What can we learn from interviews with kinship carers, teachers and therapists about the experiences of children in kinship care?

Mel Serlin

A thesis submitted in partial fulfilment of the requirements of the University of East London in collaboration with the Tavistock and Portman NHS Foundation Trust for the Professional Doctorate in Child Psychoanalytic Psychotherapy.

Submitted as part of M80

July 2017
Abstract

The aim of this study is to learn more about the experiences of children who live in kinship care and some of the ways in which their lives will be different to children living in foster or adoptive families. A small research project is presented looking at the experiences of a child in kinship care who received therapy through the Tavistock Outreach in Primary Schools project.

Data is gathered through semi-structured interviews with his kinship carer, teacher and therapist and analysed using Interpretative Phenomenological Analysis to identify key themes. These findings are then considered in the context of other research findings leading to the formulation of four key areas of discussion: belonging, invisibility, learning from experience and access to services. I propose that these are key areas for consideration when thinking about the experiences of children in kinship care.
Table of Contents

Acknowledgements

1. Introduction
   1.1 Background 1
   1.2 TOPS 2
   1.3 CAMHS 5
   1.4 Kinship Care 8
      Legal Context and Developments 8
         Children Act (1989) 8
         Adoption and Children Act (2002) 9
         Family and Friends Care (2010) 10
         Children and Families Act (2014) 11
         Special Guardianship (2015) 14
         The impacts of abuse and neglect on children (2017) 15
         Serious Case Reviews (2017) 16
   Prevalence 16
      Kinship foster care 17
      Informal kinship care 18
      Special guardianship 18
   Implications for Policy 19
   1.5 Aim of Research 23

2. Literature Review
   2.1 Search Methods 25
   2.2 Social Work Literature 25
      Introduction 25
      The value of kinship care 27
      The impact of intergenerational family difficulties 28
      Assessment and support 33
         Routes into kinship care 33
         Assessment of kinship carers 36
         Organisational factors 37
         Support 40
         Training 41
   Outcomes for children in kinship care 43
      Placement duration 43
      Relationship between social work support and placement disruption 46
      Comparison between kinship and foster care 47
   Children’s Views 51
      Children’s understanding of their situation 51
      The challenges of adapting to kinship care 52
      The benefits of living in kinship care 54
      Family contact 55
      School life 59
2.3 Clinical Literature  
   Introduction  
   Mental health needs of children with a history of maltreatment  
   Service provision  
   CAMHS access for children in kinship care  
   Mental health and kinship care  
   Clinical interventions  
   Child psychotherapy and kinship care  
      Psychoanalytic work with deprived children  
      Child psychotherapy and kinship care  
      Working in schools  

3. Research Methods  
3.1 Research Design  
   Interpretative Phenomenological Analysis  
   Sample Size  
   Ethical considerations  
   Participants and research setting  
   Data collection  
   Confidentiality  

3.2 Research Protocol  
   Identification of research subjects  
   Inclusion process  
   Recruitment of participants  

3.3 Research Process  
   Ethical approval  
   Recruitment Process  
      Meeting with TOPS team  
      Initial responses  
      Implementation of protocol  
      Interview questions  
      Identifying cases  
      Recruitment  
      Factors affecting recruitment  
   Revision of interview questions  
   Pilot interview  
   Introductory meetings  
   Interviews and transcription  
   Follow-up  

3.4 Data Analysis  
   IPA: Process
4. Findings

4.1 Introductory Meetings

4.2 IPA: Results

4.3 Analysis of Themes
   Feeling
      Theme 1: Difference/standing out/embarrassment
      Theme 2: Anger (underpinned by feelings of loss)
      Theme 3: Having/Being a good enough parent
   Managing
      Theme 1: Keeping a low profile
      Theme 2: Growing up male: brothers, fathers and sons
      Theme 3: Special/Proud/Eager to please
   Understanding
      Theme 1: Why his mother is not able to parent him
      Theme 2: Why his sibling is adopted
      Theme 3: Legal Arrangements
   Engaging
      Theme 1: Referral
      Theme 2: Treatment
      Theme 3: Outcomes

