

Competence and African American Children in Informal Kinship Care: The Role of Family

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Abstract:

African American children are more likely than any other racial or ethnic group to live in kinship care, yet there is little empirical knowledge available to help understand the attributes of these families that contribute to children's development of competence. This study analyzed existing longitudinal data to explore the family-level factors that promote these children's competence. Hierarchical linear modeling revealed that *average* quality of the biological mother's relationship with child, the quality of the biological father's relationship with child, and kinship care family functioning predicts children's *average* competence. Additionally, *changes* in family resources and family functioning over time are related to corresponding *changes* in children's competence levels. Results from this study highlight that African American informal kinship care families possess the strengths and resources that contribute to children's competence.

Keywords: Child welfare | Grandparents raising grandchildren | Promotive factors | Social competence | Academic competence | Multilevel modeling

Article:

1. Introduction

Kinship care is a term used to describe relatives raising a child when the child's parents are unable or unwilling to do so (Annie E. Casey Foundation, 2012). According to 2010 United

States Census, more than 5.8 million children under the age of 18, live in a household headed by a grandparent (Lofquist, Lugaila, O'Connell, & Feliz, 2012). While the majority of these families are multigenerational, with the parents of the grandchildren also living in the home, analysis of the American Community Survey data suggest that over 2.8 million grandparents are the primary caregiver for these children (U.S. Census Bureau, American Factfinder, 2010). In addition more than 1.5 million children live in households headed by aunts, uncles, cousins, older siblings or other relatives, but census data do not report the primary caregiving relationship for these children. An analysis of the 2009 Survey of Income and Program Participation (SIPP) reveals that more than 1.8 million children who do not live with either parent reside with a grandparent and 632,000 reside with other relatives (Kreider & Ellis, 2011). While kinship care is common among all races and cultures, this report confirms that African American children are more likely than any other racial or ethnic group to live in a household without either parent present and to be raised by kin.

Kinship care living arrangements are commonly classified as formal or informal. Formal kinship care is the care of children by relatives that is supervised by the child welfare system. This living arrangement is often referred to as kinship foster care or public kinship care. According to the Adoption and Foster Care Analysis and Reporting System (AFCARS), just over one quarter of the children in the custody of the child welfare system live in public kinship care arrangements, approximately 103,943 children (USDHHS, 2011). This may be an underestimate, as placements with relatives may be underreported by some states. In addition, there are a number of children involved with the child welfare system but have not been taken into the child welfare system's custody, so their living arrangement with kin is not counted in foster care statistics; these types of living arrangements are sometimes called voluntary kinship care (Murray, Ehrle Macomber, & Geen, 2004). Taken together, it is likely that children involved with the child welfare system represent no more than 25% of children living with kin. The majority of kinship care arrangements are informal, also known as private kinship care; informal kinship care occurs outside the legal authority or monitoring of the child welfare system, although it often is initiated for many of the same reasons as formal kinship care arrangements (Gleeson et al., 2009 and Jendrek, 1994).

Over the past several decades all forms of kinship care have increased (The Annie E. Casey Foundation, 2012). The increased numbers have been accompanied by concerns about the functioning and overall well-being of children in kinship care. Human service professionals, researchers, and the general public have raised questions about the abilities of extended family members to foster the healthy development of children, often using “the apple does not fall far from the tree” analogy. In addition, the majority of research that has examined the functioning of children in kinship care has focused on placement stability, safety, and well-being (e.g., Gleeson, 2012). Less focus has been placed on pathways to positive developmental outcomes, such as the development of competence.

1.1. Competence in children in kinship care and African American children

It is important to study children's competence in addition to placement stability and challenges because competence is associated with positive outcomes and plays a role in reduction of behavior problems and other negative outcomes (Landy, 2002). Research reveals that both social and academic competence protect children against delinquency, substance abuse, and teen pregnancy (Fraser et al., 2004, Landy, 2002 and Schneider, 1993), and promote children and adolescents' self-esteem, mental health, and high school graduation rates (Landy, 2002 and Valiente et al., 2008).

