The Grounded Theory Review (2020), Volume 19, Issue 2

Doing One's Best: Becoming a Kinship Caregiver

Kara Vander Linden, Ed.D., Saybrook University, USA

Catherine J. Tompkins, PhD, MSW, George Mason University, USA

Abstract

A kinship family is one where a family member, other than a biological parent, is primarily responsible for the child. In-depth, unstructured interviews with kinship caregivers and children from 15 kinship families were conducted to gain a thorough understanding of interactions and relationships among kinship family members. Other data sources included notes from monthly kinship care committee meetings, kinship care focus groups, and kinship family support groups. The resulting grounded theory, *Doing One's Best*, explains a process of becoming a kinship caregiver and doing what one can regardless of multiple factors that make the situation difficult. Chaos increases as situational, relationship and emotional complexity are exacerbated by occurring together, leading to compounding complexity and the need to engage in behaviors to survive.

Keywords: classic grounded theory; kinship families; complexity; caregiving, surviving

Introduction

In preparation for this classic grounded theory (CGT) study, the researchers identified an area of interest, the substantive area, which, for this study, was kinship care. Kinship care defined in its purest form is raising a child for a family or a friend (KFI, 2019). Kinship caregivers are any adult relative or adult fictive kin providing full-time nurturing and protection of children, with the most prevalent type of kinship care provider being a grandparent--predominantly a grandmother (Child Welfare League of America, 2011). In 2012, approximately 4.2 million households in the U.S. (3% of all households) included both grandchildren under 18 and their grandparents. A grandparent headed over 60% of these households, and 33% had no parent present (U.S. Census Bureau, 2014). Among grandparent caregivers, about 12% are younger than 45 years old and 54% range in age from 45 to 59 years. Twenty-five percent are between the ages of 60 to 69 and 9% are over 70 years old (Pew Research Center, 2013). Researchers and practitioners most often explore kinship care through a child welfare lens, generally concluding that child welfare outcomes, such as safety and permanency, are stronger in kinship care compared to foster care (Winokur, Crawford, Longbardi, & Valentine, 2008). Because kinship care is most often seen as a better alternative to foster care for the children, the assessment of challenges and needs within kinship families focusing on the kinship caregiver, children, and the biological parent is often not

explored. This study focuses on the kinship caregiver and the children with future research needing to include the biological parent.

Grandparents who are the primary caregivers for their grandchildren experience positive and negative aspects of the caregiving relationship (Kirby, 2015) but we need to understand more about these experiences. Often, custodial grandparents live in families where their children are unavailable to parent due to adolescent pregnancy, incarceration, death, child abuse, neglect, or addiction (Smith & Palmieri, 2007). Additionally, the complications of raising a child as a grandparent can have a negative impact financially, especially in terms of retirement; socially, as raising a child later in life can be isolating; and emotionally, as the grandparent may feel anger toward their child as well as guilt. These stressors can lead to challenges in caregiving from grandparents in kinship families (Smith & Palmieri, 2007).

Methodology

Classic grounded theory (CGT) is "a general research methodology linked with data collection that uses a systematically applied set of methods to generate an inductive theory about a substantive area" (Glaser, 1992, p. 16). The primary stages used in this CGT study were preparation, data collection and analysis, sorting and creating a theoretical outline, and writing the theory. While method stages are presented linearly, the researchers engaged in a recursive process, working multiple stages simultaneously.

In preparation for a CGT study, a researcher identifies an area of interest, the substantive area, which, for this study, was kinship care. As the opioid crises and other social problems are on the rise, it is imperative to have a theory grounded in the data providing guidance to assessment and interventions to families where the head of household is a family member other than the biological parent. An initial literature review was not conducted, and preconceptions were suspended to remain open to the data as dictated by the method.

In CGT, data collection and analysis are done in an integrated recursive process of collecting, coding, and analyzing data using constant comparative analysis with memoing interwoven throughout the process. While CGT can use any data, qualitative or quantitative (Glaser & Holton, 2004; Glaser 2001), open-ended intensive interviews with a grand-tour question are the most common form of data used and were used in this study. A grand-tour question is a broadly worded question designed to facilitate participants discussing the substantive area (Glaser & Strauss, 1967). The grand-tour question for this study is: What is it like to live within a household headed by a grandparent (or other relative)? Data analysis began with the collection of the first data and guided the researchers as to where to gather data next and what questions to ask. This process is known as theoretical sampling whereby data analysis and data collection continuously inform each other (Glaser, 1978).

The first author and a graduate student interviewed the participants. Fifteen kinship families, living within a 50-mile radius of each other, were interviewed for this study. All of the respondents were from a family system that does not include either a biological parent or stepparent residing permanently in the same household with the children. The families were found by distributing flyers to social workers employed at the local department of family services, posting flyers at local health clinics and referrals from kinship families known to the researchers.

All interviewed caregivers were grandparents except one who was an aunt. The children being cared for ranged from 3 to 17 years old. Only children who were at least 12 years old were permitted by the University's IRB to be interviewed. Twelve children were interviewed. All interviews with children took place with the caregiver present. Theoretical sampling also led to the use of kinship caregiver data from the local county's monthly kinship care committee meetings, kinship care focus groups and support groups. Theoretical sampling led to more interviews with kinship caregivers but not with additional children.

