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"There's so much history": shared parenting dynamics in kinship families

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ABSTRACT

Shared parenting, when adults collaborate in childrearing, is a practice of interest for children in out-of-home care. Yet, little is known about its feasibility and outcomes for kinship families who have preexisting relationships with birth parents. This article shares qualitative results from focus groups that explored participants' experiences and attitudes toward shared parenting. The sample comprised 25 kinship caregivers and 34 child welfare professionals. Findings revealed that shared parenting within kinship families is often less feasible than desired. This article identifies barriers and facilitators of shared parenting, offers a shared parenting typology, and explores implications for policy and practice.

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Introduction

Kinship care – the full-time care of a child by a relative or other adult who is close to them – often occurs when birth parents are unable to serve as the primary caregiver for a child. Within the child welfare system, kinship care is generally preferred as an out-of-home placement because it allows children to maintain stronger ties to their family, culture, and community (Generations United, 2021; Hong, Algood, Chiu, & Lee, 2011; Krakouer, Wise, & Connolly, 2018). Research has also shown that children in kinship care fare better than those in non-relative foster care on outcomes such as well-being and permanency (Bell & Romano, 2017, Ferraro et al., 2022; Winokur, Holtan, & Batchelder, 2018).

Nearly 32% of the more than 600,000 children served by the foster care system in 2021 were formally placed with a relative; this figure includes both caregivers who were and were not licensed by the system as a foster parent (Children's Bureau Administration on Children, Youth and Families, 2022). Yet a large percentage of kinship families

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care for their relatives' children informally – outside of the child welfare system – either through arrangements such as legal custody or guardianship or without legal grounding. Without formal child welfare involvement, informal kinship families receive little to no public support and are not reflected in national kinship care statistics, suggesting that the prevalence, needs, and impact of kinship care are likely far greater than what is formally documented.

Children enter the full-time care of kin for a variety of reasons. According to the 2021 Adoption and Foster Care Analysis and Reporting System (AFCARS) data, nearly 69% of the children living in formal kinship care in 2021 were removed from their parent's care because of neglect, and 42% were removed due to their parent's drug use; notably, over 25% of children in the dataset experienced both (Children's Bureau, 2022). While these figures are not necessarily generalizable to all kinship families, they provide insight into the challenges that many birth parents face, especially as they navigate their relationships with the child and kinship caregiver.

Unlike non-relative foster families, kinship caregivers typically have a personal connection to the birth parents – and the struggles they face – before a child enters their care. Relationships within a kinship family have been described as a triad, with ties between the birth parent and child, caregiver and birth parent; and child and caregiver (Goodman, 2007). These existing relationships, which can be a strength of kinship care, may also lead to relational tension and strain within the family system, which can complicate childrearing (Chateauneuf, Turcotte, & Drapeau, 2018) and affect the family's well-being (Kiraly & Humphreys, 2013; Rose et al., 2022). In addition, the trauma of removing a child from a parent's home can result in feelings of grief and loss for all involved, and caregivers may suffer emotionally, physically, and financially from the stress (Engstrom, 2012; Harding, Murray, Shakespeare-Finch, & Frey, 2020; Kelley, Whitley, Sipe, & Yorker, 2000; Kiraly & Humphreys, 2013, 2016).

Despite the challenges, maintaining a relationship with their birth parents can have long-term benefits on the well-being of children in out-of-home care, regardless of whether reunification occurs. Because of these positive outcomes, there have been recent calls for focusing on shared parenting in both foster and kinship families, including a federal funding opportunity for programs promoting the practice through evidence-based models (Children's Bureau Administration on Children, Youth and Families, 2021). Shared parenting occurs when caregivers do not necessarily live with the birth parents but collaborate with them to raise the child and, when feasible, work toward reunification (Cecil, McHale, Strozier, & Pietsch, 2008; Child Welfare Information Gateway, n.d.; Feinberg, 2003). Yet few studies explore the unique

dynamics between family members in kinship care and how they impact their ability to co-parent.

Purpose and rationale

This study sought to understand the feasibility of shared parenting from the purview of caregivers and child welfare professionals. Given that kinship care has been found to be a protective factor and that the child-parent dyad is critical, we wanted to learn if the practice of shared parenting could be a protective intervention used in kinship care. We sought to understand caregivers' and workers' experiences with shared parenting, including their perceptions of the barriers and practicalities of the practice.

While the literature points to the importance of birth parent involvement in a child's life, little is known about its impact on the kinship family system. Moreover, the literature is virtually silent about kinship families' willingness to engage in shared parenting and its impact on kinship caregivers' health, well-being, and capacity to provide care. We also do not know what system- and organization-level policies, practices, and worker assumptions impede or promote shared parenting in kinship care. Thus, this article reports the findings of a two-part qualitative study that explored the views and experiences of kinship caregivers and child welfare professionals.

Literature review

Terms such as co-parenting, parenting partnerships, and parental cooperation have long been used to describe the practice of sharing responsibility for raising a child and partnering within parenting roles (Gable, Belsky, & Crnic, 1995, Feinberg, 2003, Montalto, 2005). Shared parenting has been commonly explored within the contexts of divorced or separated parents, sometimes related to shared custody, and for outcomes related to child well-being (McHale, Kuersten-Hogan, & Rao, 2004, Nielsen, 2017). The practice of co-parenting for children in out-of-home care began in the 1980s, by encouraging birth family inclusion and collaboration in foster care (Minuchin, Colapinto, & Minuchin, 2006) and has since primarily focused on building relationships between foster and birth parents and working toward permanency and/or reunification (Casey Family Programs, 2018, Bengtsson & Karmsteen, 2021, Children's Trust Fund Alliance, 2020, Child Welfare Information Gateway, 2019, Montalto & Linares, 2011). North Carolina Department of Health and Human Services (NCDHHS) (2019) emphasizes that shared parenting can play a critical role in preserving families by bringing parents and caregivers together for the well-being of the child. Cooperation and solidarity between co-parenting adults have been linked to better social and emotional adjustment in children (Caldera & Lindsey, 2006, Choi, Parra,

& Jiang, 2019, Linares, Rhodes, & Montalto, 2010), whereas high levels of conflict have been linked to insecure attachment and increased internalizing and externalizing behaviors (Caldera & Lindsey, 2006, Linares, Rhodes, & Montalto, 2010, McHale, 2009, McHale & Fivaz-Depeursinge, 2010).

To encourage these positive outcomes, shared parenting has emerged within practice and policy. Programs in foster care such as the Model Approach to Partnerships in Parenting (MAPP) foster parent training curriculum, Birth Parent and Foster Parent Partnership (BFPP), and Quality Parenting Initiative (QPI) facilitate relationship building between the foster and birth parent with the support of caseworkers (Casey Family Programs, 2018; Children's Trust Fund Alliance, 2020). States including North Carolina, Illinois, and Vermont have child welfare policies that encourage, and even mandate, shared parenting between foster and birth families (Christian, 2019; Illinois Department of Children and Family Services, 2021; North Carolina Department of Health and Human Services NCDHHS, 2019; Vermont Department for Children and Families, 2021). However, kinship families, who are more likely to practice shared parenting than non-relative foster parents, need different supports. For example, they may not need tools such as ice breaker meetings, which help foster parents get to know the birth parents.

Factors impacting the effectiveness of shared parenting arrangements

Across the shared parenting literature, researchers have identified relational factors that can either strengthen or inhibit shared parenting arrangements. Such factors include mutual understanding of parenting roles, responsibilities, and how the child will be raised, as well as the levels of respect and support in the partnership (Feinberg, 2003; Holtan, 2008). These dynamics have been shown to impact levels of family functioning, conflict within the co-parenting relationship, and birth parent level of involvement (Holtan, 2008). Other facilitating factors in the literature include communication, compromise, partnership, and modeling of appropriate parenting behaviors (Casey Family Programs, 2018; Strozier, Armstrong, Skuza, Cecil, & McHale, 2011).

In contrast, families with differing perceptions of their roles may experience more conflict and less empathy for the other's perspective or needs. Caregivers and child welfare professionals alike may be inclined to discount the capacity of the birth parent to fulfill their role (Engstrom, 2012; Strozier, Armstrong, Skuza, Cecil, & McHale, 2011). Other challenges include power struggles; conflict over parenting approaches; and feelings of sadness, guilt, and fear (Strozier, Armstrong, Skuza, Cecil, & McHale, 2011). Overall, it is important to identify and consider factors that might affect shared parenting when considering its feasibility and what supports may be needed for it to succeed.