Only a few studies examine the competence of children in kinship care. Of these studies, all are cross-sectional, and all reveal higher levels of competence for children in formal kinship care compared to children in foster care. One such study, conducted by Keller et al. (2001), evaluated the competence of children in kinship foster care compared to children in foster care, using the Child Behavior Checklist (CBCL; Achenbach & Rescorla, 2001). The sample was drawn from children in 14 states who participated in the Casey Family Program. The children in formal kinship care (n = 67) demonstrated higher levels of social competence and total competence compared to children in foster care (n = 173). In this study, the competence levels of children in formal kinship care did not appear very different from children's competence levels in the general population. Two published studies conducted outside the US also used the CBCL to assess competence in children in kinship care and foster care and reported similar results (Holtan et al., 2005 and Tarren-Sweeney and Hazell, 2006). Further, Shin (2003) assessed academic competence using the Wide Range Achievement Test — Revised among 152 foster youth in one Midwestern state and found children placed in formal kinship care had higher reading levels than children in foster care. Although the studies summarized in this section add to the literature on competence of children living in kinship care, they did not examine predictors of children's competence nor did they focus on children in informal kinship care.

There is a vast amount of literature (e.g., Landy, 2002, Schneider, 1993 and Valiente et al., 2008) available on predictors of competence in children in the general population, but less literature exists on predictors of competence specifically for African American children. The research on predictors of competence in African American children in the general population indicates associations among family-level variables such as positive parent-child interaction, adequate social support, and healthy family functioning and the development of competence (Brody et al., 1995, Oravecz et al., 2008 and Toldson et al., 2006). However, it has not yet determined whether these and other family level variables promote competence among the substantial percentage of African American children who do not reside with their biological parents and are reared by kin. This study aims to evaluate the extent to which several different family-level factors predict *overall competence*, as well as *changes in competence*, among these children.

Determining how family-level factors predict overall competence as well as changes in competence requires longitudinal data. In longitudinal studies, a child's score on a variable at any given point in time reflects both the child's *average* level on that variable as well as any *time-specific* factors that may lead to higher or lower than usual levels. For example, some children,

such as those whose caregivers have a higher level of education and those whose caregivers work in higher paying occupations, will generally have more family resources (e.g., food, clothes) than other children. However, a family's resources can also vary from one wave (data collection point) to the next. A child's family may typically have a lot of resources, but if that child's caregiver is temporarily laid off at one wave, the child may have fewer family resources than usual at that one wave. Both the overall level of each predictor variable (e.g., average family resources) as well as wave-to-wave variation in these predictor variables (e.g., change in family resources) may independently contribute to a child's competence at a particular point in time. Whether the child generally has a lot of family resources is a between-person effect, as it captures how children generally differ from each other. Whether the child has higher or lower family resources than they usually have at a particular wave is a within-person effect, as it captures how these resources differ for a particular child from that child's average level of family resources. Both of these effects may independently shape children's competence and therefore we include both types of effects as predictors of competence in our models.

2. Theory and research hypotheses

According to Fraser et al. (2004), protective and promotive factors contributing to positive outcomes for children could be categorized into three domains: (1) individual psychosocial and biological factors; (2) family factors; and (3) environmental conditions. Our research hypotheses focus on the second domain of family-level factors because the competence literature has suggested that family components (e.g., parent–child relationship and family functioning) are the key predictors of competence in children in the general population (Landy, 2002, Oden, 1987, Sani, 1997 and Schneider, 1993). Influenced by the risk and resilience framework, we conceptualize the factors that predict competence among children in kinship care as promotive rather than protective factors. Protective factors exert little effect when risk is low, but their effect emerges when risk is high (Fraser et al., 2004 and Smokowski et al., 2004). Promotive factors directly increase the likelihood of a positive outcome across low, moderate, and high risk groups (Fraser et al., 2004). Therefore, we tested direct effects rather than interactive effects to identify factors that promote competence.

First, we hypothesized that the *average* quality of the biological mother's relationship with child, the quality of the biological father's relationship with child, caregiver's stress, caregiver's social support, kinship care family functioning, and kinship care family resources are related to *average* competence in African American children in informal kinship care (between-person effects).

Second, we hypothesized that *changes* in these family factors over time are related to corresponding *changes* in competence in African American children in informal kinship care over time (within-person effects).