5. Discussion

5.1 Belonging

5.2 Invisibility

5.3 Learning from experience

5.4 Access to services

6. Limitations, Conclusions and Recommendations

6.1 Limitations

6.2 Conclusions
   Recruitment
   Findings and experience of research

6.3 Recommendations
   Implications for practice
   Dissemination of ideas
   Recommendations for future research

References
**List of Figures**

<table>
<thead>
<tr>
<th>Figure</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Figure 1</td>
<td>Percentage of kinship cases seen by TOPS per year</td>
<td>101</td>
</tr>
<tr>
<td>Figure 2</td>
<td>Four levels of interview data analysis: SENCO</td>
<td>114</td>
</tr>
<tr>
<td>Figure 3</td>
<td>Four levels of interview data analysis: therapist</td>
<td>115</td>
</tr>
<tr>
<td>Figure 4</td>
<td>Examples of groups of themes: kinship carer</td>
<td>117</td>
</tr>
<tr>
<td>Figure 5</td>
<td>Example of a theme which related to all participants</td>
<td>118</td>
</tr>
<tr>
<td>Figure 6</td>
<td>Relationship between themes</td>
<td>120</td>
</tr>
</tbody>
</table>
List of Appendices

A:  Participant Information Sheet
B:  Consent Form
C:  Research Protocol
D:  Parent and Carer Counselling Service leaflet
E:  Covering letter for revised documentation
F:  Permission letter from REC
G:  Permission letter from Nochlor
H:  Lead Therapist Information Pack
I:  Interview Questions
J:  Interview Areas
Acknowledgements

With thanks to:

My family and friends for their ongoing support and encouragement
Katie Argent for inviting me to undertake my research on the TOPS project
Dr Graham Music for suggesting I focus my research on kinship care
Marta Cioeta, the TOPS clinicians and administrator for supporting my research
Dr Jenifer Wakelyn and Margaret Rustin for their patience, enthusiasm and expertise
and above all,
My three research participants for sharing their thoughts and experiences with me
CHAPTER 1
Introduction

1.1 Background

The role of extended family in the upbringing of children has remained an accepted idea throughout history and across cultures. It is perhaps most commonly associated with the Nigerian proverb “It takes a whole village to raise a child”.

“Everyone in the family participates especially the older children, aunts and uncles, grandparents, and even cousins. It is not unusual for African children to stay for long periods with their grandparents or aunts or uncles. Even the wider community gets involved such as neighbors and friends. Children are considered a blessing from God for the whole community. This communal responsibility in raising children is also seen in the Sukuma (Tanzania) proverb "One knee does not bring up a child" and in the Swahili (East and Central Africa) proverb "One hand does not nurse a child." (Healey, 1998: p.1)


“For some ethnic and indigenous populations, co-parenting grandchildren has also been a normative, anticipated option...However for the majority of Australians, like in many Western industrialised countries, this has not normally been the case. Increasingly though, grandparents are assuming the full-time parental care of their grandchildren, often because of mental illness and drug addiction of the biological parent(s).”

When children live in the full-time care of extended family members due to being unable to live with their parents, this raises fundamental questions about the responsibilities of family and state. In their study on kinship care in Scotland, Aldgate
and McIntosh (2006: p.2) note “A major issue in discussing kinship care is that there is no agreed definition of the term.” Argent (2005: p.2) suggests that in the U.K.;

“The term “kinship care” has come to mean the care given by relatives or friends to children with whom they have an existing relationship. In this sense, “kinship” describes a social network rather than a blood relationship.”

In recent years, different terminology has been introduced by policy-makers such as “family and friends carers” and “connected persons” which define the different types of former relationships children have to those who offer them care. This will have a particular implication for social workers tasked with undertaking assessments of potential carers.

I decided to use the term ‘kinship care’ within my research, as it has longevity, is international and understood within different professional fields. Although I agree with Argent’s suggestion that this term encompasses both ‘kith and kin’, my interest in this study is in children living with relatives, as this raises particular issues for families which I want to explore. From my clinical experience of children living with ‘kith’ where adults knew children from a local community setting and offered them a home, specific sorts of issues were presented.

1.2 TOPS

Prior to undertaking my clinical training in child psychotherapy I worked for a year in the Tavistock Outreach in Primary Schools (TOPS) service as an honorary therapist.

