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Preserving Family: Themes from a Qualitative Study of Kin Caregivers

Don Cohon, Lisa Hines, Bruce A. Cooper, Wendy Packman, and Elizabeth Siggins

This article presents themes from a qualitative study of 58 African American female kinship caregivers in San Francisco. Core concepts that emerged describe various paths along which children move into kin homes, and caregivers' mixed emotional reactions to becoming surrogate parents. Women also discussed multiple family roles they assumed after taking in children. Responses highlight three primary reasons for becoming caregivers that center on providing for and protecting these children—particularly from the perceived threat of the public foster care system—and ultimately preserving the family unit. Paradoxically, caregivers' reasons mirror the stated goals of the public foster care system, which they view as a threat to family stability. We discuss the problems of implementing practice and policy recommendations for permanency and family preservation and how to bridge the gap between the deeply held negative beliefs of African American caregivers towards the public system and begin to build trust.

Introduction

The U.S. Census Bureau released figures in May 1999 showing that more than 5.5 million children nationally are being raised in homes in which a grandparent resides and that 2.4 million of these grandparents have sole responsibility for children under age 18 (Bryson & Casper, 1999). In California, there are 845,921 grandparent-headed households and in San Francisco County, 16,426 (U.S. Bureau of Census, 2003). This informal practice of one family member stepping in to help another has been used increasingly by the child welfare system as a placement resource for children removed from biological parents. As of September 2001, 130,869 (24%) of a total 542,000 children in foster care were living in a relative foster family home (U.S. Department of Health & Human Services, 2003). Beginning in the early 1990s, research studies of kinship foster care began appearing more and more frequently in scholarly journals (Gleeson, 1999a).

An important practice and policy issue for children in kinship placements involves their safety, well being, and permanency as set forth in the Adoption and Safe

Families Act of 1997 (P. L. 105-89). Much recent literature has focused attention on kinship care and permanency (Geen, 2003; Malm & Geen, 2003; Gleeson, 1999a; Bonecutter & Gleeson, 1997; Testa, Shook, Cohen, & Woods, 1996; Thornton, 1991). P. L. 105-89 recognized three legal permanency options—reunification with parent(s), adoption, or legal guardianship—none of which consider informal biological ties of kin as sufficient to ensure a lasting commitment that is permanent. Recently, states have begun using subsidized guardianship—transferring legal responsibility of a minor child from the state to a private caregiver and paying a monthly subsidy—as a vehicle for achieving permanency for children (Beltran, 2002; National AIA Resource Center, 2002). Some have argued that kinship foster care is another category of permanency, stating that "Kinship foster care can be viewed as a form of extended family preservation; original ties to the family are maintained, but under the close supervision of the social service agency" (Pecora, LeProhn & Nasuti, 1999: 176; Child Welfare League of America 1994). But this arrangement does not achieve the cost-saving goal of discharging the child from the foster care system, and these authors stress the need to provide kinship foster families ongoing supportive services, training, and reimbursement (Pecora, et al., 1999). Testa (2001) frames the permanency debate regarding kinship placements by contrasting two perspectives of social organization—one based on informal biological ties and the second based on formal bureaucratic policies. He proposes a third interactional perspective that has led to practice and policy changes (Testa, 2001).

This article reports selective findings from semi-structured interviews of 58 women acting as surrogate parents for kin children. One important theme that surfaced out of respondents' comments focused on family preservation, which for these women meant a family unit that naturally included extended kin. A single purpose guided this study—to explore and compare the experiences of two similar groups of African American female kin caregivers, one receiving private services from Edgewood's Kinship Support Network (KSN) and one receiving public services at the San Francisco Department of Human Services (DHS). An initial hypothesis of the study was that there would be significant differences in women's responses between the two groups, but the data did not support this, and we generally report their comments together. Edgewood's KSN is a privatized model that delivers services at the community level without evident participation in a public sector program and is described in more detail elsewhere (Cohon & Cooper, 1999).

Methodology

Study Setting

The study sample is comprised of women of African American ethnicity. While there may be generally accepted cultural norms for African Americans, it is useful to

acknowledge that every community has a unique social and cultural context within which these norms and values are shaped. This means that the literature describing African American families as a homogeneous group may not apply to residents of a particular locale (Daniels, 1990). Historical settlement patterns, coupled with a greater degree of racial tolerance toward blacks than may have existed in northeastern cities, make generalizing from San Francisco's African American population to other African American communities unreliable.