In CGT, data analysis uses constant comparative analysis as the researcher engages in substantive and theoretical coding. Substantive coding includes open and selective coding. Open coding led to the discovery of the core category and subcategories, which become the focus of the research and theory. The core category accounts for the most variation in the data. Once the core category emerged, the researchers began selectively coding which involved limiting coding to concepts related to the major categories (Glaser, 1978). Coding continued until no new indicators of categories emerged, known as theoretical saturation. Next, the researchers engaged in theoretical coding which conceptualized how the substantive codes related to each other (Glaser, 1978).

Throughout the process of coding, the researcher engaged in memoing, theoretical notes about emerging codes and their relationships. Memoing is the core of the process and should take precedence because memos become the emerging theory (Glaser, 1978). Once theoretical saturation occurred, the researchers began sorting concepts and memos conceptually which created an outline of the emergent theory. The researchers used the theoretical outline and sorted memos to compose the first draft of the theory. Once the researchers were confident in the emerging theory, relevant literature was analyzed and integrated. The authors of this manuscript worked together on the process of analysis--from the coding to the emergence of the theory. The process included weekly meetings to ensure codes were conceptual and not descriptive, the discussion of what additional data was needed (theoretical sampling), sorting of the codes, memoing, writing the theoretical outline and the theory.

Doing One's Best

The chaos created by compounding complexity is the problem that emerged from the data in this kinship care study. *Compounding complexity* is the complex environment within which kinship caregiving occurs and the factors that contribute to the complexity[1]. Compounding complexity becomes the context within which the process of Surviving the complexity takes place. To understand *Doing One's Best*, a brief overview of *Compounding Complexity* will be presented,

[1] The details of *Compounding Complexity,* the context in which *Doing One's Best* takes place, are described in Tompkins and Vander Linden (2020). Our study on kindship care had the possibility of having more than one core category. Glaser explained when this occurs the researcher should focus on one core category while demoting the other and then later can focus on the other core category while demoting the first. This is what we did. The first writeup focused on the conditions of compounding complexity whereas this article focuses on the process doing one's best to address the complexity. When viewed as a whole, the two theories produced a more complex theory of Surviving the Chaos. *Surviving the Chaos* is a survival process of taking on the caregiving role and doing what one can despite multiple factors that make the situation increasingly complex.

followed by a more detailed explanation the process of *Doing One's Best*. It consists of two stages: rescuing and taking-on. Throughout the stages of this process, the complexity factors, along with other factors, will be discussed in relation to their effect on kinship caregiving and the need to engage in surviving behaviors in order to do one's best within the situation.

Compounding Complexity

Compounding Complexity emerged as a significant category which explains the complex environment within which kinship caregiving occurs. There are three interrelated categories of factors that contribute to complexity in kinship caregiving: situational, relationship, and emotional complexity. Factors involved in situational complexity for kinship care families include society and community laws, policies, and expectations, whether formal supports (social services) have been sought, and if individuals are eligible for the formal support, the presence of conflict, the prevalence of change, and dealing with the situational logistics, such as the point in life of the caregiver including health and financial status (Tompkins & Vander Linden, 2020).

Within kinship care there is a relationship history (all past interactions between individuals) and a present relationship status (current state of interactions that exist between individuals) between the triad of family members (child, biological parent, and grandparent/other kinship caregiver) that contributes to the relationship complexity of the situation (Tompkins & Vander Linden, 2020). Emotional complexity is created by the emotional responses to the factors contributing to the situational and relationship complexity. These emotions guide choice and behaviors (Tompkins & Vander Linden, 2020).

Situational, relationship, and emotional complexity were discovered as the context in which Doing One's Best takes place, which will be explained in detail below as a survival process of taking on the caregiving role and doing what one can in spite of multiple factors that make the situation difficult. *Doing One's Best is a process that explains the response that* takes place within a complicated situation that becomes increasingly complex as situational, relationship and emotional complexity interact, leading to compounding complexity.

Core Variable: Doing One's Best

Doing one's best is the greatest effort possible, at a particular point-in-time, that a person can put forth when taking on the caregiving role and making the best of the situation. Compounding complexity (Tompkins & Vander Linden, 2020) may prohibit the caregiver from doing her best. Factors contributing to the compounding complexity are often used as justifications for not taking on, but once a decision to take on has been made, the caregiver needs to be able to cope with or change the factors contributing to the compounding complexity in order to do her best, which will be discussed later within the stages. Other people (especially those outside the situation) often use a caregiver's level of commitment as a measure of whether a person is doing one's best. When doing one's best, caregivers find ways to work with conflict. The level of control a person has over a situation (or factors within a situation) affects one's ability to do one's best. The more control a person has, the more successful she may be at doing one's best. One grandmother expressed how she did her best saying, "She was supposed to stay six months, and she stayed five years. At points I was like lord I can't take all of this, but I did."

Roles are a factor that affect in doing one's best. Role identity, role identity conflict, changing roles, changes in levels of attachment and role confusion are factors that contribute to compounding complexity and affect the ability of a caregiver to do her best. Establishing and maintaining roles will vary depending on the level of enabling and proactivity of the caregiver. For example, whether or not the biological parent is around and if so, whether or not they are living in the same house as the caregiver and the children, and whether or not they are in and out of the lives of the children or are consistently around affects how roles are defined and managed. Parenting behavior coming from a caregiver who is not the biological parent may lead to parental confusion and conflict. These are all factors that contribute to compounding complexity that caregivers try to manage in the process of doing one's best.

