Family Processes in Kinship Care

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Abstract
Over thousands of years and across diverse cultures and contexts, extended families have provided care for children. When children cannot be cared for by their parents, care provided by other relatives and close nonrelatives, known as "kinship care," is increasingly recognized as the favored alternative for children in need of foster care. "Formal" arrangements involve the child welfare system; "informal" arrangements, without child welfare involvement, may still involve formal procedures, including legal custody and decision-making power. Informal kinship care is also referred to as "private kinship care," and formal kinship care is also referred to as "kinship foster care," when the state assumes custody of the child, and "voluntary kinship care," when the state does not assume custody (Geen, 2003b). Unless noted, this chapter uses the term "

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Over thousands of years and across diverse cultures and contexts, extended families have provided care for children. When children cannot be cared for by their parents, care provided by other relatives and close nonrelatives, known as "kinship care," is increasingly recognized as the favored alternative for children in need of foster care. "Formal" arrangements involve the child welfare system; "informal" arrangements, without child welfare involvement, may still involve formal procedures, including legal custody and decision-making power. Informal kinship care is also referred to as "private kinship care," and formal kinship care is also referred to as "kinship foster care," when the state assumes custody of the child, and "voluntary kinship care," when the state does not assume custody (Geen, 2003b). Unless noted, this chapter uses the term "kinship care" to refer to both formal and informal arrangements.

In 2009, 423,773 children were in formal foster care in the United States. Nearly 1 in 4 resided with relatives (U.S. Department of Health and Human Services [DHHS], 2010). Precise estimates of the number of children in informal foster care are difficult to obtain; however, recent data (U.S. Census Bureau, 2008) indicate that more than 2.3 million children reside with relatives other than their parents. Of this group, an estimated 69% live with a grandparent. The majority of grandparent caregivers are women. Caregiving grandparents, and kinship caregivers in general, are more likely to be African American, to be single, to live in poverty, and to have more people living in their homes than noncaregiving grandparents or nonkin caregivers (for review see Cuddeback, 2004; Fuller-Thomson & Minkler, 2007; Minkler & Fuller-Thomson, 2005).
CONTEXT OF KINSHIP CARE

A wide range of circumstances prompt kinship care arrangements, including military deployment; long-distance employment; parental physical, mental health, or substance use problems; parental death; lack of material resources; young parenthood; neglect, abuse, or abandonment of children; and parental incarceration (Beeman, Kim, & Bullerdick, 2000; Bunch, Eastman, & Moore, 2007; Gleeson et al., 2009). In the midst of such challenges, families often demonstrate profound commitments to each other and to the children in their care. For example, expressions of love, efforts to keep the children out of nonkin foster care, and instances of caring for children despite their own physical or financial hardships are common among kinship caregivers (Minkler & Roe, 1993; O'Brien, Massat, & Gleeson, 2001).

When compared to nonkin foster care, formal kinship care is associated with many positive gains for children. In addition to supporting familial, cultural, and community ties (Hegar, 1999), studies document more regular contact with birth parents (Berrick, Barth, & Needle, 1994), greater stability in placement (Koh, 2010), high rates of placement with siblings (Testa & Rollock, 1999), high rates feeling consistently loved (Wilson & Conroy, 1999), reduced risk of running away (Courtney & Zinn, 2009), and lower risk of developing depression and substance use disorders once in placement (Keller, Salazar, & Courtney, 2010).

Gains for kinship caregivers include rewards related to supporting the children’s well-being and watching them grow, experiencing joy and pride in relation to the children, feeling blessed by the children’s presence, helping their own adult children, keeping their families together, and fulfilling a sense of duty (Burton, 1992; Gleeson et al., 2009; Minkler & Roe, 1993; O’Brien et al., 2001; Ruiz, 2004). Gains for birth parents include more regular contact with their children in kinship care, as well as gratitude for the love, safety, and care their children receive and the caregiver’s role in keeping the child out of nonkin foster care (Gleeson & Seryak, 2010; Smith, Krisman, Strozier, & Marley, 2004). Further, multigenerational bonds are often associated with kinship care can strengthen families’ resilience in the midst of difficult life experiences (Bengtson, 2001).

INTERACTING, MULTIFACETED CHALLENGES

While kinship care can yield important gains for children, caregivers, birth parents, and families, it is not without its challenges, including complex relational processes, financial strains, physical and mental health problems, and cumbersome service systems. These challenges interact in dynamic ways, often exacerbating each other. This chapter offers an integrative, multisystemic framework to consider these complex, interacting challenges and to strengthen families’ inherent resilience (Walsh, 2006). While recognizing and building
upon families' bonds, strengths, and resources, this multisystemic framework provides a roadmap for understanding and addressing key challenges families face when engaged in kinship care. It can complement an array of family therapies employed in kinship care, including structural (Minuchin, Colapinto, & Minuchin, 2007), intergenerational, contextual (Brown-Standridge & Floyd, 2000), parent-child interaction (Timmer, Sedlar, & Urquiza, 2004), attachment-based (Strong, Bean, & Feinauer, 2016), and integrative approaches (for discussion see Ziminiski, 2007). Other family therapies that do not target, but nonetheless assist families engaged in kinship care may be augmented with the kinship care-specific information addressed in this chapter.

