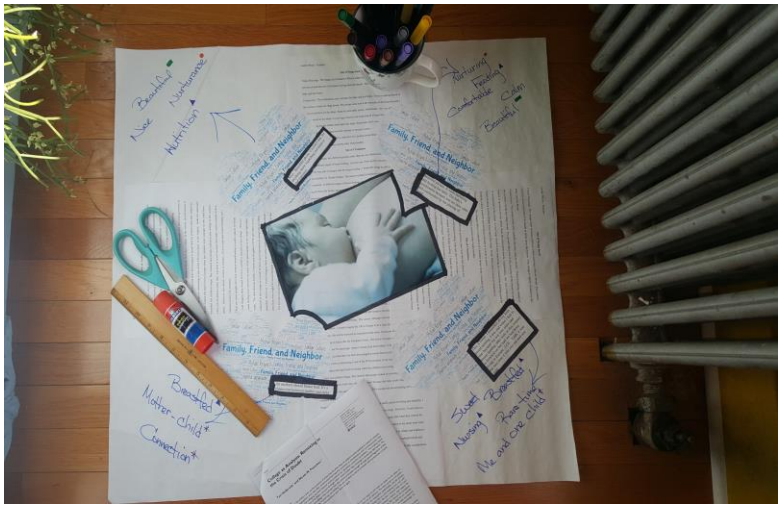
The themes were synthesized through structural synthesis, which allows the researcher to creatively explore, verbally or through writing (research memos), the most likely response to the research questions (Angrosino, 2005; Creswell, 2013).

In lieu of the observations that were not allowed because of the pandemic, I created a Photo Novella experience (Azzarito & Kirk, 2013; Pink, 2007). The Photo Novella was comprised of a PowerPoint presentation that contained stock photos representational of the major routines in infant and toddler care: sleeping, eating, diapering, early learning, and relationships. The pictures were acquired through Google Images and filled the frame of each slide. This presentation was shown over Zoom. I created specific questions to guide the conversation around the images, but these were quickly abandoned as the FFN providers by the third and fourth photo began to react comfortably and respond to the images on the screen.

The Photo Novella data were handled similarly to the interview transcript data (Azzarito & Kirk, 2013; Mitchell, 2011; Pink, 2007; Rose, 2016). First, the responses from the individual reactions were reviewed to identify significant statements. Then, significant statements from each FFN provider for the same picture were examined to identify same, similar, and different responses to create clusters through the process of collaging and mapping (Bazeley, 2013; Pink, 2007; Ravitch & Carl, 2016).

Figure 1

Clustering in Phenomenological Reduction



Pilot Study

The small pilot study that was conducted prior to this study was birthed from a funding opportunity to expand services to infants and toddlers through a federal program. The application required a current community assessment, which revealed a staggering need for infant and toddler care. At the time of the community assessment, the community was serving less than 10% of the needs of its infant and toddler population. The proposal submitted requested funding to serve 50 additional infants and toddlers, which would not move the needle on the shortfall of infant and toddler childcare slots in this community but would be appreciated by these additional 50 families. At that time, the shortfall of slots in the county was over 500, with the largest shortfall being in the city where the program was located (ACNJ, 2014). This finding was also true for the State of New Jersey (2010) as well as the rest of the country (Gould & Cooke, 2015; Oser & Cohen, 2003). Most infants and toddlers were in FFN care and the state as well as the

county childcare resource, and referral programs had little to no information on this group at that time.

Although I used this form of childcare for my own infant many years prior, I had never really thought about this care with regards to early learning. As a parent, I wanted someone I could trust who would not allow my baby to cry without comforting him, who would keep him fed, safe, and loved. This realization was curious to me as an early childhood professional who also had a specialty in infant and toddler development and infant mental health. Although I was a professionally trained infant and toddler specialist, my intellectual knowledge completely succumbed to deep cultural and ancestral instincts when it came to my infant.

Aware of the changes in kindergarten expectations (e.g., children expected to recognize their name in print, be able to hang up their sweater/jacket, and so on) only because of required community partnership policies that pertained to funding sources, I was interested to know how these informal providers were receiving information on these changes and what they were doing about them regarding the children in their care. As a childcare administrator, I knew what the professional development needs were for providers of young children, but how was this group—whom I never saw represented at workshops and conferences—keeping up with information on early learning best practices? I delved into the research for answers, but the few studies I found only left me with more questions.

Given the ill-fitting measures used in many of the studies as well as the conflicting information between studies, I was not sure we knew who these providers were as caregivers to young children. For example, one study found the majority of FFN providers were not interested in attaining a degree or receiving a certification in early childhood education, but the study's recommendations were for monies to support FFN providers in attaining college degrees and

certificates in early childhood (Powell, 2011). How can a professional development opportunity be created for a population we either do not know well or do not respect their opinion as to their needs regarding the care to young children? The majority of these providers are mature women who have reared families and lived many more years than most of the researchers who are researching them (NWLC, 2017). This influenced the focus of this study, which was to find out directly from the FFN providers their understanding of caregiving to young children and their role as caregivers. The pilot study that led to this slightly larger inquiry was comprised of the following.

Pilot Participants

The pilot used convenient, criterion-based, and snowball sampling to secure three FFN providers. After the initial interview and the first observation, one FFN provider could no longer participate as the infant in her care was no longer coming daily because the parent had been laid off. Although the FFN provider continued to care for this child when the parent needed respite or had to run an errand, these arrangements were made with too short turnaround for me to arrange a second observation. Formally, two providers remained throughout the study. The providers were all located in the State of New Jersey: one in Northern New Jersey and the other in Central Jersey. Specifically, one was located in an Urban/Suburban setting and the other in a Suburban setting.

Pilot Methodology

The methodology for the pilot study included interviews, bracketing, epoche, research memos, observations, Critical Friends, phenomenological reduction, textural description, and structural description.

Pilot Interview

The FFN providers were interviewed twice, once by phone and again after the observation. Initially, the FFN providers were very reluctant to allow me into their homes. I planned to have two in-person interviews but decided to conduct the first interview over the phone, which seemed to put the FFN providers at ease. The second interview was conducted at the provider's home.

The in-person interviews were approximately 45 minutes in duration. Questions about the FFN providers' previous experiences in caring for children were discussed during the phone interview, and questions about their present caregiving experience were asked during the in-person observation (Marshall & Rossman, 2006). I also used the phone interviews to begin relationship-building with the FFN providers. I shared specifics about the study, the anonymity of the interviews, and the participants' option not to answer any questions that made them feel uncomfortable (Bogdan & Biklen, 2007). The interviews were tightly focused on the FFN providers, which worked for a while because I was reluctant to reveal my 20-plus-year professional background in early childhood education and policy. I did not want the FFN providers to feel that I might be judging the care they were providing. I was also concerned about maintaining boundaries as we were in a relaxed environment—their home. Initially, I only revealed that I was a doctoral student. However, as my contact with the FFN providers continued, they began to ask me personal questions. To continue building our relationship, I shared a small aspect of my professional work and basic information that they could find in a Google search about me regarding my family. This turned out to be the game changer: Instead of making our communication stilted and awkward, the FFN providers began to talk freely with me.

Pilot Bracketing

I bracketed my thoughts and feelings before and after conducting interviews and observations and analyzing data. Marshall and Rossman (2006) suggested bracketing only after interviews, but I found this process to be helpful in preparing me to get centered and focus on the interview or observation. This space allowed me to explore my thoughts regarding the interview or observation. I not only wrote about my anxieties over the interview or observation, but I also wrote about possible scenarios and how I could respond to them; this allowed me to enter the research space calmly and openly.

Pilot Phenomenological Reduction

Each interview transcript was initially analyzed separately and then against the other interview transcripts for the same FFN provider before being analyzed across FFN providers. This process allowed me to identify different levels of analysis, which I could then later cluster together to reveal the essence of the phenomenon (Marshall & Rossman, 2006). For example, I reviewed the interview transcripts and highlighted short phrases or words that seemed to encapsulate or represent the meaning of the section (Groenewald, 2004). I then took these short phrases and words which were highlighted and/or captured in the margins of my transcripts and began to create clusters of similarities in meaning and language across transcripts (Bazeley, 2013). Once the larger group of similarities and meanings were created for each transcript, I used labels found in the literature and began clustering the similarities and meanings underneath the appropriate label. I did not employ any data analysis programs in this process. Working closely with the data seemed to mirror the intimacy in this childcare modality, which seemed the most appropriate way to work with these data. I used the interview that took place during the observation to circle back to any questions I had from this process. For example, a few phrases

and words did not fit under any of the labels, so I checked back with the FFN providers, not in writing but just using a conversational format to examine these few inquiries.

I asked the FFN providers if they wanted to review their interview transcripts to be sure they accurately represented their intended communication, but they were not interested in reading the transcripts. I wanted very much to have this co-researcher experience with them because I was invested in their voices coming through, but they were not interested—or so I interpreted their refusal to be disinterest—and I reluctantly respected their wishes (Angrosino, 2005; LeCompte, 2000). Actually, "reluctantly respected their wishes" came after a discussion with one Critical Friend for the study. Initially, I did not feel the FFN providers and I had formed a co-researcher relationship, but after talking with the Critical Friend, I realized that I had a preconceived idea about what or how this co-researcher relationship should look and function. In my informal conversations with the FFN providers (e.g., before and after interviews, before and after the observations, etc.) concerning the progress of the inquiry, these experiences were evidence of our co-researcher relationship. The FFNs and I already were co-researchers, although our partnership did not look like the "textbook" model of co-researcher. The co-researcher relationship that the FFNs and I created was our unique and organic version. Angrosino (2005) discussed the need to be flexible in creating research partnerships with research participants and allowing the research partners to lead this process on their own terms and in a manner that is a "good fit" for them. I utilized this flexible process with both FFN providers successfully (Angrosino, 2005; LeCompte, 2000).

Pilot Observations

The study included two observations of 45 to 60 minutes for each FFN provider. The observations were captured by hand using field notes and jottings (Bogdan & Biklen, 2007;

Emerson et al., 1995). The FFN providers refused to be videotaped as they did not want anyone to see how fat they were, and video lived on into perpetuity. I did not push the idea of videotaping, but instead used thick description to describe the environment as well as what occurred in the environment without interpreting (Bogdan & Biklen, 2007). Describing the observation using rich detail without interpretation also reflects phenomenological theory in maintaining an "innocent" perspective to the data (Bogdan & Biklen, 2007). An example is as follows:

> FFN #1. I believe she used monies from him to get that Invitro Fertilization done. I just don't get it. Purposely having a baby with no father involvement, what's the point? I guess I'm old fashioned though. No, let me correct that. I am old-fashioned! (laughing) I guess though it's no different than these guys having babies all over the place knowing they don't have no job or anything, but they keep making babies…. Lord have mercy.
>
> FFN #2. Her mom brings her food, but I feed her, I keep her clean, I talk to her and play little games with her. We read books. She has a favorite book here called…oh, what is the name of that book? (Reaching into a cardboard box of toys) Oh, here it is, *Baby Dance!* Have you ever read this book? It's great and she loves it! It talks about up and down and all around and cooing to the baby…. (laughing while moving hands up and down).... I do the motions for her because she's getting so big, I can't lift her up real high. She's almost 25 pounds and she's not even one year old yet. She won't be one until November, next month.

Data from the interviews that occurred during the observations were analyzed using the same approach as the regular interviews. However, instead of applying the observation interview data to the telephone interview data analysis, I compared and contrasted the telephone interviews with the telephone interviews, the observation interviews with the observation interviews, and the observation data with the observation data (LeCompte, 2000). I later integrated data from the telephone interviews and observation interviews.

Pilot Critical Friends

After comparing and contrasting the observation interview transcripts with each other, I applied the same labels and began to cluster the short phrases and words using the same process

as the interview data. I kept separate any short phrases or words that did not fit under an existing label (LeCompte, 2000). At this point, I created a research memo to share with my Critical Friend (Creswell, 2013; LeCompte, 2000). In this memo, I shared my frustration with the phrases and words that did not fit any of the existing labels. The Critical Friend helped me to see that the outliers all had to do with information about the babies' parents. These short phrases and words were basically gossip about the parents, which I decided not to include.

We also talked about the cluster of sentences and phrases that were highlighted in the phenomenological reduction process. These clusters revealed themes and threads once they were clustered, but I could not see any themes. Initially, none of the clusters appeared to relate to each other. I expected, at this point, for the themes to pop off the paper, but nothing revealed itself as I had expected. I recorded each cluster on an index card on the advice of the Critical Friend, and then we physically moved and shifted these clusters against topics in the literature to see if a larger picture was revealing itself (LeCompte, 2000). Bringing the research questions back in at this point was the missing piece. After this revelation, I indulged in a process called structural description (Creswell, 2013; Marshall & Rossman, 2006). Structural description is considered one of the final steps in the phenomenological process. This description process allows the researcher to creatively explore, verbally or through writing, all possible themes to locate the essence of the phenomenon (Marshall & Rossman, 2006).

Pilot Findings

Two prominent themes were revealed. The most prominent theme identified was the limited understanding of early experiences for young children by the FFN providers; the second theme was family-driven. The pilot study research questions were:

1. How do FFN providers describe their relationship to the child in care?
2. What do FFN providers identify as their caregiver responsibility to child in their care?

I believe the theme that reflected the FFN's relationship to the child as the grandmother or auntie or neighbor really spoke to the FFN's relationship to the parent primarily and the child secondarily. The relationship between a child and an FFN provider is really driven by the relationship between the FFN provider and the parent. In this regard, the FFN provider likely perceives the relationship to the child as an extension of the parent, regardless of their relational status as grandmother, friend, or neighbor. The second research question concerning the FFN's responsibility to the child was strongly evident in the FFN's belief in keeping the baby safe, clean, and fed. These characteristics in caregiving are called custodial care (Uttal, 1996). To the FFN providers, providing these basic but important practices of caregiving were believed to be demonstrations of love. The FFN providers clearly saw their responsibility as providers of care to the child as protectors and nurturers. They did not see themselves as having any responsibility for early learning.

Lessons learned from the pilot were used in the design of the larger study. However, the pandemic restrictions eliminated the inclusion of observations in the study, but also provided the opportunity to use a more creative methodology. Also, the process of textural description was not found to contribute meaningfully to the process and thus was not included in the study design. However, the significant lesson from the pilot study concerning preconceived ideas about the way things should look was monitored in memos to keep this bias from coloring the study. My preconceived expectations almost resulted in my not noticing the shared power process that the FFN provider and I created.