The TOPS project is an NHS “primary school based specialist service for children and families with complex, chronic and severe emotional difficulties.” (Cioeta and Geater, 2014a: p.1) The service works within five schools in the London Borough of Camden “all in geographical areas of long-term deprivation and disadvantage” (2014a: p.1) and is part funded by charitable donations and investment by each of the participating schools. A Lead Therapist and two honorary therapists are located within each school offering a range of therapeutic interventions, including:
“assessment, individual and group work with children, family work, parent support and consultation, whole class interventions, staff support, consultation and training, work with other key professionals and referrals to specialist agencies.” (Cioeta and Geater, 2014a: p.1)

As well as helping individual children and their families, one of the broader aims of locating TOPS therapists within schools is to enable “education staff to develop a good grasp of child mental health so that this becomes integral to school culture” and to “reduce anxieties about stigma and blame in the wider community, promoting the idea that help with complex emotional difficulties can be an ordinary part of community life.” (Geater, Argent and Cioeta, 2011: p.5).

Children are referred to the project by their schools for help with a range of emotional and behavioural difficulties which may be affecting their capacity to learn, their relationships with teachers and peers, and may at times result in internal school exclusions.

The service uses a range of outcome measures to assess the child’s level of clinical need at the point of referral. Analysis of CGAS (Child Global Assessment Scale) measures show: “83% of children seen by a TOPS therapist fell within the ‘clinical’ category and 17% in the ‘borderline’ category” (Geater, Argent and Cioeta, 2011: p.22). This finding is corroborated by the use of Strengths and Difficulties Questionnaires (SDQ’s):

“The average combined scores of the pre-therapy Parent Report SDQ and Teacher Report SDQ show that all referred children fell within the clinical range. This means that all children were identified by an internationally recognised measure as being in need of support from trained mental health clinicians.” (Geater, Argent and Cioeta, 2011: p.21)

Many of the children who receive treatment from the service are understood to come from complex and challenging backgrounds:

“There are many areas of difficulty in the children’s family’s lives, for example, nearly 1 in 2 of the children seen by TOPS have a parent or parents
with mental health difficulties (43%), and nearly 1 in 4 of the children who access TOPS have a parent or parents with substance misuse difficulties (23%). In addition, using school data on the percentage of children receiving Free School Meals as a proxy indicator of poverty, over half of all children seen by TOPS therapists come from backgrounds with limited financial incomes (61%). Many of the families also have difficulties with housing, often living in overcrowded or in temporary accommodation.” (Cioeta and Geater, 2014b: p.27)

Many of the families seen by TOPS are or have been involved with social care and “often have histories of non-engagement with services.” (Cioeta and Geater, 2014a: p.1)

“In the last financial year nearly a third of the families seen by TOPS have previously or are currently working with social services (32 families). This means that 1 in every 3 children seen by TOPS have or have had social work intervention.” (Cioeta and Geater, 2014b: p.27)

In light of this, the service concludes;

“The referral of such complex cases by schools to the TOPS service suggests that schools see TOPS as an effective resource to support such complex and disadvantaged families and also that schools see TOPS as central to supporting their statutory safeguarding responsibilities.” (Cioeta and Geater, 2014b: p.27)

Statistical data gathered on clinical appointments indicates a high attendance rate: “during 2013/14 attendance to child therapy sessions was excellent with 87% of sessions offered attended by children” (Cioeta and Geater, 2014a: p.5). The service suggests this demonstrates that “the school based service is easily accessible to parents and children and succeeds in engaging so called ‘hard-to-reach’ families.” (Cioeta and Geater, 2014a: p.5)

“It is notable that the majority of sessions that are offered by TOPS therapists are attended which is likely due to the fact that the service is based
in school. The locality of the project promotes joint working between families and the service; the service is coming to the family rather than the family having to come to the service. The fact that the service is offered in a neutral and child-centred environment encourages parents to engage with the therapy offered and also supports the parent to focus on the child’s needs during the sessions. The availability of TOPS staff means that the service is flexible and responsive to the needs of families, resulting in excellent attendance figures.” (Cioeta and Geater, 2014b: p.32)

1.3 CAMHS

During my four-year clinical training, I worked in the Fostering, Adoption and Kinship Care Team (FAKCT) at the Tavistock Clinic. This is a specialist multi-disciplinary CAMHS team providing therapeutic support to children and families where children are unable to live with their birth parents. In a publication exploring the work of the team Barratt and Granville (2006: p.162) noted that in recent years the team had been receiving increasing numbers of referrals for children living in kinship care, most of whom had similar early experiences to those who were looked-after or adopted:

“In most of the kinship cases we see, the major issue that has led to the children needing an alternative placement has been parental drug and/or alcohol misuse. There have often been accompanying issues of adult mental health difficulties, domestic violence, child abuse, and neglect.”