This framework can also complement family-oriented individual and group interventions in kinship care that address parenting, health issues, stress and coping, and navigating complex service systems (Kelley, Yorker, Whitley, & Sipe, 2001). Of particular note, caregiver support groups, often highly regarded by participants, have shown capacity to reduce depressive symptoms and to improve coping, social support, self- and child care, caregiver-parent relationships, and resource access (Burnette, 1998; Dressel & Barnhill, 1994; King et al., 2009; O'Brien et al., 2001). Multifamily groups also hold potential to effect positive systemic changes and to strengthen social support (Crambley & Little, 1997; Engstrom, 2008). This multisystemic framework begins with consideration of families' relational processes in kinship care and broadens to consider salient contextual factors that interact with families' kinship care experiences (e.g., permanency and legal concerns; poverty; physical and mental health problems; and obstacles to service engagement). It concludes with multisystemic practice principles to support thriving among families engaged in kinship care.

COMPLEX RELATIONAL PROCESSES

Defining Family Inclusively in the Context of Kinship Care

Although there have long been calls for systemic, family-centered approaches in kinship care (Bartram, 1996; McLean & Thomas, 1996), practice and scholarship in this area often focus on individuals, dyads, or subsystems of the family, typically the children and caregivers who coexist. A systemic perspective recognizes that the well-being of the children, caregivers, birth parents, and other family members is intricately interwoven and interdependent. A multisystemic perspective moves thinking beyond the individual or dyadic level to a recognition that there is a dynamic, mutually influencing interplay among all members of the family system and, simultaneously, between the family and the sociocultural contexts with which the members interact. This perspective enables us to move flexibly between close-up views of family interactions and wide-angle views of interactions between families and broader systems.

An inclusive, systemic approach to the family is required to adequately understand and address the ways in which individuals' and subsystems'
experiences reverberate in mutually influencing ways throughout the relational network. For example, a grandmother’s decision to become her grandchildren’s primary caregiver influences relational processes beyond the kin caregiving triad (i.e., grandmother, birth parents, and children), including those with her partner, adult children, other residential and nonresidential grandchildren, and extended family members. These relational adjustments, in turn, influence the family’s kinship care experiences. For example, a partner who is supportive of the kinship care arrangement may be counted on to contribute to a warm, mutually supportive tenor within the family, while one who does not support the arrangement may repeatedly express dissatisfaction, fueling stress and conflict for the couple and the family. An inclusive assessment of the family involves exploration of all family members’ perspectives about and adjustment to the kinship care arrangement, and their mutual influence. This important information might otherwise be overlooked in a narrow focus on individuals, dyads, or triads.

Additionally, attention to the broader family system can identify overlooked sources of support (Engstrom, 2008; Minuchin et al., 2007; Walsh, 2006). Families frequently develop and maintain caregiving patterns that rely on specific members, typically women, to assume primary caregiving responsibilities (McGoldrick, 2011). Particularly when caregiving arrangements are made in crisis situations, established patterns are often readily relied upon, with limited attention to alternative possibilities or additional sources of support. The potential role of a grandfather may be overlooked. Those who may have been less involved in childrearing in the past may now have the ability to be actively involved in caring for their grandchildren and helping their adult children. Efforts to support family well-being and kinship care stability require consideration of the ways in which families establish caregiving arrangements and how members can create a collaborative, team approach to caregiving. Although one person may assume primary caregiving responsibility, other members can offer valuable additional assistance. An aunt may regularly take the children to the park both to strengthen their relationship and to provide the caregiver respite. A grandfather may cook his specialty on Sundays, bringing the extended family together. A pastor may provide a supportive ear and spiritual encouragement for the caregiver; a parish youth group may be a valuable connection for teens. It is important to involve extended family and community members, including “non-blood” relatives and others who are considered “family” to “widen the circle of caring” within the family (American Humane Association [AHA], 2010, p. 25; see Boyd-Franklin & Karger, Chapter 12, this volume).

**Genograms to Facilitate an Inclusive Definition of Family**

Genograms facilitate exploration of family structural patterns, relationships, and sociocultural contexts to inform family assessment and intervention in rich and meaningful ways (McGoldrick, Gerson, & Petry, 2008). They are
particularly useful in gaining a broadly inclusive view of the family and identifying potential resources in a wide circle of caring. They can draw explicit attention to nonresidential family members with important roles; those who could be sources of support; and those who may be missed in conversations about the family, including fathers’ and partners’ families. Questions that inquire about who is considered part of the family, who attends significant events, and who is sought out in times of need may also assist with developing an inclusive understanding of the family (AHA, 2010). Exploring family interactions, communication, and supports across relational networks, as well as members’ satisfaction with current relational processes, can highlight key points of intervention to expand emotional and practical resources and to support the well-being of the entire family system.

Additionally, a genogram and timeline enable clinicians to explicitly address multigenerational caregiving and cumulative strains associated with multiple caregiving responsibilities. It is not uncommon for kinship caregivers to be caring for multiple generations of family members, as well as for neighbors or friends (Burton, 1992; Minkler & Roe, 1993). Extensive caregiving responsibilities, especially with limited resources, can fuel distress within the family (Hughes, Waite, LaPiere, & Luo, 2007), which makes it crucial to assess and improve the fit between caregiving demands and available resources.