3. Methodology

3.1. Sample

This study is a secondary analysis of longitudinal data collected from families caring for related children in informal kinship care arrangements (Gleeson et al., 2008). Interviews were conducted with the primary caregiver in an initial interview and again every six months over an 18-month period. The families interviewed for the original study were recruited from Cook County (which includes Chicago) and the Collar Counties surrounding Chicago. Recruitment strategies included providing information to families about participation in the study at health fairs, parades, and other community events, as well as through public service announcements on Gospel and popular music radio stations. Families were eligible to participate in the study if they were caring for at least one related child, between the ages of 18 months and 11 years of age, for whom they were not the parents; they were not involved with the Department of Children and Family Services (DCFS) at the time of initial interview; the child had not been adopted by the caregiver and was not previously involved with DCFS and discharged to the relative caregiver through subsidized guardianship. If more than one child in the family met the eligibility criteria, one child was randomly selected as the focus of data collection. In the initial study, a total of 207 caregivers completed the initial interview (Gleeson et al., 2008).

In the current study, we focused specifically on the development of competence among African American children; thus, we included only African American children with at least one competence score at any wave. Because the CBCL competence scales are included only in the version of the CBCL form that is applicable to children ages 6 to 18 years of age, then only children who were age six at some point during the study are included in this analysis. Therefore, the final sample consisted of 143 African American Children (52.4% female) and their families. While most (57.3%) had competence scores at all four waves 15.4% had competence scores at 3 waves, 10.5% at two, and 16.8% at one wave. At the initial assessment, children were between the ages of 4.3 years (52 months) and 11.2 years (134 months), with a mean age of 8.08 years (97.0 months). The caregivers were primarily female (95.1%), African American (98.6%), not married (78.3%) and ranged in age from 22 to 70 years old ($M = 47.5$ years). The most common relationship between the caregiver and child was grandparent (60.8%), followed by aunt or uncle (23.8%), great aunt or uncle (6.3%), cousin (4.2%), sibling (3.5%), and great grandparent (1.4%).

3.2. Dependent variable

3.2.1. Competence

Competence was measured by the relative caregivers' rating of the child using the CBCL Competence Scale. The CBCL Competence Scale is designed to assess the competencies of children as reported by parents and others who see children in homelike settings (Achenbach & Rescorla, 2001). The CBCL is one of the most common measures of child functioning used in research on child welfare, special education, and mental health. It has also been used in research

with children from various racial and ethnic backgrounds. The 16 items on the CBCL Competence Scale are from three subscales that capture different aspects of competence: activities (6 items, e.g., participation in sports, jobs, and/or chores.), social (6 items, e.g., group activities and social relationships), and school (4 items, e.g., performance in academic subjects, grade repetition). The total competence score is obtained by summing the raw scores of the activities, social, and school competence subscales. We used T-scores that are standardized by children's gender and age group (Achenbach & Rescorla, 2001). Higher scores on the competence scales indicate a greater degree of competence.

The content and criterion validity of items on the CBCL competence scale have been supported by nearly four decades of research, consultation, feedback, and refinement, as well as by findings that all items discriminate significantly between demographically similar referred and non-referred children (Achenbach & Rescorla, 2001).

3.3. Potential promotive factors

3.3.1. Relationships with biological parents

The quality of the child's relationship with each of their parents was measured through a single item assessing the caregiver's perception of the *quality of the biological mother's relationship with child* and a single item assessing the caregiver's perception of the *quality of the biological father's relationship with child* (Gleeson et al., 2008). Caregivers rated the child's relationship with each biological parent on a 6-point ordinal scale: no relationship/no contact, very poor, poor, neither poor nor good, good, very good.

3.3.2. Caregiver's stress

Caregiver's stress was measured by the 12-item Parental Distress Subscale of the Parenting Stress Index (PSI) Short Form (Abidin, 1995). Each item is rated on a 5-point scale (strongly disagree to strongly agree). Ratings are summed and converted to percentile scores. High scores on the subscale indicate high levels of parental stress (clinical range = 85th percentile or above). The Parental Stress Index has demonstrated excellent reliability and validity in several studies (e.g. Anderson, 2007, Goodman and Hayslip, 2008 and Pipp-Siegel et al., 2002). Abidin (1995) reports test-retest and internal consistency reliability of the Parental Distress Subscale ranging from .85 to .87 and a .92 correlation between the Parental Distress Subscale and Parent Domain scores and the full-length PSI.

