This paper highlights the complex conflicts that can exist in the systems that surround children placed in ‘kinship care’ with grandparents, other relatives or family friends. Systemic ideas are useful in addressing these conflicts by exploring participants’ differing perspectives and positions as they are constructed through language. A brief description of a research project with kinship carers and their families leads to a focus on the dilemmas faced by families in the ways that relationships, family ties, and positions of authority are constructed. After exploring a case example the article concludes that welfare services, in particular social services, need to provide a more active and holistic role in these families because of their particular needs.

Keywords  kinships; systemic practice; social work; family therapy; identity; contact

Introduction

This article is based on my recent doctoral research listening to the experiences of kinship carers, and also the analysis of therapy sessions with kinship care families. It is a subject which resonates personally due to my parents’ and partner’s kinship care experiences, while systemic ideas have been increasingly important to me professionally, since my initial social work training in ecological and unitary approaches.

My definition of the kinship care of children is a loose one, with a focus on relationships rather than legal status. My research covered both formal and informal care situations and showed kinship care to be a small but significant way of caring for children in British society today, as a safety net family response to the needs of children to be looked after following the absence or inability of their birth parents. Families and friends caring for children who are not their own, sit in a complex network of family, professional and legal systems, and their connections to those systems often depend on the route by which children enter that family situation. As a result, social workers working with kinship care families can be doing so in many different contexts — in family support teams, Looked After Children services, Fostering departments, or Family Group Conference units.

In my approach I draw on language and ideas from a systemic paradigm that is known as a second order cybernetic position where the ‘problem created system’
Anderson & Goolishian, 1988) includes both worker and family. It is a move from an objective to a subjective frame, and means that the person of the therapist, and the therapist/family relationship are important considerations. I specifically take a social constructionist position that sees language and experience as socially constructed between people rather than a result of internal cognitions or emotions. People therefore speak from different positions in conversation and hold a different identity depending on the context within which they speak, a context which draws on narratives from different levels of meanings and experiences — cultural, familial, relationship and individual (Gergen & Gergen, 1992; Davies & Harre, 1999).

This article aims to provide an overview of the quantitative aspects of my research, to review briefly the place of systemic ideas in kinship care practice, to explore some ideas that came out of the research and then to use a piece of therapy dialogue to demonstrate my analysis from a systemic perspective. As such it aims to combine the different levels of understanding with which social workers have to grapple — the broader themes within which individual social work practice sits.

**Kinship care and systemic practice**

The context within which welfare professionals are working is one which leads them to draw on discourses about family as a positive force, to be preserved and made responsible for the needs of children, as well as of dangerous families where the interests of children and families collide. Differing definitions of ‘family’ mean kinship care can be seen as both a form of foster care separate from the birth family and as preserving the child’s identity through offering a home within the birth family, the involvement and support of the welfare agency depending in part on what definition it uses.

Much of the kinship care literature comes from a social welfare perspective, and was initially from the USA (cf. Hegar & Scannapieco, 1999) but more recently UK research has increased (Broad et al., 2001; Laws & Broad, 2000; Farmer & Moyers, 2005). Such research indicates kinship care families are caring for children with emotional and behavioural needs greater than those of the general population.

Writers on social work practice in kinship care emphasise the need for systemic skills, both in assessment and therapeutic work, using models from various branches of systemic therapy; for example, Whitley et al. (1999) use solution-focused interviewing, Jackson (1999) a structural therapy approach, while O’Reilly and Morrison (1993) focus on parenting education, and intergenerational therapy. The structural model is also used by Bartram (1996) to clarify subsystem boundaries between grandparents, their children and grandchildren, in order to avoid drawing children into adult conflicts. In contrast, Mills et al. (1999) point out that in African American extended family groups a very open system exists between households in contrast to firm boundaries against the potentially hostile outside world. Therapists therefore need to be careful not to impose their ethnocentric ideas of family organisation on different cultural structures.

A multi-disciplinary team approach of social worker, lawyer and family therapist has been used by the Philadelphia ‘Kids n’ Kin’ Project to provide a combination of
practical, legal and therapeutic services (McLean & Thomas, 1996). The family therapist involved describes his approach as an eclectic mix of ‘various family therapy models and approaches (i.e. structural, contextual, strategic) to address nuclear, extended, intergenerational and cultural family dynamics’, as well as psychoanalytic ideas about loss and transference (Crumbley & Little, 1997, p. 37).