**Interactions with Broader Systems**

Strengthening a family’s capacity to manage the complex challenges that often accompany kinship care requires consistent attention to the broader systems with which the family interacts. Of critical importance in culturally competent practice is consideration and flexible integration of the family’s multiple socio-cultural locations (Falcoz, 1995). Relatively, kinship care arrangements occur within or against the backdrop of the child welfare system, within which children of color are disproportionately represented. For example, children from African American and Alaska Native/American Indian backgrounds comprise approximately 14% and 0.9% of children in the United States (U.S. Census Bureau, 2005–2009), yet they represent 50% and 2% of children in formal foster care, respectively (DHHS, 2010). Explanations of this disproportionality include intersections between poverty, race, and gender that result in higher rates of maltreatment reports; racial bias in assessment and protective actions related to parenting and child behavior; and race-related differences in the quality and quantity of services that families involved in the child welfare system receive (Berger, McDaniel, & Paxson, 2005; Courtney et al., 1996). This disproportionality and contributing factors necessitate a therapeutic climate in which the role of racism in the problems families face and in the services they receive can be openly discussed and can be addressed by actions that improve their immediate situations and challenge racism across
broader systems (Engstrom, 2008; see McGoldrick & Ashton, Chapter 11, this volume).

Families engaged in kinship care are likely to be involved with multiple systems in addition to the child welfare system. These systems, including workplaces, schools, religious organizations, social networks, neighborhoods, community groups, physical and mental health services, public welfare agencies, and correctional settings, may be sources of support, comfort, frustration, and depletion. Routine inquiry regarding interactions with broader systems and ways they can be strengthened can facilitate empowerment, enhanced community connections, greater collaboration in solving problems, improved access to supportive resources, and reduced stress in the family system (Boyd-Franklin & Karger, Chapter 12, this volume; Engstrom, 2008).

**Routes to Kinship Care**

The ways in which kinship caregiving arrangements develop can affect families’ adaptation and coping. Some relatives may have been providing care since very early in the child’s life (O’Reilly & Morrison, 1993). In this context, the birth parents’ presence may have varied over time. Their intermittent involvement with the children and family system can present multifaceted challenges as families continually adjust to their presence and absence (Gibson, 2002; Russell & Malm, 2003). In other cases, birth parents may have had limited or no involvement with the children and family system over a long period of time. The family’s challenges may include strains associated with long-standing caregiving responsibilities, grief related to ambiguous parental loss, and hopes and frustrations regarding the parents’ ability to care for the children (Boss, 2006; O’Brien et al., 2001).

Some kinship caregivers assume their roles in response to sudden events, such as parental incarceration, death, substance misuse, illness, or neglect of a child. An abrupt, unanticipated call to action may prompt their caregiving (O’Brien et al., 2001). In these circumstances, families may have to adjust roles and responsibilities very quickly, with little time for emotional or practical preparation.

Other kinship caregivers may assume their roles based on their observations of family circumstances over time (Russell & Malm, 2003). While there may be complex issues regarding the situations observed, the initiation of care, and interactions with birth parents regarding the caregiving arrangements, time allows caregivers, birth parents, and others to prepare for role and residential shifts. Further, child and family adjustment may be facilitated by gradual increases in caregivers’ involvement. Finally, some kinship care arrangements emerge through “complex pathways,” in which children have lived in numerous previous settings (Gleeson et al., 2009, p. 308). These situations pose challenges related to multiple losses, attachment, and predictability.
Inquiry about pathways to kinship care and their associated challenges and achievements can facilitate contextual understanding of a family's kinship caregiving arrangement and potential points of intervention. For example, families who describe long-standing challenges with parents' intermittent presence due to military involvement, employment obligations, or health problems may benefit from discussion of ways in which the family can anticipate and shift organization to accommodate this pattern, clarify expectations and roles, and maximize their coping with this situation.

**Family Decision Making and Support**

Kinship care arrangements emerge from and are sustained through multiple decisions. These decisions are often based on assessments of parents' ability to care for their children, children's safety in their parents' home, qualities of alternative caregiving arrangements, capacities of kinship caregivers, and available supports within the family and community. While child welfare agencies frequently drive these decision-making processes as they seek to uphold children's safety, the recognition that children's well-being is best supported in the context of family connections and that involving families in decision making can facilitate family empowerment, fuels their growing use of family group decision making (FGDM). FGDM is based on family group conferences that emerged from New Zealand more than 20 years ago in response to disproportionate representation of indigenous children in out-of-home placement (Weigensberg, Barr, & Guo, 2009). Central aims of FGDM include correcting power imbalances between staff and families, supporting families' identification of needs and strategies to address them, honoring families' cultural and community connections, building on families' strengths, and enhancing outcomes for children and families (AHA, 2010; Rauktis, McCarthy, Krakhardt, & Cahalane, 2010).

These aims are achieved by partnering with families to make key decisions. Efforts are made to define family inclusively, to include all family members and important others in the decision-making process, to provide opportunity for facilitated and independent family meetings, and to pursue the family's chosen plan to the greatest extent possible (see AHA, 2010). Although research findings are not unanimous (Center for Social Services Research, 2004; Sundell & Vinnerljung, 2004), several studies have found FGDM to be associated with improved child welfare outcomes, including reduced child maltreatment and family violence; greater stability of placements; quicker exits from care; higher ratings by families on measures of empowerment and clarity of expectations; and improved engagement in parenting services, mental health treatment for parents, and counseling for children (Crampton & Jackson, 2007; Pennell & Burbard, 2000; Rauktis et al., 2010; Sheets et al., 2009; Weigensberg et al., 2009). With its recognition of the family as a resource and the power of collaborative decision making, FGDM is also likely to be helpful with families engaged in kinship care outside of the child welfare system.
Transitions

Transitional times are generally marked by uncertainty as families shift from one state of being to another. It is normal for families to experience stress as they adapt to changing circumstances and develop modified ways of interacting and coping to meet the demands of the new situation. Transitions occur in multiple ways, including those involving births, deaths, relationship commitments, separations, developmental changes, illness, and changes in daily routines (see McGoldrick & Shibusawa, Chapter 16, this volume). In the context of kinship care, it is important to consider major transitions, such as changes in caregiving arrangements, household membership, legal custody, and schools, as well as smaller-scale transitions, such as the family’s adjustment to parental visits and contacts.

