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When Kinship Caregivers Became Teachers: Role Stress and Strain from Remote Learning during COVID-19

Amanda Klein-Cox *, **Angela Tobin** and **Ramona Denby**

School of Social Work, University of North Carolina at Chapel Hill, Chapel Hill, NC 27516, USA; angpro@unc.edu (A.T.); rdenby-brinson@unc.edu (R.D.)
* Correspondence: kleincox@unc.edu

Abstract: For caregivers of school-age children, schooling at home was a significant stressor during the COVID-19 pandemic. Research demonstrates the emotional burden of taking on the role of teacher while trying to balance responsibilities related to work, household, and childcare. Yet little is known about the well-being of kinship caregivers during this time, although this population is at heightened risk for role stress and strain and emotional distress. This article shares the results of focus groups conducted as part of a larger qualitative study, the purpose of which was to understand the factors that influenced the well-being of kinship families during the pandemic, from the perspective of kinship caregivers and child welfare professionals. From these conversations, the challenges of remote learning emerged as a prominent theme, particularly for caregivers raising children with special healthcare needs, who comprised the majority of the sample. Given their pre-pandemic role stress and strain due to caregiving responsibilities, most caregivers struggled with managing their child's learning, working from home, and caring for children with trauma histories, often with limited support and access to needed services. These findings suggest that this population needs support—potentially in the form of wrap-around services and/or social safety net provisions—to reduce their role stress and strain and improve well-being.

Keywords: kinship care; remote learning; COVID-19; role stress and strain

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1. Introduction

The outbreak of the COVID-19 pandemic in March 2020 and subsequent lockdowns had a catastrophic impact on individuals' social–emotional, mental, and economic health, an unintended consequence of efforts to protect and preserve the physical health of communities [1,2]. Families raising children across the globe during this time faced heightened fears, burdens, and service needs, with fewer options than usual for receiving necessary support [3–7]. In the early stages of the pandemic, government leaders mandated a short-term break from in-person schooling to prevent further transmission of the virus. In the United States, as the pandemic continued and worsened, many school buildings—particularly in low-income communities of color—remained closed for over a year [8,9].

The closure of schools left families without educational services and childcare for their children and saddled schools with an immediate need to provide instruction at home, often for families without adequate access to the internet or technological devices [1,2,8,10]. Schools worked to increase access to remote learning by providing computers and hotspot devices, while teachers, students, and families struggled to adapt to learning through Zoom, Google Classroom, or other platforms. As a result, the quality of remote learning experiences varied significantly, with some students being left to teach themselves through asynchronous platforms and little teacher support [11]. This burgeoning system of remote learning—while critically necessary—caused many families to bear the burden of not only raising their children, but also educating them, while navigating their own employment transitions, fears about the virus, and social isolation [4,6,12–14]. The literature studying the events of 2020 is clear; for many families, the closure of schools was the most difficult part of the pandemic-related lockdowns, to the detriment of their mental health and well-being [3,7,15–20].

For kinship caregivers—the grandparents, aunt and uncles, siblings, and others raising the children of their relatives or close friends—these challenges during the pandemic were amplified. Even prior to the pandemic, many kinship caregivers faced role stress and strain by nature of becoming a caregiver to a relative's child; this is often due to the sudden nature of the onset of caregiving, the point in the life course at which they became caregivers, and/or if they provided care for multiple generations of their family at the same time [21,22]. As a result, having to take on another role quite suddenly, during a global pandemic, was a tremendous challenge for many kinship caregivers [23].

Kinship caregivers face many other circumstances in their daily lives that only increased the burden of the pandemic and put them at risk for additional adverse impacts. First, kinship caregivers are more likely to be unmarried women of color who come from under-resourced communities [24]. Research shows that economically disadvantaged families experienced many difficulties during school closures, including lacking quiet spaces for learning due to living with other family members or in smaller accommodations [8]. Critical for remote learning, many families had insufficient or no internet access or technological devices at home; this was particularly true for families of color [1,10]. Additionally, nearly half of grandparent caregivers are over the age of 60, increasing their risk for complications from COVID-19 and potentially affecting the precautions they took to avoid getting sick [25]. Lastly, children in kinship care are more likely to have trauma histories and/or special healthcare needs than the general population [23,26], further complicating adapting to a new learning modality.

There is a rich literature base examining the pandemic's impact on parents and families, particularly around how schooling at home affected their well-being and ability to manage the influx of new responsibilities. Yet little is known about the experiences of kinship caregivers, who were already more likely to experience more stress and strain, have multiple risk factors for challenges with remote learning, and raise children with increased emotional and learning needs. The purpose of this article is to share findings from a qualitative study of kinship caregivers and child welfare professionals, explore reflections on remote learning, as well as the return to in-person instruction, and discuss how these experiences affected caregiver well-being.

2. Background

The qualitative study highlighted here reflects the second of two phases of exploration into kinship caregiver well-being; this phase utilized focus groups with child welfare professionals and kinship caregivers to better understand the factors that impacted their health and well-being and that of the children in their care during the pandemic. While not an original focus of the study, remote learning emerged from these conversations as one of the predominant stressors for kinship families. This stress was especially acute for caregivers raising children with disabilities or special healthcare needs, which accounted for the majority of caregivers in the study.

The Health Resources and Services Administration (HRSA) explains that children with special healthcare needs (CSHCNs) "have or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions and... also require health and related services of a type or amount beyond that required by children generally" (as cited by [27]). Children in kinship care are also highly likely to have experienced trauma, which can also impact behavior and learning [2,21]. Trauma in childhood can affect "cognitive, behavioral [sic], affective, biological, psychological, and social development", and resulting behaviors could be confused for symptoms of a disability, when, in fact, they reflect how the child is trying to cope [26] (p. 2).

While the prevalence of CSHCNs in kinship care has not been confirmed, one study estimated that nearly 60% of the grandmother caregivers in their sample were raising a child with a diagnosed mental or behavioral health challenge, and nearly one-quarter had a child with a physical health condition [23]. It is estimated that 19% of all children nationally are CSHCNs [26]; considering this estimate in conjunction with the high prevalence of trauma in kinship care [27] suggests that kinship families are more likely to be raising CSHCNs and may have been more vulnerable to schooling-related stressors during the pandemic.

The theories of role stress and strain have previously been applied to kinship caregivers, and their salience grows when examining the additional burdens placed on kinship families during the COVID-19 pandemic [21,22]. From working to mitigate their risk factors to the virus, adapting to changes in employment, and providing emotional and educational support to children in their care who have experienced trauma, kinship caregivers were predisposed to suffer from these additional role-related burdens. Kinship caregivers raising CSHCNs had an even greater burden during this time, as access to the services, modifications, and support needed for their children's learning and well-being was limited or unavailable.

Extant research demonstrates the significant toll that remote learning took on families across types, compositions, and countries. Yet, little research exists about how kinship caregivers fared during this phenomenon and how their predisposition to risk factors may have shaped their experiences. Only two studies were found to address this, and these focused on either grandparent caregivers or relative foster placements [23,28]. Given that most kinship arrangements occur outside of the foster care system, and that not all caregivers are grandparents [25], more inclusive research is needed to understand the full experience of kinship caregivers during remote learning and its impact on their well-being. Our findings address this gap in the literature about the experiences of all kinship caregivers during the pandemic and how they helped their families adapt to schooling at home.

3. Literature Review

The literature on schooling during the pandemic demonstrates the overwhelm, frustration, and exhaustion that parents and caregivers felt while trying to support—or sometimes manage—their child's remote learning while continuing to maintain their household or work responsibilities. Much of the research cited here refers to biological parents or is generalized to any caregiver for a child. As such, the terms "parent" and "caregiver" are used interchangeably throughout the literature review. Nevertheless, the experiences that all families faced during the pandemic are generalizable to kinship caregivers and are well supported by theories of role stress and strain.

3.1. Role Stress and Strain

Role stress and role strain are similar theories but offer distinct insights into the emotional impact of having too many roles to fulfill, with competing demands for one's time and attention, which is particularly salient for kinship caregivers. The theory of role strain explains that people often feel tension between responsibilities from the multiple roles they hold, such as being a parent, employee, or spouse [29]. They must balance these roles, prioritizing their most important responsibilities to try to limit the strain felt by these competing interests. Complementary to role strain, role stress addresses the reality that a person may not know how to differentiate or prioritize competing demands. Role stress arises when the expectations from each of a person's roles are overwhelming, unclear, or in conflict [30].