In relation specifically to kinship care families’ relationships with the child welfare agency, O’Brien (1999) uses Batesonian ideas of symmetry and complementarity together with structural diagrams of alliances to plot out the shape of relationships. She describes the optimal components of the network — family members being supported and respected by each other and by the agency and the agency being satisfied as to the safety of the child (O’Brien, 2001).

The literature on systemic practice in kinship care thus generally promotes open communication, respect and clarity of role expectations within the network of people involved with kinship care children. My research project aimed to explore how family members constructed and managed these differing perspectives.

The research study

I interviewed 16 carers drawn from Child and Adolescent Mental Health clinics in the south-east of England, from personal contact and from a national voluntary agency: 12 grandparents, two sibling carers and two aunts. Twelve carers were white British and four were from black or minority ethnic families. For 15 children, the ethnicity of carer and child was the same: the other three children were all of a dual heritage background. The children had been with their carers for a period ranging from nine months to seven years and were aged from six to 16 years old. In five families care was being provided informally, six families held Residence Orders, while in three families Care Orders were held by the local authority. The major factors in the reasons for kinship care were parental substance misuse, parental mental illness, previous paternal absence, and parental bereavement. In the majority of cases (10) the children were in contact with one or other parent, though rarely both.

Two thirds (12) of the 18 children in the sample had some mental health needs, mainly emotional and behavioural difficulties. Tantrums, non-compliance or aggression with carers were the main issues, as well as anxiety and security related symptoms such as sleep disturbance, or enuresis, with the needs of two children being severe enough to warrant in-patient admission.

The majority of carers experienced kinship care as affecting their housing and financial situations adversely. Two grandmother carers were also dealing with major physical disabilities of their own. All carers except two spoke of looking after the children and young people as hard work and stressful, and regretted the curtailment of their social life and leisure activities. Nevertheless all the carers felt they would make the same decisions again in taking on the children.

Eleven carers had past or present involvement with their local social services department, while additionally a further grandparent had social work support within CAMHS. One carer felt she had been pressurised by social services to take on the care of her grandson, two carers felt they had requested help which was not forthcoming as
they had already decided to take on the care within the family and therefore the SSD had no responsibility to become involved. The research sample included three kinship foster carers. They each described both great support from individual social workers but also great battles with a system they did not feel fitted their family circumstances.

**Research analysis**

In order to analyse those language practices, my research was undertaken using a discourse analysis [for further description of the methodology and a closer analysis of dilemmas present in therapy sessions see Ziminski (forthcoming)]. I considered:

1. the language carers drew on in justifying their position and constructing their identity as a carer within these negotiations; and
2. the negotiations around entitlements to care. (I see entitlement in terms of a systemic definition which sees the giving and receiving of entitlement as an interactive process of legitimisation.)

**Constructing identities as carers**

*a) Constructing family relationships*

Carers reflected on their own caring positions, leading to a reconstruction of taken-for-granted meanings of family relationships, as for example when a grandfather took an unaccustomed family lead in childrearing. Carers saw themselves taking up the tasks of mothers and fathers while resisting taking over their place and identity in the family, particularly in relation to mothering. This was a less dominant theme with fathers, where some grandparents spoke of becoming ‘father-figures’. It appears from the carers’ accounts that the children and other family members involved were also struggling in the attempt to put these changed relationships into language. Zora (an aunt of Middle Eastern background) spoke of her relationship with her six-year-old niece, and the image of an enduring mother–daughter relationship:

Well when the mother is not around (.) she thinks (.) oh sometimes she calls me ‘mummy’ … And I don’t want her to call me mummy because erm (.) I want her to know that she’s still got a mother.

In this process carers were drawing on powerful cultural meanings of motherhood in particular, of idealised images of mothers putting others first and sacrificing one’s own needs. These sat alongside accounts of personal experiences where birth mothers were pathologised and deemed failures for not living up to this ideal.