3.3.3. Caregiver's social support

Caregiver's social support was measured with the Family Support Scale (FSS; Dunst, Jenkins, & Trivette, 1984). Respondents rated the helpfulness of 18 different social network members (e.g., parents, partner, friends, and co-workers) in raising children over the past three to six months (1 = not at all helpful to 5 = extremely helpful). Not all social network members were applicable

to all caregivers (e.g., some caregivers did not have a partner); items rated not applicable were treated as missing. Each caregiver's social support score was the average perceived support across each of the social network members that they rated. For the current study, Cronbach's Alpha coefficients range from .71 to .77 across the 4 waves of data collection.

3.3.4. Kinship care family functioning

Kinship caregivers rated their family's functioning by responding to the 19-item Family Health/Competence Subscale of the Beavers Self Report Family Instrument (SFI), which is based on the Beavers–Timberlawn Model of Family Competence (Beavers, Hampson, & Hulgus, 1990). Items are rated on a five-point scale (1 = yes, fits our family very well to 5 = no, does not fit our family). For the current analysis, items were recoded to ensure that higher scores indicated higher family functioning and then averaged. Cronbach's Alpha coefficients for the SFI Family Health/Competence Subscale ranged from .87 to .90 across the 4 waves.

3.3.5. Kinship care family resources

Adequacy of kinship care family resources was measured using the Family Resource Scale (FRS) created by Leet and Dunst (in Dunst, Trivette, & Jenkins, 1988). The scale includes 31 items, which assess the adequacy of different financial, material, and other resources in households with children (1 = Not at all adequate to 5 = Almost !Always Adequate). Not all items were relevant to all caregivers (e.g., “time with partner” was not relevant for caregivers who did not have a partner); items that were not applicable to a given caregiver were treated as missing. Each caregiver's family resources score was the average perceived support across each of the items that they rated. Cronbach's Alpha coefficients range from .88 to .91 across the 4 waves.

4. Control variables

The control variables for this study are: time (time child has resided with caregiver), caregiver's marital status (0 = not married, 1 = married), caregiver's education level (some grade/grade graduate, some high school, high school graduate/GED, some college/trade school, college graduate, graduate school), child's age (in months), and child's gender (0 = male, 1 = female). To facilitate interpretation, we centered caregiver's education at some college (the modal score), time at 56.8 months (the average at baseline), and child's age at 97.0 months (the average at baseline).

5. Analytic plan

Each child was assessed at up to four waves; because the observations across waves are not independent of each other, these data fail to meet the independence assumption of Ordinary Least Squares (OLS) regression. Therefore, we used hierarchical linear modeling (HLM) to account for the nesting of time within person (e.g., Raudenbush and Bryk, 2002 and Singer and

Willett, 2003). Unlike OLS, HLM does not require a balanced data structure, in which each person must be measured at the exact same intervals. The ability to incorporate unbalanced data allowed us to use data from all children whenever they participated, rather than use listwise deletion to remove anyone who did not have complete data at all four waves. In addition, rather than using the arbitrary metric of wave in the study to model change in competence, we used a more meaningful metric of time — *time child has resided with caregiver*. The length of time the child resided with caregiver was selected as the metric of time because it is believed to have a positive association with competence. Competence is expected to develop until it reaches full capacity; thus, it may increase over time (Landy, 2002). In addition, research suggests that stability of children's living arrangements influence their competence levels (Schneider, 1993).

To capture between- and within-person effects for each predictor variable, we used group-mean centering (Raudenbush & Bryk, 2002; also referred to as within-person centering, Singer & Willett, 2003). Specifically, we started by obtaining each child's own cross-wave average for each of the six predictor variables. We refer to these between-person effects as “average” predictor variables (e.g., average family resources). Higher values indicate that the child is on average higher on that variable than other children. We then subtracted children's own cross-wave average from their scores at each wave. We refer to these within-person effects as “change in” predictor variables (e.g., change in family resources). Positive values indicate that at that wave, a child's family resources are higher than usual and negative values indicate that at that wave, a child's family resources are lower than usual. By group-mean centering and including the cross-wave mean, we ensure that the time-varying effects of each predictor variable only capture within-person variability over time, over and above any stable individual differences in each variable. Essentially, this allows us to determine how *changes* in each predictor variable are related to *changes* in competence (see Rulison, Gest, Loken, & Welsh, 2010 for a similar application).