These theories have previously been applied to kinship care, as many caregivers experience significant stress and a decline in their mental health and well-being after taking on the new and highly demanding role of caregiver, often unexpectedly [22]. Despite the additional—and overwhelming—responsibilities that come with caring for a child or children full-time, often under traumatizing circumstances, kinship caregivers are still responsible for the previous roles they held, such as worker, spouse, or parent to their own biological children [21]. Caregivers may experience diminished well-being from their efforts to fulfill all of these roles, especially when the immediate burden of caregiving may prevent them from fulfilling the others or if they do not have the support they need to meet all of these demands. Research has shown that having insufficient support can contribute to stress and mental health concerns for kinship caregivers [13,31].

Both theories acknowledge that there are limits to how much energy one can expend trying to meet multiple demands, and these limits can affect emotional well-being, according to [29]:

> In role behavior, we begin to experience strain, worry, anxiety, or the pressures of others if we devote more time and attention to one role obligation than we feel we should or than others feel we should. This strain may be felt because, given a finite sum of role resources, too much has already been expended (p. 488).

One component of role stress theory—role conflict—occurs when "the demands of one role prevent the fulfillment of another role" [32] (p. 3). Another related component of role stress—role overload—occurs when a person does not have enough time or energy to fulfill the demands of the roles that they hold [6,30]. While role conflict and overload are similar, role conflict occurs in the short-term, when trying to complete a task or prioritize needs; role overload refers to a longer-term overwhelm, when "the volume of tasks is simply too heavy given the time available" [33] (p. 112).

Both role conflict and role overload were evident during the pandemic, as caregivers felt overwhelmed and distressed by the number of responsibilities that they had to rapidly take on, on top of their pre-existing obligations in a time of fear and uncertainty. Caregivers felt role conflict when they needed to simultaneously work and support their child's learning from home. As they faced these conflicts daily for months on end, many experienced role overload [6]; caregivers raising more than one child or younger children were especially susceptible [33], as were those raising CSHCNs [3,32]. Families had to choose how much time and energy they could devote to work or teaching their child, and, when schools re-opened, caregivers had to decide if they were willing to risk their family's health and safety by sending their children in-person to relieve these burdens [6,14,28,34]. This role overload caused many caregivers to suffer mentally and emotionally [12,32]. In fact, role stress and its components have been linked to burnout, emotional exhaustion, and decreased psychological well-being [30,32,33].

This emotional exhaustion is especially salient when a person has taken on a new role or one of their roles has changed, as the resources devoted to previous roles must then shift to this new or changed role; many kinship caregivers experience this internal conflict when they take their relative's children into care [21,22]. For example, a kinship caregiver may have to leave their job if the child in their care has many medical appointments or court hearings that they must attend. One study found that, when role stress and strain are high, kinship caregivers are more likely to rate all aspects of their caregiving experience less positively, including their motivation and ability to care for the children in their home, support systems, and children's well-being [22]. Therefore, adding the teacher role during the pandemic, which was overwhelming for most parents, may have been especially burdensome for kinship caregivers who were already feeling strained, negatively impacting their mental health and well-being.

3.2. Caregivers as Teachers

When schools closed in the spring of 2020 and transitioned to remote learning, caregivers of school-age children had to help their children adapt to a new reality. According to [12], "the process of adapting to change involves the whole family; however, parents as the leaders of the unit will need to use more of their resources to lead the family in such a process" (p. 3). As a result, caregivers around the world struggled to not only parent their children during a global crisis, but also play a significantly increased role in their children's education [6,8,12,32,35,36]. One study argued the following:

> . . . parents' roles multiplied, some as providers for their family and others as the main taskmasters (taking care of day-to-day needs such as virtual doctor's appointments, mealtimes, and chores), often while also acting as school administrators and information technology support for their children [14]. (p. 402:3)

While much of the literature referred to parents as "teachers" or "assistant teachers" [12,17], the term "school administrator" helps communicate the wide range of responsibilities associated with effectively facilitating remote learning [14]. One study suggested that, at the start of the pandemic, "home and school environments became intertwined" [37] (p. 2). As most families did not have a designated school or workspace in their homes, caregivers had to rearrange their homes, sometimes sacrificing other needed spaces, so that their children had a dedicated place to learn [2,8,13,14,16,20]. If multiple children were learning online simultaneously, it was ideal to use different rooms so that each child could hear and participate; however, families living in apartments or with family did not always have space for this [20]. Caregivers also had to share spaces or devices, adapt their own work schedules, and reimagine daily routines to accommodate virtual class meeting times, which were often overlapping when multiple children were learning at home [14,15,20].

3.2.1. Balancing Learning at Home with Working from Home

Parents working from home were especially prone to role conflict and overload while their children were learning at home [6]. One of the most consistent findings throughout the literature from this time is how much caregivers struggled with figuring out how to meet the demands of their job, take care of their children, and support their learning [2,7,16,17,20,23]. Families faced difficult trade-offs, including switching off between working and teaching throughout the day [32], changing schedules to support their children, but working longer hours and potentially sacrificing sleep or time to relax [3], taking time off or reducing how much they worked [23], and deciding whether or not to seek outside care for their child, despite concerns about the virus [5]. Parents of multiple children learning from home, each with different needs, felt a heightened sense of responsibility and strain [2,20].

Families did not take these trade-offs lightly and often suffered emotionally from making these tough decisions [6]. Many parents and caregivers felt a sense of guilt over the choices they made, concern for how those choices would affect their children, and a feeling that they could not perform competently in any of their roles [4,6,17,34]. These feelings were also expressed by caregivers who were essential workers and had less flexibility over the trade-offs they could make. Grandmother kinship caregivers who had to work outside of the home felt guilty that they could not supervise their grandchildren's schooling and worried about their academic growth as a result [23].

In addition to the role conflict and overload that caregivers working from home experienced, multiple studies noted that a significant stressor was the "non-stop, 24 h a day cycle of working and homeschooling" [4] (p. 12) that offered no opportunities for breaks—in proximity from their children or time [5,16]. A study of foster parents noted that "parents described how emotionally draining it was to both work and parent continuously without any breaks, because respite was unavailable and the health risks made childcare and/or babysitters undesirable, even if they were available" [5] (p. 377). Without time to be alone and focus on work, and with their children in the same physical space, caregivers found it especially difficult to fulfill the many tasks awaiting them [16].

3.2.2. Preparation and Capacity for Leading At-Home Learning

Adapting to the role of teacher was challenging not only because of time constraints but also because few families had any experience with learning or working from home [32]. This lack of preparation for remote learning has been tied to significant increases in parenting stress [18]. According to [17], "the shift in position from a full-time worker and full-time parent, to now include a full-time teacher, was overwhelming for some parents and triggered their insecurities" (p. 587). Many caregivers were not confident that they could support their child's learning [8,11,16,20]; in one study, less than 44% of participants felt they could adequately teach their child [15]. Families with older children enrolled in more advanced courses were especially unsure about how to help their children learn [11]. Caregivers also worried about their ability to use the different technological platforms required during remote learning [8]. Their lack of confidence often stemmed from a fear that their skillset would negatively impact their child [8,20]. One study found that parents' concerns about their ability to teach turned into guilt about how much their children had learned, if they taught them correctly, and their efficacy as parents [20]. For kinship caregivers, these concerns may have been compounded by generational gaps, with some older caregivers feeling less familiar with the content and instructional strategies that the children in their care were learning [23].

3.2.3. Children with Special Healthcare Needs

Regardless of learning modality, CSHCNs exhibit greater needs for educational and related support than the general population. CSHCNs are more dependent upon their primary caregivers, and often require support with tasks of daily living, managing behaviors, accessing and carrying out therapeutic services, and advocating for their needs in educational and medical systems [38,39]. This caregiving burden can have a negative impact on caregivers' mental and physical health and well-being [39]. According to [38], "when caring for children whose disabilities requires extensive physical care, behavioral support, or financial outlays, parents or caregivers might be more likely to experience stress" (p. 29). Research has also shown that children with disabilities are at greater risk for maltreatment, particularly neglect, and have reduced opportunities for permanency [38]. Heightened caregiver stress levels in those raising CHSCNs have been associated with harsher parenting practices and maltreatment of the children in their care [38,40].