Birth parent involvement and family relationships

Primary considerations for the feasibility of shared parenting are the relationships in the kinship triad and the extent to which the birth parents are involved in the child's life. The literature categorizes birth parent involvement with children in out-of-home care by both quantity (i.e., frequency of visits, presence or absence of the birth parents) and quality (i.e., positive, negative, or mixed experiences during visits) (Chartier & Blavier, 2021; Chateauneuf, Turcotte, & Drapeau, 2018; Gleeson & Seryak, 2010). Families with strained relationships or minimal involvement may need support to effectively work together for the benefit of the child.

Research indicates that birth parent involvement is higher in kinship care, particularly informal care, compared to non-kin foster care (Green & Goodman, 2010; Hassall, van Rensburg, Trew, Hawes, & Pasalich, 2021; Kiraly & Humphreys, 2013; Linares, Rhodes, & Montalto, 2010; Metzger, 2008). Kinship families are more likely to have unplanned or spontaneous contact with parents than foster families (Palacios & Jimenez, 2009), partly because there is often less child welfare system involvement for kinship families (Chateauneuf, Turcotte, & Drapeau, 2018). In kinship families with high involvement, birth parents are more likely to live near their children, have regular visits, maintain phone contact with their children, participate in decision making, and have a close relationship with caregivers (Gleeson & Seryak, 2010; Green & Goodman, 2010). Birth parent involvement has been tied to increased well-being of children in out-of-home care, including lower levels of depression and externalizing behaviors (McWey, Acock, & Porter, 2010; McWey, Cui, & Stevenson Wojciak, 2022). Birth parent contact can also support a child's identity formation and help reassure a child that their parents are okay (Metzger, 2008; Sen & Broadhurst, 2011). However, birth parent involvement in kinship care is also affected by parenting self-efficacy, the quality of family relationships, and children's reactions during and after visits (Gibson, Cryer-Coupet, Knox, & Field, 2020; Kiraly & Humphreys, 2013; León, Jiménez-Morago, & Muñoz-Silva, 2017). Some research has reported neutral or less positive outcomes of parent involvement, such as increased externalizing behaviors in their children (Collings & Wright, 2020; Fuentes, Bernedo, Salas, & García-Martín, 2019; Poitras, Tarabulsy, & Pulido, 2022).

Implicit in discussions of shared parenting is the assumption that the birth parent is present in the child's life and is able and willing to play a bigger role in childrearing. For some families, this may not be possible, either for the child's safety and well-being or because of the parents' own health and well-being, circumstances, or choices (Chartier & Blavier, 2021; Engstrom, 2012). For many formal kinship families, birth parent involvement may be mandated, and caregivers may feel a lack of control in the process (Green & Goodman, 2010; Rose et al., 2022). Yet compared

to foster families, kinship families receive little to no assistance in facilitating contact and visitation with birth parents, and such visits often occur in more informal settings like the caregivers' home, without the supervision of a caseworker (Kiraly & Humphreys, 2013, 2015, 2016; León, Jiménez-Morago, & Muñoz-Silva, 2017). While some caregivers appreciate this arrangement, for others, having to serve as both the protector of the child and broker of the relationship can cause additional stress and relational strain (Kiraly & Humphreys, 2013, 2015; Nesmith, 2015).

There are also times when contact with birth parents – especially unsupervised visits – may jeopardize child safety (Fuentes, Bernedo, Salas, & García-Martín, 2019; Geen & Berrick, 2002; Kiraly & Humphreys, 2013, 2016). Given the lack of support received around visitation, child safety is a main concern for kinship caregivers when involving birth parents (Green & Goodman, 2010; Kiraly & Humphreys, 2013, 2016; Rose et al., 2022). It is critical to weigh the risks, benefits, and feasibility of birth parent involvement and, when possible, plan strategies to facilitate positive interactions.

For many kinship caregivers, managing relationships with birth parents is a stressor (Dunne & Kettler, 2008; Kiraly & Humphreys, 2013; Lee, Clarkson-Hendrix, & Lee, 2016). Birth parents with children in out-of-home care report mixed feelings about their relationships with caregivers (Bengtsson & Karmsteen, 2021; Gleeson et al., 2009; Kiraly & Humphreys, 2015). Parents may trust the caregiver's ability to care for their child but still be upset that they are not the primary guardian, be frustrated over their lack of control in the situation, or even grieve the loss of their child (Bengtsson & Karmsteen, 2021; Kiraly & Humphreys, 2015). Some birth parents feel powerless and kept from meaningful participation in their child's life (Gibson, Cryer-Coupet, Knox, & Field, 2020; Kiraly & Humphreys, 2015). In one study, most birth parents demonstrated little or no cooperation with their child's caregiver, due to feeling "disregarded as a parent" by the caregiver, disagreeing with the caregiving arrangement, or feeling deprived of support or opportunities to fulfill their role as parents (Bengtsson & Karmsteen, 2021, 2011). Some parents also find contact with their children distressing due to the formal supervision and procedures around visitation, even if they want to be with their children (Malet et al., 2010).

When making decisions about parental involvement, it is also critical to hear the child's voice and respect their sense of autonomy as they grow. Children may have preferences around which family members they would like to see, the frequency of contact, and venue or method of contact (Sen & Broadhurst, 2011). Children may also experience a split sense of loyalty between caregivers and their biological parents, which can affect their levels of attachment and the frequency of visitation (Leathers, 2003; Van Holen, Clé, West, Gypen, & Vanderfaeillie, 2020).

Theoretical underpinnings of shared parenting

From the theoretical literature, families can be viewed as systems comprised of subsystems, as products of the environment or context in which they are situated, and as the relationships that comprise them. Three theories – family systems, ecological systems, and relational competency – underlie these perspectives of the family. Read together, these theories offer insight into the complexity of family dynamics in kinship care, the emotions experienced by members of the kinship triad, and barriers to and facilitators of shared parenting.

Both family systems theory and ecological systems theory view the family as an organization comprised of people and relationships. Family systems theory recognizes the impact on all members of the family when change – either expected or unexpected – occurs to one or more members (Bowen, 1966; Cox & Paley, 2003). When change or crisis occurs, families must respond and reorganize (Bowen, 1966; Cox & Paley, 2003), which can leave the system vulnerable (Cox & Paley, 2003). When kinship families form, resulting vulnerabilities could include relational strain and the need to redefine roles, parenting authority, and a new family hierarchy.

A relational lens adds context and nuance to the systems view. In ecological systems theory, relationship quality is comprised of how the actions of one person impact the other, the feelings they have for each other, and the power dynamics within the relationship. Hostile relations in the family can cause an imbalance of power, decreased reciprocity, and more significant negative feelings between members.

Relational competence theory explores family dynamics by looking at a person's overall efficacy in developing and maintaining a range of relationships, shaped by the positive and negative relational experiences they have had throughout their life (L'Abate, Cusinato, Maino, Colesso, & Scilletta, 2010). Relational competence has wide-ranging effects on the functionality of relationships. For example, being emotionally present allows someone to be vulnerable when hurt and empathetic when another person is hurt, but in dysfunctional relationships, members are often unwilling or unable to express these sentiments to the people they love (L'Abate, Cusinato, Maino, Colesso, & Scilletta, 2010). Particularly relevant to shared parenting, presence in a healthy relationship is independent of any power dynamics. This theory also acknowledges that some people may be unable to connect the way that their family would like or need, and this may inflame already strained relationships.

While considering individuals and relationships within families is critical, all three theories emphasize acknowledging the broader systems that surround them. For birth parents, macro-level factors have impacted their ability to care for their children and may prevent them from sufficiently addressing those challenges in support of their family's well-being

(Bronfenbrenner, 1979). Kinship caregivers also face the effects of environmental factors, such as increased economic hardship and financial stress, inadequate housing, and fewer childcare provisions (Generations United, 2020; Sakai, Lin, & Flores, 2011; Xu, Bright, Ahn, Huang, & Shaw, 2020), as well as fewer support services than foster families (Coleman & Wu, 2016; Generations United, 2021; Winokur, Holtan, & Batchelder, 2014). Stress and strain due to this lack of systemic support has been shown to affect parenting approaches and family dynamics (Xu, Wu, Levkoff, & Jedwab, 2020). Therefore, recognizing environmental effects on individual members may also help child welfare professionals facilitate kinship families' understanding of their own dynamics.