The role of the Critical Friend was significant to the pilot study. The two colleagues who served in this role each brought their experiences with phenomenological research and provided different but needed support. One was actively engaged in the data analysis process, while the other read and gave feedback on structural and organizational aspects of the study. This was not how I originally thought it would work, but each brought their knowledge and experience to support the research process, which contributed to the success of the pilot.

Presentation of Study Findings

The findings from this study are presented in the two subsequent Chapters IV and V. These chapters are organized by the research questions and discuss the corresponding finding. For example, in Chapter IV, I discuss the first research question: *How do Family, Friend, and Neighbor providers understand their role as caregiver? Does this differ by race?* I use direct responses from the FFN providers as well as references to the literature to discuss the finding. In Chapter V, I discuss the second research question: *What caregiving experiences do Family, Friend, and Neighbor providers offer? Do these experiences differ by race?* In this chapter, I followed the same process as for the first question to discuss the finding. In Chapter VI, I highlight implications of the study findings for practice, research, and policy. Findings from this study will be used to advocate on behalf of FFN providers to support them in attaining research-based resources and materials that are culturally and linguistically appropriate. Information from this study will also be used in presentations (speaker and poster) as well as articles (academic and popular press) to push against the dominate narrative in childcare that continues to promote, consciously or unconsciously, separate and unequal in caregiving settings.

Reliability/Trustworthiness

As part of creating a co-investigator relationship with the FFN providers, I offered each of the research participants the opportunity to review the transcripts to ensure accurate representation. They all refused my offer. Instead, they invited me to contact them, should I have any questions. I was not surprised by this response as the same scenario occurred in the pilot study. However, one of the Critical Friends to the pilot study helped me realize I was expecting to have a co-investigator relationship based on the literature and not based on the people involved in the relationship. Additionally, the literature might have been on people who probably did not reflect the likeness of some of the research participants or me. This time, I viewed their refusal to the read the transcripts as evidence of the FFN providers' feelings as respected and contributing partners in our relationship because they gave me another option ("Feel free to call me if you have any questions.") in response to reviewing the transcripts. In this way, the FFN providers were comfortable, and I still received what I needed. This was reflective of a co-researcher or shared power relationship, where the importance lies in how those in the relationship feel about it and the function of the relationship is perceived to be fulfilling for those involved.

Limitations of the Study

This study is presented from a passionate perspective regarding the inclusion of FFN care in the Early Care and Education milieu; however, using this study alone to make this decision would not be advisable for several reasons. First, this study is small and cannot be generalized. It does not represent a national sample of FFN providers. Although several corroborating points in this study align with findings in different studies on FFN care, these corroborations would need to be considered from a broader perspective. The few studies available were conducted in a

specific geographical area and only reflect a few providers in an exclusive area. As more studies are conducted on FFN care, stronger similarities as well as differences across this population of caregivers will be identified that will better inform policymakers and funding decisions.

Second, the racially and culturally based findings identified in this study have not been explored in the same way in other studies on FFN providers. The FFN providers in this study were all located in the northeast region of the United States. The findings attributed to Black, White, and Latinx FFN providers in this region might not be reflective of Black, White, and Latinx providers on the West Coast or in the Midwest. As studies become more diverse, racial, cultural, and geographical efforts can be made to view FFN providers through multiple lenses. This study was conducted to add to the collective research picture on FFN care.

Impact of COVID-19

I mentioned earlier the worldwide context in which this study occurred—the Coronavirus pandemic and the subsequent lockdown. I also described adaptations made to the study resulting from these unprecedented governmental restrictions. However, the biggest impact affected my ability to bring the voices of parents into the study. Initially, the design of this study included five parents who utilized FFN care; almost immediately, the two parents who worked in law enforcement started working 15-hour days to cover their colleagues who were either sick with the virus or had died from it. The third parent had started a car retrieval business a year before the pandemic that was growing painfully slowly. However, the pandemic allowed him to access all the work he desired because car dealers were drowning in returned cars from people who had lost their jobs and were turning in now-unaffordable cars at the dealership as well as those who had end-of-lease drop-offs. Most car dealers and companies had very few employees willing to retrieve these cars from dealerships due to their fears that the owners of these cars might have

had the virus. This created space for this entrepreneur to finally gain access to these opportunities, which he fully embraced; almost overnight, he started working 12 to 15 hours each day and was able to expand his business in staff and geographical location. We played telephone tag a few times, but he eventually stopped returning my calls. Thus, I had to release the idea that interviewing him was going to happen. This left two parents who were interviewed, but their data alone were not enough to include in the study. I do plan to use this information for journal submissions and/or articles.

Chapter IV

HOW DO FAMILY, FRIEND, AND NEIGHBOR PROVIDERS UNDERSTAND THEIR ROLE AS A CAREGIVER? DOES THIS DIFFER BY RACE?

Vignette: Ms. Maugerite, Baaith, and Rahmon (Rah)

Ms. Maugerite and Baaith are making biscuits at the kitchen table. Baaith is standing in the chair next to Ms. Maugerite. He picks the biscuit dough off his fingers and drops it onto the table. Ms. Maugerite glances up at the wall clock and then down at Baaith who is chatting a mile a minute about the dough, the floor, the cat, his trucks, his mom being away…and says, "Now keep your biscuit dough on your side, remember. I have mine over here and you keep yours over there. You can take yours home and we'll eat mine for dinner." Baaith nods his head as he continues chatting about the fish in the story he and Ms. Maugerite read earlier. Ms. Maugerite says, "Baaith, you can start rolling your dough so we can get your biscuits cut and into the oven." She hands Baaith the rolling pin. Baaith takes the rolling pin and turns it this way and that as he looks at it. He then begins to talk about a truck he saw that had a rolling pin on the front, and Ms. Maugerite laughs and says, "Boy, if words were money…you'd be rich...LOL." She helps Baaith roll his dough out. She hands Baaith the biscuit cutter, but Baaith shakes his head no as he pushes his hand past the offered biscuit cutter towards the glass in front of Ms. Maugerite. Ms. Maugerite puts the biscuit cutter down and picks up the glass Baaith is reaching for as she says, "I'm going to help you with the glass because it's slippery with flour." They work together cutting Baaith's biscuits and placing them on the baking sheet. With the biscuits in the oven, Ms. Maugerite and Baaith are at the sink cleaning the items used during their biscuit making activity when the phone rings. Ms. Maugerite dries her hands and sees that it's Baaith's

mother calling. She answers with excitement, "Diamond! How are you, honey?" She looks at Baaith who is dancing in the chair chanting, "Momma, momma, momma." As Ms. Maugerite cradles the phone between her ear and shoulder, she dries Baaith's hands so she can help him out of the chair. Continuing her conversation with Diamond, she says, "Hang on, honey. I have someone with me." She puts the phone on the table and pushes the "speaker" function on the phone. She says, "Baaith, talk to your momma. She can hear you. Say something, Diamond." Diamond begins to talk, "Hey Buddy…what are you still doing with Ms. Maugerite?" Baaith quietly listens and then proceeds to share about the biscuits he and Ma-maki (Ms. Maugerite) made, what he ate for lunch, what he played with, how the cat just walked into the kitchen, and then continues to talk as he follows the cat out of the kitchen. Ms. Maugerite picks up the phone laughing and says, "I think daddy needs a reminder, but then again, maybe I do too because I forgot to call him earlier to remind him...LOL." Diamond, sounding a bit annoyed, responds, "You shouldn't have to call and remind him. That's his son! You don't ever have to call and remind me to pick up my child!" Ms. Maugerite, hearing the annoyance, says to Diamond, "Honey, just call your husband and remind him to pick up his son. I'll take it from there. You enjoy your little time away. Did you take your swimsuit so you can get in the pool?" Diamond laughs and shares that she's on her way to have dinner with her colleagues but didn't think to bring her swimsuit. Sounding less annoyed, Diamond hangs up to call her husband. Ms. Maugerite calls to Baaith, "Baaith, come help me set the table. Your daddy will be here soon." Just as they sit down to eat, Rahmon comes running in the door, apologizing to Ms. Maugerite and Baaith. He turns to Baaith, who is in the highchair eating, and hugs him. Ms. Maugerite responds, "I forgot to call and remind you about picking up your little package, but I knew before you went to bed, you would remember...LOL." Rahmon laughed. "I think I left you a plate

by the stove. Get you some dinner. There's plenty, Rah. Baaith and I made biscuits." Baaith twists and turns in the chair, looking around the kitchen counters. Ms. Maugerite says, "I already packed up your biscuits to take home, Baaith. You, mommy, and daddy can have them tomorrow for dinner." Baaith smiles. As Rahmon eats, he says, "This is delicious, Ms. Maugerite. Thank you." Ms. Maugerite smiles and says, "I figured it would be one less thing you needed to do with Diamond out of town. Now all you guys need to do is go home, take your showers, put on your pajamas, and enjoy each other until bedtime."

Introduction

The vignette above is a typical scenario in Family, Friend, and Neighbor (FFN) care settings. Providing dinner because a parent is out of town or bringing a child to the pediatrician to save the parent from taking time off from work are all very typical caregiving activities that FFN providers willingly engage (Thomas et al., 2017). Although these caregiving activities are commonly observed in the literature as part of this relationship-based caregiving modality, the understanding attached to this type of service delivery was considered a result of the family dynamic between the family member (parent) and the FFN provider (grandparent). Taking a child to the pediatrician or providing dinner for a parent do not seem irregular when one considers that the child is the grandchild of the FFN provider, but these caregiving experiences are also provided to those not related to the FFN provider (Shivers et al., 2016). In other words, families in FFN care who are not related to the FFN provider also receive caregiving in the form of phone calls to remind dads about picking up the child, running errands to support families, and an occasional dinner, to name a few experiences (Thomas et al., 2017). In these instances, the literature has identified these caregiving activities as characteristics of FFN care (OPRE, 2016; Susman-Stillman & Banghart, 2011; Thomas et al., 2017). However, the findings presented in

these chapters provide a different lens to consider in this personalized caregiving approach to familial and non-familial children.

The following data chapters are organized by the research questions for the study. Each chapter presents the major finding aligned with the research questions. In an effort to fulfill the intent of this inquiry, which is to better understand FFN care from the providers of this care, the following chapters use actual participant responses to bring these voices forward. As these findings reflect, push against, and expand on existing meanings in the literature, these aspects are discussed.

Specifically, this chapter explores the first research question of this dissertation study, *How do Family, Friend, and Neighbor providers understand their role as a caregiver? Does this differ by race?* The following information includes a discourse on the perception that FFN providers have of themselves as caregivers and how this perception influences their delivery of care. Finally, this chapter examines critical areas identified by FFN providers in the care of young children as seen through a lens of race.

A Paradigm of Caregiving

> *(pause)...I don't know...(pause)...maybe I'm both all the time. I never thought about it.* (Sofia, Latina FFN, Interview Two, 9/21/2020)

The quote above captures the collective responses of five FFN providers regarding their perception of themselves as caregiver or grandmother in the daily care of their grandchildren. Did they consider themselves caregivers when they were caring for the child while the parent was at work, or did they see themselves as grandmothers? Their perception of themselves as caregivers was important to realize within the larger scope of FFN care. Ascertaining this information from the FFN providers was interesting and surprising.

All the FFN providers perceived themselves, in the care of young children, as "caregiver-grandmother." An interesting aspect of this finding was that none of the FFN providers seemed to have considered these two roles, caregiver and grandmother, as separate identities, based on the "sighs" and "pauses" in their responses. More intriguing than their visual and verbal responses to this inquiry was the fact that these FFN providers were racially and culturally diverse:

> (Deep sigh)...Such a combination of feelings. (pause) First and foremost, I feel that I am his grandmother...(pause)...However...mmmm...I feel a responsibility to teach him when he is with me. I was a preschool teacher, kindergarten teacher, and first grade teacher, so I have a desire to teach. (Gayle, White FFN, Interview Two, 9/23/2020)

> Mmmm...I guess I view myself as both. Grandma/caregiver or Auntie/caregiver. (pause)...I don't know...(pause)…I don't see it as different...(pause)...I care for them all the same. Children are children...(pause)...I love them all. If something happened to them, I would be as upset about it as I would for my own. (Helene, African American FFN, Interview Two, 9/23/2020)

> Well...I guess...(pause)...always grandma or auntie. As long as they don't call me out of my name, I'm good with whatever...LOL. (Julia, African American, Interview Two, 9/28/2020)

> (pause)...I don't know...mmmmm...I guess when there are other children here, I feel like a caregiver...(pause) When I am here with my grandson alone, I feel like grandma… (sigh)...I'm more careful with his safety than I was with my children because he's not my child. So, in that sense...(pause)...I don't know, maybe I'm both all the time. I never thought about it. (Sofia, Latina FFN, Interview Two, 9/21/2020)

> Mmmmm...Well, you know...(pause)...I guess I feel as both because this is my profession...(pause)...I really feel that I bring my professional knowledge to my grandparenting. (Victoria, White FFN, Interview Two, 9/29/2020)

The similarities in the meaning of their responses were surprising, but the similarities in their verbal responses were shocking. In each of the FFN providers' responses, there were numerous pauses and sighs. The FFN providers would respond, then suddenly stop talking; a few would look off as though deep in thought; then they would slowly or with a curious laugh

continue with their response. The effort-taking that went into each FFN provider's response around this consideration was palatable.

This shared perception of caregiver and, simultaneously, grandmother is referred to as "caregiver-grandmother" in this study. The newly aware understanding as "caregiver-grandmother" presents a different understanding of the "characteristics" of FFN care. In the literature, the personalized care that FFN providers offered was assumed to be the result of familial relationships between the FFN provider and the family; however, this finding provided a different lens to consider (Shivers et al., 2016). It may offer an explanation for this intimately familiar care and its similar caregiving to non-familial families as well as familial families.

The existing literature has paid little attention to the fact that familial and non-familial children and families receive the same intimately familiar care (Siddiqui et al., 2017). In recent studies, soft assumptions have been offered regarding non-familial children and families receiving the same personalized care as familial children and families (Thomas et al., 2017). These soft assumptions assumed that non-familial families using FFN care were close friends of family members and, therefore, were "like family," but studies have shown that approximately 20% of FFN families are not related or considered to be family friends (NSECEPT, 2016). The fact that FFN providers are notoriously difficult to locate or identify can be found in most studies, which makes this assumption viable (Altamirano & Leidy, 2012; Bruner & Chase, 2012). However, more recent studies have shown that families learn about FFN care through "word of mouth" or familial and familiar connections, but these families are not always relatives or personal relations (OPRE, 2016; Powell, 2011).