Consequently, caregivers of CSHCNs faced even greater demands on their time and energy when supporting their child's learning at home [32]. Across countries, parents of children with diagnosed disabilities had far more negative experiences during remote learning than parents of children without disabilities [36]. Caregivers worried that their children "were not able to participate fully in remote instruction because of their disabilities" and expressed concerns about their ability to progress academically [23] (p. 12). In one study, only one-third of caregivers felt that their child's needs were met while schools were closed, compared to over 85% before the pandemic [11].

CSHCNs also may have struggled to adjust to and engage with remote learning, due to difficulty attending to tasks, behavioral disruptions, and changes to routines [2,5,32,41]. Caregivers have noted that their children had different learning needs at home than they did at school [41]. For example, one study noted how children diagnosed with Attention-Deficit Hyperactivity Disorder (ADHD) found it difficult to pay attention to class on a video platform [2]. A study of kinship caregivers found that CSHCNs often did not independently engage with their learning, complete their homework, manage their behaviors, or make academic progress [23].

Many caregivers of CSHCNs felt that they did not receive the support or services they needed for remote learning [41]. In some cases, students were not receiving modified work or accommodations required by their individual education plans (IEPs) [20,23,41]. Families also experienced significant disruptions to services, meetings, and evaluations for their children, from both school and community providers, sometimes because they were difficult to deliver effectively in a virtual environment [11,18,20,28,32,41]. For example, students who received one-to-one support from a special education professional during school before the pandemic were often not able to receive this support during the pandemic due to social distancing requirements [41]. Consequently, caregivers had to work intensely with their children to make up for the lack of services provided and to try to help them stay on pace with the school's expectations [32,42]. However, families lacked the training and resources of special education and related service professionals [41,42]. These additional demands and worries put caregivers of CSHCNs at greater risk of poorer mental health and well-being during the pandemic [3,23,32].

3.3. Caregiver Well-Being

The research emerging from the pandemic demonstrates a clear consensus; schooling-related role stress and strain contributed to significant declines in caregiver mental health and well-being [3,4,6,15,17,23,35,37,43]. In addition to heightened stress, many caregivers experienced increased levels of anxiety and depression [4,6,18,19]. In some studies, more than one-third of the sample was experiencing clinical levels of depression and/or anxiety [18,19]. A study of grandmothers raising grandchildren found that 44% of the grandmothers were clinically depressed during the pandemic [23]. These findings were especially pertinent for families whose children were learning at home [3,7], especially if their child struggled to adapt to remote schooling [35].

Yet, schooling alone did not lead to a mental health crisis among parents and children. It is important to consider the other factors that compounded the role stress and strain of parents and caregivers. These include socioeconomic challenges such as a loss of employment or not having enough food, fear about the virus and related implications for essential workers or the immunocompromised, the isolation and lack of social support that so many experienced because of the lockdowns, and the lack of respite care and breaks for caregivers [4,7,43]. According to [37], "being female, possessing a lower income, being a single parent, having a child with [special educational needs and/or neurodevelopmental disorders], and/or being from an ethnic minority background may have further exacerbated parental psychological distress" (p. 6). Multiple studies also found that caregivers of CSHCNs had increased incidence of stress and mental health challenges during remote learning [3,32]. Kinship caregivers, who are more likely to meet all of these criteria, were particularly at risk for pandemic-related mental health declines.

Concern for the well-being of the caregiver is especially important given the connection between the mental health and well-being of the caregiver and that of the child [3,18,43]. For example, one study found that, as parenting stress increased, so too did the anxiety levels of the children in their care [18]. Similar connections have been found between children's behaviors and the level of depression their kinship caregiver experienced [44]. Prior research has also shown that caregiver stress is tied to increased behavioral concerns among the children in their care [45] and decreased perceptions of child well-being [22]. A study conducted in summer 2020 found that high levels of stress and diminished mental well-being among grandparent kinship caregivers was associated with harmful parenting behaviors, including corporal punishment and neglect [40]. It is, therefore, critical to understand and support caregivers' well-being to also have positive effects on child well-being.

Support for At-Home Learning

Families took on this teaching role without additional time, and often, without support [3]. Because of the lockdowns, other public health orders, or an unwillingness to put family members at risk of spreading COVID-19, many families lacked their usual support system from family members, friends, or childcare and after-school programs, and they received limited additional support to help them manage their new role [3,6,15].

During this time, schools were the primary place that caregivers sought support with their children's learning, and this support may have been as simple as "recognition of the challenges faced by non-teachers in education delivery, and reassurance that parents' and caregivers' efforts to support their children's learning are 'enough'" [3] (p. 6). For others, just being able to reach their child's teacher when they had a question had a positive impact on parents and caregivers [11,19,23]. It has been shown that feeling supported by the school and connected with the child's teacher may have mitigated some of the stress and strain that caregivers were experiencing and improved their mental health and well-being [3,19,43].

However, many families felt they received insufficient support from their child's school and that schools were not as communicative or responsive as they needed [2,11,14,20,36]. Grandmother caregivers ". . .reported frustration when teachers were not available, or were only available asynchronously or during limited times. . ." [23] (p. 10). This was especially true at the beginning of the pandemic as teachers and schools struggled to quickly develop a new system of instruction [11]. As a result, parents and caregivers struggled. In one qualitative study, some families expressed that they did not know what or how to teach their children [20]. Families and school staff also had far fewer opportunities to interact and share this information than they did before the pandemic; not being in the school building limited the occurrence of conversations that typically happen when picking up or dropping off children at school [46,47].

Instructional support alone may not have addressed all of the needs of families who were experiencing more COVID-19-related difficulties [19]. A study of school social workers supported this sentiment, noting the need for emotional support for parents and caregivers experiencing distress and burnout, as well as assistance with technology and their children's own social–emotional learning [46]. The significant needs of kinship families, along with their risk factors for both pandemic-related stressors and reduced well-being, make it even more critical to provide holistic support for this population. However, much is unknown about the specific types of educational and social–emotional support that would truly help kinship families, especially in the wake of the pandemic.

4. Materials and Methods

4.1. Project Overview

The focus groups detailed in this article represent a two-phase study on kinship caregivers across the United States, led by a multidisciplinary team of researchers. The first phase—a series of Delphi Rounds—informed the development of the focus group protocol in Phase II. The study was approved by the Institutional Review Board at [de-identified university] (protocol number [de-identified]).

The study focuses on the factors that impact kinship caregivers' psychological and physical health and how they may differ along sociodemographic lines, how the physical and psychological stress and strain associated with caregiving may have heightened throughout the COVID-19 pandemic, and what types of effective intervention and support are available for kinship families. The researchers sought a national sample of both kinship caregivers and child welfare professionals to gain first-hand perspectives on these issues.

This article arose from overwhelming agreement in the focus groups that remote learning was the biggest pandemic-related stressor, as well as an unexpected finding; caregivers were open about the challenges the children in their care faced, and the researchers were surprised by how frequently special healthcare needs were mentioned. In fact, 68% (n = 17) noted that at least one of the children they were raising had developmental, learning, or physical disability, and/or emotional and behavioral health challenges. This article explores how school closures during the pandemic impacted caregivers, paying particular attention to those raising CSHCNs.

4.2. Design and Data Collection

Multiple qualitative methods—Delphi Rounds and focus groups—were used to learn about the needs and priorities of kinship families, seek clarification and precision from kinship caregivers and child welfare professionals in defining those needs, and explore them through in-depth conversations. To ensure a national sample and abide by safety recommendations during the COVID-19 pandemic, all activities were conducted remotely. The Delphi rounds were facilitated as questionnaires through the Qualtrics survey platform, and focus groups took place on Zoom. All confirmed participants completed a consent form and a separate demographic survey in Qualtrics at the start of their involvement with the study. Focus group participants were asked to give verbal consent for recording the sessions to facilitate transcription of the conversation.