Transitions associated with changes in caregiving arrangements and visits require caregivers and parents to share and shift responsibilities for the children’s care. Like a pilot and copilot flying a plane, caregivers and parents need to collaborate as they make these adjustments in pursuit of their shared mission to support the children’s well-being. Just as unplanned, abrupt transfer of control between the pilot and copilot may jolt the plane, so, too, can children and families be jolted. Collaborative planning, including clear communication about roles, boundaries, and expectations, can facilitate smoother processes as responsibilities and roles shift. Additional core strategies to enhance families’ adaptation involve the following:

- Identifying transitions, including the ways they may require evolving adaptation over time.
- Normalizing associated stresses.
- Taking steps to make changes less abrupt and disruptive.
- Facilitating adaptive interpretations of changes.
- Developing ways of coping with the new circumstances (Cowan, 1991; Minuchin et al., 2007).

Navigating Evolving Relationships

As the family’s organization, roles, and responsibilities shift, caregivers, birth parents, children, and extended family must navigate evolving relationships with each other. Family members may experience conflicted loyalties, strained relationships, and challenges with attachment (Engstrom, 2008; Poehlmann, Dallaire, Loper, & Shear, 2010). They may also experience problematic relational triangles across generations and subsystems (Minuchin et al., 2007). The intensity of these experiences is likely to be influenced by preexisting relationships and the circumstances prompting the kinship care arrangement. More specifically, preexisting collaborative family relationships, in which challenges are approached with teamwork and conflicts are resolved effectively, position families well for adapting to their evolving relationships, organization, and
roles. Alternatively, families experiencing long-standing relational strains, communication difficulties, unresolved conflict, and hostility are likely to be more vulnerable to the relational challenges associated with kinship care arrangements. Additionally, vulnerability to these challenges is likely to increase when stigmatized circumstances, such as substance use problems, incarceration, and child maltreatment, prompt the kinship care arrangement.

For example, a child residing with his maternal grandmother due to parental substance abuse may experience deep love for her; however, this affection may be complicated with feelings that the attachment makes him disloyal to his parents, discounts his relationship with them, and reflects negatively upon them as parents. Additionally, while the child maintains his love for his parents, he may at the same time feel hurt, confused, and frustrated by their difficulties. The grandmother in this situation may also experience conflicting loyalties as she balances her love for her daughter and son-in-law, her belief in the importance of the child’s relationships with them, her efforts to support their roles as parents, and her commitment to ensure her grandson’s well-being and safety by monitoring parental visits. The birth mother in this situation may simultaneously feel grateful for her mother’s assistance, critical of rules her mother sets for her son, and upset by monitored visits. The extended family members may also experience conflicting loyalties based on their love and concern for each member of the caregiving triad, their own involvement in the caregiving arrangement, and the challenge of supporting each family member’s well-being.

As noted earlier, the complex relational processes may fuel problematic relational triangles as the family members seek to manage uncomfortable feelings and reduce stress in the system. The child may join with his mother in critiquing his grandmother’s rules and visitation monitoring. The mother may experience this alliance with her son as an opportunity for connection with him and as an avenue to support her parenting role. This relational process could risk undermining consistent limits for the child, destabilizing the grandmother’s daily interactions with him, and fueling stress within the family. However, in a family whose approach to solving problems is to talk directly about them until a solution is achieved, the grandmother can readily initiate conversation with her daughter. They can collaborate about how they will support the child’s well-being, come to an agreement about appropriate rules and limits, and identify ways in which each of their vital roles can be supported as they care for the child.

Supporting the approach of systemically oriented clinicians, research documents the importance of close relationships between caregivers, birth parents, and children. In fact, in a study with 459 grandmothers raising grandchildren, triple bonding, meaning close relationships between the grandmother, birth parent, and child, was associated with the highest rates of well-being for the grandmother and child. As bonding decreased, so too did measures of well-being (Goodman, 2007). Similarly, research regarding parental incarceration suggests that strong parent-caregiver relationships are associated with
increased parent-child contact, which, in the majority of studies, is associated with diverse gains for parents who are incarcerated. Contact through letters has consistent benefits for children, while the effects of visits appear to vary by context for children. Most notably, visitation that is part of an intervention is more likely to yield benefits for children. Several factors may influence the effects of visits, including the prior relationship with the parent, the child-friendliness of the facility, and the preparation of the entire family for visits. Audio and video technologies, such as video conferencing and recordings of books or messages from parents, as well as pictures, cards, journals, scrapbooks, and phone calls, are also recommended ways to support contact and relationships during parental incarceration (Poehlmann et al., 2010).