This information shifts the paradigm of FFN care from being driven by familial connections to an approach to care being driven by caregivers who perceive themselves as "caregiver-grandmother." These perspectives demonstrated that FFN providers do not provide care that is intimately familiar because of family ties or familial connections; rather, FFN providers bring a familial connection context to their care as "caregiver-grandmother." Although the personalized care provided by FFN providers may look different from family to family as it is responsive care, the impetus of care or care from the context of the familial is the same, whether the children and families are related to the FFN or not:

> The joy I feel in caring for my grandchildren is the same joy I feel when I care for any child and I hope they enjoyed their time with me too. (Julia, African American FFN, Interview Two, 9/28/2020)

> We become family, the children and the parents. I don't charge people for keeping their kids. I just want to help. I know how it feels to need help. (Sophia, Latina FFN, Interview Two, 9/21/2020)

> I never take money for caring for children, but you would think I did from my joy for doing it. It makes me feel good to help people. (Helene, African American FFN, Interview Two, 9/23/2020)

These responses offer a deeper understanding of the FFN providers' motivation to provide care. Julia and Helene used the word "joy" to express what they received from providing care to children. This feeling of joy was not an outside experience, but rather one that comes from within. As each individual FFN provider shared their responses, they displayed signs of emotions with smiles, laughter, and tears. Sophia used the word "proud," but stated there was another word in Spanish that really captured what she meant. As she continued to describe her meaning, she used the word "love" and made the physical motion with her hands of something coming from the heart. Sophia became tearful as she talked about parents sharing positive reports about the children who had been in her care regarding "good" report cards or positive teacher

reports. These deeply felt emotions shared by the FFN providers were understandable when viewed through the lens of "caregiver-grandmother." The idea or role of a "grandmother" as being the source of unconditional love sans judgment or helping with no expectation of something in return other than easing a burden or putting a smile on another's face is what many people have known or understood to be what "grandmothers" represent. The understanding of the FFN provider as a "caregiver-grandmother" helps to better understand the "ingredients" of FFN care, or why FFN care might include activities such as taking a child to the pediatrician or picking up medicine from the pharmacy for the child (Mendez, 2020).

Understanding the lens that FFN providers are using as caregivers demonstrates the distinctive difference in care between them and formal care providers. In formal care, the providers mostly perceive themselves as teachers or Early Care and Education professionals, whereas FFN providers perceive themselves as "caregiver-grandmother." These differences directly impact how care is delivered. For example, someone who perceives oneself as a "teacher" or "early childhood professional" would probably not consider picking up medicine for one student or child in the room as part of their responsibility, nor might someone retired consider pursuing a certificate or degree in early childhood to achieve career goals. Although in a few studies FFN providers expressed interest in attaining certificates and degrees, these participants were younger FFN providers who were not the majority. The majority of FFN providers are grandmothers who are over 60 years old (Shivers et al., 2016). These very different perspectives on caregiving provide an argument for FFN care to be identified as its own childcare modality and not measured against formal childcare indicators where it will always be viewed through a deficit lens.

The Locus of Caregiving

> *We talk together, she tells me how she feels and I love that.*
> (Julia, African American FFN, Interview Two, 9/28/2020)

Prior to identifying the "caregiver-grandmother" perspective held by these providers, their approach to care seemed peculiar. The FFN providers included in their caregiving responsibilities activities such as fulfilling errands for the parents and taking the child to different appointments (First 5, 2012; Thomas et al., 2017). Although the "caregiver-grandparent" lens provided an understanding of the inclusion of these personal caregiving opportunities to children and families, this new understanding triggered a curiosity about what these providers received for their caregiving. This curiosity was piqued even more when payment for caregiving services was considered. Another significant difference between informal care (or FFN) care and formal care or Center-based care and Family Child Care (FCC) is remuneration. In formal childcare, the providers are paid to deliver caregiving services to the child, but in FFN care, most do not charge. In FFN care, spaces where remuneration is not requested apply to familial as well as non-familial families:

> I just really have fun with him! It gives me a reason to sing the silly songs, play, walk in the woods and take the time to be in nature which I love but there always seems to be a grown-up thing to do instead...(laughing) (Gayle, White FFN, Interview Two, 9/23/2020)

> It makes me feel really good. I hope that I am offering them something that will enhance their lives as they have enhanced mine. (Helene, African American FFN, Interview Two, 9/23/2020)

> I get joy from taking care of my grandchild. As I watch her grow up and do things, I know that I contributed to who she is and I get pleasure from that. We talk together, she tells me how she feels and I love that. I create this special relationship with all the kids I care for. (Julia, African American FFN, Interview Two, 9/28/2020)

> I get excited when they start doing things they weren't doing before…(laughing) I know that sounds crazy, but I do. I never get tired of seeing the first time I come in to get them from a nap and see them standing up in the crib! It always brings me to tears. Just talking about it makes me tear. (Sofia, Latina FFN, Interview Two, 9/21/2020)

> It's emotionally satisfying. I'm grateful for the gifts they each give me. It also keeps me from becoming an old lady...(laughing) (Victoria, White FFN, Interview Two, 9/29/2020)

These responses reflected those found in the literature: "Caregivers frequently said that they do not see childcare as a source of income, and they do not expect money for providing care.... Kind gestures or small favors from families and feelings of love sufficed as payment" (Thomas et al., 2017). Engaging the children in "singing the silly songs" and taking the time to have conversations that are meaningful to the child were mutually satisfying to these providers. For these caregivers, experiences that nurture the child and the relationship might be considered more valuable than money (Thomas et al., 2017).

Reassurance in Caregiving

> *They need to know when they cry you will pick them up. I'm going to find out why you are crying.* (Helene, African American FFN, Interview Two, 9/23/2020)

The caregiver-child relationship has been found, in recent studies, to be a significant aspect of FFN care (Susman-Stillman & Banghart, 2011). In one study, secure attachment characteristics were found in 80% of the children in FFN care (Siddiqui et al., 2017; Susman-Stillman & Banghart, 2011). Another study found verbal engagements between the FFN provider and child to occur in over 70% of the observation period (Susman-Stillman & Banghart, 2011). Studies are beginning to capture and report the value-added benefits of FFN care as researchers become more knowledgeable about this informal childcare modality and as assessment tools are designed specifically to be used to assess this care. In older studies, FFN care was ridiculed for its dismal performance on measures in these same areas (Alexandre et al., 2013). However, more positive findings are being reported from more diverse and creative assessment approaches (First 5, 2012; Susman-Stillman & Banghart, 2011). These newer findings are providing a more

authentic perspective of FFN care instead of measuring informal care using a formal care tool or a tool that has indicators based on formal care (Shivers, Farago et al., 2016; Susman-Stillman & Banghart, 2011).

These newer findings are causing a different perspective of FFN care to emerge (Shivers, Farago et al., 2016; Thomas et al., 2017). These findings are also building connections to broader Early Childhood research findings. One such example is the recognition of a positive caregiver-child relationship. This recognition comes not because of anything that has changed in FFN care, but as a result of assessments considered to be "goodness of fit" for FFN care and the implementation of diverse research methodologies. This new recognition in the caregiver-child relationship influences and impacts brain development. The National Scientific Council on the Center the Developing Child at Harvard University (2015) coined the term "serve and return" to identify the back-and-forth in adult-child interactions which stimulates and supports brain development in young children, who are the largest number of children in FFN care:

> One of the most essential experiences in shaping the architecture of the developing brain is "serve and return" interaction between children and significant adults in their lives. Young children naturally reach out for interaction. This back-and-forth process is fundamental to the wiring of the brain, especially in the earliest years.

As mentioned earlier, previous studies on FFN care found this care to be of minimal quality, but most of studies used tools that were designed for formal care settings (Alexandre et al., 2013; Susman-Stillman & Banghart, 2011). Not to infer that "serve and return" is only related to talking, but Julia provided a clear example of how "serve and return" is working in some FFN care settings and the response it receives: "We talk together, she tells me how she feels and I love that." The FFN providers are not only participants in these "serve and return" connections, but they enjoy them along with the child.

Guidance and Respect in Caregiving

I didn't correct the children that weren't related to me too much.
(Helene, African American FFN, Interview One, 9/16/2020)

One place where FFN care was differentiated regarding children who were related and those not related was in the area of discipline or guidance. The FFN providers were respectfully discerning:

> My friend's son didn't need caregiving so much as support and guidance as he was 2 years old. I did discipline him differently than my own. For example, you don't know how people discipline their children, but you know how you expect your kids to discipline your grandkids. Although...now that I've said that out loud, it might not be a given...(laughing). Well, too late now...(laughing)...but in the case of a child not related to me, if I felt the child did something rude such as throwing something, I would tell them that I didn't want them to do that because someone could get hurt. If that had been my grandchild, I would have said something like, "You know we don't do things like that." So, I was very careful not to say anything that I thought might sound judgmental because I didn't want the child to feel put down because at his house they throw things... (laughing) (Gayle, White FFN, Interview One, 9/16/2020)

> I did not correct the child too much who wasn't related to me. I would explain that their mother/father/grandmother wouldn't want them to behave in that way. I didn't want them [child] to feel badly, if certain things we didn't do at my house was done at their house. (Helene, African American FFN, Interview One, 9/16/2020)

Issues around self-regulation and positive guidance are sensitive and challenging in most early care settings. In a survey of childcare directors, challenging behaviors in children was the major concern in these programs (National Scientific Council for the Developing Child, 2018). This topic also tends to be a highly requested one at most early care and education professional development opportunities. It is not surprising to find differences in this area of caregiving in FFN care settings. However, each FFN provider expressed sensitivity to different families having different approaches to parenting, and these differences were recognized as differences and not deficits.

Terms of Endearment in Caregiving

Sometimes when I have children who aren't related to me with my grandkids, the kids not related to me will begin to call me grandma.

Another dimension of the "caregiver-grandmother" lens is in the use of terms of endearment in some of the FFN care settings. Endearment terms are reflective of cultural practices among African Americans, Latinx, East and West Indian, and African populations (Wheeler, 2018). When these terms are used with non-familial persons within the same race and culture, they confer respect. This designation recognizes this person as being family or like a family member. FFN care is typically identified in much of the literature as "part of the child's family or at least considered extended family members" (Bruner & Chase, 2012, p. 4).

Among the African American and Latina FFN providers, in this study, labels of "Auntie" or "Tia" were used by the children. However, these labels, although familiar in terminology, do not overshadow or subvert the role of family members who are the familial aunt. Helene shared an example of how this endearment term is introduced and used in the FFN setting:

> Sometimes when I have children who aren't related to me with my grandkids, the kids not related to me will begin to call me grandma from hearing my grandkids, but I stop them. I tell them first that I love them. Then I tell them they have their own grandmas, and I don't think they would be happy with them calling someone else by their name. I also tell them they can call me Auntie if they want, which they usually do. (Helene, African American FFN, Interview Two, 9/23/2020)

In this example, Helene gently corrected the child, but gave him another name to use in addressing or referring to her, which was not her first name. To this FFN provider as well as the others below, a child calling them by their first name would have been considered disrespectful. However, in this intimate setting, names such as "Auntie" and "Tia" are more reflective of the emotional and social environment than the child calling the provider "Mrs. Smith." The use of

these terms in lieu of formal names was mentioned by the African American and Latina FFN providers:

> I've been caring for children over 25 years. Not all have been family, but most have been. However, even those not family become like family. They call me Auntie. (Helene, African American FFN, Interview Two, 9/23/2020)

> I also care for my great niece and sometimes my granddaughter will get confused and call me "Auntie" too. When she does that, I look at her and say, "Oh, I'm your Auntie now?" Now, that she's 3 years old, she'll say something cute like, "I know who you are, Dora [reference to Dora the Explorer]!" She was cracking up laughing. That little girl is something else...(laughing) (Julia, African American FFN, Interview Two, 9/28/20202)

> The boy next door is 10 years old now, but I kept him after school for years. He calls me Auntie or Tia. (Sophia, Latina FFN, Interview Two, 9/28/2020)

Although endearment terms are used in some of these intimately familiar caregiving settings, there are rules or boundaries about their use; Helene's response is one example: "I stop them. I tell them first that I love them. Then I tell them they have their own grandmas, and I don't think they would be happy with them calling someone else by their name." The FFN providers are clear in their role of "caregiver-grandmother" and maintain clear delineation that this role is not synonymous with "mother" for the child. This clarity was shared by Sophia: "I am more careful with my grandson's safety than I was with my children because he isn't my child. I love him and I'm his grandmother, but he is not my child." This was also expressed by Gayle, who shared no knowledge of or experience with these terms of endearment:

> I had to supervise one grandchild because his mom had a drug problem, but they lived here with his mom and little brother at my house. She was the mom and I referred to her as their mom. So, the children were clear that I was grandma. It was important to me that my daughter felt that I respected her as the primary caregiver of her children. (Gayle, White FFN, Interview One, 9/16/2020)

These terms of endearment might seem confusing for someone on the outside of these arrangements, but the function and understanding of these arrangements from the inside or among those who use them are quite clear.

Racial and Cultural Influences

The use of endearment terms was one area where racial and cultural differences were noticed. Although all the FFN providers shared a collective perspective as "caregiver-grandmother," which resulted in similar approaches to caregiving across providers, the absence of the use in endearment terms, or the reference to a type of extended family by Gayle (the one White FFN provider who cared for a non-related child) was interesting:

> I wasn't so much taking care of the child as I was home and there was a friend who needed support. I didn't charge her. It was actually perfect because her son and my youngest were the same age, so they kept each other company. They are still friends today. (Gayle, White FFN, Interview One, 9/16/2020)

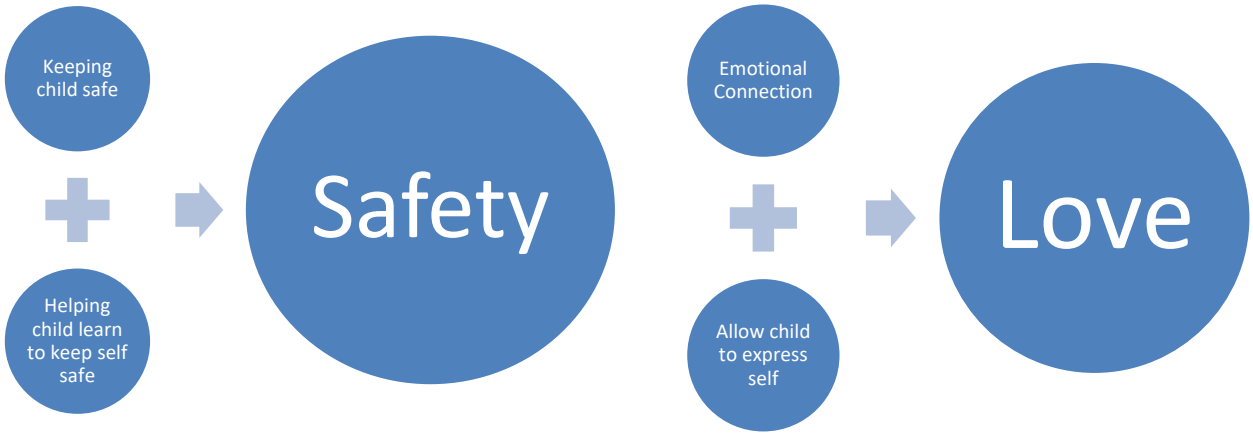
In her response, Gayle referred to the parent of the child in care as a friend, not by any endearment term, which may or may not have been for the purpose of the research context. However, this inquiry will have to be considered in another study as there was only one White FFN provider who offered care for a child not related to her in this study.