We developed our research and interview questions through a comprehensive review of the literature, insights gained from the team's professional and lived experience with and as kinship caregivers, and a cumulative review of the unanswered questions and findings from our earlier studies on kinship caregiver stress and strain. The responses from the Delphi rounds, which took place in mid-summer 2021, were also used to develop the focus group protocol. Participants were asked about stressors and strengths of kinship caregivers, impacts of the pandemic on the mental health and well-being of kinship families, needed support and the quality of virtual support received, experiences with shared parenting, and awareness of kinship care among policymakers and the public. The team conducted a total of 11 focus groups—six with kinship caregivers and five with child welfare professionals—at the end of summer 2021. Each focus group lasted 90 min and had between three and eight participants.

4.3. Sample

Purposeful, snowball sampling methods were used for the first two phases of the study [48]. Recruitment for the Delphi rounds and focus groups occurred simultaneously through the same initial channels: a national listserv of child welfare organizations across the United States and an [de-identified state]-based kinship caregiver support group, which was founded by a member of this research team. Follow-up emails were sent through these channels to increase participation and ensure that all available focus group slots were filled.

The recruitment messages described the study, anticipated time commitment, eligibility requirements, and gift card incentives. While confidentiality was preserved for all participants, prospective caregiver participants were informed that the group founder on the research team would neither have access to identifying information for the kinship caregivers in the study nor would participate in the caregiver focus groups. These initial messages also encouraged readers to share the opportunity for this study with other kinship caregivers or child welfare professionals that they may know. For example, it was possible for a child welfare professional to send the information about the study to kinship caregivers with whom they work.

All participants were required to be at least 21 years of age, and kinship caregivers were required to be a full-time caregiver to a child or children within their family for at least one year. Child welfare professionals were required to have at least two years of professional experience in the child welfare field and experience with kinship families. Participants who met these requirements were able to sign up for only one phase or both the Delphi rounds and a focus group. Caregiver participants were excluded only if they were under the age of 21, were not a full-time kinship caregiver, or had been providing care for less than one year. Professionals were excluded if they were younger than 21, if they did not work with kinship caregivers, or if they had fewer than two years of relevant experience.

In all, 26 child welfare professionals and 35 caregivers applied to participate in the Delphi Rounds, and 72 professionals and 51 kinship caregivers applied to take part in a focus group. Ultimately, 17 child welfare professionals and 36 kinship caregivers met the criteria for participation and completed all three Delphi rounds. The final sample for the focus groups comprised 34 child welfare professionals and 25 kinship caregivers. A total of 11 caregivers and 12 professionals completed all three Delphi rounds and participated in a focus group. A brief demographic description for each group of focus group participants is shared below; the full results of the demographic surveys can be found in Tables 1 and 2.

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

Table 1. *Cont.*

	Delphi Rounds Participants (n = 36)		Focus Group Participants (n = 25)	
	n	%	n	%
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 (USD)				
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
Caring for 4 children	3	8.3	2	8.0
Caring for 5+ children	5	13.9	2	8.0

Table 1. *Cont.*

	Delphi Rounds Participants (n = 36)		Focus Group Participants (n = 25)	
	n	%	n	%
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 cared for more than one child, multiple age ranges were selected, resulting in a total greater than 100%.

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

Table 2. *Cont.*

	Delphi Rounds Participants (*n* = 17)		**Focus Group Participants (*n* = 34)**	
	n	**%**	***n***	**%**
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
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

Table 2. *Cont.*

	Delphi Rounds Participants (*n* = 17)		Focus Group Participants (*n* = 34)	
	n	%	*n*	%
Workplace setting				
Private or non-profit 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%.

4.3.1. Kinship Caregiver Participant Demographic Information

All but one of the kinship caregivers who participated in the focus groups were women. Just under two-thirds of the caregivers identified as White, and one-third identified as Black or African American. One caregiver identified as Alaskan Native or Native American. Nearly half of the caregivers were in their fifties, but participants ranged from 36 to 75 years old. While 80% of caregivers were from [de-identified state] due to our sampling method, participants represented 12 states. Over half (52%) were married or in a domestic partnership, and 24% were divorced. There was a wide range of income levels in the sample; while 18% had a yearly household income of over USD 80,000, 32% had a household income of less than USD 40,000. The majority of caregivers were employed—full-time (48%), part-time (28%), or self-employed (8%). Just two (8%) were unemployed.

Sixty-four percent were grandparents raising grandchildren, and 56% were raising more than two children full-time. Nearly all (92%) of the caregivers were raising children between the ages of 6 and 10 years old, 60% had children ages 11 to 15 years, and 56% had children under the age of 5. Sixty percent had child welfare system involvement when the children came into their care, suggesting that 40% of the sample may have been informal kinship caregivers. On the basis of the focus group results, the research team determined that 68% of the caregivers were raising CSHCNs.

4.3.2. Child Welfare Professional Participant Demographic Information

All of the child welfare professionals who participated in the focus groups were women. Approximately 62% identified as White, 24% as Black or African American, 12% as Hispanic or Latinx, and 6% as Alaskan Native or Native American. The professionals ranged from 23 to 65 years old, with approximately 30% in their thirties. Participants came from 14 states, and nearly 62% represented public child welfare agencies. More than half were child welfare workers, and just over 35% were managers or administrators. Approximately 47% had a master's degree in their field, and nearly 53% were social workers. Just under 59% of participants had 10 or more years of experience since achieving their highest degree, and approximately 38% each had either 5 to 10 years or more than 10 years of experience working with kinship families.

4.4. Data Analysis and Confirmability

Given that the sampling frame for this study inherently created a potential conflict of interest for one of our team members, multiple steps were taken to protect the identities of the study participants and mitigate the risk of bias in analysis. All study correspondence was restricted to one member of the research team without potential conflicts of interest. This researcher also conducted all of the kinship caregiver focus groups; the researcher who founded the caregiver support group only participated in focus groups with child welfare professionals. All focus group recordings and documents with identifying information about the caregivers were stored in a separate and secure OneDrive file from the remainder of the study documents. Only the de-identified documents were shared with the team and stored in the team's shared OneDrive folders.

The team used the Zoom platform to host the focus groups, and the conversations were recorded. Zoom also created transcriptions of the recordings. Multiple team members cross-checked the content of the transcripts with the video recordings to ensure accuracy in transcription. The transcripts were also de-identified at this time to protect the confidentiality of participants. Finalized transcripts were uploaded to the Atlas.ti Web platform, which allowed the research team to collaboratively code the documents.

The research team primarily followed the flexible coding framework [49]. This methodology was relevant for this study because it presumes that the researchers have familiarity with the extant literature in the field and that the process of coding would not be completely inductive. First, the team developed a series of index codes that were aligned to the focus group protocol and used to identify large sections of text that discussed the broader conceptual framework of the study; all quotations were also coded as either "caregiver" or "professional" to facilitate later analysis [49]. Per the authors' recommendation, codes for key quotations and "aha" moments were also used to identify statements of interest from the conversations [49] (p. 727).

Throughout the initial round of coding, the researchers kept track of potential analytic codes to be used that were more specific and intended for smaller sections of the text [49]. The research team met multiple times to develop a complete set of analytic codes, as well as themes that emerged that were either reflective of or missing from the literature on kinship families. Two researchers then conducted multiple rounds of coding with the analytic codes, adding more codes as other themes emerged and cross-checking each other's coding results. Once the decision was made to focus on remote learning, the team conducted an additional round of coding to condense the data [50]. After creating a map of the entire set of codes on an online whiteboard, similar codes were combined, unclear codes were renamed, and additional codes were created to ensure that the framework was comprehensive and exhaustive. As an additional confirmability measure, once the two primary coders agreed on the labeling schematic, the third researcher, who possessed a more objective view because she did not interview the research participants, debriefed with the pair of coders multiple times to assess the viability and alignment of the coding plan with respect to the raw data and original research probes.

Once these adjustments were made, the team used the Atlas.ti Desktop platform to run more in-depth analyses of the data. Co-occurrence tables were created to visualize which index and analytic codes were frequently used together across transcripts. Combined with code frequencies, these tables allowed the team to identify the most prominent patterns in the data and the contexts in which they were found. The researchers synthesized important quotations with the list of themes to highlight the participants' perspectives on each of the findings.