Given the critical intersections between family relationships and well-being, it is important that clinicians explore and build upon the family’s bonds. Such exploration can be facilitated by inquiring about specific domains of relationships across generations, including affection, love, communication, involvement, supportiveness, conflict, and satisfaction (Goodman, 2007). Relationships may be enhanced with clinical interventions that

- Focus on the strengths of the family’s connections.
- Facilitate open communication.
- Clarify key expectations, including those related to daily routines, parenting, coparenting, and visits with birth parents.
- Improve conflict resolution processes.
- Identify and support stress management strategies, including respite.
- Foster collaboration across triangular connections.
- Enhance family members’ involvements with each other.
- Support opportunities for the family to have fun together (Engstrom, 2008; Houck & Loper, 2002; King et al., 2009; McKay, Gonzales, Quintana, Kim, & Abdul-Adil, 1999; Minuchin et al., 2007; Poehlmann et al., 2010).

Where relational disconnects and ambiguous loss persist, families can benefit from opportunities to label and grieve this experience, as well as from efforts that support living well in the midst of ambiguity (Boss, 2006).

**Changing Roles, Expectations, and Limits**

Changes in roles and expectations associated with kinship care can challenge families in many ways. Family members who assume a caregiving role may struggle to balance elements of their prior relationships with increased responsibility for the children’s well-being. Common challenges include integrating the children into the current household, supporting harmonious relationships between all children and others in the household, establishing family routines, clarifying expectations, coparenting with birth parents, responding to the daily rigors of childrearing, and setting limits (Gibson, 2002).
Depending upon the children's age, the caregiver's prior role, and the interactions with birth parents, effective limit setting may be among the greatest challenges the family experiences (Russell & Malm, 2003), and these difficulties can disrupt the stability of the placement (Goodman, 2007). Some caregivers may be reluctant to set limits as they assume their new roles or as they seek to diminish any additional upset or disappointment for the children. Other caregivers may struggle with inconsistent, overly protective, or harsh limit setting (De Robertis & Litrownik, 2004; Harden, Clyman, Kriebel, & Lyons, 2004), which can exacerbate problematic behaviors and contribute to a negative cycle within the family. Finally, some may manage limit setting with birth parents and children effectively, but may not enjoy how they are perceived. As described by one kinship caregiver, “You become the heavy” (O'Brien et al., 2001, p. 731).

Interactions around limit setting are likely to reflect complex feelings about the kinship care arrangement. Children may test limits with the hope that if their behavior is too problematic, they will be able to return to their parents (O’Brien et al., 2001). Some may test limits to understand the boundaries and expectations in the caregivers’ home and to confirm the predictability and security of the arrangement. Some children may chafe against limits in reaction to expectations that differ from those they have known. For example, a young adolescent whose parents were disengaged may have had considerable autonomy prior to the kinship care arrangement. The change in expectations may involve a sense of loss of that autonomy and difficulty understanding the rationale for structures she does not feel she needs. However, consistent structure, expectations, and limits, even when they differ from those that children have previously known, together with warmth and affection, positively influence children’s experiences in kinship care (Altshuler, 1999). Finally, caregivers’ love, commitment, protectiveness, strain, and fatigue may be manifested in their limit setting, and birth parents’ multifaceted feelings about the kinship caregiving arrangement are likely to influence the degree to which they support the caregivers’ limits (Russell & Malm, 2003).

Exploring how limits are set, how positive behavior is acknowledged, how children respond to both limits and praise, how these processes may reflect feelings about the kinship care arrangement, and how the family feels these processes are working provides valuable inroads to understanding and addressing interactions and emotions that may be particularly challenging. Further, family stress can be alleviated and well-being can be supported throughout the family system with the following clinical strategies:

- Normalizing the challenges families face in this area.
- Facilitating direct communication regarding the feelings reflected in these processes.
- Anticipating ways in which transitions, including visits with birth parents, may affect these processes.
- Strengthening the family’s effectiveness in setting limits and offering praise.
Developmental Considerations

Multiple developmental considerations influence kinship care experiences for families. Birth parents' youth and developmental capacity may have precipitated the kinship care arrangement. Older birth parents may have had repeated challenges raising their children. Such varied developmental circumstances intersect with the family's adjustment to and coping in the kinship care arrangement, as does variation in children's needs related to their age and developmental processes. Although infants and younger children have particularly high needs for care, as children age, concerns arise regarding peer relationships, academic functioning, preparation for independent living, and engagement in high-risk behaviors and contexts.

While grandparents are frequent kinship caregivers, it is important to recognize that kinship caregivers encompass a wide range of developmental phases. They may be young adults, including aunts, uncles, and older siblings, whose own preparation to launch independent living coincides with their assumption of caregiving responsibilities. In other situations, they may be middle-aged adults managing multiple caregiving and work responsibilities, or older adults preparing for time of their own. Additionally, health, well-being, and the degree to which caregiving is experienced as "off-time" are likely to vary across diverse developmental contexts and to affect adjustment to and maintenance of caregiving activities (Solomon & Marx, 2000).

Adapting to and maintaining caregiving activities are also influenced by the family's developmental phase. Kinship caregiving responsibilities may complement or challenge a family's life-cycle expectations (McGoldrick, Carter, & Garcia-Preto, 2011). For example, an individual or couple with unfulfilled hopes of rearing children may welcome caregiving as a way to meet this developmental expectation. Likewise, families who are already in the midst of raising young children may find kinship caregiving consistent with and enriching for this phase in their family's life. Alternatively, assumption of caregiving responsibilities may hasten the accommodation to children for newly committed partners and may delay or eclipse prior childbearing or adoption plans. For example, a couple who previously planned to have children may find that caring for their nephews causes them to put these plans on hold and to reconsider whether their current emotional and financial resources can support a larger family. Finally, families in later life may find caregiving to be a generative way to contribute to younger generations, to be an unanticipated activity at this phase of life, particularly after fulfilling earlier childrearing and employment responsibilities, or both (Burton, 1992; Minkler & Roe, 1993; O'Brien et al., 2001).