During my training, I offered weekly psychotherapy sessions to a child living in kinship care with his older sister and also undertook assessments of children living in grandparental care. I became aware of some of the particular rewards and tensions that this arrangement brought to different members of the family. I found that kinship placements were accompanied by a different range of issues to those I had encountered with looked-after children living with unrelated carers or the types of challenges faced by adoptive families in establishing new relationships and attachments. For example, what is the impact on individuals and relationships when a sibling becomes a legal guardian or a grandparent takes on the care of a young child at a later stage of life? How might it affect the relationship between an older sibling and their parents, when
they become the carer for their parents’ children? Or a grandparent must monitor their own child’s contact with their children? How can psychoanalytic ideas such as the Oedipus complex be helpful in thinking about intergenerational relationships in families where aspects of unconscious phantasy may have become reality?

As I approached the end of my training and began to think about opportunities for working as a qualified clinician, I was conscious of the growing emphasis on child psychotherapists being located in community settings such as schools and G.P. practices. Consequently in the final year of training, I gained experience of working in a local health centre as part of a developing FAKCT community outreach service, where I saw further kinship families. In discussion with my supervisor, I became aware of the lack of clinical papers exploring psychotherapy with children in kinship care. When the TOPS manager invited me to undertake my doctoral research on the work of the TOPS service, this provided me with an opportunity to bring together these ideas; to learn more about the experiences of children in kinship care and explore the particular challenges kinship families face, through investigation of clinical work with children seen for therapeutic treatment within a community setting.

In the last three years since completing my training and whilst undertaking my doctoral research, I have been working in an NHS Tier 2 looked-after children CAMHS team in another London borough where I am (the first and only child psychotherapist) located within a looked-after children social work department. Referrals to the team are received from social workers where there are concerns about the child’s mental, emotional and behavioural needs, particularly where children’s difficulties make it hard for carers to look after them safely, resulting in placement instability and concern within the professional network.

On arrival in the team I was asked to join a psychologist who was undertaking work with a small child living in kinship care with his great aunt. The child had been removed from his parents’ care, previously been in foster care and at the time of referral to our team still had a looked-after social worker. However as a special guardianship order had been granted, the case was due to transfer to a post-order team. By the time this occurred, my colleague had left and the child was engaged in weekly individual psychotherapy sessions with me. As such I made a case for continuing this work, as I
did not feel it clinically appropriate that his NHS treatment should end on account of his case transferring to a different social work team. I realised that there was also a question of whether if I closed the case he would be able to access treatment elsewhere. In the borough where my team is based, children needing therapeutic support who are not looked-after (or children in need for whom access to other clinical services are available) would be referred to a Tier 3 CAMH service. However, as in many Tier 3 services, due to rising pressure on NHS resources, unless children suffer with a diagnosable mental health disorder they may not meet thresholds for CAMHS treatment. The consequence of this is a gap in services for children living in kinship families who need therapeutic support to help process the impact of family difficulties, which may be continuing to affect relationships and caregiving capacity.

This situation brought alive for me these issues of service provision for children in kinship care. It made me realise that I was internally holding on to an ‘ideal’ model of services in my mind based on my experience within the FAKCT team, in which all children who have suffered relational trauma in their early years and been separated from their parents were able to receive a specialist clinical service regardless of the legal order under which they were cared for i.e. a care order to the local authority, a placement order to adoptive parents or a special guardianship order to a kinship carer.

I was left with questions about where children in kinship care belong in clinical services and how might gaps in provision by other agencies (such as social workers completing life story work for children in kinship care), contribute to a sense of deficit in attending to the emotional needs of kinship families which could result in referrals for CAMHS support? I also wondered about key issues which clinicians need to be aware of when working with kinship families, such as understanding the legal context and type of practical and emotional challenges which kinship families may face.