Another area that reflected racial differences in the FFN providers concerned areas of critical importance in the care of young children. These "areas of critical importance" were identified by the FFN providers. The FFN providers were asked to share, based on their belief and understanding, three critically important areas of caregiving for young children. Interestingly, two of the three areas that were offered were the same across the providers—safety and love. This was not surprising since this had been a pattern in most of their responses, which was attributed to their shared lens as "caregiver-grandmother." In the initial data extrapolation using only the words "safety" and "love," this was thought to be another example of the "caregiver-grandmother" lens, but when the definitions were reorganized by race, they revealed a different story—a story as old as time, but certainly not a fairy tale.

These responses are captured in the graphics below. In the first set of graphics are the definitions for safety and love offered by Gayle and Victoria, who were the two White FFN providers, while the second set of graphics presents the definitions shared by Helene (African American FFN), Julia (African American FFN), and Sophia (Latina FFN).

Figure 2

White FFN Providers' Definitions of Safety and Love

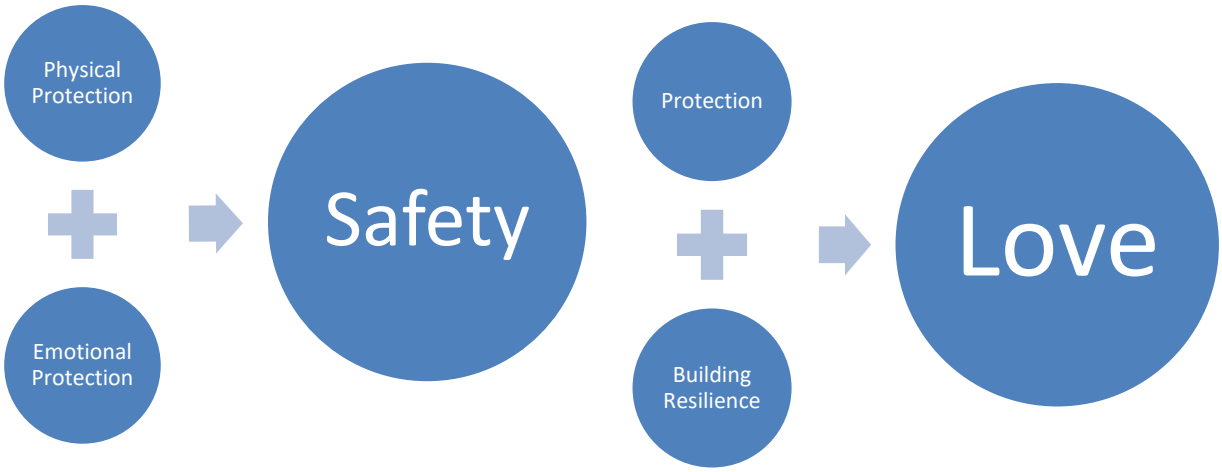


> **Safety.** To make sure he doesn't hurt himself. Every once in a while, I get panicked about something happening to him. I am more conscientious about his safety than I was about my own children. I also think safety is part of teaching him to keep himself safe but maybe that's love too...(laugh)
> **Love.** To make sure he knows that I want the best for him. That he feels warmth from me. (Gayle, White FFN, Interview Two, 9/23/2020)

> **Safety.** Being present with the children. When my kids were growing up, I was so unfocused. Now I know better. Be in the moment with them and encourage them to be present with you.
> **Love.** Making mistakes is allowed. Wherever you are and whatever you are doing know it is all perfect. (Victoria, White FFN, Interview Two, 9/29/2020)

Figure 3

African American and Latina FFN Providers' Definitions of Safety and Love



Safety. They need to know when they cry you will pick them up and find out why they are crying.
Love. Nurture them. We have to tell our children when they are young how smart and beautiful they are because no one else will tell them the good things about themselves. I feel this is part of my job. (Helene, African American FFN, Interview Two, 9/23/2020)

Safety. I make sure the plugs are covered. I make sure there is nothing they can get into. I have child locks on the cabinet. I have safety knobs on my stove.
Love. I do their hair if it needs doing. I cut their nails and toenails. I want them to know how they should look every day. I tell my kids to always look their best when they come outside. (Julia, African American FFN, Interview Two, 9/9/28/2020)

Safety. It is my responsibility to keep the children safe until their parents return for them in the evening. If something happened to them, I would feel responsible. So, I am very careful.
Love. If they fall and cry, I pick them up and soothe them. I tell them I care about them. I think it is important for children to know they cared for. Sometimes parents are too busy to remember to tell their children that they are loved and cared for but we have to do it, so they hear it often. (Sophia. Latina FFN. Interview Two, 9/28/2020)

Gayle and Victoria defined safety as keeping the children safe and helping the children learn how to keep themselves safe. They also defined love as an emotional connection and allowing the children to express themselves. Helene, Julia, and Sophia defined safety as physical protection and emotional protection. Helene, Julia, and Sophia defined love as protection and building resilience.

Hiding in the Weeds of Caregiving

Keeping child safe & Helping child learn to keep themselves safe
vs.
Physical & Emotional Protection

In Gayle's and Victoria's definitions of safety, there was no mention or reflection of the need for protection. Their references to safety were more around bumps, bruises, and burns or the health and safety practices early childhood students are taught regarding safety (Gayle and Victoria are both early childhood professionals). Safety is a continuum in this regard in that it goes from keeping the children safe to helping the children keep themselves safe. In her response, Victoria spoke to being focused and being in the moment with the child, which would be required to intentionally achieve the outcome of supporting the children in keeping themselves safe.

Julia's idea of safety very much reflected her training as a home-based childcare provider. Her idea around safety centered around concrete or physical examples, e.g., electrical outlet plugs, child safety locks, and so on—what she does to keep the children safe in her environment. Helene's reference to safety came from an emotional perspective in that the children can depend on her to always help and support them when they are hurt or distressed; Sophia spoke to physical protection or making sure the children do not hurt themselves while in her care. Julia, Helene, and Sophia saw safety from the perspective of what they do to keep

children safe in the environment, emotionally and physically. These three providers were the minoritized participants in this study. As Black and Brown women living, working, and negotiating racially biased systems as well as hearing and seeing the stories and experiences of family, friends, and neighbors who have had similar experiences, protection around and for Black and Brown babies in their care would most likely be considered crucial in the care of young children.

Also interesting from the perspective of protection was Gayle's statement: "Every once in a while, I get panicked about something happening to him." Gayle is the daughter of first-generation immigrants to America, who were challenged by language differences and social class biases. Her family was small as was their social circle until she and her sister started school. In Gayle's sharing, there were flashes of concern around physical protection that peeked through the confident veneer of the continuum of safety. It would be interesting to dig deeper with her to see if this was a "ghost in the nursery."

Thorns of Love in Caregiving

Emotional Connection + Allow child to express themselves
vs.
Protection & Building Resilience

Gayle and Victoria viewed love as emotional connection and allowing the children to express themselves. Gayle felt that love was ensuring the children know that she wants the best for them, while Victoria felt that love makes space for mistakes without judgment. These components or ingredients of love for Gayle and Victoria are supportive of a child's growing sense of self. How powerful is it to know and feel that those around a child and those who look like a child only want the very best for that child, and that the child's mistakes are considered part of the learning experience.

Helene, Julia, and Sophia viewed love as protection and building resilience. Julia viewed love as "presenting your best self to the world at all times," while Helene and Sophia viewed love as "telling the children they are loved, smart and beautiful." Helene stated, "...no one else will tell them the good things about themselves," while Sophia spoke to "I tell them [children] I care about them. I think it is important for children to know they are cared for." Although these responses centered around the child's developing sense of self, this effort was in resistance to a negative. Julia, Helene, and Sophia wanted the world to see the value and gifts in the Black and Brown children in their care as they did, but they knew from their own racialized experiences that these children will be perceived from a deficit lens. In their own way, each of these caregivers are providing Black and Brown children in their care an empathetic loving-kindness experience that they hope will result in a shield of protection for the children from harmful and hurtful acts of racism that these caregivers know are unavoidable. The differences in these early messages of love and safety to young children between Black, Brown, and White children are striking and appalling. For one group of children, love and safety are empowering and inviting, but for another group of children, love and safety are cautious and fearful. How inequitable is this scenario to Black and Brown FFN providers who care for Black and Brown children and their families?

Although the meaning of love is grounded in social and emotional development across all the FFN providers, the ingredients or components that have informed and influenced this meaning are quite different. In the case of Gayle and Victoria, innocence and the freedom of childhood to make mistakes without life-altering repercussions and desiring the best of everything for the children as opportunities are accessible and available. In the case of Helene,

Julia, and Sofia, the innocence and freedom of childhood shared by Gayle and Victoria are not always accessible in the same way for Black and Brown children.

The children for whom Helene, Julia, and Sofia provide caregiving must look their best when they go out because they will be judged as thugs and deemed irrelevant to society. FFN providers of Black and Brown children must tirelessly tell these children how smart and valuable they are to prepare them for the institutional and interpersonal repercussions of racism. These children could lose their lives over an innocent mistake, and simply wishing the best for them is not going far without tireless advocacy efforts, relentless intervention, and a network of support. The cultural transmission of resistance to racial oppression in all its forms is the love that Black and Brown FFN providers offer to Black and Brown children. This life-sustaining early learning experience is probably not something these children would receive in a typical formal childcare experience.

This aspect of the study might have been missed if the participants had not been racially diverse and the lens of race had not been utilized in the data extrapolation process. Without the use of a racial lens in FFN care research, broad assumptions might be made from limited and incomplete findings. In several of the more recent studies, the participants represented different races and cultures; however, the participants who were representative of minoritized populations seemed to be homogeneous within most studies (Porter & Vuong, 2008; Shivers et al., 2016; Thomas et al., 2017).

In response to the research question that framed this chapter, FFN providers understood their role as caregivers to be "caregiver-grandmothers," which influenced how they understood the caregiving of young children and delivered care. There was no separation in these identities across the racially and culturally diverse FFN providers in this study. However, when these

findings were viewed through the lens of race, what was initially thought to be a nuance of difference revealed the very real influence of racism hiding in the weeds.

In the next chapter, I continue to discuss this intimately familiar care and its comprehensive approach to caregiving. Specifically, the next finding expands on the lens of "caregiver-grandmother" and how it influenced the FFN providers' approach to care.

Chapter V

WHAT CAREGIVING EXPERIENCES DO FAMILY, FRIEND, AND NEIGHBOR PROVIDERS OFFER? DO THESE DIFFER BY RACE?

Vignette: Ms. Mavis, Tammy, and Desiree

Tammy knocks hard on the screen door. Ms. Mavis yells, "Coming." Tammy begins to grab and pull the door with urgency. She yells, "IT'S NOT OPENING! IT'S NOT OPENING!" Ms. Mavis comes to the door and, just as she unlocks it, Tammy snatches the door open; it flies out of her hand and slams against the house making a loud, crashing sound. Ms. Mavis looks at Tammy and says in a loud voice, "You couldn't wait until I came to the door?!" In response, Tammy raises her voice even louder, "WELL! YOU SAID COME IN!" Ms. Mavis takes a deep breath, opens her mouth, and hears Desiree in the house crying. Realizing for a moment that she had forgotten all about her, she turns and runs back into the house, leaving Tammy standing on the porch. Desiree has tears and snot running down her little 2-year-old face. Ms. Mavis reaches to pick her up as Desiree shakily reaches back. Ms. Mavis says, "What's wrong, baby?" as she simultaneously inspects Desiree and looks around the room. Seeing nothing out of place and Desiree appearing unharmed, Ms. Mavis assumes that she was scared by the loud voices. She grabs some tissues and sits down, putting Desiree on her lap. As she wipes Desiree's nose and eyes, she says, "Desiree, you're all right. It was just Ms. Mavis and mommy being silly." Desiree turns to look down the hall. A door closes somewhere in the house, and shortly after Tammy comes walking down the hallway, huffing and puffing as she adjusts her clothes. "Mommy, mommy!!" Desiree calls as she wriggles off Ms. Mavis's lap to run to her mother. Tammy responds, "Hey, Dezzi-girl. Mommy had to pee!" Ms. Mavis looks up at Tammy and says, "Is

that why you were trying to rip my door off its hinges?!" Tammy, standing in the doorway still huffing and puffing and straightening her clothing, responds, "Yes....I mean, no ma'am. I wasn't trying to break your door, but I really did have to pee. Anyway, you said, 'Come in,' but the door was stuck." Ms. Mavis looks incredulously at Tammy and pauses before saying, "I said 'Coming' because the door was locked!" "Oooohhhh....my bad," says Tammy, who laughs hysterically at the misunderstanding. Very quickly, Tammy's laughter turns into deep coughing and "squeaky toy" wheezing. She falls into the nearest chair with her hand on her chest, heaving, coughing, and wheezing. "Calm, Tammy, calm.... Where's your inhaler?" asks Ms. Mavis as she pushes herself up off the couch and walks towards Tammy. Tammy shakes her head no. Ms. Mavis watches Tammy as her inhales grow more and more shallow with each cough and asks, "Do you need an ambulance?" Tammy shakes her head no. As she walks to the kitchen, Ms. Mavis continues to repeat like a mantra, "Calm, Tammy, calm.... Calm, Tammy, calm." Ms. Mavis quickly returns with tissues and a glass of water. She hands these to Tammy. Tammy tries to sip the water between coughs, and slowly her coughs become less frequent and less deep. Ms. Mavis goes back to the kitchen as she continues to repeat, "Calm, Tammy, calm.... Calm, Tammy, calm." When she returns, Tammy is sitting with her head back on the chair, breathing as though she had run a marathon; her cough is shallower, and her wheezing is dropping in pitch. In a winded and hoarse voice, Tammy assures Desiree that she's okay. Ms. Mavis waits for Tammy to finish talking to Desiree and says, "I put on some coffee. I read black coffee is good for asthma attacks. Where's your inhaler?" "Ran out... (heaving breath) ...few days," responds Tammy. Ms. Mavis looks at her for a moment before asking, "Do you not have the money?" Tammy, still trying to catch her breath, says, "No, Ma.... (breathing with less gasping) ...I mean, yes…. (periodic coughs and wheezing) keep forgetting... (coughing a little more but

with less depth)." Ms. Mavis waits quietly until it appears that Tammy is breathing better before she says, "You know there's no shame in asking for help, right?" Tammy chuckles. "(coughing) You sound like my mother. (profusion of coughs...in almost a whisper) I sure miss that lady." Tammy wipes the tears that were already welling in her eyes from the asthma attack but are now flowing down her cheeks. Ms. Mavis walks back to the kitchen without responding. Desiree, who was watching television, looks at her mother crying and walks over to her. She pats her hand and says, "Don't cry, ma-ma. Don't cry." Tammy's tears turn into a full cry and with it returns the deep, deep coughing and wheezing. Ms. Mavis comes back with the coffee and hands the cup to Tammy. As Tammy sips the coffee through tears and coughs, Ms. Mavis says, "Tammy, you have a young child that needs you to be healthy and here. So, let's make a deal. Desiree and I will pick up your prescription." Tammy starts to open her mouth to protest, and Ms. Mavis puts up her hand to indicate stop and continues, "I know you are superwoman.... I see the cape... (laughing) ...and I know you don't need any help, but sometimes you have to let people help you, not for you but so they can get their blessing by helping. Will you allow me and Desiree to get our blessings from helping you?" Tears still falling, Tammy slowly nods her head yes.