Limitations of the literature

With most literature focusing on contact and relationships between children and birth parents in non-relative foster care, less is known about dynamics within the kinship triad and the needs for relational support, particularly in the United States (Holtan, 2008; Winokur, Holtan, & Batchelder, 2014). To inform policy and practice in the United States, it is critical to better understand the nature and quality of relationships within kinship families, the supports families receive, and how these factors impact the feasibility of effective shared parenting arrangements.

Study overview

Given recent interest in and federal funding for shared parenting, as well as the limited literature base on the subject, research was needed about the prevalence and feasibility of shared parenting. The researchers sought a national sample of kinship caregivers and child welfare professionals to gain first-hand perspectives on these issues. This two-phase study, consisting of Delphi Rounds and focus groups, was approved by the Institutional Review Board at The Ohio State University (Study Number 2021E0435) and conducted in Summer 2021.

The study's original aims pertained to kinship caregiver well-being during the COVID-19 pandemic and the factors that affect it; learning more about shared parenting was a secondary research question. During the focus groups, caregivers and professionals shared powerful stories of relationships between caregivers and birth parents, whether they had experience with shared parenting, and the need to make difficult decisions in the best interests of the children in care. As a result, what was once a secondary aim of the study became a significant point of interest. This article will share these findings and explore the feasibility of shared parenting in kinship families.

Materials and methods

Given that the findings reported here are from a larger study, parts of the methodology section are derived from Klein-Cox, Tobin, and Denby (2023) article describing other findings from the study.

Design and data collection

The current study utilized two phases of qualitative research – Delphi Rounds and focus groups – to identify, pinpoint, and clarify the needs of kinship families through the lens of kinship caregivers and child welfare professionals. All activities in this study were implemented remotely to reach a national scale and to adhere to COVID-19 precautions at the time of data collection. Participants completed questionnaires for the Delphi Rounds through Qualtrics and participated in focus groups on Zoom. Prior to participating in either phase of the project, all participants filled out a consent form and demographic questionnaire in Qualtrics. Focus group participants provided verbal consent for recording the sessions to allow the conversation to be transcribed for analysis.

Delphi Rounds were selected to maximize the input of individuals with lived experience into the design of the focus group protocol. This methodology utilizes a series of brief questionnaires, each of which is developed from responses to the previous questionnaire (Iqbal & Pipon-Young, 2009). Questions for the initial Delphi Round were informed by a comprehensive literature review; the team's experience as practitioners, researchers, and members of kinship families; and the research team's previous findings and unresolved questions related to kinship caregiver stress and strain. The second and third questionnaires were developed primarily from the first round of responses. The team used the results from the Delphi rounds to develop the focus group protocol, which included questions on impacts of the pandemic on the functioning and well-being of kinship families, the need for supports and the quality of virtual supports received, attitudes toward and experiences with shared parenting, and ways to improve the awareness of kinship care among policymakers and the public. Focus groups for caregivers and professionals were held separately; the team conducted six focus groups with kinship caregivers and five with child welfare professionals, each lasting 90 minutes, with three to eight participants.

Sample

Researchers implemented purposeful, snowball sampling methods to simultaneously recruit participants for both phases (Patton, 2015). Professionals and caregivers were recruited through a listserv of child welfare agencies across the

country and a kinship support group that is led by a research team member and based in Ohio. The recruitment messages outlined the study purpose, inclusion criteria, time commitment, and incentives, with follow-up e-mails to encourage participation and increase the sample size. Messages also encouraged readers to share the opportunity with other kinship caregivers or child welfare professionals. While the team protected the confidentiality of all participants, recruitment materials for kinship caregivers emphasized that the group leader on the team would not be able to access any identifying information for participants or be present for any focus groups with caregivers.

Eligible participants had to be 21 years of age or older, and caregivers had to provide full-time care to at least one child of a relative or family friend for one year or more. Child welfare professionals needed a minimum of two years of professional experience with kinship families to be eligible to participate. Caregivers and professionals who met the eligibility requirements were able to participate in the Delphi Rounds, a focus group, or both.

A total of 26 child welfare professionals and 35 caregivers submitted applications for the Delphi Rounds, and 17 child welfare professionals and 24 kinship caregivers met the criteria for participation and completed all three Delphi Rounds. The team received applications from 72 professionals and 51 kinship caregivers for the focus groups, and 34 child welfare professionals and 25 kinship caregivers participated. Twelve professionals and eleven caregivers participated in both phases of the study.

Demographic profile of kinship caregiver focus group participants

The sample of caregivers was almost entirely female (96%) and predominately White (64%), with 32% identifying as Black or African American and four percent identifying as Alaskan Native or Native American. Due to our sampling frame, 80% of caregivers were from Ohio, but participants represented 12 different states. Nearly half of the caregivers were in their fifties, with participants ranging from 36 to 75 years old. The majority (52%) were married or in a domestic partnership. While 18% had a yearly household income of over $80,000, 32% earned less than $40,000. Most caregivers had full-time (48%) or part-time (28%) employment and were grandparents raising their grandchildren (64%). More than half (56%) had more than one child in their care. Ninety-two percent of caregivers had a child between six and 10 years old. Sixty percent of caregivers reported some level of child welfare system in their caregiving arrangement, indicating that at least 40% of the sample may have included informal kinship caregivers without current system involvement. Ninety-two percent of caregivers had legal guardianship or custody of the children in their care. See Table 1 for the full demographic profile of the kinship caregiver focus group participants.

Table 1. Kinship caregiver participant demographics.

	Delphi Rounds Participants ($n = 36$)		Focus Group Participants ($n = 25$)	
	n	%	*n*	%
Race/ethnicity[a]				
American Indian or Alaskan Native	0	0.0	1	4.0
Asian	0	0.0	0	0.0
Black or African American	6	16.7	8	32.0
Hispanic or Latinx	5	13.9	0	0.0
Native Hawaiian or Other Pacific Islander	0	0.0	0	0.0
White	26	72.2	16	64.0
Prefer to self-identify	1	2.8	0	0.0
Prefer not to answer	0	0.0	0	0.0
Gender identity				
Man	10	27.8	1	4.0
Non-binary	0	0.0	0	0.0
Woman	26	72.2	24	96.0
Prefer to self-identify	0	0.0	0	0.0
Prefer not to answer	0	0.0	0	0.0
Age				
<30 years	2	5.6	0	0.0
30–39 years	10	27.8	2	8.0
40–49 years	6	16.7	6	24.0
50–59 years	8	22.2	12	48.0
60–69 years	8	22.2	3	12.0
70–79 years	2	5.6	2	8.0
State				
California	2	5.6	0	0.0
Colorado	4	11.1	0	0.0
Connecticut	1	2.8	1	4.0
Florida	1	2.8	0	0.0
Georgia	3	8.3	0	0.0
New Jersey	1	2.8	1	4.0
New York	1	2.8	0	0.0
North Carolina	1	2.8	0	0.0
Ohio	13	36.1	20	80.0
Oregon	6	16.7	2	8.0
Pennsylvania	1	2.8	1	4.0
Texas	2	5.6	0	0.0
Yearly household income				
$20,000 or less	2	5.6	1	4.0
$20,000–$40,000	4	11.1	7	28.0
$40,000–$60,000	6	16.7	1	4.0
$60,000–$80,000	12	33.3	5	20.0
$80,000–$100,000	3	8.3	2	8.0
$100,000 +	4	11.1	3	12.0
Prefer not to answer	5	13.9	2	8.0
Marital status				
Divorced	7	19.4	6	24.0
Married or domestic partnership	24	66.7	13	52.0
Separated	0	0.0	2	8.0
Single, never married	4	11.1	3	12.0
Widowed	1	2.8	1	4.0
Employment status[a]				
Full-time employment	21	58.3	12	48.0
Part-time employment	4	11.1	7	28.0
Retired	6	16.7	3	12.0
Self-employed	1	2.8	2	8.0
Unemployed	5	13.9	2	8.0
Children in care				
Caring for 1 child	13	36.1	11	44.0
Caring for 2 children	10	27.8	6	24.0
Caring for 3 children	5	13.9	4	16.0

(*Continued*)

Table 1. (Continued).