Carers drew on lifecycle discourses where the level of fit between their old and new life-stages, as well as images of ‘how life should be’ at their particular age, appeared to determine interviewees’ levels of stress or comfort in their role. The dominant life-cycle story was of ordinary family life as slow forward progress against
which the experience of kinship care was measured as going backwards, round in circles, or leapfrogging forwards.

we’ve gone back to where we were 26 years ago, back to the start again … And we’ve got to look at it this way that they will always be here. And we’ve got to wait now until we are in our sixties.

(Sally, white British maternal grandmother, 45)

When questioned, carers made a distinction between the use of the word ‘family’ as inclusive, which promoted a story of group support for carer and child, and a more restrictive interpretation of ‘family’ limited usually by household or lineage, with the aim of excluding certain people. Carers described a dynamic construction of ‘family’: the effect of the experience of kinship care on that construction was to drive a change of meaning, but it could be in the direction of either greater inclusion or restriction.

b) The meaning of family ties

Carers’ accounts of kinship care saw them as acting to preserve family connections: carers also recounted changes in the quality of those connections, such as descriptions of a greater intensity between a grandmother and grandchild compared with other grandchildren.

A particular issue was whether accounts of emotional ties were portrayed as complementary or competing, particularly in relation to birth parents. Where a parent had died, the loss seemed possible to be put into words, and carers were more able to take a both/and position regarding the emotional attachments of the children. This was in contrast to the general absence of talk about loss in relation to children of living parents, where accounts of competitiveness in affection were given by some, which could lead to potential difficulties for children in how to show affection for both carer and birth parent. Thus Cath, maternal grandmother and carer to Josh (nine):

I was there at the birth. … If she came here, it was always me that could rock him to sleep, she couldn’t even get him to sleep.

A less common position taken by some carers was that of holding multiple views about birth parents, mothers particularly, recognising their failures but also the importance of the emotional attachment between child and parent alongside that of carer and child.

Carers also drew on family accounts of closeness and belonging, on interpretations such as ‘being there’ as a defining characteristic of their family. This appeared to engender feelings of safety and security for carers at times of potential conflict and stress. My analysis found few accounts where family duty and obligation were related as part of carers’ stated reasons for undertaking the kinship care role, ‘duty’ being seen as excluding positive choice or affection.

c) Clarifying authority positions

Understanding authority and responsibility in kinship care encompasses personal, family, professional and societal levels of meaning. Carers claimed authority to care by
virtue of their family relationships and personal identity, as well as through support from professional and legal authorities.

In all the interviews, the relationship between carers’ and birth parents’ authority and responsibility was a focus for observation and reflection, whether in descriptions of amicable shared care arrangements or in those of high conflict where the authority of the Court and social services was invoked as decision-makers as to who was entitled to care. Grandparents, or other experienced carers, drew on personal identities as authority figures within their families to help manage day-to-day. In the absence of such an identity carers called on other sources of authority — supportive birth parents (alive or dead) or social services for example — to bolster their own position.

Where birth parents were holding strongly to an account which privileged their own authority to care above that of the carers, the invocation of a legal authority seemed highly likely due to the pervading societal discourse about the rights of birth parents:

his dad has told him that there is this Court Order, this Residence Order it is a kind of guilt thing on his part that (. . .) he kind of, he tells the kids he wants them, they should be living with him, (1) … .

(Diane, white British maternal aunt)

A less common, but nevertheless powerful story when evident, was that of joint family care, of the care of the child being a family rather than individual responsibility. There are some indications from this research that this ‘joint care’ discourse may be drawn on more by carers who are not grandparents as a response to being in a less obviously ‘parental’ position with a child, or where several family members are vying to be carers.

Negotiations in care decisions and contact

For some families, negotiation about taking on the care of a child took place solely within the family. This appeared to allow greater attention to individual family members’ opinions, including the child. However, in other families, conflict arose, as carers considered the actions of birth parents in relation to cultural constructions of how parents and themselves ‘ought’ to act in caring for the children involved. Birth parents’ failure to parent properly then justified a carer’s entitlement to look after the child, a justification that was a widespread and powerful one also used by the Court and Social Services. Using professional authority appeared to be one way for carers to avoid conflict with the birth parent, putting the responsibility for judging parental failure elsewhere, and instead presenting kinship care as a rescue from public care. Particular dilemmas arose in a few cases where family members appeared to prioritise the mother–child relationship despite difficulties in the care provided, putting them in a dilemma of how to act in the child’s best interests.