4.5. Trustworthiness, Dependability, and Transferability

The team used five methods to establish the trustworthiness and dependability of the data in this study: member checking, peer debriefing, prolonged engagement, coding system, and thick descriptions [51]. These are described briefly below.

4.5.1. Member Checking

To reduce potential bias in interpretation, focus group attendees were invited to participate in a voluntary member checking process [50]. This was introduced at the end of each focus group, as well as through a follow-up email. After all transcripts had been cleaned and de-identified, the research team read them thoroughly and developed a list of themes that arose during the conversations. Member checking participants received this list, as well as a de-identified transcript of the focus group in which they participated. Participants were given an electronic gift card to review these documents, provide corrections to the transcripts as needed, and comment on the accuracy of the themes. A total of 11 caregivers (44% of the sample) and 18 child welfare professionals (53%) participated in this process.

Ultimately, few changes were requested, and participants had a high level of agreement with the initial themes.

4.5.2. Peer Debriefing

The process of peer debriefing involves researchers reacting to and processing their interpretation of the findings with one another [52]. In this study, the research team of three independently reviewed the raw data generated from each of the Delphi rounds and focus groups to reach conclusions about what the subjects were conveying. Then, the researchers met together to discuss impressions and their respective interpretations.

4.5.3. Prolonged Engagement

In the methodological approach of prolonged engagement, a researcher remains in contact with a research participant over an extended period of time, which is especially valuable for authentic engagement and understanding the lived experience of participants [53]. In this multi-phase study, we were able to involve many of the same participants in the Delphi rounds and focus groups. By engaging participants over the course of weeks and having their responses in Phase I inform the structure and questions used in Phase II, we had the benefit of learning about the participants' stories and journeys on a deeper level.

4.5.4. Coding System and Inter-Rater Reliability

As described above, meetings with the research team helped ensure agreement on the codes that were included in the coding scheme, as well as how each researcher would interpret and define each code. These meetings were critical for promoting inter-rater reliability and ensuring that each researcher would code a given section the same way. To establish norms, two researchers individually coded a subset of the transcripts, read and provided feedback about the other's coding decisions, and then conferred to discuss questions or places where their coding differed [48]. This process was repeated throughout the rounds of coding to resolve any confusion or discrepant interpretations of the codes themselves or how they could be applied to the transcript text.

4.5.5. Thick Descriptions

We use thick descriptions in qualitative research to increase the transferability—known as generalizability in quantitative research—of the data and elevate the voices of research participants. Thick descriptions provide depth and give an account or meaning to the research participant's experiences and reality [52,54]. In this study, to the extent possible, each of the analytic themes and codes was contextually discussed using direct quotes from the research participants.

5. Results

From the focus groups, the research team identified three themes pertaining to schooling during the pandemic: (1) role stress and strain associated with the "teacher" role; (2) challenges and benefits of remote learning; (3) challenges and benefits of returning to in-person school. Each theme is discussed below.

5.1. Theme 1: Role Stress and Strain Associated with the "Teacher" Role

When asked to identify the biggest stressors that arose for kinship families during the pandemic, participants mentioned school closures and remote learning consistently. Particularly for younger children and CSHCNs, caregivers were responsible for ensuring that they were able to access online classes and assignments, understand the content of the lessons, and remain engaged. These additional responsibilities weighed heavily on kinship caregivers, as they navigated yet another role being assigned to them, often to the detriment of their well-being.

5.1.1. Difficulty Balancing Work and Schooling

Supporting or even leading at-home learning was especially difficult for the kinship caregivers in the workforce. As many of the focus group participants were getting used to working remotely in their own careers, they were also being asked to support their children's adjustment to learning through virtual platforms. As one caregiver explained, this period of time was particularly challenging for children in kinship care, who have histories of trauma:

> When schools went remote, it was really a struggle to work from home and attempt to teach. You know, when you have a child with past trauma, they don't do well with a lot of change and chaos and all that stuff, so my granddaughter was literally having meltdowns every day because kids were being disruptive, and she felt like she couldn't hear the instructions. And she's a child that doesn't really melt down either, so you know so I'm trying to deal with that and work from home, and you know, etc., Then we went to a [new] program and homeschooled, and that was a struggle because I'm trying to now work from home, learn a new school program, and teach at the same time.

A grandmother explained how she changed her grandson's schooling schedule and sought additional care so that she could work and support him with remote learning:

> My grandson was in kindergarten, and he was trying to work from home, and that wasn't an option for us because I couldn't do my job and try to watch him on his computer. So he just went to the babysitters, and with the assignments his teacher gave him, we just did it later on in the evenings and submitted them, and I told her I can't do both. . .

Because they were unable to do everything required of them at once, caregivers had to adjust schedules, spaces, and expectations to accomplish as many of their responsibilities as possible. Caregivers noted that when their employers were empathetic and flexible, it eased the pressure they were feeling because of these overlapping demands on their time.

5.1.2. Caregiver Well-Being

In describing their experiences during remote learning, caregivers shared feelings of overwhelm, frustration, and guilt. They described how the struggles of managing schooling at home brought them to tears and caused them to feel burned out. One caregiver explained the significant burden this placed on caregivers:

> I think we should get paid for when COVID did hit, and we had to teach these kids at home because I looked at all of that, I said, "now who they think gonna do all this work the teacher's supposed to do?" We doing it at home, and we don't even get paid. Really? . . . "Oh no you didn't, you going right back to school, COVID or no COVID, cause you not staying home with me!" I read all these things that they wanted us to do. I said, "people gonna have a breakdown." I said they don't even get that.

Another caregiver explained the unique challenge of navigating remote schooling with children who had only recently been placed in kinship care and the distress she experienced as a result:

> . . . homeschooling the two little ones was really challenging. I had to turn my laundry room into the classroom, and by the time about two, maybe three weeks before school was finished, I just emailed the teachers and said "I'm done, I can't do it anymore. If they have to be held back, they have to be held back, but I cannot," and we were already like so far behind at that point, . . . and I just couldn't keep up with it. They had a lot of behavioral issues when they came to stay with me, and they came in November 2019, so, when COVID hit, it was you know March 2020, which did not leave for very much time and for them to adjust to much of anything.

Given the significant needs of their children, kinship caregivers had to bear the additional burdens of recent transitions and traumas, on top of the demands of remote learning. Many caregivers in our study shared feelings of depression and burnout as a result of these stressors.

5.2. Theme 2: Challenges and Benefits of Remote Learning

The online schooling experience during the COVID-19 pandemic brought about substantial challenges for families of school-age children, many of which were exacerbated by the circumstances present in kinship families.

5.2.1. Children with Special Healthcare Needs

Multiple caregivers explained the added challenges they faced adjusting to remote learning if they were raising CSHCNs or children dealing with the trauma they had experienced. These challenges included managing children's emotions and behaviors, providing them with appropriate instruction, and lacking needed modifications for assigned schoolwork. One caregiver explained the following:

> It was very difficult with schooling, homeschooling. And I know I'm not alone in knowing that a lot of kids who are in care of other family members or foster care have been through a trauma, which makes it even more difficult to deal with. I have three. . . . They . . . all have ADHD, the other one has some more serious issues so. In a way, nothing is easy, but especially with homeschooling, that was really hard . . . not so much on me, it was hard on me, but it was really hard on them too, because that's not how they know how to learn, and it was easy to just say you know there were too many home distractions. . .

Another caregiver shared the difficult journey that she and the children she is raising experienced during remote learning, given their additional needs:

> The school part was extremely difficult because all four of my grandkids have a diagnosis. They're all diagnosed ADHD . . . my grandson, it is so difficult to try to teach him that even the teachers struggle. The help that they get, you know the special instructions, they're like, how do you connect with this child? They may one minute just blow you away because you're like they understand this, and then the next minute they couldn't tell you anything you talked about. So that was very, very big struggle, I had to do a lot of soul searching in myself for that, because two of them, even though they are the hyper ones, they just get it, you know, and it was so easy teaching them.