	Delphi Rounds Participants ($n = 36$)		Focus Group Participants ($n = 25$)	
	n	%	*n*	%
Caring for 4 children	3	8.3	2	8.0
Caring for 5+ children	5	13.9	2	8.0
Age of children in care[b]				
0–5 years	29	80.6	14	56.0
6–10 years	30	83.3	23	92.0
11–15 years	19	52.8	15	60.0
16–21 years	7	19.4	1	4.0
Relationship to children in care[a]				
Aunt/uncle	16	44.4	6	24.0
Cousin	4	11.1	1	4.0
Grandparent	15	41.7	16	64.0
Great-aunt/uncle	4	11.1	0	0.0
Sibling	2	5.6	0	0.0
Other	3	8.3	3	12.0
Placement through child welfare system				
Yes	22	61.1	15	60.0
No	14	38.9	10	40.0
Kinship arrangement[a]				
Adoption	2	5.6	2	8.0
Grandparent power of attorney	0	0.0	0	0.0
Informal arrangement between my relative and me	8	22.2	1	4.0
Legal guardianship/legal custody	28	77.8	23	92.0
Other	2	5.6	1	4.0
Financial support received[a]				
Child-only TANF	12	33.3	13	52.0
Child support payments	6	16.7	2	8.0
GAP (Guardian Assistant Program)	5	13.9	1	4.0
Licensed foster parent stipend	11	30.6	3	12.0
None of the above	5	13.9	5	20.0
Other	7	19.4	5	20.0

[a]Respondents could select multiple answer choices on this question. Percentages were calculated using the total number of participants, resulting in a total greater than 100%.
[b]Respondents were asked to provide the age range for each of the children in their care. Because many respondents care for more than one child, multiple age ranges were selected, resulting in a total greater than 100%.

Demographic profile of child welfare professional focus group participants

The child welfare professional focus groups were entirely female, and the majority (62%) of participants identified as White. While the oldest professional was 65 years old, the youngest was 23 years old, with approximately 30% in their thirties. Participants represented 14 states, and over 60% worked for public child welfare agencies. Approximately 53% were child welfare workers, and nearly half (47%) had a Master's degree in their field, with approximately 53% being in social work. The majority (59%) had 10 or more years of experience since earning their highest degree. The full profile of child welfare professional focus group participants can be found in Table 2.

Data analysis and confirmability

To avoid the potential conflict of interest from the sampling frame, the team worked to ensure confidentiality of participants and prevent undue bias

Table 2. Child welfare professional participant demographics.

	Delphi Rounds Participants ($n = 17$)		Focus Group Participants ($n = 34$)	
	n	%	*n*	%
Race /ethnicity [a]				
American Indian or Alaskan Native	1	5.9	2	5.9
Asian	0	0.0	0	0.0
Black or African American	6	35.3	8	23.5
Hispanic or Latinx	2	11.8	4	11.8
Native Hawaiian or Other Pacific Islander	0	0.0	0	0.0
White	9	52.9	21	61.8
Prefer to self-identify	0	0.0	0	0.0
Prefer not to answer	0	0.0	0	0.0
Gender identity				
Man	0	0.0	0	0.0
Non-binary	0	0.0	0	0.0
Woman	17	100.0	34	100.0
Prefer to self-identify	0	0.0	0	0.0
Prefer not to answer	0	0.0	0	0.0
Age				
<30 years	6	35.3	4	11.8
30–39 years	3	17.6	10	29.4
40–49 years	3	17.6	9	26.5
50–59 years	4	23.5	9	26.5
60–69 years	1	5.9	2	5.9
70–79 years	0	0.0	0	0.0
State				
Alabama	1	5.9	0	0.0
Arkansas	0	0.0	1	2.9
California	0	0.0	4	11.8
Delaware	0	0.0	1	2.9
Florida	2	11.8	3	8.8
Maryland	2	11.8	5	14.7
Missouri	1	5.9	2	5.9
New Jersey	0	0.0	2	5.9
New Mexico	1	5.9	2	5.9
New York	4	23.5	3	8.8
Oregon	1	5.9	0	0.0
South Dakota	0	0.0	2	5.9
Texas	3	17.6	4	11.8
Virginia	2	11.8	5	14.7
Highest academic degree				
High school graduate	0	0.0	0	0.0
Associate's	0	0.0	0	0.0
Bachelor's	10	58.8	18	52.9
Master's	5	29.4	16	47.1
Doctorate	2	11.8	0	0.0
Degree field				
Education	1	5.9	2	5.9
Law	1	5.9	0	0.0
Nursing	0	0.0	0	0.0
Psychology	4	23.5	4	11.8
Public Health	1	5.9	0	0.0
Social Work	8	47.1	18	52.9
Other	2	11.8	10	29.4
Years practicing with current degree				
Less than one year	0	0.0	0	0.0
1–5 years	1	5.9	8	23.5
5–10 years	7	41.2	20	58.8
10 or more years	0	0.0	0	0.0
Years working with kinship families				
Less than one year	0	0.0	1	2.9
5–10 years	5	29.4	13	38.2

(*Continued*)

Table 2. (Continued).

	Delphi Rounds Participants ($n = 17$)		Focus Group Participants ($n = 34$)	
	n	%	*n*	%
10 or more years	2	11.8	13	38.2
Less than one year	0	0.0	1	2.9
Professional role				
Administrator/manager	4	23.5	12	35.3
Researcher	0	0.0	0	0.0
Worker	12	70.6	18	52.9
Other	1	5.9	4	11.8
Workplace setting				
Private or nonprofit child and family service agency	3	17.6	12	35.3
Public child and family service agency	14	82.4	21	61.8
Other	0	0.0	1	2.9

[a]Respondents could select multiple answer choices on this question. Percentages were calculated using the total number of participants, resulting in a total greater than 100%.

during analysis. A team member without conflicts of interest managed all correspondence with participants and led the kinship caregiver focus groups. Files with identifying information from caregivers were also managed by this team member and stored separately and securely in OneDrive. The team member with a potential conflict of interest only participated in the focus groups with professionals and received access to de-identified transcripts of the caregiver conversations.

Focus groups were recorded and transcribed through Zoom, and the transcripts were cleaned, de-identified, and reformatted in Microsoft Word. Multiple team members cross-checked the content of the transcripts with the video recordings to ensure accuracy in transcription. Final transcripts were collaboratively coded in the Atlas.ti Web platform. To norm the coding process, two researchers individually coded a sub-set of the transcripts, read and provided feedback about the other's decisions, and then conferred to discuss questions that arose or places where their coding differed. This process was repeated throughout the rounds of coding.

The research team began with Deterding and Waters (2021) flexible coding framework, which leverages researchers' knowledge of the literature and understands that coding may not be fully inductive. In the first round of coding, two researchers used index codes to classify large sections of text based on concepts from the focus group protocol and the underlying framework for the study. At the same time, the researchers separately tracked potential analytic codes to be used to provide detail for smaller amounts of text and then finalized a complete set of analytic codes that also included themes from the initial analysis or concepts from the literature. Subsequently, the researchers coded the transcripts using the analytic codes and added more codes as needed. The two researchers met weekly to address questions or concerns, resolve coding discrepancies, and discuss emerging themes.

To focus on shared parenting, the team condensed the data through one more round of coding (Miles, Huberman, & Saldaña, 2020) and mapped all of the codes with the conceptual framework. The mapping process helped identify redundancies, unclear code names, and gaps in the coding schematic. To enhance the study's confirmability, the third researcher, who was not involved in the focus groups, provided an objective assessment of the alignment between the coding plan, underlying data, and research questions. After making these adjustments, the team ran frequency counts and created co-occurrence tables in the Atlas.ti Desktop platform to better understand how often different codes were used together. In combination with key quotations, these analyses helped the team distinguish and provide context for important findings from the data, grounded in the words of the participants.

Trustworthiness, dependability, and transferability

This study utilized five methods from Morse (2015) to ensure trustworthiness and dependability of the data. First, prolonged engagement allowed the researchers to follow study participants for a longer period of time – through both Delphi Rounds and focus groups and over many weeks – to engage them more authentically and learn about their lived experiences (Canosa et al., 2018). After their participation, focus group members were invited to take part in member checking (Miles, Huberman, & Saldaña, 2020), and 11 caregivers (44% of the sample) and 18 professionals (53%) opted to participate. These participants were asked to correct errors in a de-identified transcript from the group in which they were a member, provide context as needed, and offer feedback on an initial list of themes. Participants strongly agreed with the initial findings and only noted a few minor changes to be made to the transcripts.