Although a small number of African Americans lived in San Francisco since the 19th century, the major growth in San Francisco's black population occurred during World War II, increasing 600 % between 1940 and 1945, as black southern migrants, mostly from Texas, Louisiana, and Arkansas, came to seek employment in shipbuilding and other wartime industries (Broussard, 1993). In contrast to earlier African American inhabitants, these newer residents experienced the same racial animosities that excluded Chinese immigrants in the late nineteenth century, reducing available housing, isolating them in urban ghettos, and forcing unrelated families to live together for mutual aid (Daniels, 1990). For these families, relying on extended family to care for young children was an accepted response to family disruption caused by labor migration and discrimination, becoming a common part of their life experiences (Daniels, 1990). These historical reasons for stepping in to assume a parenting role differ from those of the past twenty years, during which crack cocaine has played a significant role in family disruption (Minkler & Roe, 1993). We found that the majority of caregivers seen by KSN have had prior personal experiences of being raised by kin during their own childhoods and that this pattern among San Francisco's African American families has been a common practice (Cohon, Hines, Cooper, Packman, & Siggins, 2003; Brown, Cohon, & Wheeler, 2002).

Study Design

This was a qualitative study employing a semi-structured interview to comprehend details about feelings and thought processes that are difficult to derive from more conventional research methods (Strauss & Corbin, 1998). These research strategies lend themselves to the study of situational and structural contexts—"context-specific inquiry"—an approach particularly suited to the exploration of a complex social phenomenon, such as kinship care, with its multiple contexts of family and culture interacting with the legal and social service systems (Johnson, 1995).

Study Sample

The sample of 58 women consisted of two groups of African American kinship caregivers living in San Francisco. We limited ethnicity to African Americans because over 80% of KSN caregivers were African American and only included females because they comprise more than 90% of primary caregivers for related children. Lists of

potential participants were developed from two sources. Group A (n = 26) was made up of caregivers referred to Edgewood's KSN between July 1993 and March 1999. Group B (n = 32) was composed of relative caregivers who were active cases at the DHS during the same period. Participants from both groups were selected based on being African American women residing in San Francisco who were raising a relative child aged 6-12 and who had received a minimum of six months of services from either KSN or DHS.

These two caregiver groups had no significant demographic differences. They had a median age of 55. Forty-five of the 58 caregivers in the study (78%) were related to the biological mothers of the children in their care. Of the maternal relations, 28 caregivers were maternal grandmothers; 11 were maternal aunts; four were maternal great aunts; and two were maternal great grandmothers. The thirteen other interviewees were related to the biological fathers. Of these paternal relations, 10 were paternal grandmothers and three were paternal aunts. We conducted a test of mean ranks on the highest grade of school completed for 26 Group A and 31 (1 case had missing data) Group B caregivers and found that group A had fewer years of formal education, but that this was not a significant difference. Most caregivers in both groups had completed high school or received a GED.

Qualitative Interview Instrument

Institute staff reviewed two previous studies of kinship caregiving that employed qualitative methods (Minkler & Roe, 1993; Johnson, 1995). Dr. Minkler graciously gave permission to use the questionnaire and codebook from their study of grandmothers raising children whose parents had abused crack cocaine (Minkler & Roe, 1993). Our modifications of their interview are best described as an extended replication, which often have differences in populations and procedures.

Interview Procedures

Institute staff reviewed separate alphabetical lists for KSN Group A clients (sorted by caregiver's name) and for DHS Group B clients (sorted by child's name) and contacted potential participants who met the sample criteria. All subjects signed voluntary consent forms to participate in the research interview and were compensated for their time. In the initial telephone conversation, Institute staff told caregivers the purpose of the research and gave them information about the interview process (i.e., sample questions, length of interview, fee amount). Interviews were conducted within one week of telephoning, generally in caregivers' homes.