Inquiring about expectations for this phase in the individuals' and family's development provides families the opportunity to reflect upon and maximize the fit between kinship care arrangements, expectations, and aspirations. This process can be facilitated with questions regarding the ways in which plans or activities have been altered, postponed, or relinquished with kinship caring.
Identifying steps to support individual and family developmental goals in the context of kinship care can enhance adjustment, growth, and resilience throughout the family system.

PERMANENCY, REUNIFICATION, AND LEGAL CONCERNS

When children are in foster care situations, there are well-founded concerns about the permanence of these situations and the potential for reunification with their parents. "Permanency" generally refers to legally binding arrangements, including adoption, guardianship, and parental custody (see Rampage et al., Chapter 10, this volume). Although kinship care arrangements may involve lasting relationships and commitments, in the absence of legal binding, they do not reflect permanency as it is typically defined (Testa, 2001). The 1997 Adoption and Safe Families Act (ASFA) aimed to quicken the time to permanency for children by requiring movement toward termination of parental rights once a child reaches 15 of 22 consecutive months in foster care, unless family is providing the child's care. ASFA allows for kinship care to become the permanent plan (Geen, 2003b). In this context, numerous studies have examined permanency and reunification in kinship care. A recent meta-analytic review found that although children in nonkinship foster care were somewhat more likely to be reunified with parents, the finding was not statistically significant; however, that group was more likely to be adopted less likely to have a relative assume guardianship, and less likely to continue in care than children in formal kinship care (Winokur, Holan, & Valentine, 2009).

While a permanent, caring arrangement that supports a child's growth and well-being into adulthood is of critical importance, families engaged in kinship care may favor lasting arrangements over binding ones, and permanency may be defined differently by family and child welfare systems (Geen, 2003a; Testa, 2001). It is important to explore family members' expectations regarding the permanence of their kinship care arrangement, their permanency goals, obstacles to these goals, and resources needed to support these goals. Steps to support relational permanence and a lasting sense of belonging can contribute to well-being for children and families (Samuels, 2008).

POVERTY

Poverty is one of the most potent challenges for many families engaged in kinship care. A recent U.S. Census Bureau report (Kreider, 2008) illustrates the heightened risk of poverty among children living with relatives other than their parents: Approximately 17% of children living with at least one parent experienced poverty in 2004. This number jumped to 34% for children livin
with other relatives, and was highest, 45%, for children living with grandmothers. Nationally representative comparisons between kinship and nonkinship formal foster care also demonstrate significantly greater risk of poverty and food insecurity among those in kinship care (Ehrle & Geen, 2002; Main, Ehrle Macomber, & Geen, 2006).

In addition to daily challenges to get by with limited income, poverty is associated with numerous biopsychosocial risks for families. Low socioeconomic status in childhood, lack of resources to buffer against stressful life experiences, and cumulative social disadvantage are particularly problematic and increase the risk of physical and mental health problems across the life course (Adler & Stewart, 2010; Cohen, Janicki-Deverts, Chen, & Matthews, 2010; Engstrom, 2011). Poverty and related deprivation can also stress family relational processes, complicate other challenges accompanying kinship care, and eclipse clinical work with families. Further, a family’s financial and material needs may risk the stability of the kinship care arrangement (Simpson & Lawrence-Webb, 2009).

Despite the high risk of poverty and its negative effects, kinship caregivers often do not receive financial assistance and other services for which they are eligible (Geen, 2004). Several factors contribute to this problem. First, eligibility for benefits is complicated and differs by state. Benefit eligibility typically depends on the kinship caregiving arrangement, the child’s Title IV-E status, the kinship caregiver’s fulfillment of foster care licensing requirements, the receipt of competing benefits and, for some benefits, current income level. Second, some families are not informed about available benefits either due to workers’ unawareness of them or to efforts to reduce public spending. Third, other considerations may keep kinship caregivers from accessing benefits, including lack of awareness of resources, reluctance to ask for help or engage with welfare agencies, and intrusive, unhelpful experiences with service providers (Simpson & Lawrence-Webb, 2009). While there is variation across states, resources for kinship caregivers to explore include foster care payments, Temporary Assistance for Needy Families (TANF) child-only grants or Income Assistance Grants, food stamps, Medicaid, State Children’s Health Insurance Program (SCHIP), Supplemental Security Income (SSI), Social Security survivors benefits, child care subsidies and other child care assistance programs, preschool and Head Start programs, and supportive services from child welfare agencies (Ehrle, Geen, & Clark, 2001).

Given the profound impact of poverty on families’ well-being, it is imperative for clinicians to know about the resources available in their communities and to link families to them. Rather than viewing resource linkage as a case management activity separate from clinical work, a more integrated clinical approach incorporates this activity and recognizes that helping families access and navigate service systems can facilitate family problem solving and empowerment. Working with families to identify problems, generate possible solutions, select a solution, take action, and evaluate those actions can strengthen their active coping, their efficacy in accessing resources, and
their management of other challenges (Walsh, 2006). Clinicians’ advocacy in broader systems may be required in some instances; however, it is important that families take action to improve their situations to the greatest extent possible (Boyd-Franklin, 2003). Clinicians are also in a unique position to advocate for collective responses from broader systems. This advocacy may involve participating in efforts to improve public policies and programs that serve families engaged in kinship care, advocating for change through letters and calls to legislators, and developing more responsive services in their own agencies.