After computing the between- and within-person scores for each child, we estimated a series of two-level models using SPSS. In these models, level 1 included time-varying predictors (e.g., time with caregiver, child's age, and all of the change in predictor variables) and level 2 included child-level predictors (e.g., child's gender, caregiver's marital status and education, and all of the average predictor variables). We first estimated an unconditional means model, to estimate the average value for competence in the absence of any predictors. From this model, we also calculated the intraclass correlation (ICC), which is computed as the variation in intercept divided by the total variance. The ICC indicates the degree to which observations are correlated within a child: values close to 1 indicate a high degree of cross-time similarity in competence (i.e., that most of the variation is between children rather than within children over time). Next, we estimated an unconditional growth model, including fixed linear effect for time, where time was defined as time the child has resided with the caregiver. We also tested models that added a fixed quadratic effect of time as well as models that added random linear and quadratic effects of time; however, none of these effects improved model fit and therefore we did not include them in

any of the following models. We then added variables to control for child's gender, age along with caregiver's marital status and caregiver's education (Table 1; Model 1). Then, we added the between- and within-person effect for each predictor separately to explore the unique contribution of each of the predictors (Models 2–7). Finally, we included all of the predictor variables simultaneously (Model 8).

Table 1. Potential Promotive Factors of Competence.

	Model 1		Model 2		Model 3		Model 4		Model 5		Model 6		Model 7		Model 8	
Fixed effects	Coef f.	S E	Coef f.	SE	Coef f.	S E	Coef f.	SE	Coef f.	S E						
Intercept	44.46 ^{****}	1.48	44.33 ^{****}	1.46	44.23 ^{****}	1.41	43.66 ^{****}	1.46	44.18 ^{****}	1.49	44.15 ^{****}	1.46	43.27 ^{****}	1.51	42.90 ^{****}	1.40
Level 1 (Time)																
Time w/care giver	0.01	0.02	0.01	0.02	0.01	0.02	0.01	0.02	0.00	0.02	0.01	0.02	0.00	0.02	0.01	0.02
Child age (centered at 97.0 months)	0.07 [*]	0.03	0.08 ^{**}	0.03	0.08 ^{**}	0.03	0.08 ^{**}	0.03	0.07 [*]	0.03	0.06 [*]	0.03	0.08 ^{**}	0.03	0.09 ^{**}	0.03
Change in relationship w/mother			0.33	0.42											0.22	0.45
Change in relationship w/father					0.33	0.38									0.36	0.40
Change in family function							2.26 [*]	1.01							1.97 [*]	1.15

relationship w/father					**	33									***	31	
Average family functioning							3.58**	1.08								2.43*	1.13
Average family resources								1.44	1.15							-0.23	1.26
Average social support										2.20*	0.98					1.17	0.95
Average caregiver stress												-0.07***	0.03	-0.03		0.03	
Random effects																	
Level 1	51.20****	4.21	51.59****	4.261	51.72****	4.31	50.44****	4.146	50.36****	4.147	51.28****	4.233	52.97****	4.513	52.86****	4.59	
Level 2	41.26****	7.57	39.08****	7.362	34.21****	6.78	37.55****	7.054	40.08****	7.397	38.79****	7.331	36.74****	7.276	26.71****	6.15	

* $p < .1$. ** $p < .05$. *** $p < .01$. **** $p < .001$.

6. Results

The unconditional model partitioned the variance in competence into variance across children (intercept variance = 50.92) and variance within children (residual variance = 51.78). Based on these values, we calculated the ICC as 0.50 (50.92 / (50.92 + 51.78)), which indicates that roughly 50% of the variance was within-person and the remaining 50% of the variance was across children.

Model 1 indicated that there was no significant linear relationship between time the child has resided with caregiver and competence. There was, however, a significant positive relationship between child age and competence: competence increased with age. There was no significant relationship between caregiver's marital status and competence or between child's gender and

competence. There was, however, a significant positive relationship between caregiver education and competence: children whose caregiver's had completed more education had higher competence than children whose caregiver's had completed less education.

Models 2 and 3 indicated that children who on average had better relationships with their mothers had higher competence, as did children who on average had better relationships with their fathers (i.e., significant positive between-person effects). Changes in the relationship with the mother and father did not significantly predict changes in competence (i.e., no within-person effects of relationship with mother or relationship with father).