This caregiver continued, sharing their experience with a child with multiple mental and behavioral health diagnoses and early traumatic experiences:

> She's got a diagnosis of reactive attachment disorder, stress, and trauma-induced anxiety. And the ADD. I'm pretty much what I'm learning so far is the difficulty in teaching her is that her brain, even though she's with us since she was two years old, is still fixated on getting food and surviving so beyond that it's like nothing else gets in.

These challenging experiences were supported by comments from child welfare professionals. One professional noted how difficult this experience was for caregivers, particularly when they lacked needed information and support, saying that "there's still this level of the intensity of behaviors are just so much more extreme and our kinship caregivers don't always have the same level of like knowledge and insight in terms of how to manage trauma."

These situations were amplified when they felt the children's teachers were not providing appropriate modifications or accommodations outlined in their individualized educational plan (IEP). A grandmother shared how she had to be resourceful in order to meet her grandson's needs:

> My biggest problem during COVID was actually the school, just stupidity, like the 11-year-old is on an IEP and they didn't modify his classes at all. . . . toward the end I got smart and I asked the teacher for modified lesson plans, because he just wasn't getting it. And then I started looking on the Internet for alternatives like Jill Biden had a Washington DC tour, a video tour. And we were able to substitute that for one of his social studies lessons, so at the end, the teacher worked with me really well, but in the beginning it was rough.

Other kinship caregivers in our study also noted how they had to fight for the educational support that their children needed and deserved; another grandmother noted how much she had improved her own parenting skills through this advocacy and by seeking out resources for her grandson. Caregivers had no choice but to learn how to adjust their children's learning environment, experiences, or materials to meet their needs, often with little guidance from the schools. They also had to become strong advocates for the CHSCN they were rearing.

5.2.2. Technology and Technological Literacy

Child welfare professionals in particular spoke of issues accessing appropriate technology or internet connections to facilitate remote learning and helped improve kinship families' access to the technology needed. Many professionals noted that their agencies or local school systems distributed devices to families so that children could participate in remote learning. One shared the following:

> In my area, they give out the laptops and they gave out Wi-Fi if needed, and then they set up Wi-Fi hotspots in a lot of the high school parking lots so for the high schoolers, so if they didn't have it, they could go sit in the actual parking lot of the high school and you could connect to the Wi-Fi and do that.

While these distributions were helpful in increasing access for families, solutions such as having to log in from a parking lot may not have created the most conducive learning environment. A professional shared how many families living in rural areas do not have internet access, but this is not a reflection of their economic well-being; however, it is a barrier for making remote learning viable for all kinship families in her state, and families often had to leave their homes to access the online schooling platforms in other locations. Child welfare professionals from other rural parts of the country echoed these experiences as well.

Yet even with the appropriate devices and internet access, professionals noted that many kinship caregivers struggled with learning how to use the technology. One participant explained that many of the grandparent caregivers used little technology in their daily lives before the pandemic and lacked knowledge around how to navigate the systems required for their children's learning and their own communication with the schools. Another professional explained:

> Of course, it was a challenge right, because now, they have to help with virtual learning, you know they have to you know navigate appointments, maybe you know tele-visits, or you know those kinds of things which, again, you know can be challenging to someone who has not had that type of experience with you know technology.

Professionals shared how they supported caregivers through these capacity-building challenges, as well as through tutorials and phone call walkthroughs to teach them how to use the technology and access their children's learning environments and other needed support.

However, most caregivers did not identify either using or accessing technology as one of their biggest problems with remote learning. One grandmother, in trying to navigate a challenging situation with her grandson's online classroom, shared that people made assumptions that she would struggle because she was a grandparent, when, in fact, she was independently seeking out additional online resources to supplement her grandchild's school curriculum. She said, "The school's technology officer was kind of treating me like a dumb grandmother, you know, like I didn't know what I was talking about". Perceptions of caregiving grandparents may have impacted the level and quality of support they received from schools and other resources.

5.2.3. Lack of Confidence in Supporting Children's Learning

A number of kinship caregivers did not feel they could adequately support the children in their care with the content they were learning, often because their older children were in more advanced courses or they felt far removed from being in school. A great-grandmother shared the following:

> The worst thing for me was having the kids at home doing homework virtually and trying to teach the kids. It's been a long time since I've been in school and just trying, you know, to help them, and especially my great grandson because he's on an IEP program, so that was even more difficult for me.

Another caregiver discussed one of the children she was raising and said, "Thank God, she was very smart because I could not have helped her with any of her homework. She managed to keep up with her classwork and was on the honor roll all year last year". Similarly, another participant said, "…the 15-year-old is all honors classes, and I wasn't really able to teach her her math. I didn't take those classes, but she's a smart girl, and she was able to get through it."

The challenges of supporting children through remote learning were also noted by the child welfare professionals. One professional noted that their agency provided educational support to caregivers who were unable to assist their children with their schoolwork at home and had an educational specialist with whom they could consult in their work with families during this time.

5.2.4. Children and Families Who Thrived during Remote Learning

Despite the challenges of adjusting to learning at home, some caregivers found that remote schooling was beneficial to their family. In some cases, they were grateful that because of the school closures, they had additional time to spend with their children and bond through this experience. When asked about the positive aspects of the pandemic, one grandmother noted, "The positive, I got to be right here with him, homeschooling. That little boy's smart". Another caregiver shared that remote learning worked well for their family, saying that "my kids' school district was virtual when COVID started. They enjoyed being virtual. We chose to stay virtual, and so I was their teacher for a year". Other kinship caregivers shared that their children who were more introverted appreciated and succeeded in schooling from home.

For some CSHCNs in kinship care, being away from the physical school environment was beneficial to their ability to learn. One professional noted, "…Some of our kids, the behavior has been better actually since they've been at home, and the situations are a little better controlled…" A grandmother explained the impact of the additional support she could provide at home:

> My granddaughter is autistic, so she's on an IEP. That was extremely difficult, but at the same time, it was a little bit nicer because I could give her the one-on-one that she needed. Because at the time she did not have an aide at school, she does now, and so that you know I could really see that she was benefiting from that one-on-one time.

While remote learning presented many challenges for kinship families, some ultimately preferred the virtual environment. Caregivers had to weigh these pros and cons when faced with a decision to send their children back to school in-person.

5.3. Theme 3: Challenges and Benefits of Returning to In-Person School

The focus groups took place at the start of the 2021–2022 school year; thus, caregiver participants were able to discuss their decisions around how their children would be educated in the new school year. While some families chose to continue homeschooling, many families expressed a desperation to have the children back at school.

5.3.1. Desire to Return to "Normal"

In one focus group, two caregivers laughed about how ready they were for their children to go back to school. The first caregiver shared, "My husband kind of joked with me, I was ready for them to go back to school about a month before they did. I had their backpacks and everything ready". Another caregiver replied with the following:

> . . .that is so funny because in the closet you know right by the door that they exit there was all of their book bags completely filled sitting there for at least two weeks prior. And you know I kept waiting for those bags to go out the door.

Other caregivers were more concerned with the loss of learning that may have occurred because of the school closures and were eager to see their children go back to begin catching up. One participant explained, "I'm just glad the kids are back in . . . because I feel like I feel like they lost the whole year. . . I don't think they, you know, profited from those years at all". Another caregiver shared the importance of connection that occurs through in-person school and explained that it was her children who were especially excited to return:

> They were happy, they wanted to go back to school, and you know even, especially the one really in special needs class because he hadn't seen his teacher, he loves his teacher you know. Those are people that understand him and so I think they were happy to go back.

While much of the discussion about social isolation during the pandemic pertained to friends and family, this participant highlighted how much children may have missed interacting with their teachers and other school staff.

5.3.2. Inconsistent Schedule Due to COVID-19 Outbreaks

Despite caregivers' desires for children to return to in-person learning, many expressed frustrations about going back to school while the pandemic continued and subsequent shutdowns were common. For children in kinship care who had previously experienced upheaval and disruption in their personal and educational lives, this was particularly hard. One caregiver shared the following:

> . . .emotionally, it was really hard like wondering what was going to happen, when we were gonna get back to what's normal, and any kind of changes in, at least in my grandkids. . . is a bit of work so getting back to school, not going back to school, getting back to school, not going back to school, oh you're going next week, nope not going this week. It was, that part was hard. It was hard.