Data Analysis

Grounded theory (Glaser & Strauss, 1967), a qualitative approach to data collection and analysis, was the primary method used to investigate the responses of caregivers. The data consisted of over 150 hours of audiotapes, which had been

transcribed verbatim by a trained data entry person and randomly reviewed for accuracy by Institute staff. Transcribed interviews were entered into ATLAS.ti Visual Qualitative Data Analysis Version 4.2 Build 57 (Scientific Software, 1999), a computer program based on grounded theory. Four Institute staff members were involved in the initial open coding of the transcripts, developing categories and themes inductively from caregivers' words (Glaser, 1978). Two outside consultants later participated in reviewing and systematically comparing and contrasting categories, a process that yielded more inclusive, abstract categories. All persons engaged in the analysis wrote analytic memos. Regular meetings of staff were convened to review the codes, categories, and memos to refine core categories into general themes that accurately reflected the experiences and comments of the caregivers. Using ATLAS.ti, staff created network views of themes to elaborate the links between categories, a process called axial coding (Glaser & Strauss, 1967). A draft document describing core categories and themes was reviewed and edited repeatedly by staff and one outside consultant before reaching a consensus.

Limitations

Because our sample was purposefully selected from two programs in San Francisco, it is not representative of all kin caregivers. As with other researchers who have conducted qualitative studies of grandparent caregivers (Minkler & Roe, 1993; Johnson, 1995), we knew that we were outsiders to the lives of these women. Even though the individuals who carried out the interviews were African American women, their status as part of a research team, not having personal experience raising children, and their younger age, may have inhibited participants' responses. We structured the process of data analysis using multiple perspectives of staff and outside consultants with the aim of achieving more balance in our conclusions, but ultimately the themes we settled upon are based on subjective judgments. Furthermore, people's perceptions and belief structures are continually modified as they mature and encounter new life events (Kelly, 1955) so that findings based on analyses of one interview provide only a freeze-frame or cross-sectional look at an evolving process for each of the 58 individuals in our sample.

Core Themes

Routes to Caregiving

We heard many varied stories of how children came to live with extended family. Twenty-five of the children from both KSN and DHS programs were placed during infancy with their relative caregiver. Some women took the babies home when the hospital would not release a child to their parent(s) because of substance abuse problems.

> The doctors and the hospital won't let the mother and father take her home. They called me and said "Come out and git her." I'd say she's about a week, and then they were gittin' everything ready to take her home. [Interviewer] "And why wouldn't they let her take her home?" [Caregiver] "Because they did take drugs."

Caregivers who learned of a child without time to prepare often expressed angry feelings, having been left out of the placement decision process. One grandmother reported that she became a caregiver: "When my daughter walked out of the house and didn't come back." A few women noted situations that alerted them to step in and take over full-time parenting responsibilities, describing circumstances in which the biological parent(s)' behavior required them to intervene. For others, news of trouble came only after the public CPS became involved with the family.

In a number of families, the transition was negotiated outside the public system, an informal process among family members that continues to be the manner in which the majority of kin living situations traditionally are arranged (Child Welfare League of America, 1994; Bryson & Casper, 1999). In one family, maternal and paternal grandmothers discussed a change in the grandchild's residence before the child came to live with the paternal grandmother. In other cases, parents realized that they could no longer care for their children and/or that they were in danger of having the children removed, and asked a relative to take on this responsibility.

> My son asked me to try and get him (sic. kin child) from his mother. She was on drugs and he don't really have a home; he just lives on his friends' couches. His father asked me to take him because he thought he was being abused.

Reasons for Caregiving

The decision to become a surrogate parent was described by women from both groups as automatic, reflexive, and without deliberation about the potential impact, positive or negative, on their lives. One maternal grandmother commented:

> It's not my choice, it's just something you have to do, and I can't see it any other way. One of my friends said to me once that she thought that maybe I should have let the baby go to a foster home, that maybe she thought it was too much for me. And I don't feel the same way about this person anymore, because I don't see a choice. It's not a choice, it was not a choice, it's something I just had to do.

For many women, taking care of others was a common occurrence. Forty-nine of the 58 respondents stated that they knew of other women who were also caregivers for other family members. Their responsibilities included aging parents, aunts, siblings, or spouses with disabilities or illnesses, foster children, and of course relative children.