The vignette above is reflective of a typical Family, Friend, and Neighbor (FFN) care experience where the caregiving experiences are inclusive of the family. Tammy cannot remember to collect her inhaler from the pharmacy: "Where is your inhaler?" asks Ms. Mavis. "It ran out...days ago. No time to pick it up," responds Tammy. Tammy's asthma attack and her subsequent emotional dissolve: "You sound like my mother... (pause) I sure miss her" is responded to with the same engagement that a child in care would have received in a similar scenario: "I'll put on some coffee. I read black coffee is good for asthma attacks," says Ms. Mavis. Then, in what seems to be typical fashion, at least by the FFN providers in this study, a

solution is offered to resolve the dilemma: “Let’s make a deal. Me and Desiree will pick up your prescription.” Notice that the FFN provider does not lecture Tammy about not taking care of herself. Instead, she offers a responsive care solution that will support the parent to better manage her critical health condition. This type of approach to care is a common “ingredient” in FFN care. The use of the term *ingredient* implies a deep and different meaning that is contextual to this study:

> I use the word “ingredients” here purposefully. Different from “component,” “ingredient” carries with it other layers of meaning that are important for this work. “Ingredient” conjures up the idea of cooking, an activity that is often correlated to female bodies and includes creatively bringing very different things together in order to create something new (a meal) that both contributes to life and is life sustaining. (Mendez, 2020)

The responsiveness that FFN providers bring to caregiving is not a one-dimensional element or component of caregiving, but rather a multidimensional “making” that comes as a result of being submerged and immerged in experiences of love, respect, disappointment, joy, cultural practices, as well as other life experiences. The result of this produces a roux of caregiving that has its own unique flavor.

Introduction

This chapter is organized by the study research question, “What caregiving experiences do Family, Friend, and Neighbor care provide? Do these differ by race and culture?” The finding aligned with this question is FFN providers offer a caregiving experience that is inclusive of the child and family. This inclusive caregiving experience does not differ by race or culture. Specifically, all five of the diverse FFN providers in this study not only supported the children to survive but also the family to thrive. As presented in the vignette, Ms. Mavis does not lecture Tammy about taking care of herself but reminds her that her being healthy and well is also

beneficial to Desiree: “You have a young child that needs you to be healthy and here.” FFN providers’ inclusive perspective of childcare makes them different from formal childcare providers who perceive the focus of care to be exclusively the child.

Building on the finding presented in the previous chapter, FFN providers perceived their caregiver self and their grandmother self as one perception of themselves as caregivers or as “caregiver-grandmothers.” Thus, coupling that with the finding presented in this chapter, FFN providers perceived the caregiving of children to be inclusive of the family, offering a clearer understanding of the “ingredients” of FFN care. For example, the previous chapter revealed that FFN providers perceived themselves to be “caregiver-grandmothers”; this chapter reveals that these “caregiver-grandmothers” perceive the child and the family as their focus of care, whereas formal childcare providers typically perceive themselves as teachers and consider the child as the focus of care. Realizing this difference in perspective provides a context to better understand FFN care, which was the impetus of this study. The difference between formal and informal childcare is not being highlighted to identify one as better or worse, but rather for the purpose of understanding FFN care from the lens of the providers of this care instead of the lens of formal childcare through which it is typically viewed (Powell, 2011).

More Hands Make Light Work in Family, Friend, and Neighbor Care

I try to give them an extra set of hands.
(Victoria, White FFN, Interview Two, 9/29/2020)

In different responses across the FFN providers, examples revealing the lens of “caregiver-grandmother” as well as the ensuing perspective of child and family are evident:

> Oliver’s dad sometimes comes and has lunch with us at least once a week. So, I prepare something for him to eat with us on those days. Oliver’s dad is a picky eater, so I really have to think what to make when he comes (laugh). (Gayle, White FFN, Interview 1, 9/16/2020)

> I've had parents tell me that they felt more love from me than from their own parents. I know they meant this a compliment, but I sure didn't think it was a compliment. It made me feel sad because I understood why some things were happening with the parent around their lack of showing affection to the child and the child's constant need for affection. (Helene, African American FFN, Interview 1, 9/16/2020)

Gayle's sharing revealed her perspective on the child and family as the focus of care in how she handled Oliver's father coming for lunch. She viewed this as a positive experience for them both and wanted them both to enjoy this time together: "Oliver's dad is a picky eater, so I really have to think what to make when he comes (laugh)." Gayle does not require payment for caring for Oliver, but her desire is not only for Oliver to be happy and content but his father as well when he comes for lunch. This experience also demonstrates a tremendous difference between FFN care (informal childcare) and formal childcare (Center-based and Family Child Care [FCC]). In formal childcare, the meals are prepared with only the child in mind, and parents who visit at lunch time are not always welcomed to share lunch; in programs where they can share lunch, nothing is made with the parent in mind. Helene noted that her caregiving has resulted in some of the parents sharing how they feel more love from her than from their own parents. Although some caregivers would find this complimentary, Helene expressed her discomfort in this sharing. Helene is concerned with the mom and baby connection, which was creating behavior issues in the child who desperately needed demonstrative signs of love from a mother who was not able to be responsive in this way. In these instances where neither FFN provider is being paid, both are presenting a responsive care experience for the child as well as the parent.

Another example that demonstrated the inclusivity in caregiving by the FFN providers was Julia's experience with a Latinx family. Julia felt the child's chronic issue of constipation was due to a lack of vegetables in the child's diet. In her response, she shared that she was not

aware that most Latinx families have a different understanding of vegetables and she had to help the mom understand what she meant by vegetables:

> I asked the mom one day when she was dropping the baby off, "Where are his vegetables?" She spoke English, so I knew she understood me. She [the mom] began to increase the starchy vegetables she was already sending. So, one day I asked her, "Do you eat green and orange vegetables?" Well...honey, she looked at me like I was speaking a different language.... (laughing). I knew then what I had to do because I've had to do it before with some of my young Black parents. The next week, I made some carrots and some spinach and some cabbage. When she came, I reminded her about our conversation about vegetables. I took her in the kitchen, and I explained that I felt the baby stayed constipated because he needed some vegetables in his diet. I made sure to tell her that what she brought was fine because I didn't want her to think I felt she was a bad mom or anything, but I wanted to try giving him some vegetables to see if that would eliminate the problem…literally…(laughing). That boy's stomach was as hard as my floor most times. I knew he was uncomfortable. He cried all the time. I made her a plate and invited her to sit down and eat. She did and she loved it.... (laugh). The baby crawled over to her while she was eating, and she fed him some too. So, she agreed. The next day when she brought the baby, she asked me how I made the vegetables because she wanted to share it with her family. I told her I would show her the next evening. So, the kids and I did a field trip the next day and walked down to the Farmer's Market to get the vegetables. When she came, I showed her how to clean the vegetables and prepare them. This time I told her to pack up what she cooked and take it home. She was so excited. I didn't have no more problems with that baby's bowels after that (laugh). (Julia, African American FFN, Interview 1, 9/21/2020)

This level of responsiveness is an "ingredient" shared by the FFN providers. In helping the child, Julia's suggestion to include vegetables in the child's diet resulted in her buying additional fresh vegetables and providing a cooking class for the child's mother. The FFN provider did not look for or expect remuneration for the vegetables she bought, which the mom was encouraged to take home and share with the rest of her family, nor for the additional time required to clean, prepare, and cook the vegetables. This entire effort by the FFN provider was done to bring relief to the child. To Julia and other FFN providers, picking up prescriptions and teaching a parent to clean, prepare, and cook vegetables are considered part of taking care of the child.

The No Judgment Zone in Childcare

I didn't want her to think I felt she was a bad mom or anything.
(Julia, African American FFN, Interview Two, 9/28/2020)

Another aspect in FFN care that was reoccurring across the providers was this presence of sensitivity within the inclusive nature of care. Specifically, the FFN providers were very sensitive to not appearing judgmental towards the parents. As Julia stated in her response above, "I made sure to tell her that what she brought was fine because I didn't want her to think I felt she was a bad mom or anything, but I wanted to try giving him some vegetables to see if that would eliminate the problem." In another example, Helene shared, "You have to be careful when you talk to parents about the child's anxiety or behavior because you just don't know how they will take it." Additionally, Gayle shared in one of her responses:

> I was very careful not to say anything that I thought might sound judgmental to a parent. I guess I learned this from my mother who lived next door to me while I was raising my children. Even though she knew more than I did about raising children, she never took over or overruled me or my husband. (White FFN, Interview Two, 9/23/2020)

These statements mirrored the importance for FFN providers to create respectful and responsive relationships with the parents.

Engaging Families in Family, Friend, and Neighbor Care

I take care to know my parents because they become part of my family and I become part of their family. (Sophia, Latina FFN, Interview Two, 9/28/2020)

The intimacy in caregiving found in FFN care is better understood when viewed through the lens of "caregiver-grandmother" who would typically view the child as well as the family as part of their caregiving context. In the response noted above, Sophia reflects the importance in the parent and provider relationship as she "takes care to know my parents." She did not say she somehow gets to know them, or they need to get to know her, but she with focused intent engages "her" parents. Her statement "we become like family" implies a close relationship

between an FFN provider and the parents. In the literature, families in FFN care were found to go to the FFN providers for advice and support before going to outside sources. “Parents reported supportive relationships with their informal caregivers and informal caregivers reported supportive relationships with the parents and children for whom they provided care” (Johnson et al., 2015, p. 5).

In the literature, these intimate and personal acts of caregiving typically seen in FFN care are consistent across related and non-related families in care (Thomas et al., 2017). In earlier studies, the intimately familiar care provided to non-related families was either ignored because it was not considered a significant population or these non-related families were assumed to be in “family-like” relationships with the FFN provider (Powell, 2011; Susman-Stillman & Banghart, 2011). However, in more recent studies, we now know that up to 91% of FFN providers were caring for children with whom the providers had no previous relationship, but the intimately familiar caregiving typically seen in FFN care was still provided (NWLC, 2018; OPRE, 2015).

Caregiving for the Greater Good

Will you allow me and Desiree to get our blessings from helping you?
(Vignette: Ms. Mavis, Tammy, and Desiree)

Reflected in the vignette between Ms. Mavis and Tammy is an example of the level of trust and support that these relationships create over time. For example, Tammy has an asthma attack at Ms. Mavis’s house. Ms. Mavis asked Tammy about her inhaler and learned that Tammy had not picked up a refill: “Tammy, you have a young child that needs you to be healthy and here. Let’s make a deal. Desiree and I will pick up your prescription.” The relationship between the FFN provider and Tammy allowed her, the parent, to share challenges she is having without the fear of judgment. As this was a responsive relationship, the FFN provider was aware of the parent’s personality and presented a solution that might have been perceived by the parent as a

weakness and refused. Instead, the FFN provider knew how to position the offer for the parent to accept the support: “I know you are superwoman and don’t need any help, but sometimes you have to let people help you not for you, but for them. So they can get their blessing by helping. Will you allow Desiree and I to get our blessings from helping you?” In knowing how important it was to Tammy that she appear independent, Ms. Mavis presented “helping” from the perspective of herself and Tammy’s daughter, Desiree. In this scenario, the help had to be offered in a particular way to achieve the desired outcome of being accepted. Ms. Mavis knew what was important to Tammy and, without any need to be regarded as the “rescuer” in this situation, she was able to present the offer in a way that would not challenge Tammy’s resistance to receiving help.

In another example, Victoria shared a different and possibly one of the most difficult conversations to have with a parent in formal or informal care:

> I am noticing in one of my grandchildren some interesting behavior issues. I’ve brought this to my daughter’s attention, but she’s not really accepting that maybe something is happening with him. He has a lot of temper tantrums which should have subsided by now. When he was younger, his temper tantrums were over the top. So, I guess that now they are less intense, she feels that he’s getting better, but what she’s not seeing is that he shouldn’t be having them at this age. So, I spoke to his dad and he sees what I see and has tried to talk with her to no avail. So, we’ll have to wait for her come around. I would like for him to get some help before the school identifies it, but what can you do when a parent is not accepting but wait? (Victoria, White FFN, Interview 2, 9/29/2020)

Victoria was the FFN provider for her grandchildren. In this sharing, the mother of the child, who was also the daughter of Victoria, was not open to the possibility that her child’s behavior might be problematic in a different setting and may be symptomatic of something else happening developmentally with the child. To create a solution which is another “ingredient” often observed in FFN care, the FFN provider talked with her son-in-law who shared Victoria’s concern about his grandson’s behavior potentially being problematic in a setting with more

children. The son-in-law/husband also talked with his wife about his concerns regarding the child's behavior, but his concerns were also minimized by the mother. In this example, Victoria also had no personal desire to be the "rescuer" in this situation, but only wanted to alleviate or eliminate the difficulties that may arise for the family as a result of the grandchild's behavior when he attended public school.