In negotiations around contact with birth parents, carers were prepared to promote positive relationships with parents in order to improve their own relationship with the children, which was easier to accomplish where a birth parent acknowledged the carer’s right to care for the children. Conflict between parents and
carers was described most frequently at the point when kinship care decisions were being negotiated, but reduced as time went on. Occasionally a total rift remained, but more usually contact was maintained through drawing on descriptions of family closeness and belonging, as well as personal affection. However, the actual experience of contact could still be difficult because of contradictory meanings that could be given to people’s actions, for example several adults contesting the authority to discipline a child during contact visits.

Where there was a Care Order and social services’ involvement, negotiations around contact were much more structured, defined by an authority outside the family that carers, children and parents then reacted to. In non-conflictual situations, a much more flexible connection was possible, denoted by a difference in language, using words such as ‘meeting up’ rather than ‘contact’.

Case example

The above analysis focused on the interviews undertaken with carers, but the understandings about family constructions, family ties and family authorities are ones with which therapists and social workers also have to contend in their practice with kinship care families, and which permeate through the child welfare and therapeutic systems of which they are a part. This struggle for understanding between therapist and family members is shown in the following analysis from an ongoing family therapy session.

The extract involves a white female therapist talking to Mia (10) and her Asian paternal grandmother and foster carer Anila about her parents. Mia came to live with Anila having been taken into care because of her mother’s neglect: her father was dead. Anila and Mia lived together, but were part of a broader network of friends, family and religious community. The therapist (a CAMHS social worker) was working with several levels of the family and professional system; she had met the paternal grandmother, the child’s local authority social worker and the maternal extended family; and had also made a referral for individual therapy for Mia.

[In the following extract, ‘Th’ is the therapist, (.) means a pause and nonverbal additions are in italics.]

Th And were there other things where you’re more like your mum’s side do you think?

Mia Yes, some things.

Th What do you think the things are that you are more like your mum’s side?

Mia I’m not sure. (Smiles)

Th What do you think Anila? Do you think there are bits of ways M — some ways in which Mia is like her mum’s side or

Mia I sometimes (.) have the same voice as her as well.
[And it’s (inaudible)]

Anila  [Oh yes .]

Th  Yes.

Anila  Especially the little voice.

Th  Who do you most look like?

Mia  Mmm . both.

Th  Both. You look like a real mixture do you?

Mia  Yes. Because I’ve got my mum’s hair I think because it always gets tangly (. ) and mattly (1) Erm (Shrugs and looks at Anila).

Anila  Yes, but

[there’s a great deal of]

Th  [Do you see your son in in Mia?]

Anila  Oh, yes I mean absolute (.)

Mia  [It was erm]

Anila  [In fact people get (. ) startled. [gives example of teacher’s comments at the similarity between them]

…

Th  (1) I mean how how does it feel when people say how much you look like your Dad?

Mia  I like it.

Th  You like it. (1)

Mia  But when Nana says that I look exactly like my mum or act (. ) then I get angry with her. (Anila laughs)

Th  Because it feels (1) why why do you get

Mia  Because I want to be (. ) I want to be like both.
Analysis of extract

This is one of a number of possible accounts about this extract, one that highlights conversation and language: while not denying the emotional content of the interview, it is not the primary focus. I explore the conversation as a struggle for meaning, working with dilemmas around family belonging and individual identity.

Mia creates an account detailing connection to both her parents. She is supported and encouraged in this by the therapist who appears to be drawing on professional discourses about identity and family heritage, as well as the centrality of parents to this process. The task she appears therefore to be pursuing is the joint one of promoting the relationship between Mia and her grandmother while not ‘writing mother out’ by going along with the anti-mother position she is invited into by Anila. She encourages descriptions of similarity to both parents, so providing legitimacy for Mia’s ‘both’ discourse, and then goes on to draw out the difficulties for Mia in relation to how Anila responds to those similarities.