The presence of conflict also affects doing one's best. Conflict can be classified into two types: internal conflict and external conflict. Internal conflict is a struggle within oneself to decide or to move forward within a situation. External conflicts are struggles relating to the compounding complexity factors, especially in relation to the people involved in a situation. While working through the conflict, the new caregiver contemplates abdicating (giving up) versus maintaining the caregiving role. It is often difficult to maintain consistency because of the conflicting roles of the parents and kinship caregivers. If consistency is established and maintained through the process of doing one's best as described later in this paper, the kinship caregiver is more likely to refrain from abdicating, and a long-term primary caregiving relationship may be established between the new caregiver and the care receiver(s) (grandparents and grandchildren) as they work together – doing their best to survive the chaos. As one grandmother explained, "We have had some struggles but recently we have been doing much better. We have both made some adjustments."

Doing One's Best is attempting to bring order to the chaos and confusion resulting from the complexities and the lack of permanency associated with the situation. In kinship care situations, it involves doing what is needed to create and maintain a better environment for the care receivers than was the case prior to or during the occurrence of the trigger event.

Trigger Event

The process of *Doing One's Best* begins with a trigger event which is an event that is significant enough to disrupt the status quo of life, adds to life's complexity, and results in change. A trigger event may be one event or several events that often create increased stress in the life of a caregiver. Two common types of trigger events are destabilizing events and tragic events.

Destabilizing events are events that upset the normal routine, such as losing a job; while tragic events are occurrences that cause great suffering, destruction, or distress in the life of those involved. Tragic events are often related to accidents, crimes, or death. One kinship caregiver who was a part of this research was caring for her niece because both her sister and brother-in-law were killed in a car accident. The trigger event may have to do directly with the child, such as a teenager becoming unruly, but often the trigger event is an event in the life of the caregiver (biological parent) that does not directly pertain to the child, such as a loss of job, the addiction to drugs or alcohol, or the onset of an illness, all of which were seen in the data. One

caregiver stated: "my baby was 30 years old when she died. She was out in the street doing what she wanted to do. In the wrong place at the wrong time."

A trigger event adds to the situational complexity (Tompkins & Vander Linden, 2020) that already exists within the situation. Trigger events often result in change as the caregiver tries to address the ramifications of the trigger events. They often exacerbate problems which already exist within the situation and cause a person to feel loss of control and power. Trigger events may cause the needs of the individual to conflict with societal and community laws, policies, and expectations, such as caring for ones' own child. For example, it is most often a societal norm that biological parents are the primary caregivers for their children. Trigger events often complicate the logistics of caring for a child and leads the caregiver to seek additional support.

The additional stress of dealing with a trigger event may also increase the level of conflict within the situation. The caregiver may experience more internal and external conflict which contributes to situational, emotional and relationship complexity (Tompkins & Vander Linden, 2020). Internal conflict is a struggle within oneself to decide or to move forward within a situation. External conflicts are struggles relating to the factors or people involved in a situation. Factors that affect internal and external conflict when faced with dealing with a trigger event are harboring and conveying feelings, conflict between a person's hopes and expectations with reality, and emotional conflict. The trigger event also generates an emotional response that further guides a person's actions, behaviors, and choices within the situation. The trigger event may create emotional conflict within the individual as the person weighs and chooses between two or more options, none of which are ideal. The emotional complexity factors that may affect the outcome of the trigger event include, love, discomfort, unhappiness, and the inability to function as a primary caregiver. One of the children interviewed in the study stated, "My mom is in Washington state with her husband, with my stepdad; she never married my dad because I came before they got married."

A trigger event compounds the complexity of a situation by causing a person to reach one's limit of ability to cope with the situation. Reaching one's limit is going beyond an individual's ability to take-on more responsibility or even continue with the current level of responsibility. A trigger event often relates to coping with change within a complex situation and the caregiver may already feel she[2] has reached her limits and cannot cope with the complexity brought by the change, including the logistics of caring for the child during this change. A trigger event often causes a caregiver to feel like she no longer has the power and/or control needed to deal with the situation, especially when individual or family needs conflict with societal laws, policies, and expectations. From one of the grandmothers interviewed:

> We have a wonderful friend who is Billy's therapist. Ms. P. has helped Billy understand why he is not staying with his parents by telling him that they had--they took some money that they shouldn't have . . . quite a lot of money and they had to go away to work to pay the money back.

[2] The personal pronoun she is used because in this study and statistically, the kinship caregiver is often female.