As a parent who dealt with a similar scenario, Victoria knows how difficult this reality can be: "I thought watching her brother who came from the hospital at birth with Early Intervention would have made her more open but...(sigh)...maybe that is why she's not. I don't know." However, instead of pushing the issue, Victoria and her son-in-law have decided to stop talking about it as her daughter becomes very agitated. Instead, they have jointly decided to allow the process to unfold in its own time. If this scenario had occurred in formal childcare, this child might have been expelled or suspended for his challenging behavior, which would have forced the parent to confront this reality in a much less subtle manner.

Family, Friend, and Neighbor Care and Family Dynamics

> *You tell him, if I am going to keep this baby, I need to be able to communicate with her and she needs to be able to communicate with me.* (Julia, African American FFN, Interview Two, 9/28/2020)

Another example where a sensitive subject was addressed by the FFN provider was Julia's response to a situation. In this example, Julia became involved in a mother wanting her child to be taught American Sign Language, but the father was not in favor:

> I had a child that was hearing impaired. The therapist would come to my home and teach me how to use sign language to communicate with the child. The mother had not specifically discussed using sign language with father but had mentioned it to him as an option. She assumed from that discussion that he was on onboard. One day the child started to sign to the mother, who got so excited that she was able to communicate with the child. Knowing how she felt to be able to communicate with the child, she had the child sign to the father. The father lost it! He didn't want his child using sign language because he felt it would limit her. I don't know what he was thinking. The mother came

> in here the next day and I could tell she had been crying, so I asked her what was wrong and she told me. I couldn't believe it. So, I told the mom, "You tell him, if I am going to keep this baby, I need to be able to communicate with her and she needs to be able to communicate with me. Now unless he's going to stay home with her, he needs to rethink his decision." He came and talked to me about how he felt and we had a really good conversation.... (laughing) I have two sons that I raised by myself. I think I communicate with men better than I do women because they trained me good... (laugh) Anyway, he reluctantly agreed to have her continue with the sign language. (Julia, African American FFN, Interview 2, 9/28/2020)

Julia's story demonstrates how the FFN provider can be pulled into what would typically be considered "family" business. This speaks to the level of relationship that FFN providers and the families co-create. In this sharing, Julia was not angry with the father but rather confused that his concern about the child being limited by using sign language would actually result in the child only being able to communicate by reading lips and not engage in a conversation. Julia later shared that her conversation with the father resulted in him sharing a fear he had around sign language: "What if her hearing returns? She might not try to speak if she can communicate with sign language and then she will never speak." Julia shared:

> I have two sons and I knew there was something he wasn't saying. It just didn't make sense that he was concerned that she would be limited by using sign language. The more he talked, the more I could hear the emotion behind what he was saying. He was working hard trying to keep it out of his voice.... (laughing) I learned from my sons that when emotion comes into the conversation, you have to break eye contact, so I turned around and acted like I was wiping off my counters. I asked him about the child starting kindergarten in a few years where there will be many more children. How will she get her needs met if her hearing hasn't returned? He hadn't thought of that and that made him come around. (Julia, African American FFN, Interview 2, 9/28/2020)

Julia was able to have a conversation with the father in a way that created a non-judgmental space where he was comfortable revealing his fear of the child learning sign language. Julia, who has over 20-plus years of experience working with children who had special needs, was able to share her stories about children using sign language versus seeing other children who were not taught sign language. "If you could have seen that mom's face talking

about the baby responding to her in sign. It just filled up your heart. I guess it was like a parent hearing the child say its first word or make its first step." As with the other FFN providers, Julia's conversation with the father was not for her to be seen as the "rescuer" or to prove that she knew more, but to create more opportunity for the child and the family. As Sophia stated, "...they become part of my family and I become part of their family."

These two scenarios are examples of how these similar "ingredients" of respect, responsiveness, and non-judgment are used by these more mature "caregiver-grandmothers" to create and support inclusivity in FFN care. In the responses provided above, although one FFN provider was the actual grandmother (Victoria) and the other FFN provider (Julia) was not related, their efforts to engage and co-create with the parent as well as support a resolution were examples of the "ingredients" at work in these arrangements. The differences in how these "ingredients" present were reflective of the personalities of the FFN providers and the parents.

This intimately familiar care settings situate the child and family at the center of care. Previous vignettes (e.g., *Chantelle, Is that you, baby?*) as well as the vignette that opened this chapter gave examples of the FFN providers together with the child showing care for the parents: "Desiree and I will go pick up your prescription" and "Mykel, let's me and you get momma something to drink. Baby, what you want?"; they also illustrated the FFN provider and parent in partnership to take care of the child, such as in those instances where the FFN provider takes the child to the pediatrician or other location. One such example was Gayle's response:

> I accompany Oliver to a private preschool program located 30-35 minutes from my house. It was a really exclusive program that provided such an amazing program to young children. His parents really wanted him to have this experience, but they were working. This program was half-day and required the parent to stay with the child, so I took him. We were able to do this three days a week for two years. It was an awesome program and Oliver really enjoyed it. I also learned a lot with regard to their approach to child development and practiced those things with him. (White FFN, Interview One, 9/16/2020)

Notice how Gayle used the term “accompany” as she went with Oliver when she was the one driving him to the experience. She also shared: “I also learned a lot with regard to their approach to child development and practiced those things with him.” From Gayle’s perspective, she and Oliver enjoyed this experience together. She could have easily said, “I take Oliver to....” but that would not have reflected the true experience as Gayle perceived it.

Family, Friend, and Neighbor Care Experiences...Priceless

I know that I am contributing to who she is and get pleasure from that.
Julia, African American FFN, Two, 9/28/2020)

As the majority of these FFN providers did not receive monetary remuneration for their caregiving, I was curious about what they felt they received, if anything, from these experiences:

> I am so thankful that I have the opportunity to be with him. I also get satisfaction that I’m contributing to his life. (Gayle, White FFN, Interview Two, 9/23/2020)

> It makes me feel really good. I hope that I am offering them something that will enhance their lives. (Helene, African American FFN, Interview Two, 9/23/2020)

> I get joy from taking care of my grandchild. I know that I am contributing to who she is and get pleasure from that. (Julia, African American FFN, Interview Two, 9/28/2020)

> I feel proud of the children I have cared for, whether they are related or not. (Sophia, Latina FFN, Interview Two, 9/28/2020)

> I'm grateful for the gifts they give me. Their curiosity and intuitiveness ignite my own. (Victoria, White FFN, Interview Two, 9/29/2020)

All the FFN providers spoke to a deep emotional fulfillment that they received from providing care to children. This deep emotional fulfillment was present across these diverse providers. Gayle, Helene, and Julia shared their feelings of contributing to and enhancing the child’s life. Sophia shared that she feels a sense of pride, while Victoria specifically shared that the benefits she receives contribute to her own quality of life. The feelings expressed by the FFN providers, e.g., thankfulness, satisfaction, pleasure, gratefulness, were all benefits that cannot be

monetized. In these experiences, there were no "personal wins" from the perspective of the FFN provider but rather mutual gains as the parent achieved the outcome desired, the child received the experience the parent wanted for them, and the FFN provider was deeply satisfied that all involved were well and happy. These emotionally fulfilling experiences in lieu of payment and in exchange of care are highly irregular when viewing them through the lens of formal childcare where payment is required; however, when using the lens of "caregiver-grandmother," this consideration does not seem so irregular. This perspective was also seen in the literature: "Caregivers frequently said that they do not see childcare as a source of income, and they do not expect money for providing care. They related that kind gestures or small favors from the families—and feelings of love and "paying it forward"—sufficed as payment" (Thomas et al., 2017, p. 4).

In several of the Photo Novella experiences, reflections of love and emotional language were used by the FFN providers (see Figure 4).

Figure 4

Photo Novella: Reflection of Love and Emotional Language

Very nice. It looks like she's comfortable and the baby is comfortable. The baby's head is nicely supported. (Gayle, White FFN, Photo Novella, 9/30/2020)

> I like this picture. Mom is cuddling baby. It looks like she just put the baby to sleep. She has a pillow to support her arm, so she's comfortable too. (Helene, African American FFN, Photo Novella, 9/30/2020)
>
> This is good. Her position holding the baby is good. Hope she is singing to him as she's holding him while he sleeps. (Sofia, Latina FFN, Photo Novella, 9/24/2020)
>
> Good idea for mom to hold baby to help them sleep. In some cultures, they hold the baby the entire time the baby is sleeping. I think we Americans are obsessed with being independent. (Victoria, White FFN, Photo Novella, 9/27/2020)

In the responses to this Photo Novella experience, Gayle and Helene commented on the comfort of the infant in this picture, but caregivers Sofia and Victoria used the word "good" to describe their thoughts: "This is good. Her position holding the baby is good." "Good idea for mom to hold baby to help them sleep." There was no mention of "spoiling" the baby or anything critical about this caregiver holding a sleeping baby or leaving toys on the floor. Their comments focused on the nurturing or comforting that was happening between caregiver and infant and the positioning or way the infant was being held to make this comfort possible.

Another Photo Novella experience involved looking at toilet training (see Figure 5).

Figure 5

Photo Novella: Toilet Training

> Oh…I think the baby is too young for that. I know this is a practice that some people use, but I don't think it's appropriate until the baby can sit up by himself, which I don't think they can by the way the caregiver is holding onto them. It takes only a few seconds for babies to drown. (Gayle, White FFN, Photo Novella, 9/30/2020)
>
> It's okay but I think the child is too small. Maybe with a potty?? (Sophia, Latina FFN, Photo Novella, 9/24/2020)
>
> Now that's something different. I've never heard of this, but I've never tried it so I can't pass judgment. (Julia, African American FFN, Photo Novella, 9/24/2020)
>
> This baby seems too young to be on a toilet even with mommy holding on. Doesn't seem safe. The baby also doesn't seem well supported, but I'm old school. Also, no support for his dangling feet. I'd rather see mommy use a potty, if she can't afford diapers. (Victoria, FFN, Photo Novella, 9/27/2020)

In this Photo Novella experience, the FFN providers questioned the safety of the child in this toileting experience. Areas of safety seemed to be where the FFN providers spoke out strongly, and this was also noticed across these diverse FFN providers. This area, safety, seemed to be where the providers made more forthright statements. For example, Gayle commented on the concern of safety, but also explained her reason for why this seemed an unsafe practice to her: "I think the baby is too young for that. I don't think it's appropriate until the baby can't sit up by himself…. It takes only a few seconds for babies to drown." Sofia did not want to criticize but was compelled to highlight the unsafe practice: "It's okay, but…" Julia stayed true to not being judgmental but referenced, "Now, that's something different." Victoria also shared what she perceived as unsafe toileting practice but placed her opinion on the fact that she was "old school." She also mentioned the idea that this "too-soon" practice might be due to a financial need which would result in the parent/caregiver doing what they had to do to satisfy the need. Victoria as well as Gayle are both formally trained early childhood professionals and thus included in their comments factors that made this practice questionable from a developmental perspective: "Also, no support for his dangling feet." and "I don't think it's appropriate until the

baby can't sit up by himself." Although their responses were similar regarding the safety of this practice, there was no criticism of mother/caregiver for implementing this practice. All comments from the FFN providers spoke directly to the unsafe practice, with varying amounts of justification for why the practice was unsafe, e.g., child too young, child physically not ready to sit up independently and therefore not developmentally prepared for this milestone.

Compassionate Care in Family, Friend, and Neighbor Care

> *I don't know who to feel sorry for mom trying to do it all or baby needing attention.* (Sophia, Photo Novella, 9/24/2020)

Inclusivity in FFN care goes beyond most formal childcare efforts regarding family engagement or family involvement. FFN providers considered the well-being of families as pertinent to the well-being of the child. This was also seen across the diverse FFN providers in the study. In the inquiries regarding families, the FFN providers' responses were immediate. They did not pause or take a moment to think; their responses were "on the tips of their tongues." These responses were not shared from a perspective of criticism or gossip but rather from a space of concern and compassion:

> I see families needing support from a system of friends. They don't seem to have contemporaries who are the same age as them with children of the same or similar ages. It just seems like when my kids were growing up, my husband and I socialized more with friends who also had young children too. (Gayle, White FFN, Interview Two, 9/23/2020)

> Young families are so disconnected from each other. If you listen to them, you hear how one parent is running in one direction with one child to get them to this or that activity and the other parent is running in the opposite direction with the other kid. By the time they come together, everybody is tired and goes to their separate corner. We need to bring back family dinner so families can reconnect. (Helene, African American FFN, Interview Two, 9/23/2020)

> I wish I could just point a magic wand and say, "You get a nanny, and you get a nanny and you get a nanny".... (laughing) Everyone needs a nanny for the whole family.... (laughing) (Victoria, White FFN, Interview Two, 9/29/2020)

Gayle later shared:

> My husband and I try to be my daughter and son-in-law's social circle but it's not the same. I know this but I'm not sure she does. I'm not sure she knows how different it would be if she had a close friend around her and her husband's age who was married with a child or children the same age as Oliver who they could meet at the zoo or share an occasional dinner. (White FFN, Interview Two, 9/23/2020)

The concern around the need for peer support and the frenetic lifestyle of young families was a concern expressed by all the FFN providers. However, in typical FFN fashion, Gayle shared how she and her husband try to fill this void with her daughter and son-in-law because they need it, but she also understood how much more fulfilling it would be if this support and connection came from peers. Helene expressed the challenge in young families meeting numerous commitments which significantly reduced their time and energy for family activities. Victoria shared that she would like to provide nannies to all young families to reduce their stressors and allow them time to be together.

Concerns regarding challenges in juggling numerous commitments by young families was also shared in FFN providers' responses to another Photo Novella experience (see Figure 6).