As noted, the common experience for many San Francisco African American women has been to use extended family when their children needed care, and the majority of our kin caregiver sample had prior experiences of being cared for by their own grandparents. Thirty-one (53%) saw their grandmother frequently during their own childhood, and twenty-one (36%) reported living with her for a long period of time. Nineteen (33%) of these caregivers reported that there were times their own children (e.g., the biological parents) lived with their grandparents or other relatives.

Three primary reasons for assuming the surrogate parent role emerged from women's responses, and we describe these alliteratively as to—*provide, protect, preserve*. The *provider* role is consistent with Minkler and Roe's observation of their grandmothers' motives for caregiving—"to provide a safe and nurturing home." (Minkler & Roe, 1993: 53) One woman overheard her grandchildren talking.

> They used to come over here to visit, and the first thing the kids did was ran to the kitchen and wanted to eat. So I watched that. So, M was telling her little brother one night, "Oh, we don't ever have to worry about eating, we'll never have to worry about not having food or clothes and stuff, because Grandma is going to give all of us that."

Respondents' stories also conveyed a related pair of role functions that we called the *protector* and the *preserver*. *Protecting* these children is one of the main reasons grandparents said they became caregivers, particularly to shield them from a number of specific dangers. The primary threat involves a negative view of the foster care system, and this was the case for women in both KSN and DHS groups. Mrs. T described the disruption she believes children experience when placed in foster care, emphasizing the importance for family to take care of family.

> If you put them in the system they get bounced around and bounced around and their lives are ruined. Some kids get good foster parents and some kids don't. I think that a family should take care of the children, love it enough and raise it up. That's the best thing that can happen to a child. Because I think it's good for children to grow up with their family and I think it's just very sad when they grow up in a foster home or they have been adopted out. And they want to know who their family members are, and then they find out they have all this family here and nobody loves them enough to share what they have with them. I think that's just the worst thing for a child to have to come to in life.

Rightly or wrongly, caregivers worried about what would happen when children were placed with people whom they believed were doing it just for the money. They thought foster parents would not endure as much as a family member because they were not "blood related" or deeply committed to family bonds. They imagined a foster family

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home would only offer basic care—food, clothing, and shelter, but would lack emotional support and love.

Two other specific threats were noted in women's stories. Caregivers also *protect* children from neighborhood violence, as these two grandmothers explicitly stated their fears:

> Not safe, I wouldn't say that the streets of San Francisco are safe for any child; it's not a back yard.

and,

> Watching them all the time; you can never watch them enough, to make sure nobody's going to kidnap them or harm them.

Lastly, intra-familial tensions are a particularly difficult aspect of caregivers' *protector* role arising from the need at times to shield children from their biological parents, as Mrs. L's skepticism suggests.

> I don't know about their parents taking care of them. They would have to come be with me for long time before I would turn these children loose.

Mrs. K., another grandmother in her fifties, fiercely defended the three children in her care from their mother, her own daughter.

> Nowadays, I almost can't stand her. She's my child, but I can't stand her. I can't stand drunks, especially lady drunks. I just... I get along with her father. I think she's too comfortable with them living with me. And sometimes she will get to a place and will start complaining. And I let her complain, and then I tell her to go get herself some help and get herself together and raise her own kids if she doesn't like the job that I'm doing. Because the only way that I'm going to give them up is if she's on the right track. There's no way in the world that I would let those little girls live in an alcoholic environment because she's not responsible. What if she wanders off and gets lost, or lights a cigarette and falls asleep? Everybody's dead, for what?

The third reason women assumed a surrogate parent role was to *preserve* their family. They parented grandchildren in order to maintain a family unit that in their view naturally includes kin or close personal friends, sometimes called fictive kin (Stack 1974). For some, the idea of family preservation involves their hope that a child's mother would be able to reunify with them. As one grandmother said:

> I want to keep my family together; this is why I do it. I just want to keep everybody together, and you have to sacrifice when you do that. It's better to keep the family together, or after a while, they're like strangers to each other once they get back together.

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Another caregiver expressed a similar purpose of preserving the family for the children's sake until their mother returned.

> Well, I was upset when they took T, and I wouldn't want anything to happen to A. All I'm trying to do is keep the children in the family together so that when my daughter gets them all back, they will all be together, they won't be scattered from one place to another. I've seen so much of that happen to little children.