The trigger event leads to the primary caregiver (biological parent) abdicating the caregiving role. Abdicating is when an individual who has been the primary caregiver gives up that role or responsibility. Abdicating often occurs when the primary caregiver reaches her limit. The trigger event may lead to a voluntary abdicating, where the caregiver gives up the role by choice, or it may be involuntary, where the primary caregiver is forced to give up the role by someone with more authority. In most cases this outside authority is the State but not always (Myers, 2010). If voluntary, the caregiver often feels incapable of continuing the caregiving role, seeks out a new caregiver and both the caregiver who is abdicating the role and the new caregiver perceive this abdication as temporary (Myers, 2010). If forced or involuntary, an outside authority (i.e., the state) has found that the caregiver is incapable of continuing the caregiving role. The outside authority finds a new caregiver and determines if the abdication will be temporary or permanent: One grandmother explained it this way, "You know, so I went along and I said okay, I'm taking custody of both children."

The trigger event results in a caregiver abdicating the role to a new caregiver and creating a new caregiving situation. Within this new caregiving situation, the new caregivers and care receivers continuously work to address the chaos that results from the trigger event(s) by doing one's best. The new situation is not always better than it was prior to the trigger event for the caregiver but the caregiver is driven by motives such as being the family stabilizing influence, family watchdog, family arbitrator, or family heritage keeper, which are described later in the theory.

While the change in the caregiver role may lessen the complexity of the situation for the previous caregiver, it frequently increases the complexity in the life of the new caregiver and may also increase the complexity in the life of the care receiver. Doing one's best often involves identifying and trying to address the most pressing factors that are contributing to the complexity of the situation (i.e compounding complexity). These factors may include situational complexities such as housing, finance; relationship complexities such as integrating the care receiver into the existing family structure; and emotional complexities such as the emotional states of those involved in the situation. For example, the new caregiver may be adjusting to a change in life plans, lifestyle, and expectations. Many new caregivers thought they would be retired at this point in life but instead they continue to work in order to support themselves and the children they are caring for and they are back to a child-rearing stage of life. The care receivers may have similar adjustments such as getting use to a new living environment and learning what may be new expectations from a family member who did not have a permanent, primary caregiving relationship with the care receiver in the past. During doing one's best, the new caregiver and care receiver do their best to work towards creating a new equilibrium in life. *Doing one's best* can be broken into the stages that track the development of a transitioning caregiving relationship (going from biological parent--child caregiving relationship to a kinship caregiver-- child caregiving relationship). These stages are rescuing and taking on.

Rescuing

The first stage of *doing one's best* is rescuing. Rescuing is taking action to save someone from physical or psychological/emotional harm by providing relief from a trigger event which is a traumatic or destabilizing event. There are three types of rescuing: helping out, stepping in, and

taking on. Within each type of rescuing there are two common variations: enabling and protecting. These two variations will be explained first and then related to the types of rescuing, since these two variations affect the different types of rescuing.

Enabling is a reactive behavior in which one individual indirectly supports another individual's negative behavior (i.e., the grandparent enabling her daughter--biological parent). This may include repeated bailing out, another "one-more chance," ignoring or avoiding the problem, joining them (in the behavior, the blaming or justifying), do for the person, and controlling the person or the problem. The level and duration of enabling may vary based on the frequency and severity of the behaviors of the second individual (biological parent) and the stamina and resources of the enabling individual. Enabling often becomes a habitual pattern of behavior within the relationship history of these two individuals. The enabler often offers justifications for the enabling.

Protecting is a proactive behavior in which one individual tries to keep other family members safe from the difficult circumstances that brought them together. Protecting often involves a high level of care which may include physical, emotional, and psychological care and support. It often occurs for a longer duration of time because returning to the previous situation is not a safe and acceptable option. One grandmother illustrated this saying,

> J has been in my home basically since he was about 18 months, he was abused, his father had him for probably 3 or 4 months until he was 18 months old, being physically abused so I stepped in, and brought him to my home and tried to get him--I wanted his mother to have a relationship with him--which was very difficult at the time.

Both variations may result in creating a dependent and reliant relationship within the various types of rescuing and are often seen within the same situation. The new caregiver (i.e., the grandparent) engages in enabling the previous caregiver (i.e., the biological parent) while protecting the child. The protection of the child may become the justification for the enabling of the parent.

Types of Rescuing. As stated previously, there are three types of rescuing: helping out, stepping in, and taking on. Factors that affect rescuing range from reactive to proactive, level of care provided, and the duration of care. Helping out is the temporary process of meeting the needs of another. The level of care is limited and often takes the form of physical and financial needs. Helping out can be reactive or proactive. It is reactive when the help is asked for and proactive when the help is offered. While in the rescuing phase, some caregivers foresee the reality of a more long-term arrangement early on and begin to identify obstacles for taking on the caregiving role long-term. There may be concerns about meeting the physical, psychological, and emotional needs of the child or children as well as housing and financial concerns. Within kinship care, helping out often begins as protecting but becomes enabling, as discussed earlier, when the previous caregiver (the biological parent) does not take the steps necessary to reassume taking care of the needs of the child (or the caregiver's [biological parents'] own needs) as seen in this statement by a grandmother. "I have legal custody, but I have never assumed that I would take her indefinitely. I thought my daughter would get her degree, graduate and then move out with T."

Stepping in occurs when a person proactively decides to accept responsibility for the care of a child. Concerns about the care the child is receiving are often a motivating factor for stepping in. The level of care provided is often more substantial than helping out, involving all aspects of care for the child. The duration of care may be perceived as temporary but often is long lasting. As the duration of care increases, the new caregiver is more likely to engage in enabling the previous caregiver while protecting the child. One grandmother explained it this way:

> Well, my daughter, she's having problems . . . so I had to step in. He was living with his other grandmother, then moved his uncle's, and [didn't] getting along, so I said, 'Well, come on up here,' so he's up here. Yeah, my daughter - she's doing better now. She's messed up a lot of her teenage years, but she's going to get her GED, and she's going to be alright.