Model 4 indicated that not only did children who had higher levels of family functioning have higher total competence, but also that *changes* in family functioning coincided with *changes* in total competence. To facilitate interpretation of these significant between- and within-person effects for family functioning, we plotted the key results in Fig. 1. In this figure, the x-axis represents *change in family functioning* (i.e., whether a child has higher or lower family functioning than usual at a particular wave, regardless of which wave it is) and the y-axis represents a child's predicted competence score. The predicted competence for children who on average have relatively low family functioning (Family Functioning = -1 SD = 3.40) and the predicted competence for children who on average have relatively high family functioning (Family Functioning = $+1$ SD = 4.60) were plotted for different values of changes in family functioning (ranging from -1 to $+1$), all else being equal. Thus the difference between the light gray and dark gray lines illustrate the between-person effect of family functioning and the slope of the lines illustrate the within-person effect of change in family functioning. Notably, children with higher average family functioning consistently have a higher predicted competence score than children with lower average family functioning. This between-person effect is illustrated by the difference between the two lines (dark gray line always higher than the light gray line). The positive slope of both lines indicates that at times when children have higher family functioning than normal (scores above 0), they also have higher competence scores. For example, children who generally have lower family functioning (light gray line) have a predicted competence score of 42 at waves when they have a family functioning score that is 1 point *higher* than usual whereas they have a predicted competence score of only 37 at waves when they have a family functioning score that is 1 point *lower* than usual.

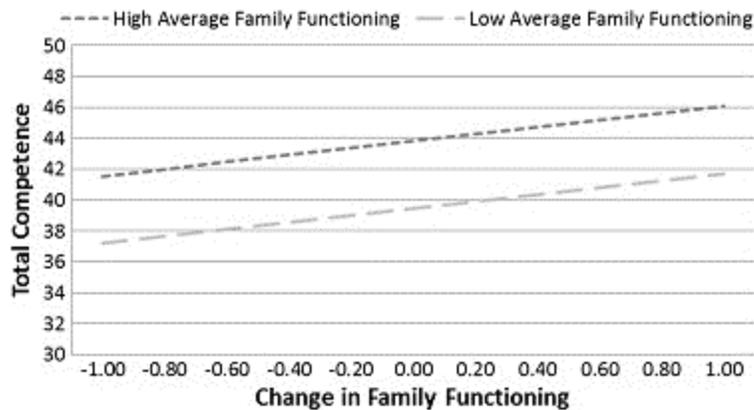


Fig. 1. Note: Predicted competence as a function of average family functioning and change in family functioning. Plots are for otherwise average girls (8 years old, been with the caregiver for 5.5 years, caregiver was not married and had a high school education).

Model 5 indicated that even though average family resources was not significantly related to average total competence, *changes* in family resources were related to *changes* in total competence. This within-person effect is illustrated in Fig. 2. Note that in comparison to Fig. 1, there is less of an overall difference between the two lines (indicating the small, positive, but non-significant effect of average family resources). The positive slope of both lines, however, illustrates that at assessments when children have more family resources than they usually have, their competence is also higher.

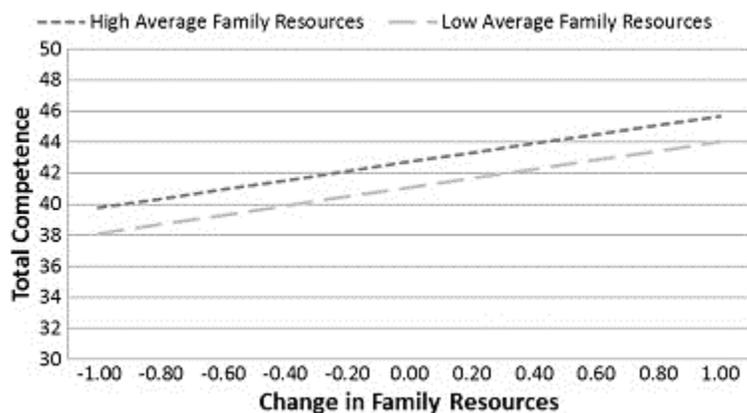


Fig. 2. Note: Predicted competence as a function of average family resources and change in family resources. Plots are for otherwise average girls (8 years old, been with the caregiver for 5.5 years, caregiver was not married and had a high school education).

Models 6 and 7 indicated that children whose caregivers reported more social support on average and children whose caregivers reported less stress on average had higher average competence.