PHYSICAL AND MENTAL HEALTH CONCERNS

In the context of kinship care, physical and mental health concerns are typically multidimensional and multigenerational. Parents’ physical and mental health problems, including problematic substance use and co-occurring concerns, often prompt kinship care arrangements (Beeman et al., 2000; Gleeson et al., 2009) and may have early-onset, long-term effects on children’s well-being (Balsa, Homer, & French, 2009; Fechter-Leggett & O’Brien, 2010; Ferguson, Boden, & Horwood, 2008; Osborne & Berger, 2009). When abuse, neglect, and abandonment precipitate kinship care, children may experience psychological trauma, other mental health problems, behavioral difficulties, cognitive impairments, academic difficulties, and increased risk of involvement in the juvenile justice system (Margolin & Gordis, 2000; McMillen et al., 2005; Ryan & Testa, 2005).

Psychiatric and alcohol use disorders are prevalent among youth in kinship care. For example, among older youth preparing to exit formal kinship care, an estimated 12% have experienced posttraumatic stress disorder (PTSD) in their lifetimes. This rate far exceeds the 1–6% lifetime prevalence found in community samples (Keller et al., 2010). An estimated 13% of older youth in formal kinship care experience conduct disorder or oppositional defiant disorder (McMillen et al., 2005). Such estimates illustrate the high potential for serious emotional and behavioral difficulties among children in formal kinship care. Further, among older youth in formal kinship care, we see lifetime rates of alcohol use disorders (8.5%) that are at the high end of rates found in comparable community samples (American Academy of Child and Adolescent Psychiatry, 2005; Keller et al., 2010).

Parental difficulties, such as substance misuse, mental health problems, and physical illness, may involve long-standing strain for kinship caregivers, particularly grandparents and other close relatives. Kinship caregivers may also experience stigma, embarrassment, and disappointment related to the birth parents’ struggles, and such feelings may inhibit help seeking (Hungerford, 1996; O’Brien et al., 2001). The challenges associated with caring for a child experiencing complex biopsychosocial needs can add to this cumulative strain for kinship caregivers (Burnette, 1999; Hayslip, Shore, Henderson,
& Lambert, 1998). High levels of caregiver strain, together with limited resources, may contribute to the increased risk of placement disruption that children with behavioral and other health problems experience in their formal kinship care arrangements (Chang & Liles, 2007; Kelley, Whitley, Sipe, & Yorker, 2000).

While demands and resources influence well-being among kinship caregivers, several studies indicate that kinship caregivers experience rates of physical and mental health problems, particularly depression and stress, that exceed those of nonkinship caregivers and noncaregiving grandparents (Berrick et al., 1994; Blustein, Chan, & Guanais, 2004; Ehrle & Geen, 2002; Minkler & Fuller-Thomson, 2005). Research with grandmothers finds the negative effects on health particularly pronounced when caregiving begins or increases (e.g., Hughes et al., 2007). However, research also finds declining health over time among this group, consistent with age-related progression of health problems (Musil et al., 2011).

The complex psychosocial concerns and high risk of physical and mental health problems among families engaged in kinship care are likely to interact with and exacerbate other difficulties. In addition to routine inquiry about physical and mental health problems, including substance abuse, and their impact on the family, key practices include the following:

- Recognizing and addressing the impact of caregiving transitions on health.
- Linking families to appropriate specialized health services.
- Providing psychoeducation regarding health conditions.
- Facilitating family processes that are associated with better health outcomes, including close, mutually supportive interactions, effective resolution of conflicts, open communication regarding health conditions and treatment, clarity in family organization, and effective coping skills.
- Improving access to material and social resources to strengthen the family’s capacity to manage physical and mental health concerns in the context of kinship care (Kelley et al., 2000; Wechs, Fisher, & Baird, 2002).

OVERCOMING OBSTACLES TO SERVICES

Families engaged in kinship care often face numerous barriers to accessing services, particularly mental health services. Potential barriers include the following:

- Lack of information regarding resources.
- Lack of transportation or insurance.
- Lack of child care.
• Cost.
• Stigma.
• Perceptions regarding the need for assistance and the potential usefulness of services.
• Multiple demands on the family’s time.
• Physical limits on caregiver mobility.
• A history of negative experiences with service providers.
• Agency factors that impede access, including long waiting lists for services and the absence of culturally competent services (Corrigan, 2007; Geen, 2004; Groe, Zuckoff, Swartz, Bledsoe, & Geibel, 2007; King et al., 2009; Simpson & Lawrence-Webb, 2009).

In addition to addressing agency barriers, numerous studies indicate that intensive engagement approaches that commence with initial family contact improve service engagement. For example, the Strategic Structural Systems Engagement model draws upon principles of brief strategic family therapy to diagnose, join, and restructure the family from the beginning of contact through the first session (Coatsworth, Santisteban, McBride, & Szapocznik, 2001). Similarly, several other approaches begin clinical work and attend to family engagement with services from the point of initial contact. Central elements include active attention to caregiver perceptions of and concerns about services and problem solving to reduce obstacles to services. In particular, engagement is improved with clarification of the need for services, support for the caregiver’s commitment and capacity to participate in services, and problem solving to address barriers to engagement (e.g., expectations of services, previous service experiences, transportation, multiple time demands, and child care) in the initial contact. Engagement is also furthered by actions that address immediate concerns. Experiencing a gain in the first session can positively influence family members’ perceptions regarding the usefulness of services and inclination to continue with them. Additionally, clarifying the nature of the helping process, including roles of the clinician and family, service options, expected outcomes, and timelines, can facilitate engagement and continued participation in services (McKay & Bannon, 2004; McKay et al., 2004). Providing services in families’ homes or convenient locations, accommodating scheduling needs, offering crisis assistance, and maintaining a flexible stance may also strengthen families’ engagement and ongoing involvement in services.