Caregiver Roles

When discussing their roles as caregivers, women described these grandchildren as their own. In part, this may be because many women had raised them since birth. It was difficult for them to separate their ideas about a grandmother's role from that of surrogate mother, and many allowed their grandchildren to call them "Mom," while they referred to them as "my kids." One caregiver stated:

> I had no idea I would be having other people's kids. They're like mine now. When I address people, that's the way I address them, my kids. I mean, like when she [child's natural mother] was here it makes a mother feel bad trying to take over her kids, but this is just something I automatically say. I don't mean it in that sense, and I know that they are hers. I know this. I'm trying to get myself into the habit of saying my grandkids, but it's hard.

Among the women in our sample, not only do kin caregivers' roles change from grandparent or aunt to that of parent, but also at times they play multiple family roles with different functions, as this comment illustrates:

> The difference is that I'm neither a grandmother, nor their mother, I'm both, and it's hard. Because if I were their mother, it would be different, and if I were their grandmother it would be different. If I were their grandmother, I would pick them up on the weekend, and then bring them home, but I can't do that. And because they know their mother, I'm not their mother. It's hard to be both.

Reactions to Caregiving

When asked "Is this stage of your life different from what you had thought?" 71% (n =41) women answered "Yes." They had anticipated a life with more freedom and opportunities to travel, not one in which they would be parenting a grandchild. Fifty-nine percent (n = 34) acknowledged feeling angry and sad at their life circumstances. Most had expected and hoped that they would play a role in their grandchildren's lives, however, not as surrogate parents.

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> I expected it to be free and easy, a lot easier. I thought that I would have to help my daughter with her kids, financially, and maybe on the weekends, but I didn't expect to raise them.

Some felt unfulfilled because there was still so much they wanted to do, but caregiving responsibilities stood in their way. They did not have the time or the money to be "carefree" or travel because resources were being used to help their grandchildren live a better life.

> Oh yeah, I don't have a bad life. It's not bad. But it's not, you know… Sometimes I would like to be carefree, where I wouldn't have to worry about cooking or cleaning. Living by myself. I have never, since I've been grown, ever lived by myself. I have always had someone in my house. So that would have been exciting. Just to say, "Oh, this is my apartment, I'm living here by myself." I have never. When I first got married, my oldest brother he moved out with me. I raised my sisters and brothers up under me. Then I raised my children, and now I'm raising my grandchildren. And I keep having this dream that I'm going to raise my great-grandchildren. And my granddaughter M tells me, "Oh Grandma, you going to raise my kids." Oh, no! "Oh, yes you are." She just turned six. So I told her it might be true, because I keep having this dream that I'm going to raise great-grandchildren.

In contrast, a number of women indicated that their lives were better off by having responsibility for these child(ren).

> I have no complaints right now. Well, it might even be better. At my age, who knows what it would be like with no kids to keep me in the house. I might be healthier at this age, they keep me young, because we always doing something.

Others reported that taking care of the children offered companionship, filling a void and creating a situation in which there is mutual support.

> Well, what I do enjoy, is I call him my running buddy, since we were all doing this summer, you know. If we go to the movies or something, or if I'm going to go downtown, I like to have company, and he's great company.

Furthermore, some women noted that having another chance to parent lessened feelings of sadness and guilt about their own children, perhaps helping them cope more effectively. One fifty-five year old grandmother raising five children, viewed surrogate parenting as an opportunity to make up for perceived failures.

They are a joy. She's a joy. I can teach her how to cook; she wants to learn to cook, and things. It's that I can mould her; I'm hoping that I can mould her into the woman that I wished her mother would have been. It's like getting a second chance of raising children, you'll do it right, you figure you'll do it right this time.

Discussion

Routes to Caregiving and Roles

As was found in previous studies, children of all ages came to live with their relatives along various pathways (Minkler and Roe, 1993; Cimmarusti, 1999). Although they arrived by different routes, when presented with a relative's child, women felt that they had "no choice" but to take on the surrogate parent role. For many of these San Francisco women, assuming this role mirrors their own life experience of being raised by kin and also may reflect a societal view that caregiving is a women's issue (Minkler, 1999:202). In this way, our sample of caregivers resembles the women described in other research (Minkler and Roe, 1993; Osby, 1999). Frequent use of extended kin for caregiving represents a view of family that stretches the boundaries of a more traditional, perhaps idealized, nuclear unit to one that is flexible, but in practice has historically been a normative structure for many groups (Stack, 1974; Martin & Martin, 1978; Brown, et al., 2002). For African Americans particularly, family is more a process or "an ever-evolving system that responds to normal and nonnormal changes and events through adaptation" (Wilson, 1989:380).