Taking on is often reactive and less voluntary. Once a decision to rescue is made, it is often perceived that there is not a choice besides taking on. Taking on occurs when a person decided to accept responsibility but feels like there is not another choice because most often, any choice outside of the family system is not an initial option for caregivers. Taking on can be seen as temporary or may from the start be seen as permanent. Like in stepping in, as the duration of care lengthens, the new caregiver is more likely to engage in enabling the previous caregiver (i.e., supporting the biological parents' negative behaviors by bailing them out) while protecting the child.

Rescuing involves two steps: adjusting and accepting. For rescuing to be successful, then the caregiver must adjust to the new situation and ultimately accept it. Adjusting and accepting are complicated by aspects of relationship, situational and emotional complexity (Tompkins & Vander Linden, 2020). The compounding complexity often complicates decision-making within the situation. Rescuing often occurs without contemplation of long-term consequences. Adjusting is the first step in rescuing. Adjusting to what can be seen as a non-traditional situation often involves figuring things out that relate to aspects of relationship, situational and emotional complexity. In terms of relationship and situational complexity, the new caregiver often struggles with figuring out things such as the level of involvement of previous caregiver(s), determining how far to acknowledge the previous caregivers (acknowledging existence), and clarifying and rationalizing the situation to the care receivers and others. In a kinship caregiving situation, the parent who has abdicated her role may still be present or be totally absent in the life of the child and new caregiver However, the parent may also be in-and-out of the life of the child and creating a situation that is unpredictable and unstable. The new caregiver many be enabling this behavior to protect the child. In each of these cases the grandparent is faced with determining the level of involvement of the caregiver(s) who have abdicated their role and explaining, clarifying and rationalizing this to the child and others which may cause strain in those relationships adding to the relationship complexity. Adjusting also involves dealing with aspect of emotional complexity including not really wanting to be in the situation (the situation not being ideal), the situation being unplanned and not a part of the caregiver's original life plan. In the data from this study, caregivers discussed having to put on hold plans for retirement and what they hoped to do in retirement due to caring for the child, as one grandparent explained:

> It was never, never supposed to be permanent. I am writing a book--I have a lot of other things. It never occurred to me that I would be mothering. I am mothering--I am not grandparenting. I am mothering a teen.

Accepting is the second step in rescuing. Accepting is coming to terms with the situation. It often involves dealing with aspects of emotional complexity including denial and grief. In kinship care situations, the grandparent may be in denial or experience grief about the actions and behaviors of the previous caregiver (biological parent) that lead to the abdicating of the caregiving role. This is especially true when the new caregiver (grandparent) is the parent of the previous caregiver. When the new caregiver is the grandparent, denial may also exist over the role in the life of the child that led to the biological parent abdicating the role. The new caregiver (grandparent) may also experience grief over the situation being different than what was expected or hoped for. One grandparent demonstrated her unmet expectations when she said,

> I would call every week or every 2 weeks and she would say, I don't want to talk to them and I would give them the phone anyway – you need to let them hear your voice and I know that you are not going to be mean to the children on the phone so I would just give them the phone and of course we didn't have no relationship with my daughter and we used to be really close, I mean I taught her how to read when she was like 3 years old.

There are disappointments and frustrations involved with rescuing, adding to the emotional complexity. Frustrations include challenges and barriers, discomfort, unhappiness, unacceptance, turning away and challenges with decision making and making future plans. Initially the situation is most often seen as the caregiver helping out, whereas the caregiver does not have a perception of a loss of freedom nor a perception of the full weight of taking on the caregiving role. However, as time progresses and the situation from which the rescuing took place does not show signs of improving, the reality of the situation begins to set in. The situation has become more than helping out or stepping in; the situation moves from a perception of temporary to long-term or permanent and a perceived sense of loss of freedom (taking on the caregiving role). One grandmother explained her thoughts as she realized the permanence of the situation. She said, "I told my daughter when you get yourself together, at least they are still in the family and they are still your children, they are going to always know you are their mother."

As the perception of the situation changes from short-term to long-term, the caregiver begins to consider her role within the situation. The caregiver is faced with two basic choices: abdicating, in which another new caregiver (i.e., another family member) would be sought, or carrying-on. Carrying-on begins with continuing with tasks and responsibilities that were started during the rescuing phase. While making this decision to carry-on, the caregiver may contemplate motive and other factors that may affect carrying-on. Often these factors relate to aspects of situational complexity, as described by one grandmother. She explained,

> First it was really stressful for me and very overwhelming and I was really tired a lot. I didn't have any social life whatsoever. Nothing. Because my whole life just revolved around whatever the child needed. I didn't have any time to do anything else. I would just go to work and come home and take care of her.