Figure 6

Photo Novella: Juggling Activities

As the providers' responses indicate, the FFN providers used slightly different words to express their thoughts, but the message was the same across all five diverse caregivers. Figure 6 depicted a mom sitting at a table working on her laptop. Standing in the chair next to her is a young child, approximately 2-2.5 years old, attempting to put on adult-size eyeglasses. Various snacks are on the table in front of the child, but none seem to be of interest to the child. The mother's mouth is open as if she might be saying or singing something, but her eyes are on the laptop screen. This picture triggered the same deep concerns and compassion for the parent that the FFN providers expressed in their interviews around questions concerning the needs of young families:

> Oh boy...I guess there is a lot of this taking place now... (laughing) I think that little one needs some attention. I really don't like how they are standing in the chair and the adult is not even looking at her. There is also a lot of things in front of the toddler, but it doesn't seem to have her attention. (Gayle, White FFN, Photo Novella, 9/30/2020)

> Normal picture of families today. I don't know who to feel sorry for mom trying to do it all or baby needing attention who isn't feeling loved. (Sophia, Latina FFN, Photo Novella, 9/24/2020)

> This was me thirty years ago. (quick and audible exhale…brief chuckle…no smile) Always focused on both but somehow not focused on either. This is not good. It's also not safe for the child to be on the chair like that. Oh boy…when I think about all the potentially unsafe things I allowed my kids to do under the guise of "independence" because I was writing a grant or writing a paper for school. (staring at the picture… audible sigh…no facial expression) Now I look back and realize that all that juggling was just about crossing things off my "To Do" list. Being efficient. Super Mommy. No quality. (Victoria, White FFN, Photo Novella, 9/27/2020)

Gayle and Sophia spoke to the dichotomy of being absent while being present regarding parents working from home during the Coronavirus pandemic. Sophia expressed the compassion shared by the FFN providers regarding the needs of families: "I don't know who to feel sorry for: mom trying to do it all or baby needing attention." None of the FFN providers made judgmental

statements about the mom; instead, their comments came from a place of empathy around the mother's challenge, "to do it all."

"Ingredients" of Family, Friend, and Neighbor Care

The "ingredients" employed by FFN providers—caregiving inclusive of the family, respectful and responsive relationships between FFN and families, non-judgmental attitudes towards parents, among others—are reflective of the approach to care that makes FFN care unique. Receiving care from a "caregiver-grandmother" who envisions a broad perspective of childcare that is inclusive of the family must feel like having a fairy godmother, especially for Black and Brown families who navigate more daily stressors. Having one more nurturing space where one's race, class, culture, and gender are not issues to be despised but respected might be why FFN care is the preferred care for young children (NWLC, 2017). Having this trusting and loving space for a young child could easily be viewed as a gift, especially for minoritized children. Young families often find FFN care during one of their significant "growing pain" experiences, transforming from a couple to a family. As Helene stated in her experience in suddenly becoming a single parent, "Sometimes the help would come before I even realized that I needed it," which might be the safety net that young families, particularly Black and Brown families, need and FFN care offers.

The FFN providers in this study were mature and diverse women who collected a rich array of "lessons learned" as well as witnessed the lessons of others. These life experiences have influenced and informed their caregiving practices and beliefs into a rich roux of caregiving; namely, a caregiving style that has created "caregiver-grandmothers" who perceive caregiving as inclusive of children and families; a perspective so deeply and humanely held that it transcends

race. Although formal care has its own “ingredients,” merging these two entities does not make one childcare potluck; rather, it creates a complex potage that offers a broth to a bisque or a true continuum of responsive care.

Chapter VI

RESEARCH IMPLICATIONS AND CONCLUSIONS

Studies on Family, Friend, and Neighbor (FFN) care are few but slowly growing in number (Porter & Paulsell, 2011; Saltzman & Miller, 2020). In some of the earlier studies, tools designed for formal childcare settings, e.g., Center-based and Home-based, were used to measure FFN care, an informal, home-based program, but offered erroneous findings (Alexandre et al., 2013). In other studies, formal and informal home-based childcare programs, which are vastly different in program implementation, service delivery, program structure, and process systems, were used interchangeably, resulting erroneous findings in this small field of research (Bromer & Korfmacher, 2016; Porter et al., 2010). These inconsistent findings have contributed to conflicting information about FFN care, such as studies that reported FFN providers do not want information on child development or FFN providers want to be certified caregivers (Powell, 2011; Thomas et al., 2017). As older studies have negatively impacted the reputation of FFN care in the childcare milieu, newer studies have begun to identify the mismatch between FFN care and ill-fitting measurement tools used to measure quality (Porter et al., 2010; Powell, 2011; Susman-Stillman & Banghart, 2011).

These newer studies seemed to inspire other researchers to use more creative approaches in their studies to understand the differences between formal and informal home-based childcare programs (Porter et al., 2005; Shivers, Farago et al., 2016). As researchers began to better understand the differences between home-based childcare programs, these newer studies started to include FFN provider feedback through focus groups and the creation of assessment tools specifically for the informal home-based childcare population (Brown-Lyons et al., 2001; Susman-Stillman & Banghart, 2011). In the older FFN studies, there was little to no active

participation from FFN providers. Most of these older studies focused on the implementation of measurement tools that were designed for formal care but used in informal childcare settings to assess quality (Brown-Lyons et al., 2001; Susman-Stillman & Banghart, 2011).

The purpose of this study was to contribute to the existing FFN care literature. This group of informal providers tend to be more mature, browner, and more linguistically diverse caregivers than those recognized in the formal childcare milieu who are younger and White. This study did not attempt to speak for these responsive and respected caregivers because they are capable of telling their own stories, but these stories need to be shared in broader childcare circles to bring a more representational voice to the world of childcare. In an effort to create these spaces and opportunities for FFN providers, it became vitally important to understand this form of childcare from the perspective of those who provide it or from an insider's perspective.

This chapter discusses the major themes and implications from this study. A brief overview is provided to situate these themes and implications. Much like the data chapters which were organized around the study findings, this final chapter is organized around the themes revealed in the study. Implications for practice, research, and policy across themes are presented together. This chapter concludes with Researcher Reflections on the study.

Revisiting Questions and Findings

This inquiry was framed by two research questions: (1) *How do Family, Friend, and Neighbor providers understand their role as a caregiver? Do these differ by race?* and (2) *What caregiving experiences do Family, Friend, and Neighbor providers provide? Do these experiences differ by race?* The finding that aligned with the first research question indicated that all five FFN providers in the study (2 White, 2 African American, and 1 Latina) did not see their caregiver selves as being different from their grandmother selves. Hence, the term "caregiver-

grandmother" was created and used to reflect this duality. This finding also yielded a hidden reality when the lens of race was used to examine how the lens of "caregiver-grandmother" was utilized across providers.

The finding aligned with the second question identified that the caregiving experiences provided by the FFN providers were perceived as inclusive of the child and family and not solely focused on the child. The intimately familiar care provided by the FFN providers to the families they served looked different from one family to another family because the care was based on the individual strengths and needs of the family. This approach to care was shared by all five FFN providers in this study.

Implications and conclusions discussed in this chapter were based on the research questions and subsequent findings from this study. Table 2 is provided to offer a visual example of these connections between the research questions, subsequent findings, and major themes.

Table 2

Connections between Research Questions, Findings, and Major Themes

Research Question	Subsequent Finding	Major Themes
1. How do Family, Friend, and Neighbor providers understand their role as a caregiver? Does it differ by race?	FFN providers understand their role as a caregiver as "caregiver-grandmother." This understanding is the same across races represented in the study. Racial differences surfaced in the way "caregiver-grandmother" is implemented and in the interpretation of caregiving.	FFN providers perceive their role as caregivers differently than formal childcare providers; quality improvement efforts designed for this population should reflect this difference. FFN providers should have access to information that supports them in balancing their highly protective caregiving style.
2. What caregiving experiences do Family, Friend, and Neighbor providers provide? Do these experiences differ by race?	FFN care provides a caregiving experience that is inclusive of the family, not just the child. This is consistent across races represented in the study.	Quality improvement initiatives that focus only on the child sans culture might not serve or be of interest to the FFN providers.

Discussion of Themes

Theme #1

FFN providers perceive their role as caregivers differently than formal childcare providers; quality improvement efforts designed for this population should reflect this difference.

The first major finding of this study revealed how FFN providers perceived their role as caregivers: "caregiver-grandmothers." None of the five diverse providers felt being a "caregiver" was in any way different from their role as "grandmothers." They were each perplexed to consider this any differently:

> (Deep sigh) Such a combination of feelings. (pause) First and foremost, I feel that I am his grandmother.... (pause) However...mmmm...I feel a responsibility to teach him when he is with me. (Gayle, White FFN, Interview Two, 9/23/2020)

> (pause) I don't know. (pause) I don't see it as different. (Helene, African American FFN, Interview Two, 9/23/2020)

> (pause) I don't know, maybe I'm both all the time. I never thought about it. (Sofia, Latina FFN, Interview Two, 9/21/2020)

Gayle (White FFN), Helen (African American FFN), and Sofia (Latina FFN) reflected the responses given by all the FFN providers when asked about being a "caregiver" vs. a "grandmother" when providing childcare to their grandchildren. This finding revealed how the FFN providers saw themselves, but it also indicated a possible difference in their understanding and approach to care, compared to formal childcare providers. As most FFN providers give caregiving experiences that support positive self-esteem in the children and other important social-emotional aspects, formal childcare providers intentionally provide kindergarten readiness. Although some FFN providers might offer some kindergarten readiness experiences

based on something they read or heard about, these experiences are not always from a space of knowing exactly what skills and abilities kindergarten is expecting children to have upon entry.

The Case of Two Separate and Unequal Systems of Care

These differences in informal and formal childcare providers extend beyond the perception held by these providers and create inequitable situations that impact children and families. Specifically, providers who care for children in formal childcare settings are provided "professional development" opportunities that support them in creating rich early learning experiences which yield strong child development outcomes. This is not the case for most FFN providers who do not receive "professional development" because they are not considered by the childcare milieu as professional childcare providers. To clarify: This statement is being made from a value-added position or from the space of continuous quality improvement, not from the belief that FFN care lacks quality because the providers are not recipients of ongoing quality improvement opportunities.

The FFN providers in this study did not receive training as FFN providers. Any training they received came from their prior individual employment experiences or higher education pursuits:

> I was a preschool teacher, kindergarten teacher, and first grade teacher, so I have a desire to teach. (Gayle, White FFN, Interview Two, 9/23/2020)

> I really feel that I bring my professional knowledge to my grandparenting. (Victoria, White FFN, Interview Two, 9/29/2020)

> I was an infant/toddler teacher for many years when I came to this country. (Sophia, Latina FFN, Interview One, 9/21/2020)

> Oh yes, I had a lot of training when I started doing this. I worked for fifteen years at a state institution for children with special needs. I also was trained to be a Family Child Care provider, but every month they were adding another form you had to fill out. It started to feel like I was just filling out forms, not really engaging with the children, so I

> stopped taking their little payments. (Julia, African American FFN, Interview One, 9/21/2020)

This seemingly insignificant issue of who has access to quality improvement opportunities and who does not have access has created two different systems of childcare—one that is intentionally supported in its efforts to deliver significant child outcomes, and the other that is minimally or inconsistently or unresponsively given information that could lead to powerful child outcomes. This is not to insinuate that FFN care does not enhance the development of the child in care; this concern is about the continuous changes in science around early learning and the need for all children to be recipients of these informed practices in ways that are culturally and linguistically responsive. For example, having a "caregiver-grandmother" who received information on infant brain development in a responsive manner now has another option for considering a baby who sleeps all day. Instead of considering this baby to be "a good baby" because he or she is quiet, the provider might consider whether this child is being stimulated enough to engage. These are the qualitative differences that informed "caregiver-grandmothers" could have in their caregiving repertoire or "toolbox." The information mentioned is for the purpose of enhancing what the FFN providers already bring to the "caregiving table." These caregivers know the children and families very well. They tend to create significant connections with the families they serve, including those not related to them. Informing their intuitive caregiving practice with science-based information would allow these providers to help a child entering their kindergarten experience not only to be competent in self-help skills, the ability to communicate with adults to meet their needs, and experience in self-regulation, but also to develop age-appropriate emergent literacy/math/science skills.

Although several states are providing some quality improvement effort to their FFN care population, these initiatives do not seem to be designed based on the population of focus. An

example of an inequitable design or unequal dissemination was identified in the efforts made in Detroit:

> Some caregivers do foster children's cognitive and social-emotional development by promoting early literacy and math skills, taking children on learning-oriented outings, and facilitating child-to-child interactions. Others struggle to provide these early learning opportunities for two reasons. First, most informal caregivers reported that they are not trained in child development. Second, some caregivers report that they do not have access to child-centered materials or activities because they lack money or transportation. (Thomas et al., 2017, p. 5)

This quote demonstrates the unequal opportunities that are exacerbated by inequitable circumstances. These are the seemingly insignificant nuances that scream inequity. As research continues to show stronger connections between knowledgeable caregivers and quality outcomes for children, continuing to ignore these inequitable opportunities perpetuates two separate and unequal systems of care (IOM & NRC, 2015; Powell, 2008; Susman-Stillman, et al, 2011).

Race-based Differences

Although the lens of "caregiver-grandparent" was a perspective shared by the five diverse FFN participants in this study, the expansiveness of this lens differed by race. For the African American FFN providers and the Latina FFN provider, the lens of "caregiver-grandmother" extended to familial as well as non-familial children and families. This was evident through the terms of endearment used among the Black and Brown FFN providers with non-familial families. For example, in the African American and Latina FFN settings, the non-familial children as well as some of their parents referred to an FFN provider as "Auntie." The use of terms of endearment was not mentioned with the one White FFN provider who cared for a child not related to her. This extended family concept was prominent only among the African American and Latina FFN providers.

Racial differences were also detected in the level of protection identified by the African American and Latina FFN providers in their definition of safety and love, which they identified as critical aspects in the care of young children. These heightened protective urges in caregiving were only present among the African American and Latina FFN providers.

Theme #2

FFN providers, in particular Black and Brown providers, should have access to information that supports them in balancing their highly protective caregiving style with a promotive caregiving style.

The need to protect by Helene, Julia, and Sofia was so profound that it was also identified in their understanding of love, *protection + building resilience = love*. Although understandable, these heightened protective urges by Helene, Julia, and Sofia are concerning because they are grounded in a deficit perspective of safety and love. Consciously or unconsciously, this perspective could be contributing to the victimization of the very children they are trying to protect. Specifically, this overly protective care could reinforce in Black and Brown children the idea that they are powerless victims instead of empowered self-advocates. Providing minoritized FFN providers with support to shift from a perspective of protective urges (deficit-based) to one of protective factors (strength-based) may sound strange, given that FFN providers primarily care for young children. However, the impact of the Doll Experiment conducted by Kenneth and Mamie Clark (1948), which showed a preference by Black children for White dolls, still exists today among Black preschool children (Studivant & Alanis, 2020). This verifies the very real presence and influence of racism in preschool children.