The research team used peer debriefing to work collaboratively to process how each member interpreted the findings (Lincoln & Guba, 1985). The three researchers in this study first reviewed the data from the Delphi rounds and focus groups independently to reach their own conclusions about the findings and then met regularly to discuss their thoughts, interpretations, and ideas about the study results.

The ongoing team meetings and coding process described above helped facilitate agreement on what codes would be used and how they would be interpreted and defined, no matter who was coding (Patton, 2015). Finally, thick descriptions allowed research participants to tell their own stories in their own words and provided additional depth or meaning to the experiences they shared (Lincoln & Guba, 1985; Younas et al., 2023). Each finding from this study below is supported by direct quotations from participants in the focus groups.

Results

Three main themes about shared parenting were derived from the focus groups: 1) differing perceptions of shared parenting as a concept versus as a feasible practice; 2) strained relationships and family trauma as barriers to shared parenting; and 3) communication, mediation, and accountability as enabling factors for shared parenting. Each will be discussed in detail below.

Perceptions of shared parenting as a concept versus as a feasible practice

Focus group participants were asked to share their experiences with shared parenting – either within their own family or the families they support. Caregivers were also asked to reflect on the benefits and challenges they noted from their experience, and professionals were asked to identify enabling factors and barriers to the practice.

Lack of feasibility for effective shared parenting

When discussing the topic conceptually, responses were generally positive; participants could see how a collaborative relationship between the birth parent and caregiver could be beneficial for the child and family. However, when sharing about co-parenting in their own families or with kinship families they support, few participants had a positive experience to relate. Many caregivers conveyed the ambivalence and anxiety that they often felt when interacting with the birth parents of the children in their care. One caregiver admitted:

> I think the kids would be very unhappy if they didn't see their parents, but on the other hand, they would be very unhappy if they didn't come back home to my house. So in my instance I think it might be a good . . . I don't know, it's, I don't like it, I don't like it at all. If I had my way about it and I thought the kids would be happy, I wouldn't care if their parents were ever involved again.

One professional noted that shared parenting occurs infrequently in practice: "*I think a lot of them would love it, but in reality . . . it's probably less than 10% I would say, I think, for my families*." This bore out among the caregivers; although they were not asked directly, of the 24 focus group participants, only five mentioned that both birth parents were either present or played some role in their child's life. Nine caregivers either indicated explicitly that neither parent was involved or made no mention of involvement. For two families, a birth parent was deceased. Even for those with some relationship with the parent, meaningful shared parenting was not always possible. Concerns about the birth parent's capacity to be a positive presence in their child's life included substance use, mental illness, physical or intellectual disabilities, and incarceration. A great-grandmother expressed:

> There's mental health, there's addiction, that is the reason why they're there. Yet, it seems like there used to be hope that they could . . . go to rehab and come back and get all the love that they wanted . . . and then take over raising their kids again. I don't see that ever happening.

However, some caregivers still expressed an openness toward future opportunities for birth parent involvement if circumstances were to change. One grandmother shared:

> I just want to keep the door open for her somewhere down the road that she knows who her parents are. But you know I am the responsible party here, and my daughter cannot do it, and having her around is not always a positive experience.

This sentiment was shared by another participant, who shared that she would not prevent the children in her care from having a relationship with their mother if she became healthy. These caregivers demonstrated that while they were acutely aware of the reality of their own situations, and their circumstances inhibited the possibility of shared parenting, they did see the value in the children having a relationship with their parents.

Instances of successful shared parenting

The focus groups did reveal that some families can make a shared parenting arrangement work effectively, tailoring the practice to their own needs and desired level of involvement. One professional noted, *"I've seen it play out a few times now, where it's like the most beautiful scenario, where we have grandparents teaching their children how to be parents in a way that's healthy."* A grandmother explained the arrangement that she and her husband have with their son:

> Our schedules are such that . . . we have them during the week, he has them on the weekend. It works for us, and I just feel like I have to justify to anybody who questions that, like my friend group, you know, like why doesn't he raise his own kids? Well it's working for us, you know, it's working for the children, and they're all happy.

Because her son was not the perpetrator of his children's maltreatment, he was in a better position to repair the harm that had been done and work to have a positive relationship with his children.

A similar pattern appeared in other participants' accounts of positive and productive relationships with birth parents. Another grandmother, whose grandchildren came into her care when her daughter was incarcerated, explained the current arrangement with her daughter:

> . . . she thought [it] would be best that I take care of them, you know, so I just kept custody of 'em and stuff and I just take care of them. She's in their life and stuff . . . She's not like a deadbeat or anything like that. She helps out a lot.

A child welfare professional observed that shared parenting arrangements are typically with parents who do not pose a danger to their children and who had

less severe reasons for their removal, such as a brief period of incarceration for a minor offense. However, when the harm caused by the birth parent was significant or if they had not overcome the issues that prevented them from parenting appropriately, a shared parenting arrangement was far less likely to be made.

Balancing relationship building with child safety and protection

Participants implied that before co-parenting can occur, there must be healthy relationships across the triad. One caregiver shared how their family built a relationship with the birth father over time:

> . . . we've really worked hard to keep her involved with the father's side because all of them are great and willing and they don't pose a danger to her. . . So it started small, we met for dinner, we eventually built up some trust and set her on dinners or for the day. And this is all based on what she wanted. This started at age six and we've just worked up to now . . . they have their own relationship, they text each other.

Yet sometimes even a relationship with the birth parent is not possible, particularly when the safety and well-being of the child are a concern. Kinship caregivers and child welfare professionals mentioned issues related to safety – especially if the removal was due to abuse, violence, or other harm to the child – as a roadblock to shared parenting. One professional summed up the challenge inherent in advocating for co-parenting with someone who has endangered the child. She said:

> People don't end up in this situation because they're doing great and they're parenting great. So I think what we're asking of individuals and I know at least from my perspective, as a system we're asking them to keep these kids safe, so if we're talking safety and that's the underlying factor, I'm not then going to be encouraging you to share your parenting duties with someone who has consistently put that child [at] risk . . .

This participant continued, providing a helpful distinction between a child having a relationship with the birth parent and allowing the birth parent to be at least partly responsible for the child:

> We just focus on the concept of bridging the gap . . . ensuring that birth parents play a meaningful role in a child's life, if possible . . . And so the more people in their life that provide them with that solid foundation of knowing that they have unconditional love, . . . great. But taking on an active parenting role and like co-parenting with someone who placed that child at risk very frequently, that would be a tricky thing for me to sell.

Caregivers shared anecdotes of how visitation and other attempts to build a relationship with the birth parent put themselves or the child in danger. One grandmother shared an egregious example:

> It was after about two years of us having them, [the mother] never called or . . . anything like that, we allowed her to take the kids to the zoo. She lied about where she took them, she ended up not taking them in there. My granddaughter, she came back with

> a humongous cigarette burn on her shoulder. And my grandson had to go to the ER because he . . . was running around barefoot . . . and gotten a rusty nail in his foot, and she just brought them back and dropped them off.

Another caregiver recounted how her grandchild's father spent time in prison because he broke his son's femur; yet after he completed his sentence, the court gave him mandatory visitation with the child. In situations such as these, efforts to maintain the child's safety – physically and emotionally – preclude any ability to form a relationship with the birth parent or work toward shared parenting.

However, some professionals felt that caregivers sometimes go too far in trying to protect the children in their care. One said, *"I think we sometimes get too caught up in being overly protective where it . . . kind of pushes the birth parent out of the picture so there's really no collaboration going on."* This comment demonstrates the heavy burden placed on caregivers to simultaneously navigate these risks, protect their families, and stay open-minded to a relationship with the birth parent.

Strained relationships and family trauma as barriers to shared parenting

Caregivers and professionals alike made it clear that the strain in relationships with the birth parent were longstanding and deeply painful. One grandmother shared the ongoing conflict present in the relationship she has with her daughter:

> I'm going through my daughter telling me all the horrible things I did as a mother, and I think well if I'm so horrible, how can I be raising her kids? But, and I know every parent makes mistakes, I did. I thought I tried pretty hard with both sets of children. I have to answer to myself whether it's enough, and sometimes it never will be.