For Anila, Mia’s identity is constructed through the account of Mia as her son’s daughter, physically and emotionally similar to him. She privileges her and Mia’s connection at the expense of Mia’s mother, not appearing to respond to therapist or Mia’s account of joint connection. I think here the therapist is balancing an understanding of Anila’s feelings of loss regarding her son with her awareness of Mia’s loss of and need for connection to her mother. This extract shows an ease for all involved in talking about Mia’s father and Anila’s willingness to make comparisons between him and Mia that is in contrast to Mia’s reluctance to say much about her similarities to her mother. Where similarity is acknowledged by both Mia and Anila, it is set by Anila, according to Mia’s account, within the ‘bad mother’ frame. Anila’s comments about Mia looking ‘exactly’ like Mum are read by Mia as a negative, and draw Mia into a position of being rejected by Anila in the way that her mother has been rejected, to which she then responds with anger. ‘I want to be like both’ — a solution for Mia in holding on to her past, belonging to both sides of this family, but a difficulty for both in their current relationship.

All three participants in this extract hold on to a discourse of family identity as important, but differ in their construction of ‘family’ as everyone related to Mia, or only the paternal family. Anila draws on her relationship and bond with her son, Mia’s father, as a way of giving Mia an identity as part of the family, and an emotional tie to herself. I feel this extract shows a negotiation around the entitlement of Mia to have a connection to her mother’s family, and the entitlement for Anila to care for Mia given she is not her parent. It throws up a dilemma of how Mia can achieve a sense of family belonging and personal identity that is acknowledged by the people around her.

Discussion and implications for social work practice

This research shows that in the negotiation of the entitlement of carers to care and a child to be cared for, the place of the birth parents in those negotiations cannot be ignored. One crucial question here is whether a birth parent is able and willing to be a non-custodial parent and support their relative’s care of their child. Contact is a major
issue for a number of kinship care families who need informed advice from social workers that helps them consider the child’s place in the process, and the meaning and purpose of contact. My analysis suggests success or otherwise of contact is an issue about carers’ and birth parents’ positioning towards each other, rather than being inherent in the birth parents’ attitudes. It is likely that welfare services will need to consider further therapeutic input for those families where the decision to care is still being contested, or conflict over contact continues.

My research reinforces the importance of the use of systemic ideas in social work practice with kinship care families in order to work supportively to preserve stressed kinship family situations. It also points up the usefulness of therapeutic intervention for this client group in order to work with family conflict and move from competition to collaboration, as well as working therapeutically with the professional and family network to avoid isolation, abandonment or conflict (see O’Brien, 1999, 2001; Ziminski, 2005). The dilemma for the child welfare field is that, where family conflict is high, the structure and authority of social service involvement can be what makes the kinship care situation tenable by helping the carer to feel safe and supported in relations with the birth parent. Thus it is important to give families a voice at the point of decision-making that enables intra-familial negotiations to continue alongside extra-familial negotiations with welfare services, for example through Family Group Conferences.

In this research, a high number of carers had had some contact with social services while only three were formal foster carers. Given that there are indications from this research that children in kinship care families have needs greater than those in the general population, local authorities need to create policies for kinship care families that look beyond the narrow remit of kinship foster care to broader assessments of children’s needs in kinship care. It means recognising kinship care as different from both foster care and birth family care, needing a holistic approach responsive to the needs of all family members [as discussed by Doolan and Nixon (2003)].

Whether working directly with individual kinship care families, with the wider professional network, or in the making of agency-wide decisions on policy and procedure for working with this client group, it is important that child welfare professionals be aware of their own working assumptions about family responsibilities, family preservation and the position of the welfare agency in responding to the needs of kinship carers. Workers need to tune in carefully to their own and the family use of language and the meanings, so that unspoken assumptions, for example about mothering, family ties, and so on, do not disrupt the process of work together. Within these assumptions are ideas about what ‘is’ and what ‘ought to be’ in family practices — an area explored further in relation to adult family responsibilities by Finch and Mason (1993). In systemic practice in kinship care, as in other fields of social work, the skill is in focusing on the personal interactions and relationships within the broader cultural, societal, agency and professional understandings on which workers draw.

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Note

1 Here and elsewhere in quotations, a number in parentheses denotes the length of a pause in seconds.

References


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