It is no wonder that the African American and Latina FFN providers in this study felt a strong desire to protect the children in their care. However, these feelings were not simply based on current events; they resulted from Helene's, Julia's, and Sophia's intersectional experiences as Black and Latin women (Collins, 2019). These providers knew from an intimate space the racist and bigoted adversities that the children they care for will undoubtedly experience. Perceptible and not-so-perceptible examples of these providers' strategies around resilience were discerned in their responses:

> We have to tell our children when they are young how smart and beautiful they are because no one else will tell them the good things about themselves. (Helene, African American FFN, Interview One, 9/16/2020)

> I do their hair. I cut their fingernails and toenails. I tell my kids to always look their best when they come outside. (Julia, African American FFN, Interview Two, 9/28/2020)

> I think it's important for children to know that they are cared for. Sometimes parents are too busy to remember to tell their children that they love and care for them, but we have to do it so they hear it often. (Sofia, Latina FFN, Interview Two, 9/28/2020)

Helene's resilience targets the child's growing sense of self-esteem and self-worth by telling the children they are "smart and beautiful" because they will not hear positive messages about themselves from a racist society. Julia chooses a resilience strategy that pertains to how the children are perceived by "others," so they must "always"—not sometimes—but "always look their best when you come outside." Sophia's resilience strategy involves the people who are meaningful to the child—parents/families/FFN provider—often telling the child he or she is seen and is loved. These FFN providers have created their own strategies to build resilience in the children for whom they provide care. The idea of resilience was not mentioned by Gayle or Victoria (White FFN providers), but only by the Black and Brown FFN providers.

Theme #3

Quality improvement initiatives that focus only on the child sans culture might not serve or be of interest to the FFN providers.

The aspect of quality improvement being suggested is grounded in culturally responsive principles. Instead of training Black and Brown providers to be culturally responsive, which does not make the best use of their time, their trainings should be designed using a culturally responsive framework. For example, all quality improvement opportunities should include the FFN providers' input; curriculum/training materials should be appropriate for the group and visual representations should be relevant; and participants should be invited to bring their knowledge forward to merge with the new information presented. After all, these are mature women who bring a tremendous amount of experience upon which to build. In previous opportunities, the FFN providers felt training and technical assistance opportunities were designed for formal childcare providers, or those presenting the information did not understand FFN care and/or were not responsive to a more mature and diverse provider population (Powell, 2008). "Diversity within the world of FFN childcare suggests that 'one size fits all' approaches to promoting quality in FFN care may not be optimally responsive" (Powell, 2008, p. 22). Powell advocated for more diverse strategies in communication, training, and technical assistance offerings, as well as considerations for how support should be provided to this diverse group of providers.

Research Implications

The following information provides implications on practice, research, and policy across research themes. These implications are presented to stimulate thinking and action around investments in FFN care as well as efforts to create a more inclusive childcare system.

Implications for Practice

Implication #1

FFN providers who are Black and Brown provide caregiving from an extended family perspective. Quality improvement opportunities must be responsive to this broad and encompassing lens. Quality improvement approaches that do not recognize and accommodate this perspective, or quality improvement opportunities designed for caregivers with a narrow and exclusive lens, might not be well received by this population of caregivers.

Implication #2

The mature FFN provider is not interested in attaining a degree or certificate in child development. These mature providers are retired from work, and providing childcare is one way they can support young families. They also enjoy and have fun being with their grandchildren as well as other young children in their care. This is not considered a job for mature FFN providers, as might be considered the case for formal childcare providers. FFN providers are interested in helping the children in their care to be prepared for their formal learning experience because they want to see the children and their families be successful. However, quality improvement opportunities that lead to certifications or degrees might not be attractive opportunities for mature FFN providers.

Implication #3

The following strategies are presented as guidance to providing responsive quality improvement opportunities that minimize equity gaps in care as well as provide more responsive opportunities for mature and diverse FFN providers:

- Create interactive learning opportunities that allow the caregivers to bring their cultural context to the experience.

- Provide quality improvement experiences that invite the FFN providers to be co-creative partners.
- Use examples and visuals reflective of the FFN care experience.

Implication #4

Create opportunities for Black and Brown FFN providers to understand and then mitigate their protective urges using a protective factors approach. This shift in protection is not only important for these providers but vital to the Black and Brown children and their families in FFN care. FFN providers are perfectly positioned to do this work. According to the National Scientific Council on the Developing Child at Harvard University (2015):

> Resilience is the result of a combination of protective factors. Research has identified a common set of factors that predispose children to positive outcomes in the face of significant adversity. Individuals who demonstrate resilience in response to one form of adversity may not necessarily do so in response to another. Yet when these positive influences are operating effectively, they "stack the scale" with positive weight and optimize resilience across multiple contexts. These counterbalancing factors include:
>
> - facilitating supportive adult-child relationships;
> - building a sense of self-efficacy and perceived control;
> - providing opportunities to strengthen adaptive skills and self-regulatory capacities; and
> - mobilizing sources of faith, hope, and cultural traditions.

Facilitating supportive adult-child relationships is a super-power of FFN care (Thomas et al., 2017). Providing opportunities to strengthen adaptive skills and self-regulatory capacities has also been a characteristic found in FFN care (Thomas et al., 2017). Mobilizing sources of faith, hope, and cultural traditions is the foundation of FFN care (NWLC, 2018). However, "building self-efficacy and perceived control" are where minoritized FFN providers might need support and reassurance. FFN providers might require encouragement to shift their perspective of safety from keeping the child safe to helping the child build a sense of self-efficacy to keep themselves

safe. This paradigm shift might be challenging for FFN providers to embrace as the effort of protecting a child is often seen as an act of love.

It will be critical to the success of this paradigm shift that FFN providers understand that adapting their perspective of safety—from one where the children are powerless and totally reliant on something or someone outside of themselves to keep them safe, to one where a continuum of safety helps the children become empowered in their ability to be safe as they develop—is an empowering act of love. Equally important is the FFN providers' ability to see evidence that adapting their caregiving to include protective factors is resulting in the child developing resilience.

Implications for Research

Implication #1

More research should be conducted on FFN using the lens of race. Understanding differences in caregiving that has racial and cultural influences will help to better understand this care as well as the providers of this care. FFN providers support large numbers of diverse children who are mostly the grandchildren of the FFN providers. Continuing to leave this element out of the research serves to erase this population of caregivers and keep them from being fully seen in the literature. This is a detriment to the field of Early Care and Education.

Implication #2

Additional research should be conducted on mature vs. younger FFN providers. Mature caregivers might be more responsive to different approaches to learning than young FFN providers. Strategies for best practices in learning approaches for mature students would be beneficial to training and technical assistance providers in Early Care and Education who are more accustomed to working with a younger and less diverse population of caregivers.

Implication #3

In more recent studies on FFN care, researchers began to identify the racial representation of the participants in their study. Although these racial groups were reflected in these studies, there was no mention of cultural differences within these "homogenized" racial groups (First 5, 2012; Porter & Vuong, 2008; Shivers, Farago et al., 2016; Thomas et al., 2017). Analyzing data using a cultural lens in studies where the participants are representative of a particular group might be helpful in reducing confusion across studies. For example, in some studies, findings revealed that FFN providers are interested in receiving degrees, but in another study, the findings revealed the opposite or that FFN providers are not interested in attaining degrees. In the case of this study, it was clear that these mature and retired caregivers were not interested in starting another career. Analyzing data using specific data points such as race and age might clarify some of the confusion in these studies.

In another example, in a few studies, researchers mentioned using "culturally sensitive" practices with regard to study implementation, but these practices are rarely explained (First 5, 2012; Porter & Vuong, 2008; Shivers, et al., 2016). As FFN care is comprised of the most diverse childcare providers, ignoring these aspects in the data other than to mention them regarding participant representation overlooks an important aspect of this caregiving population.

Implications for Policy

Implication #1

Policies currently in place for early childhood education are mostly directed towards formal care settings. In an effort to bring FFN care to the childcare table, policies should be reviewed by a workgroup that is representational of all aspects of childcare. This group should be charged with examining current policies around Early Care and Education to see where these

narrowly viewed policies can be expanded to represent this new paradigm of childcare that is inclusive of FFN care.

FFN care must be considered part of the continuum of childcare. This implication is not being made for the purpose of conforming FFN care to mirror formal childcare practices, but to ensure that all caregivers working with young children have the same information and materials to provide a dynamic early learning experience that is culturally and linguistically appropriate. Moreover, these experiences will result in children from all settings of childcare arriving at their kindergarten experience ready to embrace this learning experience fully.

Implication #2

Creating shifts in funding to promote equitable systems that positively impact children and families should be part of the anti-racism work that childcare should do to correct the biased system that has contributed to the erasing of its older, browner, and linguistically diverse "cousin" who cares for the majority of Black and Brown babies in childcare.

Implication #3

Much of the research on protective factors has centered on middle school and high school-age children. However, the Doll Study demonstrated that Black children as young as preschool show preferred White dolls over dolls that had the same color skin as they did. They also attributed words that reflected "nice" and "good" to the White dolls and "bad" to the Black dolls. Although this study has been replicated in recent years to find small positive shifts, these shifts for the time span are not acceptable (Sturdivant & Alanis, 2020). Protective Factor research in younger children is needed when best practice strategies to mitigate the impact of racism in young children are explored.

Implication #4

Policies to enforce zero tolerance in biased practices towards young children of color, such as the suspension and expulsion of Black boys in preschool, should be expanded to include Black girls as well as other children who identify as BIPOC.

Implication #5

Teachers and childcare staff receive mandatory trainings every year as part of their licensing requirement, and anti-racist training should be part of these yearly mandatory expectations. As FFN providers are not part—or not yet part—of the larger childcare milieu and, therefore, would not access to this information, culturally responsive messages that specifically pertain to early childhood community should be on PSAs, the sides of milk containers, the backs of cereal boxes, on the floor paper when one's care is serviced, and other convenient locations.

Implication #6

The National Women's Law Center (NWLC, 2017) has identified a strategic imperative to support and strengthen FFN care that includes telling the story of FFN care by educating policymakers as well as the general public about FFN care, the families they serve, and their need for support through public and private dollars. It is the hope of this researcher that this study contributes to the storytelling of FFN care and that subsequent efforts using these data will address other imperatives listed.

Implication #7

Lastly, to further eliminate inequitable practices in childcare and not create dimensions of inequity within FFN care, providing quality improvement opportunities in Spanish as well as other languages specific to a given community must be provided, even if these early learning training opportunities are provided in an ELL format. As discussed earlier, the majority of FFN

providers are the grandmothers of the children in their care. In Spanish-speaking communities, Creole-speaking communities, and the like, these grandmothers might not be bilingual English speakers. However, the chances of these grandchildren arriving at their formal learning setting with less preparation would be great if we cannot provide these FFN providers with the same information. It will be important for the Child Care Resource and Referral (CCR&R) organizations (also known as 4C organizations) to be included in this effort as they know their communities. The CCR&Rs should be required to have training staff who represent the races, cultures, and languages spoken in their service communities. To offer anything less to FFN providers would only be continuing the inequities already present in the childcare system.

Conclusion

The purpose of this study was to understand FFN care from the perspective of those who provide this informal and intimately familiar care. The results of this study revealed that the FFN providers did not perceive their caregiver selves as being different from their grandmother selves. In this study, the term "caregiver-grandmother" was used to capture this duality in the role. The "caregiver-grandmother" perspective also influenced these providers to view both the child and the family as the focus of care, not just the child. This provided a lens to better understand this intimately familiar care provided by these caregivers, such as taking care of a child on a Saturday or Sunday to give respite to the mother or picking up medication for a child from the pharmacy. Indicative of their perception as "caregiver-grandmother," these mature caregivers perceived caregiving differently than formal child providers who view the child as the focus of care. These providers offered an aspect of care that lovingly supports the child and family to bloom, blossom, and flourish.

FFN care has been vilified in the literature as being of poor quality and, in some studies, even dangerous to children (Alexandre et al., 2013). Although these declarations have been based on findings gathered through erroneous evaluation tools, these reports have not deterred families from preferring FFN care for their youngest children, birth to 2 years old.

Researcher Reflections

This study has been a fantastic adventure. I have been challenged to lean into areas that were not comfortable, but I also found several interesting and curious opportunities to play with my data. I was shocked to discover so many similarities across the diverse FFN providers in this study, but I was disheartened to find lurking underneath these similarities evidence of racism. While finding the breadcrumbs of racism was disappointing, it was also expected. I believe my shock in uncovering the numerous areas where these diverse providers were similar was really a surprise over not finding numerous overt racial differences. The insidious nature of racism sometimes hides so surreptitiously in the undergrowth that when it audaciously presents itself, one cannot help but chide oneself for not being prepared for the inevitable. I was encouraged by my dissertation hearing committee to lean into areas of race, given the diverse population of FFN providers. Although initially hesitant because this angle was not reflected in the literature, I am so grateful that I trusted this guidance. As I close this study, I am excited to deepen this inquiry by exploring racism and ageism in Family, Friend, and Neighbor care.

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Appendix A

Interview Guide

Guiding Questions*: Family, Friend, and Neighbor - 1st Interview*

1. How did you get started taking care of young children?
2. How long have you been caring for young children? How many children and families have you provided care to? Are you still in contact with these families?
3. Have you cared for children you were not related to?
4. Was your approach to caregiving different for the child you were not related to? What were the differences?
5. Was your interactions different with families you were not related to? What were the differences?
6. How do you view yourself as a caregiver? As a grandmother watching her grandchild until the parents return or do you view yourself as the child's childcare provider during these times?
7. How do you define the way you care for young children?
8. Do you feel that the care you provide is important to the child's next learning experience?

Guiding Questions: *Family, Friend, and Neighbor - 2nd Interview*

1. How do you view yourself as a caregiver? Grandmother, childcare provider, sister, etc.?
2. What are 3 things you have found to be critical in the care of young children?
3. What is the hardest thing about caring for young children?
4. What are the differences in your caregiving practices when the child is an infant vs. when the child is a toddler?
5. Looking back over the children and families that came to you for childcare, what would you say young families need most at this time?
6. Have you ever cared for a child with Special Needs? Did you reach out for information to help you in caring for this child? Who did you reach out to?
7. What do you get out of caring for young children? Does this differ if the child and family are not related to you?

Appendix B

Guiding Questions for Photo Novella Experience

(Questions adapted from Caroline Wang (1999) SHOWeD format)

1. What do you see in this picture?

2. What do think is "happening" in the picture? Ex. What do think the people are doing? How do you think the people are feeling?

3. Can you relate the "happening" in this picture to your life?

4. Would this "happening" look different if you were in this picture? Please describe.