For other participants, relational strain was particularly evident when discussing parental substance use. A professional said:

> . . . by the time . . . you're engaged with the relatives, they're so done. Because most of the time there's a long history of substance abuse and . . . all of the dynamics that go along with you know the substance abusing family and how they . . . keep getting let down, time and time and time again, and just relapse.

Another professional shared a similar thought: *"It's a challenge, because that support system has probably been, when I say used and abused, . . . they've done this for several years and they're tired of doing it because nothing's changed."*

One caregiver with experience as a child welfare professional became emotional in sharing her family's story. She explained how longstanding family trauma and unresolved issues often resurface when a child goes into kinship care and emphasized that these issues need to be addressed to improve outcomes for all the whole family. A professional shared this sentiment, explaining how she works to help families overcome these dynamics and understand the other's perspective:

> There's so much history, and I think that that history is what they can't get past, you know a lot of the times there's a lot of animosity between the relatives and the parents, and no one's willing to engage in any kind of therapy. No one's willing to like just listen to the other side . . . the education piece on understanding the reasons behind the drug use and the lack of reaching out for mental health services, you know getting them past that, the understanding of why they can't just pick their kids first is definitely something that I've had to work through a lot with my families.

Without these types of supports, families may struggle to work through distrust and past harms, making a collaborative co-parenting arrangement far less likely.

Emotional impact of strained relationships on the family system

Focus group participants emphasized that troubled relationships with birth parents affect the entire family system. One caregiver explained the widespread effects of the relationship with her brother:

> It's hard when it's family . . . I'm trying not to tear the family apart as much as I feel like everything he's doing is tearing the family apart . . . I think that's even more pressure is feeling like you're trying to do what's best. I'm trying to do what's best for my niece, I'm trying to do what's best for my immediate family and trying to save my you know extended family at the same time.

Participants also mentioned the emotional consequences of challenging relationships with birth parents on the children in care. One caregiver explained:

> It was triggering them every single time they talked to her. They were having some really extreme behaviors afterwards. It's very difficult for young children to understand even what's happening, you know with their parents, explaining addiction to developmentally challenged kids is really, really tough. Really tough.

A child welfare professional explained how these strained relationships manifest for many caregivers and family members as grief. She said:

> There's a lot of grief around the loss of the relationship dynamics that the individuals expected within their family . . . if I ever were to have to step in because my child was unable to care, sure I'm stepping in and I'm dealing with my grandkids' grief and loss but I'm also like really grieving for what I expected or had hoped for my own child . . . so it's just very layered and much more complex than what foster parents have to go through . . .

Often, caregivers are forced to choose between helping the parents or protecting the safety and well-being of the children in their care, and this is not an easy choice. Most caregivers expressed exasperation with the birth parent's decisions and the investments they have made in trying to help them. One grandmother shared the following about her daughter:

> We have tried to help her in the past, many, many times, spent a lot of money on trying to help her, and you know what, you're 30 something years old. You're on your own. Whatever happens, happens. You chose this path. I know I got five kids that I need to get through college, they're going to be somebody.

One professional shared the same sentiment, from a resource that she uses with caregivers:

> . . . you have to decide when enough is enough, if you've given everything that you can to try to make this work with your adult daughter or son, then you have to make a decision about who you're going to help – either that adult child or grandchild.

Yet caregivers wanted birth parents to be held responsible for the choices and actions that have impacted their children and family. Such difficult feelings are challenging for kinship caregivers to overcome, as they not only have to process their own thoughts and emotions but also support the children in their care with theirs. Such unresolved and longstanding strain on family relationships makes attempting shared parenting much more complicated for kinship families.

Communication, mediation, and accountability as enabling factors for shared parenting

Participants were asked what factors would make it easier for kinship families to work together to raise the child. When the birth parent is present, three main enabling factors were viewed as helpful by the caregivers and professionals: 1) boundaries with the birth parent; 2) clear communication between the birth parent and kinship caregiver; and 3) family mediation and support.

Boundaries with the birth parent

Establishing healthy boundaries for the care of the child and the relationship with birth parents came up frequently in the focus groups. Caregivers and professionals described how birth parents often push back against the kinship caregiver's authority over their child. A professional said:

> I think what's very challenging about it is it becomes very confusing for the child who has the authority. And I have seen more often, . . . bio parents really struggling with deferring to the authority of the individual who's serving in a parenting role, day in and day out.

A caregiver shared her first-hand experience with how challenging this can be for the children:

> They should only have one person telling them what to do, they can't have me saying something and their dad saying something different, and their mom saying something else. That's too confusing to children. So I've just made it very clear to everyone concerned that I am the one that has the final say. And it's taken a long time to get there.

Another caregiver shared that her brother and his girlfriend have not always reacted well to her rules for the niece she is raising and how stressful those disagreements can be. She said:

> They try to one up me all the time, it's just very aggravating. And we do say, we have the final say . . . if you guys can't follow the rules, we can end visitation, and that doesn't go over well, because then we get the "it's my daughter and you're not . . . her mom, you're her aunt . . . " I'm like, "well you don't have custody of her because you were in prison, you made bad choices, and that's why we're all in this situation."

A professional noted that when necessary boundaries are not effectively established by caregivers, they might enable birth parents' behavior and cause disruption for everyone in the family. Kinship caregivers must therefore assert not only their authority but also the rules and boundaries they have established to protect and support the children in their care.

Communication between caregiver and parent

Professionals emphasized that clear communication between caregiver and birth parent is critical for improving relationships and working toward shared parenting. One participant said:

> It's really open conversations with both the bio parents and the relatives with us present . . . and acknowledging that, you know you are their birth parent, nothing will ever take that away, they love you, but the child is living in a different home and day to day, they need to respect this individual . . . who is caregiving for them on a consistent basis . . . Just getting you know bio parents on board with kind of the plan or what's in the child's best interest.

Another professional explained that such conversations can be difficult because of past harms within the family system. Caregivers may struggle to acknowledge that the birth parent has made enough progress to be a responsible co-parent. This professional noted that families who are more successful at navigating these conversations are willing to participate and work toward the same goals. However, while effective communication can help facilitate shared parenting arrangements, it is difficult to accomplish in families that have experienced trauma and strained relationships. As a result, support is often needed to guide families as they tackle these difficult conversations.

Family mediation and support

The topic of family mediation came up repeatedly during the focus groups. Caregivers felt that having a mediator would help them navigate challenging conversations with the birth parent, particularly around the boundaries they have set for their relationship with the child. One grandmother said, "*It's somebody else saying . . . this is the requirements, you have to pay . . . so you know, so it's not, 'Wow you threw me under the bus, mom' or any of that stuff, it's 'This is what you need to do.*'" A child welfare professional explained why mediation can be so powerful:

> Some kind of mediation between the worker and the families, parents and families, can really make a big difference because they just don't know where to start a lot of times. You know there's just a lot of angry feelings that are sort of serving as a barrier between the two of them, and . . . they need to somehow systematically break that down to be able to recognize that . . . things may have changed.

Caregivers also expressed a need for support with visitation; those who were mandated to supervise visitation expressed a great deal of stress about this responsibility, with one caregiver saying that she felt "trapped" and did not have anyone to reach out to for help in navigating this burden. A professional explained how support from a case manager could mitigate these stressors:

> . . . I think sometimes they're like "Oh well, it's kin so they can supervise the visits, they can arrange the visits," you know. And that puts a lot of stress on the caregiver then and that could potentially impact that relationship too. Whereas if you're still there, like "okay I'm . . . the case manager, the kinship caregiver's here to support," that allows them the time then to work on that relationship side of it, not what am I going to coordinate visits, or you know, are they following the plan or not. That's a caseworker's job . . .

Having a neutral party help families broach these emotional conversations was something that caregivers desired and that many of the professionals in the focus groups offered in their work.

Discussion

The current study fills a gap in the literature regarding the experiences of kinship families and child welfare professionals with shared parenting. Reflections on the feasibility of shared parenting, as well as barriers and facilitators to the practice, emerged as themes from focus group conversations with caregivers and professionals. Based on these findings, we propose a typology that can be used to help determine the feasibility of shared parenting within kinship families.

Typology of shared parenting and birth parent relationships

The stories shared in the focus groups demonstrate that birth parent involvement can look vastly different from family to family, ranging from no contact at all to regular visits to successful co-parenting arrangements. Of critical importance was the finding that a history of trauma and strained relationships within the family system not only impact the level of involvement from the birth parent, but also the emotional effects of that involvement on all members of the kinship triad. To account for these complexities, we propose the following typology of birth parent relationships in kinship care, within which these challenging dynamics are related to shared parenting.