Although change, transition, negotiation, and re-negotiation of family roles are normative through the life cycle (Rosow, 1976; Troll, 1983; Aldous, 1995), some women discussed how functioning in multiple roles as both a grandmother or aunt and also a mother led to confusion for them and their children. From the perspective of social role theory "the parent provides the child with the sense of permanence and associated stability and continuity in relationships needed for healthy development." (Kadushin & Martin, 1988:12) The parental role involves meeting a child's needs for food, clothing, shelter, emotional support, stimulation, and a fixed place in their community as well as protecting the child from harm. Such caregiving functions address a hierarchy of basic human needs (Maslow, 1970), initially attending to physiologic needs of hunger, thirst, fatigue, and shelter (providing tangible support); then addressing needs for stability, security, consistency, protection, and lastly freedom from fear, anxiety, and chaos (providing emotional support). To enhance kin caregivers' capacity to cope with these parenting duties and to reduce role confusion, we recommend that caseworkers proactively clarify caregiving functions in order to provide adults and, where appropriate, children with knowledge of other's experiences and reactions to assuming this surrogate parent status, especially in families where the biological parent(s) are visiting or likely to be reunified.

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Reactions to Caregiving

These women expressed diverse reactions to the changes in their lives since becoming caregivers. They described fluid emotional states—anger, happiness, sadness, joy, and guilt were prominent. Comments ranged from feeling that their personal freedom had been seriously limited to very little having changed, and for some, a sense that their lives had improved because raising a child had given them new purpose. Many expressed resentment at having to forego or relinquish much-anticipated retirement dreams along with feelings of frustration and anger towards the child's biological parents. But positive reasons also emerged, such as having a second chance to parent, which for some alleviated feelings of guilt. A number of caregivers felt fortunate that they were able to help their own children and described enjoying the opportunity to watch their grandchildren grow in a secure and safe environment.

These shifting emotional states were context-dependent, sometimes influenced by interactions with biological parent(s) or the children in their homes or the child welfare system or other public bureaucracies. Casework inherently is a complicated effort, and, with kin families, the fluctuating emotions expressed by caregivers illustrated only one factor in a dynamic multi-layered situation with numerous stakeholders (Gleeson & Hairston, 1999:300-302; Cohon, Hines, Cooper, Packman, & Siggins, 2000:3-6). For some of the women, participation in groups with other caregivers provided emotional support that was beneficial, while for others, whose reactions were more severe and/or chronic, intensive casework services or mental health support were needed (Kelley, et al., 2000; Cohon, et al., 2003).

Reasons for Caregiving

Policies related to the public child welfare system's need to contain costs may have affected women's decisions to become caregivers. Placement with relatives has not automatically required financial support payments to these kinship families so that agencies have been fiscally motivated to place children with kin (Gleeson, 1999a; Gleeson, 1999b). Legislation such as ASFA (P.L. 105-89) and expanded subsidized guardianship programs are new policy initiatives, and preliminary data suggests that they may be increasing the number of kin caregivers adopting or becoming guardians for related children (Testa, 2004). Therefore, not only do internalized cultural values and life experiences contribute to a feeling of obligation to raise kin children, but also external incentives to be a relative caregiver may be brought to bear using financial supports and/or by child welfare workers with limited placement options and their agency's goals for monetary savings.

We identified three related reasons women became caregivers: to provide for these children, to protect them, and to preserve their family unit. They wanted to provide for children by addressing their tangible and emotional needs. Second, they wished to protect children, specifically from a foster care system that they viewed as a threat and as damaging the traditional structure of the extended family rather than a support for

families. Women also noted two other circumstances in which to protect children—from neighborhood violence and influences and, at times, from the children's biological parents. Lastly, women often spoke about their intention to preserve the family unit. Minkler and Roe (1993:156) found their grandmothers expressed a similar purpose of "keeping the family together" so that they put "caregiving across the generations at the top of their list of priorities." Johnson's (1995) study of 20 maternal grandmothers noted their deep commitment to keep the children together by parenting kin, an obligation that stemmed from a historical fear of a white-dominated foster care system indifferent to and unable to meet the needs of children of color.