Contemplating motive (not necessarily a conscious contemplation) is a step the caregivers go through when thinking about why they are carrying-on. Motives often relate to one or more of the following four areas: family stabilizing influence (one who promotes stability in the lives of other family members), family watchdog (one who acts as the protector of family members), family arbitrator (one who tries to resolve conflict within the family), and family heritage keeper (one who works at keeping the family close and together). The level of control a person has over a situation (or other factors within a situation) affects one's decision as to whether to carry-on. The caregiver often thinks about whether she will be able to take over the caregiving role. The caregiver may consider factors relating to her point in life as well as the point in life of the care receiver. Health and finances are also common factors considered at this point. The caregiver often wonders if there are any other choices and if carrying-on is the last resort. The alternative of not carrying-on, abdicating, is often not a choice because of the unconditional love the caregiver has for both their children and grandchildren. Abdicating is more likely to occur when a caregiver's limits are bypassed and there are too many stressors in the situation.

A caregiver transitions from the rescuing stage to the taking on stage when a conscious decision is made to become the primary caregiver of a dependent family member(s) after some level of grappling with the complexities and responsibilities of the situation.

Taking on

The transition to taking on may seem seamless to the children (depending on the age of the child) but is often a major turning point for the new caregiver. The previous caregiver (biological parent) may not notice a significant amount of change either. However, taking on is a conscious decision to absorb the primary caregiving responsibilities of a dependent family member(s) after some level of understanding of the complexities. Austinson (2011) defined taking on as the act of identifying an obstacle, choosing whether to address an obstacle and, if deciding to take-on, utilizing various behaviors to work toward minimizing or eliminating the obstacle. Caregivers who are taking on may or may not feel like they had a choice in making the decision. Unconditional love and what is best for the child and other family members may override the preference of the caregiver (and even what is best for the caregiver) and leaving the caregiver with the perception of not really having a choice. Two behaviors used in taking on are: stabilizing and normalizing, which will be described next.

Upon taking-on, caregivers may begin to engage in stabilizing, recognizing that what was initial believed to be temporary is now long-term. Stabilizing is a set of behaviors used to establish or reestablish a state of balance within life after an unsettling event or situation. Some stabilizing behaviors include seeking support and resources, accessing resources, and working the system. Seeking support and resources often starts with an individual's informal system (family and friends) and then if this level of support is inadequate, may move to a formal level of seeking support (for example through the social service system or educational system). Accessing resources is being able to acquire the resources once they have been sought out. Working the system is engaging in strategic actions of aligning to advantage themselves, others, and/or the overall system. The person may work the system by accessing resources through multiple systems. Caregivers can stabilize, create a sense of balance, on their own, with the support of family and with the support of social service interventions. Caregivers who are unable to engage

in stabilizing may wind up in a crisis situation because they are unable to create a strategy or reach out to others for guidance.

Normalizing is the process of establishing a schedule and routine while implementing a course of action due to a destabilizing event resulting from situational complexity. Redefining roles, setting boundaries, and creating a routine are strategies used to normalize a situation. To do one's best when taking on, the caregiver often finds it necessary to adopt a new role in that child's life. This often means setting aside previous roles in order to adopt the new role. This transition may be gradual or more rapid, depending on other dynamics within the situation. Both the new primary caregiver and the child may experience discomfort at the redefining of roles. The primary caregiver is more likely to experience mental or emotional discomfort while the child may act out against the new role of the primary caregiver. This often leads to the next strategy, setting boundaries which is establishing what behaviors are acceptable or not within the new defined family unit. Creating routines aids in normalizing by creating predictability within a situation. Due to the situational, relationship, and emotional complexity, caregivers alternate between stabilizing and normalizing as new issues arise while doing one's best.

There are limits of viability that make normalizing challenging. Limits of viability explains a person's acceptable limits of tolerance which includes what they value, the amount of effort they can exert, the length of time they can expend, and the emotional capacity they are capable of handling. It may also include the resources they have to expend on the situation. Regardless of the means by which people gain responsibility, there are points when they reach the limit of their ability to take on more responsibility or even continue with the current level. In these cases, the limits of viability have been bypassed. When a person reaches her limits of viability, it may prevent the person from doing her best or being able to make the most of the situation.

Discussion

The literature supports kinship care being a better alternative to foster care, but kinship care is not without its challenges and complexities (Generations United, 2019). It is essential to understand the kinship family, from the perspective of the caregivers and the children to determine if caregiving within kinship families is sustainable over the life course.

Whether or not a caregiver's role is sustained and effective over time is complicated. There is a plethora of literature on caregiving, but a minimal amount examining outcomes such as the effectiveness and sustainability of caregiving situations for the caregiver, care receiver and other relevant members of the social network (Joling, Windle, Droes, Huisman, Hertogh, & Woods, 2017; Kim, Lim, Kim, & Kim, 2018; Verbakel, Metzelthin, & Kempen, 2018).

Direct and clear communication between the dyad (and often the triad in kinship caregiving) is important to the success of the caregiving relationship. The ability of the care receiver to send clear messages and the ability of the caregiver to decode and respond to messages appropriately impacts the success of the situation (Corwin, 2018; Nussbaum, Baringer, & Kundrat, 2003). The caregiver's history, particularly concerning the element of trauma, can also impact the complex caregiving relationship and outcomes. A caregiver with a trauma history may be less sensitive to responding to the needs of a child, especially concerning the development of attachment in the relationship, through a misinterpretation of the child's behaviors (Bohr et al.,

2018). Additionally, the caregiver's history may impact other interpersonal relationships, preventing them from seeking help from other individuals or services in the community (Bohr et al., 2018). The impact of successful kinship caregiving has a significant effect on children regarding emotional, behavior, and intellectual outcomes (Sanders, 2003).