This typology considers the quality of the relationship with the birth parent in terms of its impact on the family – from harmful to beneficial. As L'Abate, Cusinato, Maino, Colesso, and Scilletta (2010) explain in relational competence theory, relationship quality is connected to a birth parent's ability to maintain a healthy relationship with their children and kinship caregivers. This model also extends the range of involvement found in the literature, proposing a scale from no involvement in the child's life to actively sharing the parenting responsibilities. While other authors have referred to the quality and frequency of involvement as axes (Holtan, 2008), the model in Figure 1 positions these components as a coordinate plane to indicate that each axis offers its own spectrum of possibilities, but these components also intersect in meaningful, and often complex ways in kinship families. The quadrants offer insight into the implications of this interaction for the family and the feasibility of shared parenting within it. For example, a child may have mandated visits with their birth parent, but the parent may put the child or caregiver's physical or emotional safety at risk. Here, shared parenting may be infeasible, especially without necessary oversight or formal support. Alternately, a family system might be rebuilding its relationships, and the child may see the birth

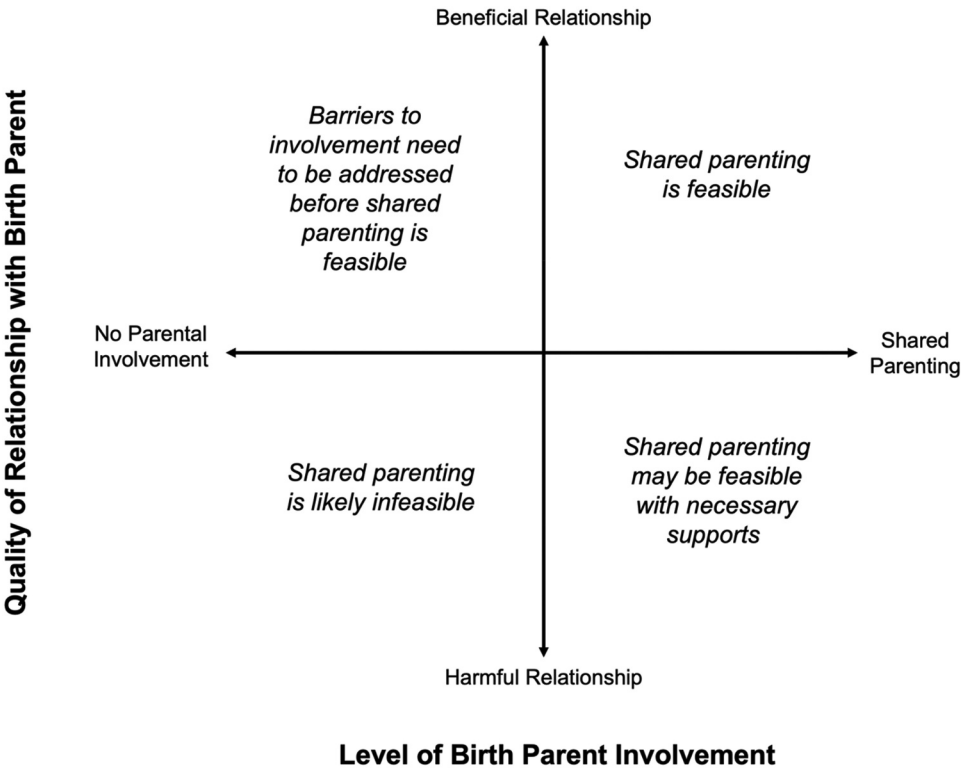

Figure 1. Shared parenting typology.

parent less often. Shared parenting may eventually be feasible for this family, but mediation or family therapy may help to facilitate this process.

Our model considers the potential influences of external factors on shared parenting relationships that are highlighted by family systems and ecological systems theories; this typology honors the fact that relationships within family systems – particularly in kinship care – are both dynamic and malleable, and these changes may result in new strengths or vulnerabilities for all members (Bronfenbrenner, 1979; Cox & Paley, 2003). As family relationships shift and potentially grow, so too does the possibility that shared parenting could occur.

Feasibility of shared parenting in kinship families

Both kinship caregivers and child welfare professionals expressed that shared parenting is appealing in theory but often more difficult in practice. Many caregivers noted that shared parenting was not currently possible in their families, often due to the birth parent's personal struggles, strained relationships within the family, or a lack of birth parent involvement in their child's life, and these challenges were not unique to the families in this study. Other studies reported that parents who had abused their children or committed other acts of violence, had struggled with mental illness, or were actively using drugs or alcohol were also less engaged in their child's life (Chartier & Blavier, 2021, Coakley et al., 2014; Kiraly & Humphreys, 2016; Nesmith, 2015).

The literature also supports our findings around the openness of many kinship caregivers to relationships with the birth parent. Nesmith (2015) found that, compared to foster parents, kinship caregivers were more likely to focus on the potential benefits of visitation for the child and feel that parents can help preserve a sense of family and reduce feelings of abandonment. Yet for many families in this study, even contact with the parent was considered harmful or was not possible, contrasting Green and Goodman's (2010) findings that birth parents are more likely to have contact with their children in kinship families, especially in informal care.

In our sample, concern for child safety also contributed to the feasibility of shared parenting – and having a healthy relationship with the birth parent. This is consistent with the literature, in which caregivers prioritized the child's safety and well-being – not only physically but also emotionally – in decisions about supporting the parent and their level of contact with the child, despite the potential effects of these decisions on dynamics with birth parents and the family system (Rose et al., 2022). Caregivers shared experiences where child safety was compromised during unsupervised visits, which is consistent with other studies in which kinship caregivers expressed that birth parents posed a physical or psychological threat to their children (Kiraly & Humphreys, 2016; Poitras, Tarabulsy, & Pulido, 2022; Rose et al., 2022).

Some professionals in the focus groups expressed concerns that caregivers may be too protective of the child in their care. Yet kinship caregivers' protective orientation toward children in their care is widely cited in the literature, particularly about their concerns related to birth parent contact (Dolbin-MacNab, Smith, & Hayslip, 2021; Green & Goodman, 2010; Kiraly & Humphreys, 2016; Rose et al., 2022). Rose et al. (2022) found that many kinship caregivers limited interactions with birth parents and noted that caregivers working to improve dynamics with the parents had to accept that, "people who they had viewed as a danger to their families were now to be trusted with the children in their care" (p. 8). Kinship caregivers in this study also struggled with this perspective shift and expressed distrust in the parents' ability to safely care for their children.

Strained relationships as a barrier to parental involvement and shared parenting

Strained relationships between caregivers and birth parents were identified as a major barrier to shared parenting among the families in the focus groups. This is supported by research that heavily cites ambivalent, conflictual, and complex relationships between birth parents and kinship caregivers (Chateauneuf, Turcotte, & Drapeau, 2018; Goodman, 2003; Kiraly & Humphreys, 2013; Linares, Rhodes, & Montalto, 2010; Rose et al., 2022; Strozier, Armstrong, Skuza, Cecil, & McHale, 2011; Vanschoonlandt, Vanderfaeillie, Van Holen, De Maeyer, & Andries, 2012). Sentiments of grief and loss, along with guilt or remorse for the birth parents' struggles, have been reported in other studies with kinship caregivers (Backhouse & Graham, 2013; Dunne & Kettler, 2008; Rose et al., 2022; Strozier et al., 2011).

As noted in other studies (Rose et al., 2022; Zinn, 2017), it was evident that birth parents' struggles and relational challenges with kinship caregivers in our study affected the entire family system, on many levels. Given the strain and trauma experienced, shared parenting may not be a one-size-fits-all approach for kinship families (Feinberg, 2003). The nature and quality of relationships between the caregiver, child, and birth parent should be explored to determine an appropriate arrangement for individual families. These considerations are also important when promoting shared parenting as a policy and practice recommendation, as well as identifying needed support for families where shared parenting is feasible and/or desired.