In the final model (Model 8), change in family resources dropped in magnitude but was still a significant predictor of changes in total competence. Change in family functioning also dropped

in magnitude but was no longer a significant predictor of change in competence at the $p < .05$ level. The average effects for relationship with mother, relationship with father, and family functioning all remained significant, positive predictors of total competence. The average effects for social support and caregiver stress were no longer significant, indicating that the relationship between these variables and competence is accounted for by one or more other predictor variables in the model.

7. Discussion

This study analyzed existing longitudinal data to explore the family-level factors that promote competence in African American children in informal kinship care. One goal of the study was to examine whether the *average* quality of the biological mother's relationship with child, the quality of the biological father's relationship with child, caregiver's stress, caregiver's social support, kinship care family functioning, and kinship care family resources are related to *average* competence. As anticipated, the findings from Model 8 (final model), suggest that the average effects for the relationship children have with their parents are significant positive predictors of competence. The higher caregiver's rated the quality of the relationships between children and their biological mothers and biological fathers, the higher children's competence levels, even after other predictors of competence were entered into these models. The findings regarding biological parents' relationships with children as promotive factors of competence are consistent with the risk and resilience literature that states positive relationships between parents and children serve an important protective function for children (Fraser et al., 2004, Garmezy, 1985, Garmezy, 1991 and Rutter, 1979). These findings are also similar to the competence literature that suggests that one of the most common predictors of children's competence in the general population is a positive parent–child relationship (Landy, 2002, Oden, 1987, Schneider, 1993 and Toldson et al., 2006). This study demonstrates that a positive parent–child relationship is important to children's development of competence whether they reside with biological parents or not.

Additionally, the final model demonstrates that healthier kinship family functioning is a promotive factor for children's competence scores. This means that children who on average have cohesive, warm families with well-defined family members' roles are on average more competent than children who on average have lower family functioning. These findings are encouraging and support Gleeson et al. (2008) conclusion that healthy family functioning is related to better outcomes for children in informal kinship care. Also, results are consistent with risk and resilience literature that has found that warmth and cohesion of family members are protective factors that buffer the effects of risk factors on child development (Garmezy, 1985 and Garmezy, 1991).

As expected, caregiver social support was positively related to competence, with higher average competence among children whose caregivers reported greater social support on average (model 6). In addition, competence was significantly lower among children whose caregiver's on average

reported more stress (model 7), which is consistent with other studies that have found better overall outcomes for children when relative caregivers are less stressed (Gleeson et al., 2008 and Goodman and Hayslip, 2008). We expected caregivers with lower levels of stress to be better able to facilitate their children's participation in activities than caregivers with higher levels of stress, because they were more psychologically healthy. Additionally, we expected that caregivers with lower levels of stress would be more available to model socially appropriate behaviors for children. Notably, however, both effects were no longer significant once other promotive factors such as the child's relationship with the mother and father and family functioning were added to the final model. This suggests that caregiver stress and caregiver's perceived social support, as well as the relationship between these variables and competence may be influenced by the child's relationship with the parents and the family's functioning.

Our second goal of the study was to determine whether *changes* in family factors over time are related to corresponding *changes* in competence. In Model 5 and Model 8, we found that *changes* in family resources is significantly related to *changes* in total competence, even after controlling for the other predictors. This finding coincides with risk and resilience research, which indicates that various internal and external family resources have a positive effect on children's development (Fraser et al., 2004 and Garmezy, 1985). For children in this study, at waves when their families' have more adequate resources (e.g. food, clothes, transportation, time to sleep) than usual they also have higher levels of competence. This suggests that the development of competence is sensitive to changes in family resources, which may be both bad and good news. The bad news interpretation suggests that the development of competence of children in informal kinship care may be impeded by sudden loss of family resources; this is concerning given the economic vulnerability of many families providing informal kinship care. The good news interpretation is that perhaps interventions that increase family resources such as linking eligible families to resources could have a positive effect on the development of children's competence.

Change in family functioning was no longer a significant predictor of change in competence at the $p < .05$ level, when other predictor variables were added to Model 8. However, the change in family functioning still showed a trend. In this study, a trend emerged that indicates that at times when kinship care families are functioning well, the children have higher levels of competence.

Consistent with conceptual and empirical competence literature (e.g., Heath and MacKinnon, 1988, Landy, 2002, Levendosky et al., 1995 and Schneider, 1993), caregiver education and child's age were significantly and positively associated with competence in all models. Research on the general population suggests that caregivers with higher levels of education provide greater stimulation and opportunities for children to develop competence, and it appears that the same is true for the kinship caregivers of African American children in this study. In addition, it is not surprising that as children get older, their competence scores increase. One would hope that children develop greater competence scores over time because as children age they gain additional interests in activities such as sports and hobbies, thus they participate in more

activities. It also could be possible that as time passes, children become more familiar with their kinship care families and communities and have additional opportunities to build social relationships with their siblings and peers.