What is ironic about caregivers' strong resolve to protect children and preserve family is that these same goals for family preservation are expressly shared by the public system against which these women are defending their families. Finding safe, stable, and permanent homes for foster children has been and continues to be a priority for national, state, and local public foster care agencies (Maas & Engler, 1959; Emlen, Lahti, Downs, McKay & Downs, 1978; Kadushin & Martin, 1988). Locally, San Francisco's DHS has a Child Protection Center, as well as a Permanent Placement unit with the priority for children who cannot be reunited "to find them a safe, stable, and supportive home," and DHS also has a Family Preservation unit whose goal is "to keep families together if there is any possibility that they can do so." (Davidson, 2003:9,7) In light of the public system's objectives for preserving family, are San Francisco's African American caregivers' fears of foster care warranted? The number of African American children in the City's public child welfare system is 54%, which is high relative to 38% nationally (DeSouza, 2003; Administration on Children, Youth and Families, 2003). However, there is not any data to suggest that San Francisco's DHS differs from foster care practices nationally.

That said, a number of national studies have found differential treatment of African American children in the foster care system. One of the more comprehensive efforts conducted over 30 years ago noted:

> In a narrower context, American racism has placed Black children in an especially disadvantaged position in relation to American institutions, including the institution of child welfare. As for the child welfare system itself, societal racism has had extensive and intensive effects upon the organization, distribution, and delivery of services to Black children. Moreover, specific aspects of the welfare system complement this racism and serve as barriers to change. (Billingsley & Giovannoni, 1972:vii)

A more recent study that did not focus exclusively on race, but examined role perceptions of relative versus nonrelative foster parents, noted significant differences between these groups with kin seeing themselves as having a strong role maintaining a

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child's contact with biological family, helping a child deal with issues of separation and loss, and engaging in parenting tasks, such as discipline or working with teachers (Pecora, et al., 1999). They also noted that "In cultures of many people of color, this form of child rearing is viewed as a part of a communal obligation to 'care for our own' as a means of counteracting institutional racism." (Pecora, et al., 1999:173). Particularly for kinship families of color, there is a commonly shared mistrust built upon a history of differential treatment from the child welfare system (Ehrle & Geen, 2002; Geen, 2003). It appears, then, that despite sharing similar goals for protecting children and preserving families, these African American women hold deeply internalized negative beliefs about the foster care system.

Recommendations

What can be done to reduce these perceptions of threat from a system whose stated intentions for family preservation and permanency for children are in accord with those of the families opposing them? One way to demonstrate good faith is to develop and carry out policies that provide government supports to preserve kin families in a uniform manner nationally (Geen, 2003). Illinois' federal waiver guardianship demonstration, California's kinGAP, and subsidized guardianship programs in over 20 different states are examples of recent policy initiatives designed to assist relatives caring for children (Testa, 2001; Testa, 2004; California DSS, 1999; National AIA, 2002; Beltran, 2002). But providing financial support as national policy has broad implications since the majority of grandparent-headed homes that are not part of the public welfare system have been shown to have needs similar to kinship families in the public system (Shore & Hayslip, 1994; Harden, Clark & Maguire, 1997; Administration for Children Youth and Families, 2000; Minkler, 1999; Fuller-Thomson & Minkler, 2001). Hence, the potential for a national policy to support kinship families and encourage permanent living situations is complicated by the question of parity between addressing the needs of those providing formal versus informal kin care.