Finally, while these intensive engagement strategies offer specific clinical tools to reduce service barriers, it is critically important that clinicians use their professional selves effectively to fortify these efforts. More specifically, multisystemic practices can be strengthened by clinicians’ attention to their own reactions to the family and to each member. Particularly when birth parents’ struggles have impaired their ability to care for their children and caused pain for their children and other family members, there may be an inclination to overlook the importance of their roles within the family and the potential
for mutually supportive interactions with other members. Not uncommonly, service providers harbor strong negative feelings toward birth parents as they attempt to engage and facilitate change with the family. They may inaccurately presume that the other family members share their negative feelings and that birth parents’ relationships with their families are damaged beyond repair. However, it is crucial for clinicians to support the potential for positive change and to involve parents with empathy for their life struggles.

The enduring relational connections of many families involved in kinship care arrangements are reflected across generations in multiple ways. For example, children in kinship care often experience regular contact and special bonds with their parents, even while recognizing the reasons they cannot live with them (Alshuler, 1999). Parents whose children are in kinship care arrangements commonly express attention to and interest in supporting their children’s well-being, hopes for their children’s future, and aspirations to improve their lives in order to be helpful to their children (Gleeson & Seryak, 2010; Smith et al., 2004). Additionally, caregiving grandparents often take steps to support the birth parents. These efforts include not only caring for their grandchildren as a way to help their own children, but also providing them with emotional and practical supports, such as food, money, and housing (Minkler & Roe, 1993). A caregiving grandfather offers a vivid description of this support in the midst of multiple caregiving responsibilities: “I take care of my wife who has cancer and my two grandbabies. I chase around after my daughter on the street trying to make sure she eats, at least” (Burton, 1992, p. 748). While attending to the safety of children and all members of the family, it is critical to honor and build upon families’ enduring bonds in the context of kinship care.

Clinicians’ negative reactions limit both their understanding of the family’s enduring bonds and their capacity for empathy with each family member. Empathy, genuineness, and acceptance, widely recognized as core ingredients that facilitate change, are especially important in the context of kinship care. First, empathy facilitates openness to change. Attuned empathy can reduce defensiveness, improve engagement in the helping process, enhance motivation for change, and facilitate achievement of meaningful individual and family goals (Miller & Rollnick, 2002). Second, a lack of empathic attunement or negative reactions to an individual member may be off-putting to others in the family, hindering effective work with the family system. As described by one caregiving grandmother in my research with families affected by maternal substance use problems and incarceration, “I didn’t like it [the agency]... She [the case manager] gave her [the grandmother’s daughter] a hard time... I went and I seen how it was, so I got her in another counseling program... They need sensitivity training... They need to get out here and see what is really going on, especially when kids come from the ghetto. They don’t know what they’ve been through to get on that stuff” (Engstrom, 2010, unpublished data). As reflected in this grandmother’s statement, insensitivity can negatively influence families’ perceptions of a program, undermine their confidence in
the service provider’s qualifications, and hinder their engagement in services. Third, modeling empathy can enhance mutual empathy among family members and strengthen their relationships. Finally, empathy is essential to counter the stigma, shame, and disempowerment that families too often experience in the child welfare system (Wells, 2010).

CONCLUSION: MULTISYSTEMIC ASSISTANCE FOR FAMILIES TO THRIVE

While families engaged in kinship care often draw upon profound strengths in the midst of difficult situations, the daunting challenges they face may prompt attention to services that help them get by or manage just a bit better. However, such a stance limits the potential gains a family can experience. Drawing upon the idea of family resilience, that a family can experience growth and become stronger in the face of adversity, it is critical that clinicians orient their work in kinship care with resilience-supporting attitudes and practices, including helpfulness, collaboration, recognition of strengths, and possibility (Minuchin et al., 2007; Walsh, 2006). This aim may be realized, in part, with attention to the supports needed for families to thrive. Although challenges must not be minimized and problems must be addressed, attention to thriving, rather than getting by, can orient interactions with families to support possibility and potential. Explicit conversations with families about what it would take for them to thrive can guide clinical work in ways that enlarge the field of what seems possible, honor families’ interests, and expand the range of gains they experience.

The multisystemic framework presented in this chapter involves several core practice principles to support thriving among families engaged in kinship care. Most notably, practice in this framework

- Defines and engages families inclusively.
- Values and integrates families’ sociocultural connections.
- Honors and builds upon families’ bonds and strengths.
- Empowers families in decision-making processes.
- Recognizes that it is normal for families to experience distress during disruptive transitions, and when demands are great and resources are limited.
- Fosters collaborative, mutually supportive family processes.
- Facilitates structural clarity, open communication, and effective conflict resolution.
- Considers and addresses multidimensional interactions between relational, legal, financial, health, and service access challenges.
- Orienting helping efforts toward resilience and thriving.
Together, these principles guide practices that build on families’ resources and aspirations to address complex, interacting challenges and to support thriving of children and families in the context of kinship care.

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