8. Limitations and directions for future research

The utilization of secondary data posed several challenges for the current study. For instance, we were limited to investigating only variables that were included in the original study; there may be other unmeasured variables that contribute to children's competence. For instance, it is documented that children's relationships with adults other than their parents are predictors of competence (Landy, 2002, Oden, 1987 and Schneider, 1993). However, we were unable to examine if the relationships between the relative caregivers and children influence children's competence because information about this relationship was not available in the original data set. While not specific to the development of competence, research conducted by Goodman, 2003 and Goodman, 2007 suggests that parent–child, parent–caregiver, and child–caregiver relationships in intergenerational triads are associated with caregiver life satisfaction, caregiver depression, as well as caregiver ratings of the child's functioning. It is also documented that parenting practices and parenting styles contribute to children's competence (Garner, 2006, Landy, 2002 and Oravec et al., 2008), but we were also unable to examine these variables because they were not available in the original data set as well.

Although the quality of both biological parents' relationships with children was strong predictors of competence in this study, results pertaining to these variables should be interpreted with caution for several reasons. First, these variables were assessed with single item measures, and reliability and validity of single item measures tend to be weak. Second, caregivers were the only source of data in this study. This is a particular concern for ratings of the quality of the biological parents' relationships with children. Parent and child ratings as well as observational measures of interactions between parents and children would certainly enhance the validity of assessment of the quality of parent–child relationships. Also, there is no way to know the meaning of caregivers' ratings. For instance, when a caregiver rated the relationship between the biological mother and child as very good, it is not clear why the caregiver perceived this relationship as very good. Anecdotal data from interviews with caregivers suggest that some define a good parent–child relationship as one characterized by a parent who occasionally visits the child and is sober and not disruptive during the visits. Others have higher expectations of parents to nurture the child and assume parenting responsibilities. However, despite the limitations with the parent–child relationship variables in this study, it is very clear that further research is warranted. It is important to further investigate the effects of biological parents' relationships with children on competence because as this and other studies have demonstrated, many biological parents of children in kinship care, especially mothers, will be a part of their children's lives whether they are the primary caregiver or not. Thus, in future studies, researchers should identify or create a measure for the biological parents' relationships with children that have strong reliability and validity. Furthermore, perhaps the caregiver's perceptions of the quality of the biological parents'

relationships with children are not only indicators of their relationships, but also of the relationship between the caregiver and biological parents. Thus, in future research, one may assess the quality of the caregiver–parent relationship to explore the effect of this relationship on children's competence.

9. Implications for practice

In recent years, social work practitioners have been encouraged to turn away from the deficit approach when working with clients and to embrace a strengths-based approach (Saleebey, 2006). The study's design and conceptual framework is aligned with the strengths perspective because it searches for strengths and resources in African American informal kinship care families that promote children's competence. This study's findings provide practitioners with empirical knowledge suggesting specific family factors that promote competence. While the findings of this study cannot be considered definitive and call for future research, they do provide some suggestions for practice that should be considered. For example, the relationship between parents and children may be a significant factor in promoting the competence of children as well as overall functioning, even when other relatives are the children's primary caregivers. This and other studies (Goodman, 2003, Goodman, 2007 and Green and Goodman, 2010) suggest that parents should not be ignored or forgotten when human service professionals encounter kinship caregiving families. It is certainly worth exploring the relationships between parents and children, parents and caregivers, and caregivers and children when working with families to enhance the development of their children. This study also suggests that exploring the functioning of the kinship caregiving family, however this family is defined, may also be important when intervening to support the development of children living with kin.

Our findings also suggest the importance of assessing the adequacy of family resources and the importance of enhancing these resources to support the development of competence in children. It makes sense that caregivers who have the resources to support their families are better able to be emotionally available to children, and to attend to their developmental needs. Given the association between changes in family resources and children's competence detected in this study, it certainly is worth assessing these needs in families, working diligently to link them to public benefits and other community resources that may help to meet these needs, and to assess the impact of increased resources on children's functioning.

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