Furthermore, policies are implemented by caseworkers, and the Urban Institute recently reported that both child welfare workers and kin caregivers agreed that agencies do not do a good job in explaining permanency options that have evolved and changed in the past decade (Geen, 2003:3). Other research also calls into question how effectively new policies are being carried out. For example, Bonecutter and Gleeson's (1997) study to develop and test a practice model to improve permanency outcomes found that "preliminary data analyses also reveal low rates of implementation of the practice principles and methods in the six months following training of the caseworkers in the demonstration group" (Bonecutter, 1999:53). In addition to the oft-described issue of being "overburdened," these researchers pointed to supervisor and caseworker turnover and mobility that they characterize as "typical in child welfare" as a partial cause of poor implementation. Improving accurate communication of policies and programs to families is a necessary step, then, towards building collaboration and reducing conflicts between

kin families and the public system. Testa (2001) and Geen (2003) both urge the use of family group conferencing or family group decision making as a means of mediating between government policies and traditional family and community structures. Edgewood has recently introduced family conferencing and will be implementing the Family Network® method throughout the agency including the KSN program, and this approach warrants further study.

However, as the findings of the Illinois project (Bonecutter & Gleeson, 1997) illustrated, new practice guidelines and training of caseworkers in shared decision making did not lead to better permanency outcomes for children. Recognizing that each kin caregiver has their own unique responses to family, caseworkers, agencies, and policies is an important step in acknowledging the limitations of prescriptive solutions as a way to promote permanency and build trust between these African American women and the child welfare system. To illustrate, it has almost become a cliché that professionals include recommendations for caseworkers to have cultural sensitivity and cultural competency training, and these courses have become part of curriculums in schools of social work or offered as in-service training for caseworkers in the field. While cultural training can provide a necessary foundation for understanding, it may also lead to stereotyping and away from treating people as unique individuals with beliefs and values shaped by their personal experiences. Although San Francisco DHS has been conducting regular in-service trainings to develop cultural competency for more than 20 years, these efforts do not appear to have increased trust for the public system among the African American women in our sample. Gleeson and Hairston (1999:284) stress the importance of understanding individuals' day-to-day lives from their perspective as prerequisite for policy and program development. Cimmarusti (1999) urges that governmental policies be flexible, allowing for idiosyncratic responses to families' changing needs for support. In fact, *do not generalize,* is a refrain echoed in descriptions of grandparents' role in African American families (Wilson, 1989; Taylor, Chatters, Tucker & Lewis, 1990; Burton & Dilworth-Anderson, 1991). In casework practice, we urge staff to adopt an approach that minimizes the use of established categories and to engage clients with an attitude of mindfulness, demonstrating respect for the distinctive qualities and beliefs of each person (Langer, 1989).

To further improve services, Bonecutter (1999) recommends that child welfare organizations integrate research into programs as a formative technique to refine and shape practice in an ongoing manner. Her position is supported by a recent government report that reviewed the experiences of five federal agencies with diverse purposes and identified four key elements in building evaluation capacity in programs (US GAO, 2003b:9). Five years ago, Edgewood developed the Institute for the Study of Community-Based Services to engage in regular assessments that inform program refinements, providing a formal process to plan, execute, and use information from evaluations. Such an undertaking represents still another recommendation for public

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agencies to put in place different organizational structures and procedures just as budget cuts are affecting many social service programs, and therefore such change may not be possible. We should acknowledge that any program innovations will be occurring in a rapidly changing economic context with shrinking funding and that new practices will place increasing demands on a system that has been repeatedly characterized as lacking adequate resources to protect and serve children and families (Malm, Bess, Leos-Urbel & Geen, 2001; US GAO, 1995; US GAO, 1997; US GAO, 1998; US GAO, 2003a). One strategy for overburdened public welfare agencies to adopt involves contracting with private groups and requiring regular outcome assessments of their services. This public-private model resembles Edgewood's KSN (Cohon & Cooper, 1999), which exemplifies a contractual, community-based service approach with the public DHS acting in a "managed care" capacity.

Conclusion

This qualitative study was with a non-representative sample of 58 female African American kin caregivers living in San Francisco. Responses to interview questions highlighted the fluid nature of relationships in these families, and the varied emotional responses of women to multiple contexts and persons. Support groups with other caregivers and, when indicated, individual interventions for specific crises have proven helpful. Caregivers' comments revealed a strong motivation to preserve family and protect children from public foster care, goals that are closely aligned with those of the child welfare system. To reduce caregivers' negative beliefs and begin building trust, we recommend that caseworkers adopt an attitude of mindfulness with clients, focusing on the individual uniqueness of each caregiver, and that overburdened public welfare agencies contract with private providers, acting more as managed care agencies by closely monitoring and requiring regular outcome evaluations from these community-based organizations.

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