This was a common sentiment among focus group participants. Another caregiver shared the following:

> I didn't hate the lockdown just to be honest, I really didn't. It kind of gave me time to spend with the kids and you know, but it's the back and forth, like make a darn decision, virtual or in school, you know, but make a decision that we can stick to.

One caregiver anticipated the frustrations of the back-and-forth nature of schooling during the pandemic and opted to keep her child at home to avoid the emotional toll it would take, explaining the following:

> . . . I'm not sending her back to public school because I foresee it not lasting long, with all the COVID increases . . . she doesn't do well with change, and so I chose to keep her in the same program because it's easier to keep them in a homeschool

> program. And if whatever changes and I made the decision for her to go back to school, it's easier for that transition than to transition from public school to a homeschool program.

Child welfare professionals echoed this sentiment as well, noting that ". . . now unfortunately we're even worse off now than what we were a year and a half ago, because we have so many schools that I think 90% of the sixth graders and one of our counties is quarantined". This participant continued by sharing that not only were routines disrupted through these shutdowns and quarantine measures, but the risk of exposure to COVID-19 was also greatly increased.

6. Discussion

The kinship caregivers and child welfare professionals who participated in the focus groups agreed that supporting the children in their care with schooling at home was one of if not the most difficult part of the COVID-19 pandemic. Caregivers, who were already overwhelmed by the multiple roles they had to balance, had to rapidly adopt a new role as their child's teacher. While some children and families benefited from remote learning, most found this new role to be onerous and distressing. Our study found that, for many kinship caregivers, their mental health and well-being suffered, particularly if they were raising CSHCNs.

6.1. Role Conflict and Overload

Kinship caregivers in our study struggled with managing the additional role of "teacher" to their children while they were learning from home, which is also demonstrated in the research on parents and other caregivers during the pandemic [12,16,18,20,32,34]. Similar to findings in the literature, caregiver participants experienced role conflict as they tried to simultaneously complete tasks for work, manage their households, and provide support for their children's learning [23,34]. Other authors argued that parents and caregivers assumed more than one new role during this time. Many caregivers had to become a "teacher, tutor, schedule keeper, playmate, and entertainer relative to their children, in addition to carrying out their daily household and professional or job responsibilities" [13] (p. 1565). As noted by our sample, those with younger children, multiple children, or CSHCNs felt these stressors even more acutely [2–4,13,18,20]. In this study and throughout the literature, caregivers were affected by role overload when it was clear that, as the pandemic raged on, it simply was not possible to meet the demands of all of their roles in the time available to them. One study stated that "teleworking during COVID-19 while parenting and homeschooling seems to present a largely untenable situation in which it is difficult to achieve a sense of competence or satisfaction in any single domain" [4] (p. 2).

6.1.1. Role Considerations for Kinship Care

While the findings from the literature are salient for kinship families, little research exists to explore how their experiences might have differed from the other family types studied. For example, kinship families might have felt stress and strain more intensely if they had recently taken their relative's children into their care, as one of our focus group participants shared [21,22]. The authors of [34] posited the following:

> For many families, the pandemic coincided with a transitional phase for the family, for example, the adoption of a child, finishing maternity leave, or children starting school. Coping with alterations to a family dynamic and the concurrent changes imposed by the pandemic was described as difficult. (p. 5)

The difference for kinship families is that these major life transitions are frequently accompanied by distress and trauma that can disrupt and impact the entire family system [21,26]. Experiencing trauma and major changes in the family can also affect a child's ability to learn, making learning from home particularly difficult [2]. One study noted that "when combined with grandchildren's preexisting mental health diagnoses and academic difficulties, it seems likely that [caregiving grandmothers] found themselves in a situation of compounding stress, which may have made remote instruction even more challenging to manage" [23] (p. 18). It is, therefore, critical to consider the kinship family context when examining the impact of remote learning on the caregiver and children in care.

6.1.2. Mitigating Role Stress and Strain

Within our study and other studies, caregivers used multiple strategies to adapt to additional role responsibilities, including shifting their work schedules, working longer hours, or arranging for alternate care for their child; these shifts are also documented in the literature [14,20]. Like the caregivers in our study, extant research found that parents with supportive and flexible employers fared better during the period of remote learning [20]. Yet, for many caregivers in our study, adjustments to their routines also caused stress, and there was little they could do to get a break from the ongoing demands within their household. According to [33], role conflict and overload can be alleviated through support such as babysitters or help with cleaning their home. However, the pandemic made these options to delegate tasks unavailable; even when stay-at-home orders lifted, such support may have been inaccessible for kinship families who were economically disadvantaged.

6.2. Caregiver Well-Being and Remote Learning

As expressed by the kinship caregivers in this study, the stress accompanying this role stress and strain was associated with decreases in caregiver well-being and increases in symptoms of anxiety and depression; this was also found throughout the literature [3,12,13,15,23]. Caregivers who may have already struggled with their mental health—as many in kinship care do—were especially at risk of declining well-being during remote learning [3]. Multiple studies found that, when caregivers felt that their child's school was not providing the support they needed, they were also susceptible to increased mental health challenges [3,13,19]. The connections between stress and mental health are also associated with the child's own well-being, the relationship between the child and caregiver, and even the children's educational attainment [3]. Caregiver stress is also connected to the quality of educational support they are able to provide to their children, making this an even more critical issue to address [18].

6.3. Experiences with Remote Learning

The literature base also supports our finding that children and caregivers, particularly in kinship families, did not always have the same reactions to the shift to remote learning [20,23]. In addition to role stress and strain, caregivers in the literature and our study felt stifled by having their families home with them all day and struggled without time or space to themselves [16,20,23]. The literature also supports our finding that caregivers benefited from having more time with their families during the lockdowns and felt that this increase in family bonding may have mitigated some of the negative effects of the pandemic [12,20]. Yet, these feelings and experiences may not have been mutually exclusive for many kinship caregivers, who may have felt a few of these sentiments at the same time.

6.3.1. Caregiver Self-Efficacy in the "Teacher" Role

The literature supports our findings that kinship caregivers and the children in their care struggled to adapt to learning virtually, for a number of reasons: feeling unprepared to be their child's teacher [18]; worrying that they had insufficient knowledge or skills to support their children academically, particularly for older students [11,16,20,23]; struggling to make time for supporting remote learning, especially for younger students [11]; having concerns about their children's learning loss, particularly for CSHCNs [4]; struggling to utilize and troubleshoot the multiple technological platforms that students had to use for school [8,14].

Much like the families in our study, many families in the extant research persisted and sought out online or other educational resources to enhance or mitigate their children's remote learning experiences and improve their own content knowledge [16,18,20]. Families were also shown to seek out peer support in the absence of resources from their children's school [8,16,47]; this was also true of kinship caregivers in this study who worked with neighbors and other homeschooling parents to educate their children.

Over time, the schooling-related self-efficacy of caregivers grew, particularly for those who chose to keep their children virtual after schools re-opened. One study found that over 40% of caregivers were more confident in supporting their child's learning and reaching out to their child's teacher than before remote learning began; these gains were the highest for families of color and those living in poverty [10]. For some, family bonding helped caregivers better support the educational needs of the children in their care:

> Caregivers were "present" in a way they had not been previously, which several found to be helpful in motivating children to complete their assignments. As a result, many caregivers became better advocates for their children . . . [and] were more willing to reach out to caseworkers for assistance. . . [28] (p. 14)

Kinship caregivers in our study also demonstrated how they successfully advocated for the needs of the CSHCNs in their care during the period of remote learning.

6.3.2. Children with Special Healthcare Needs

The literature supported our finding that, while many children struggled to adapt to a new way of learning, especially if they had pre-existing special healthcare needs or trauma histories, others benefited from the at-home learning environment [23,41]. The remote learning environment may have been especially helpful for students with learning or other disabilities, as well as those who may have been bullied for being different from their peers [2]. Other research has suggested that children with social anxiety may have fared better learning from home [28,47].