Factors that facilitate shared parenting

Establishing and maintaining boundaries with the birth parents were important but often challenging tasks for kinship caregivers in the focus groups, and this is supported by the literature (Collings & Wright, 2020; Kiraly &

Humphreys, 2016; Nesmith, 2015; Vanschoonlandt, Vanderfaeillie, Van Holen, De Maeyer, & Andries, 2012). For example, in interviews with incarcerated mothers and grandmother caregivers, Strozier, Armstrong, Skuza, Cecil, and McHale (2011) noted benefits of assigning one person primary authority over raising the child provided "clarity and comfort" to the family (p. 57). While many caregivers in our study shared how they asserted their authority, it was not always respected by the birth parents. A few professionals felt that the caregivers were not firm enough in setting or upholding these boundaries.

Consistent with other literature (Cecil, McHale, Strozier, & Pietsch, 2008; Collings & Wright, 2020; McHale, Lauretti, Talbot, & Pouquette, 2002; Strozier, Armstrong, Skuza, Cecil, & McHale, 2011), child welfare professionals in this study suggested honest and open communication between birth parents and caregivers as an important step in improving familial relationships and working toward shared parenting. Bengtsson and Karmsteen (2021) found that birth parents who effectively partnered with case workers and foster parents were able to accept their own parenting limitations and focus on what was best for the child; this focus on the child's best interest was also suggested by professionals in the focus groups.

However, some families need support, such as mediation, in having these difficult conversations, due to unresolved feelings and distrust between birth parents and caregivers. In literature and professional development curricula supporting birth parent involvement and shared parenting, case workers play a key role in overseeing and facilitating family dynamics and visitation (Christian, 2019; Nesmith, 2015; Nesmith, Patton, Christophersen, & Smart, 2017; North Carolina Department of Health and Human Services NCDHHS, 2019). Caseworker facilitation of emerging shared parenting partnerships may be even more critical for kinship families navigating challenging relationships (Strozier, Armstrong, Skuza, Cecil, & McHale, 2011).

The literature also highlights the need for additional supports such as training for professionals on supporting kinship family dynamics and visitation (Collings & Wright, 2020; Green & Goodman, 2010; Linares, Rhodes, & Montalto, 2010; Strozier, Armstrong, Skuza, Cecil, & McHale, 2011). Kiraly and Humphreys (2013) report that within child welfare systems, the onus of interacting with birth parents is often placed entirely on kinship caregivers, without adequate supports or guidance for navigating this relationship and visitation with the child. From experiences shared in this study's focus groups, kinship families are largely left to manage strained family dynamics on their own, including communicating directly with birth parents and making decisions regarding their involvement.

The typology of birth parent relationships and shared parenting proposed in this article may also serve as an enabling factor for decisions about co-parenting. Child welfare professionals working to support kinship families can

use this model to assess the quality of relationships within the kinship triad, the birth parent's level of involvement, and the family's potential – or lack thereof – to build a harmonious and effective shared parenting relationship. With information about a family's unique dynamics or what supports they might need, interventions can be tailored, and shared parenting will only be recommended or encouraged when appropriate.

Limitations

Three limitations of the study should be noted. First, because the original aim for the study was caregiver well-being, the researchers did not initially plan for the involvement of birth parents. As the theme of shared parenting became more significant during the analysis, it became clear that the birth parent perspective would have been beneficial to gain insight into an understudied part of the kinship triad, triangulate the thoughts of caregivers and professionals, and reduce any potential bias toward birth parents. An additional limitation comes from the use of a team member's support group as part of the sampling method. While many steps were taken to ensure confidentiality and mitigate bias, this connection could have affected some caregivers' decision to join the study or not, as well as the interpretation of the findings. Finally, the use of the support group as a primary sampling method did lead to an oversampling of caregiver participants from Ohio. While it is not the goal of this team to generalize our findings to other locations, participants from Ohio may have been affected by local and state child welfare laws and policies that could have impacted how they perceive their own experiences.

Implications

Much of what we know about the preference for and benefits of shared parenting in kinship care is theoretical in nature. The study discussed here and the supporting literature revealed that if shared parenting in kinship care is to be realized in practice and policy, significant research is needed to better understand its viability. Our study results suggest that it is premature for the field to move in the direction of shared parenting policy without first understanding which families it would work for and under what conditions. Shared parenting among kinship caregivers and birth parents may not always be feasible, and in circumstances where it may be advisable, we must develop stronger practice frameworks that can guide interventionists. Before practice and policy directives can be pursued, additional research is warranted so that we understand the impact of shared parenting on child well-being, as well as caregivers' capacity and sense of agency.

Research to inform viable practice approaches

Future research can be guided by the shared parenting typology offered here to construct a predictive analytic model to determine viable shared parenting conditions and variables. By understanding more about the conditions that predict child safety and well-being, a caregiver's ability to establish parameters and necessary parental accountability, the role of cultural influences across racial/ethnic groups, and relational competency, we might be better able to predict which families will do well in shared parenting arrangements. Research that helps us understand barriers to shared parenting and how to mediate them is just as critical as studies that shed light on protective factors, alliances, and the necessary steps and processes to gradually cultivate, repair, and reconcile family relationships.

In addition to predictive analytics that reveal those variables most closely associated with positive outcomes in shared parenting arrangements, future research that produces viable family assessment measures is needed. Assessment tools that can clearly reveal when shared parenting arrangements are not advisable or in the best interest of the kinship triad will serve practitioners, family court judges, and others as case planning for formal kinship families is arranged. Additionally, with these tools, and once we can predict which families have a higher likelihood of flourishing under shared parenting arrangements, future research must then inform us of the most effective family intervention models. For example, in this study we learned that if shared parenting is to be attempted in kinship care, it will likely need to be based in a grief-informed, reconciliation model that utilizes mediation to work on repairing strained family relationships. Psycho-educational training for both birth parents and caregivers – on topics such as understanding a child's inherent connection to their birth parents and ways to establish productive boundaries and communication mechanisms – can help caregivers gain relational competency and provide insight into the families' own dynamics (Crumbley, 2023). Studies that could explore the elements and process of such interventions are direly needed.

Research to inform future policy directions

In formal kinship care, child welfare professionals and caregivers must contend with policy mandates that often require reasonable efforts to preserve or reunify a child with their birth parents. As dictated by Federal Title IV-E programming, states must provide services that preserve a child's relationship with their parent (Social Security Act, 2018). For most children in formal care, the permanence plan is reunification with their birth parent (Children's Bureau, 2022). Because we know so little about shared parenting in kinship care, but we do know the benefits of the parent-child connection, future

research can set policy directions by suggesting conditions and timelines for when and how long shared parenting is attempted. For example, under the Adoption and Safe Families Act (1997), aggravated circumstances exempt child welfare agencies from reasonable efforts to involve parents. Similarly, future policy research could set benchmarks whereby a child's best interest, health, and well-being or the caregivers' capacity might determine the necessity and feasibility of shared parenting arrangements.

Finally, future studies can help us better ascertain the level of financial support needed for child and family-serving organizations to implement family mediation, reconciliation, and other therapeutic services. While caregivers and child welfare professionals both called for mediation to facilitate shared parenting, under the Family First Prevention Services Act (2018), reimbursable interventions would need to re-define post-removal support like family mediation as prevention. While FFPSA has service provisions for kinship care such as navigator programs and allows for reimbursement of prevention services, we lack "well supported" shared parenting models normed on kinship families. In short, the field is ripe with research questions to inform policymakers and practitioners about the feasibility of shared parenting in kinship care.

Conclusion

Although some studies have accounted for the unique dynamics between birth parents, children, and kinship caregivers, complex factors related to parental involvement and shared parenting relationships within the triad have rarely been discussed. With shared parenting increasingly under exploration at the federal level, it is time for researchers, practitioners, and family advocates to empirically explore the feasibility of such arrangements. Our study, albeit exploratory in nature, revealed trepidation from kinship caregivers and child welfare professionals about the extent to which shared parenting is practical, beneficial, or even desired. Still, given what we know about healthy child development in relation to parent-child relationships, juxtaposed with federal and state policy prescriptions where most permanency plans call for reunification with the birth parent, it behooves the field to grapple with research-informed strategies that discern for whom the practice is advisable. Relational strain, perceptions of feasibility, concerns for child safety, and other barriers to shared parenting in kinship care must be better understood in the context of the enabling factors and conditions recommended here (e.g., communication, family mediation, reconciliation). There is much to be discovered about shared parenting in kinship care. The findings of this study and the proposed shared parenting typology can be used to advance our theoretical understanding and clarify future research directions.

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