I hoped that through my research I would be able to investigate these questions by reviewing the literature on kinship care and exploring experiences of therapeutic work undertaken in primary schools with some children living in kinship families.
1.4 Kinship Care

Legal Context and Policy Developments

Broad (2004: p.213) defines kinship care as:

“a formal type of care and living arrangement for a child who has to live away from his/her parental home, is known to social services and is cared for full-time by a member of the child’s extended family or a friend.”

The ‘formal’ part of his statement refers to the question of who has parental responsibility for a child if they are no longer living with their birth parents? The Children Act 1989 addressed this issue by setting out a range of legal options, depending on the circumstances of the child and family.

Children Act (1989)

Under Section 20, children could be ‘voluntarily’ accommodated into the care of the local authority in situations where parents felt unable to continue caring for them and agreed to their child being looked after by someone else. This may be due to their own ill health or difficulty managing the child’s needs/behaviour. However parents would retain parental responsibility for their child. Under Section 8, a residence order could be made to determine the home where a child would live, granting the caregiver parental responsibility for as long as the child legally remained within their care.

In situations where there was evidence that a child had suffered and would be at risk of suffering further significant harm if they remained in their care of their parent(s), under Section 31 the Court could grant a care order to the local authority giving them parental responsibility alongside the child’s parents. Social care would then be responsible for finding and monitoring suitable alternative living arrangements for the child.

Children in kinship families could be cared for under any of these legal arrangements. Some kinship carers might have a child placed with them under a residence order meaning that the child was no longer under the care of the local authority, whilst others
might become a foster carer for the child who would retain their status as a looked-after child. Another alternative in some situations might be for a relative to become an adoptive parent for the child.

Irrespective of which type of legal arrangement the Court considered most appropriate for an individual child, central to the Children Act 1989 was the recognition that children are best cared for within their birth family and where parental care is not possible, the foremost alternative is for children to be brought up by a member of their extended family or a friend:

“Where a child cannot remain living with his or her parents, the local authority should identify and prioritise suitable family and friends placements, if appropriate.” (Department for Education, 2014: p.11)

Adoption and Children Act (2002)

Within the Adoption and Children Act 2002, a new legal provision was introduced called special guardianship, which became implemented at the end of 2005. The aim of this order was to provide children with a formal care arrangement which offered “greater security than long term fostering but without the absolute severance from birth family that stems from an adoption order” (DfES 2005: p.3). This was considered particularly pertinent for older children who had an established relationship to their birth family. Under a special guardianship order, a looked-after child would be discharged from the care of the local authority and their special guardian granted parental responsibility for them until the age of eighteen.

In 2005, the Government published guidance for local authorities on special guardianship regulations (DfES, 2005). Situations where special guardianship may be an appropriate legal order were stated. These included; “a local authority foster carer with whom the child has lived for one year immediately preceding the application”, “anyone who holds a residence order” and “anyone with whom the child had lived for three out of the last five years” (DfES, 2005: p5). Therefore, although not limited to these circumstances, a special guardianship order would likely be appropriate in situations where children were already living with long term foster carers or extended
family members who would be willing to offer them a permanent home. Making this order would be a way of legally confirming these existing relationships and would therefore be particularly relevant for kinship families.

**Family and Friends Care (2010)**

In 2010, the Government published guidance for local authorities in England (DfES, 2010: p.2) to “set out a framework for the provision of support to family and friends carers”. The guidance recognised that, in contrast to the definition given by Broad (2004), not all children in kinship care were known to children’s services or looked after under formal care arrangements. There were also many children living ‘informally’ with extended family members. These arrangements were made privately within families, for example, relatives offering care to a child in order to prevent social care from becoming involved.