The impact of trauma on the children mentioned in this study was significant. In addition to difficulties with learning, children who have experienced trauma may demonstrate behaviors that make schooling more challenging, such as being impulsive or unable to pay attention [26]; these were noted by a number of the caregivers in the focus groups. Similarly, one study shared the experience of an adoptive parent whose children had previously been in foster care and struggled to adjust to remote learning because of the trauma they had experienced; however, the one-on-one attention this parent was able to provide for the children ultimately provided a beneficial learning environment for them [32].

6.3.3. Returning to In-Person School

Because of the varying experiences that their families had with remote learning, most of the kinship caregivers in our study were decisive about whether or not their children should return to school in-person. The justifications they provided for their decisions correspond to the list of factors that weighed into this decision, as noted by [28], such as how a child likes to learn, if they were struggling without their peers, caregivers' own career demands, and importantly, any potential health risks in the family. However, our findings slightly contradict the literature, which suggests that many families struggled with this decision and that caregivers felt guilty about sending children back to school [28]; this was not evident in our study.

Those sending their children to school in-person still faced the potential for subsequent lockdowns after COVID-19 exposure in the school, and many in this study and in the literature expressed discontent with the back-and-forth nature of school schedules [14]. This was especially problematic because of the changes in living arrangements and school placements that their children had faced; many caregivers described how their children struggled emotionally from changes to their schedules and routines. However, caregivers in the focus groups were confident that they were doing what was best for their child.

Sending their children back to school alleviated the role burden for kinship caregivers and also allowed their children to receive the services that they needed to succeed in school [5].

6.4. Limitations

Three limitations of the study should be noted. First, the perspectives of the children in kinship care and school staff are missing from this study. As the overarching research objectives were about caregiver well-being, it was not initially necessary to sample these other populations. However, to explore the issues described in this article, it would be beneficial to triangulate the perspectives of the caregivers and child welfare professionals with input from their children's teachers and the children themselves.

An additional limitation comes from the sampling method. As mentioned, some of the caregivers were recruited from a support group run by one of the members of the research team. While the team carefully planned how to protect the confidentiality of the caregiver participants and minimize potential bias in analysis, it is possible that this connection may have influenced some caregivers' decision to join or not join the study or impacted how the results were interpreted.

Lastly, the place-based nature of the sample may have introduced bias, as most of the caregivers lived in Ohio. While the point of qualitative research is not to generalize findings, it is important to note that the [de-identified state]-based participants may have been influenced by the same or similar school policies, public health mandates and constraints, and child welfare laws and policies. It is likely that their experiences are viewed through the prism of their local and state environment.

7. Implications

The COVID-19 pandemic and ensuing repercussions revealed the deep vulnerability of families who are rearing CSHCNs, especially kinship caregivers whose premorbid state was filled with daily life stressors and caregiving strain. The findings of this exploratory, qualitative study call for us to rethink how we have traditionally framed crisis intervention, namely, traditional social work practices and interventions provided in schools. Likewise, the results suggest the need for a closer examination of prevention approaches and family support and sustainability models. The implications discussed here provide a direction for future research probes according to what we discovered about the caregiver stress and strain fueled by social Isolation, the pressure to fulfill competing demands associated with parenting, and a lack of access to systems of care or educational services. To adequately support kinship caregivers, improve their functioning, and enhance the well-being of the children in their care, our study findings suggest several practice, policy, and research directions.

7.1. Practice Implications

The ways in which kinship families experienced the ramifications of COVID-19 encourage us to reimagine what it means for such professionals as school social workers and other school-based staff to support children and families. Schools must learn from the needs that their children and families expressed during the period of remote learning, as it is likely that, for many families, these needs are still present even though schools are back in session. Research has demonstrated that school social workers, in the face of the pandemic and the mounting needs of children, families, schools, and communities, were forced to expand their roles and implement universal intervention models [46,55]. Moving forward, it is critical for schools to tailor their support and methods of engagement with families to their contexts and needs [15]. Our findings suggest that school social workers should employ prevention models that plan for contingencies and fortify families' economic, socioemotional, health, and general well-being to withstand future challenges. Moreover, some argue that social work practitioners will need to extend their purview beyond traditional social support and prevention strategies to acquire practice, skill, and expertise in disaster services and support [56]. This is of particular relevance to the unique needs and circumstances of kinship families, who often face risks to their health and well-being, as well as their children's educational outcomes.

While we are still learning about the impact of COVID-19 on vulnerable children and families, early research suggests that child- and family-serving professionals struggled to fully comprehend the level of stress children and families faced [57]. This was evidenced in our study by the grandmother whose child's school treated her as incompetent and incapable of supporting online learning. As such, existing family engagement approaches must be rethought given the increased, new, and lingering types of risks that families now face. Specifically, because of the complexity of needs that CSHCNs demonstrate, as well as the differing levels of coping and abilities demonstrated by their caregivers, engagement approaches may need to shift their focus to shoring up caregivers' inherent and natural capacities. We can no longer make assumptions about service and resource availability and the mechanisms via which such things are delivered. Instead, promoting a professional skill set that recognizes and supports the complex manifestations of stress and strain is the order of the day.

7.2. Policy Implications

Researchers have found that, when social safety net policy is generous with respect to cash assistance and other support, the likelihood of child maltreatment decreases [58]. Given the connections between caregiver well-being and child safety and well-being, it is critical that policymakers work to establish conditions under which kinship families can be supported and healthy. Thus, encouraging sustained and responsive social safety net programs and coordinated systems of care are two policy ramifications of our study results. Our findings suggest that caregivers who shared that their children thrived and they experienced less role stress and strain were better able to focus their time and energy on parenting and supporting their children through remote learning, while the caregivers who struggled the most trying to be teacher and parent experienced role conflict, noted unmet needs, and expressed a disconnect with from their child's school. Much can be introduced on the macro and meso levels to increase home-school connections, support kinship families' additional needs, and work to relieve their role conflict and overload.

Social safety net policies, service provisions, and intervention models aimed at the most vulnerable, such as kinship families, in times of disasters or economic downturns, must be increased and sustained. For example, the community school model is a meso-level, evidence-based strategy that centers schools as resource hubs, providing access to support for underserved families while encouraging family engagement in their child's education and stronger relationships between home and school [59]. A community school might offer caregivers respite care through after-school programs, provide mental health services at the school site, host workshops about supporting their child's learning, or connect families to community organizations such as food or clothing banks. Our findings call for a more aligned formal system of support, such as the community school model, where supportive home–school relationships for kinship families are supported through funded policy mandates that provide caregivers access to other resources and helping professionals.

7.3. Research Implications

One of the most salient findings of this study concerned the quality of the relationship that caregivers described having with their children. Given the increased amount of time that caregivers and children shared, caregivers began to see the children in a different light, often recognizing their abilities, intelligence, and overall agency, and enjoying their time together. What research has yet to fully explain is the effect on children's special health needs and caregivers' capacity when stress and strain can be mitigated by positive relationships between child and caregiver, as well as between caregiver and school. Therefore, additional research about relational competency is needed, particularly in kinship families. While concrete resources are vital, if we want to improve outcomes for children—educational or otherwise—we should resist urges to focus narrowly on distribution of resources but also examine personal and environmental relational models. One author found that a child's well-being is an interplay between their needs and the relational capacities of those that comprise their environment in the meso and macro realms [60]. Future research will best serve the field by revealing how kinship caregivers can increase their relational competency, ahead of crisis and disastrous moments, to affect healthy child well-being outcomes.

8. Conclusions

This study took place in 2021, in the middle of the pandemic. At the time of writing, most health precautions and public health orders have ceased, and schools are entirely back in-person. However, the pandemic has had a variety of effects on the general population's health and well-being, and it is likely that families and schools are still reeling from the collective and individual traumas they experienced [35]. What was learned from the kinship caregivers and child welfare professionals in this study can have far-reaching implications about how kinship families engage with the schooling process for their children. Although they may no longer be leading learning at home, kinship caregivers must still balance multiple roles in their lives, which can continue to impact their mental health and how they participate in their child's education. For these reasons, it is even more important to provide sufficient and holistic support to kinship families in the post-pandemic period. Supporting the emotional well-being of kinship caregivers not only improves their own quality of life and ability to parent under stressful circumstances but also offers emotional and educational benefits for the children in their care [6,43].

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