The literature relative to caregivers of older adults illustrates that caregiver stress negatively impacts the care receiver and caregiver overall (Cohen et al., 2015). Is this similar for kinship caregivers and the children in their care? The caregiving relationship is difficult to describe as either positive or negative, but a complex relationship of both positive and negative experiences (Cohen et al., 2015). Particular aspects of caregiving are likely to be stressful, and the emotional aspects of a caregiving relationship will have positive and negative qualities for the caregiver and the care receiver. We understand more about the caregiving relationship between the care receiver and caregiver when the caregiver is providing care to a dependent older adult than we do when the care receiver is a child and the primary caregiver is an older adult. It is important that we have theoretical guidance to better understand kinship families before we can make hypotheses as to whether the children raised by their grandparents will potentially step up as adults and become caregivers--whether or not the caregiving relationship will be sustained over the life course.

Implications for Practice

This research can be used to understand more clearly and completely the relationships, situations, and emotions that are often a part of the daily lives of kinship families. When the complexities of these situations interact with each other it makes it challenging for some caregivers to work through the stages of surviving the chaos, rescuing, taking on and doing's one best. It is important to use the theories emerging from this data as guides to better understand kinship families and advocate for needed resources.

Limitations and Area for Future Research

A limitation of this study is not having direct access to the biological parents of the children. A study examining the situation from the perspective of the biological parent is imperative. A grounded theory methodology is not intended to provide population estimates or random stratified survey results (Schoenberg & McAuley, 2007); however, with a better understanding of the variables to explore, a methodology that will lend itself to external validity is a future step. Another area for future research is whether the grandchildren, as young adults who were raised by their grandparents, step up and provide care to their grandparents if the need arises. There is literature to support grandchildren as caregivers for their frail grandparents (Blanton, 2013; Fruhauf, Jarrott, & Allen, 2006) but a question that needs continuous exploration is whether or not the complexities of kinship families (compared to non-kinship families) lessen the chance that the grandchildren will be motivated and capable of providing care to their grandparents if the need arises. As kinship families are more prevalent across the country, we need to understand the existing complexities to sustain the intergenerational relationships over time. It is our hope that this theory is a steppingstone to future research addressing this issue.

Conclusion

Kinship families are prevalent across the country as our foster care families. Kinship care is most often seen as the first choice over foster care because the child stays within the family and the child welfare outcomes tend to be stronger (Winokur, Crawford, Longobardi, & Valentine, 2008). We are learning that the emotions, relationships, and situations that occur as a result of kinship families may be a catalyst for chaos and may need more societal attention than first realized. This study adds to the literature by providing a theoretical framework that is grounded in the data--predominantly in-depth interviews with kinship caregivers and the children they are raising. Kinship care is often seen as what is supposed to be occurring--the best situation for the child; if the biological parents begin to raise a child and then are unable to for a variety of reasons, then a kin or fictive kin option should be initially assessed. The current study did not contradict this perspective but provided a theoretical perspective of the reality of the kinship and the importance of needed societal support. Though we are learning that kinship families are often in need of financial resources, housing and social services to address physical and mental health challenges, we need to have a clearer understanding of what the needed services are to help kinship families cope with the complexities, do one's best, and survive the chaos that is often a part of their lives.

References

Austinson, J. A. (2011). Taking-on: A grounded theory of addressing barriers in task completion. *ProQuest LLC, Ed.D*. Dissertation, Fielding Graduate University.

Blanton, P.W. (2013). Family caregiving to frail elders: Experiences of young adult grandchildren as auxiliary caregivers. *Journal of Intergenerational Relationships, 11*(1), 18-31. doi:10.1080/15350770.2013.755076

Bohr, Y., Dhayanandhan, B., Kanter, D., Holigrocki, R., Armour, L., & Baumgartner, E. (2018). Mapping the attributions of parents: A client-centered dynamic approach to assessing vulnerable caregivers and their young children. *Person-Centered & Experiential Psychotherapies*, *17*(1), 53-69. doi:10.1080/14779757.2018.1431562

Child Welfare League of America (2011). *Frequently asked questions: What is kinship care as defined by CWLA.* Retrieved from http://www.cwla.org/programs/kinship/faq.htm on 1/26/2013

Cohen, S. A., Cook, S., Kelley, L., Sando, T., Bell, A. E., (2015). Psychosocial factors of caregiver burden in child caregivers: Results for the new national study of caregiving. *Health and Quality of Life Outcomes*, *13*(120), 1-6. doi:10.1186/s12955-015-0317-2

Corwin, A. (2018). Overcoming elderspeak: A qualitative study of three alternatives. *The Gerontologist*, *58*(4), 724-729. doi:10.1093/geront/gnx009

Fruhauf, C.A., Jarrott, S.E. & Allen, K.R. (2006). Grandchildren's perceptions of caring for grandparents. *Journal of Family Issues*, *27*(7), 887-911. doi:10.1177/0192513X05286019

Generations United (2019). *Grandfamilies: Generations United's National Center on Grandfamilies works to enact policies and promote programs to help grandfamilies address challenges.* Retrieved from https://www.gu.org/explore-our-topics/grandfamilies/

Glaser, B. G. (1978). *Theoretical sensitivity*. San Francisco, CA: The Sociology Press.

Glaser, B. G. (1992). *Basics of grounded theory*. San Francisco, CA: The Sociology Press.

Glaser, B. G. (2001). *The grounded theory perspective: Conceptualization contrasted with description*. Mill Valley, Ca.: Sociology Press.

Glaser, B. G., & Strauss, A. L. (1967). *The Discovery of grounded theory: Strategies for qualitative research*. New Brunswick, N.J.: Aldine Transaction.

Glaser, B. G., & Holton, J. (2004). Remodeling grounded theory: Article 4. *Forum: Qualitative Social Research*, *5*(2), 1-17.

Harnett, P. H., Dawe, S., & Russell, M. (2012). An investigation of the needs of grandparents who are raising grandchildren. *Child & Family Social Work*, 19, 411-420. doi:10.1111/cfs.12036

Joling, K. J., Windle, G., Dröes, R.M., Huisman, M, Hertogh, C. M. P. M, & Woods, R.T. (2017). What are the essential features of resilience for informal caregivers of people living with dementia? A Delphi consensus examination. *Aging & Mental Health*, *21*(5), May 2017, 509-517. doi:10.1080/13607863.2015.1124836

KFI - Kinship Family Institute (2019). *Department of Family Services – Children and Families: Kinship Caregiving Frequently Asked Questions*. Retrieved from https://www.fairfaxcounty.gov/familyservices/children-youth/kinship-family-institute/frequently-asked-questions

Kim, Geun Myun; Lim, Ji Young; Kim, Eun Joo; & Kim, Sang Suk (2018). A model of adaptation for families of elderly patients with dementia: Focusing on family resilience. *Aging & Mental Health*, *22*(10), 1295-1303. doi:10.1080/13607863.2017.1354972

Kirby, J. N. (2015). The potential benefits of parenting programs for grandparents: Recommendations and clinical implications. *Journal of Child & Family Studies*, 24, 3200-3212. doi:10.1007/s10826-015-0123-9

Laszlo, E. (1996). *The Systems View of the World*. Cresskill, NJ: Hampton Press, Inc.

Myers, J.E.B. (2010). *Child Protection in America: Past, Present, and Future.* Oxford Scholarship Online. Oxford University Press.

Nussbaum, J.F., Baringer, D., & Kundrat, A. (2003). Health, communication, and aging: Cancer and older adults. *Health Communication*, *15(*2), 185-192. https://doi.org/10.1207/S15327027HC1502_6

Pew Research Center (2013). *At grandmother's house we stay: One-in-ten children are living with a grandparent.* Retrieved from https://www.pewresearch.org/wp-content/uploads/sites/3/2013/09/grandparents_report_final_2013.pdf

Rigel, N., Rubio, B., & Monnery-Patris, S. (2016). Is harsh caregiving effective in toddlers with low inhibitory control? An experimental study in the food domain. *Behavior and Development*, 43, 4-12. doi:10.1016/j.infbeh.2016.02.001

Sanders, M. R. (2003). Guest Editorial. *Australian e-Journal for the Advancement of Mental Health*, *2*(3), 123-126. doi:10.5172/jamh.2.3.123

Smith, G. C., & Palmieri, P. A. (2007). *Risk of psychological difficulties among children raised by custodial grandparents*. *Psychiatric Services*, 58, 1303-1310.

Tompkins, C.J., & Vander Linden, K. (2020). Compounding complexity: Examining multiple factors leading to challenges within grandfamilies. *The Gerontologist*, XX, 1-9. doi:10.1093/geront/gnz189

U.S. Census Bureau (2014). *10 Percent of grandparents live with a grandchild, Census Bureau Reports*. Retrieved from https://www.census.gov/newsroom/press-releases/2014/cb14-194.html

Vander Linden, K. L. (2008). Navigating a new experience: A basic social process. *Grounded Theory Review, 7*(1).

Verbakel, Ellen, Metzelthin, Silke F., & Kempen, Gertrudis I. J. M. (2018). Caregiving to older adults: Determinants of informal caregivers' subjective well-being and formal and informal support as alleviating conditions. *The Journals of Gerontology: Series B: Psychological Sciences and Social Sciences*, *73*(6), 1099-1111.

Winokur, M.A., Crawford, G.A., Longobardi, R.C., & Valentine, D.P. (2008). Matched comparisons of children in kinship care and foster care on child welfare outcomes. *Families in Society: The Journal of Contemporary Social Services*, *89*(3), 338-346. doi:10.1606/1044-3894.3759

Youngmee, K., & Schulz, R. (2008). Family caregivers' strains: Comparative analysis of cancer caregiving with dementia, diabetes, and frail elderly caregiving. *Journal of Aging and Health*, *20*(5), 483-503. http://dx.doi.org.mutex.gmu.edu/10.1177/0898264308317533

Declaration of Conflicting Interests: The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding: This research is funded in part by the John A. Hartford Foundation