“The most common reasons for family members and friends taking on the care of children are those related to parental factors such as domestic violence, alcohol or substance misuse, mental or physical illness or incapacity, separation or divorce, imprisonment, or death of a parent. Child related factors such as disability or challenging behaviour may also be reasons…. It may be the particular circumstances giving rise to an emergency, the willingness of family members to intervene at a particular stage, or the response of the local authority which determines whether the child goes to live with family and friends carers on an informal basis or is placed by the local authority as a looked-after child.” (DfES, 2010: p.8)

The guidance acknowledged that taking on the care of children who could not be looked after by their parents, could present considerable challenges for kinship carers who may need access to different types of support depending on their circumstances. Grandparents who have taken on the task of parenting again at a later stage of life may feel under strain, the education/employment and personal relationships of older siblings may be disrupted by becoming a parent before they were expecting to and there would be financial costs of providing for a larger household. Family tensions could also arise
due to carers managing parental contact arrangements for children when their own relationship with the child’s birth parent(s) may be fractured or under strain.

Importantly, the guidance recommended that local authority support for kinship families must be focused around supporting the needs of the child, regardless of whether living arrangements were formal or informal. Otherwise this would imply that to access adequate support, children need to become looked after by the local authority.

Local authorities were advised to publish a policy for supporting kinship carers in their area. This should provide carers with clear information about legal, financial and emotional support available to them through children’s services, local partner agencies and charities. The guidance (DfES, 2010: p.23) highlighted that “given the specific needs of many children growing up away from their parents”, information on mental health services should also be available “carers will also need to know how to access targeted and specialist services…such as…CAMHS.” Furthermore, it recommended:

“Specialist services such as Child and Adolescent Mental Health Services (CAMHS)... must be sensitive to the particular needs of children and young people living with family and friends carers.” (DfES, 2010: p.11)

In order to provide effective support and information both at a local and national level, the Government proposed local authorities should gather data on kinship families they were supporting through kinship foster care, special guardianship and adoption services.

**Children and Families Act (2014)**

The Family Justice Review (Ministry of Justice, 2011) found that legal proceedings were taking too long to reach decisions for children in care. In March 2014 new reforms were introduced with the Children and Families Act 2014. Residence orders were replaced by child arrangements orders and legal proceedings reduced to a six month time frame.

The significance of these changes for children placed with kinship carers under special guardianship orders was explored in December 2014, when the DfES commissioned a
review by researchers at the University of York and British Association of Adoption and Fostering (BAAF) to report on the use and outcomes of special guardianship orders.

This research (Wade et al., 2014: p.20) found that whilst “it was anticipated that Special Guardianship would be attractive in those placements where a child had developed a strong relationship with a foster carer” as this would enable the child to remain living with their foster family but leave the care system, early evidence showed that “Special Guardianship was primarily being used by kinship carers, with grandparents being in the majority.” (2014: p.44) The children were “younger than might have been anticipated (around one-half being aged five or younger)” and although “most children had been looked after immediately before the application was made” and “often in family and friends foster care” this was not always the case (2014: p.44). In some situations “the making of the Order was at the start (or close to the start) of the relationship.” (2014: p.20)

This raised concern that to place a child under a special guardianship order with an unknown relative, social workers would need to complete, within a reduced legal timeframe, an assessment of the relative’s capacity to offer a permanent home to the child and plan for a period of transition, which was not intended when special guardianship orders were introduced:

“This expectation is reflected in the statutory framework for Special Guardianship which does not provide for introductions, matching or for a period of monitored ‘settling-in’ as would always be the case in adoption….The period for assessment, reflection and preparation is also limited by the expectation that the child and special guardian know one another well and that the order secures what already has been established.” (Wade et al., 2014: p.44)

The researchers found many social workers were concerned about what impact this might have on the stability of these placements in the future;

“Practitioners tended to worry that rushed assessments might lead to later placement problems; especially where family structures and dynamics were
complex or children were not already settled in placement… Concern was expressed at the limited time that would be available for reflection, analysis and the appropriate preparation of carers for the task ahead.” (Wade et al., 2014: p.52)

Concerns about the availability of support for families under special guardianship orders were also raised, following reports that “access to CAMHS and other therapeutic services…was often difficult” (Wade et al., 2014: p.245). This was particularly challenging when the kinship family home was within a different local authority:

“‘I think that out of area placements can be problematic…We don’t have any contracting arrangements with local services, whether that’s special education, CAMHS or other health services… We don’t have any local relationship with them. So I think it’s a problem sometimes getting them engaged…You’re dependent on the local social work teams to advise us on what referrals can be made and help us gain access. If they are reluctant to do this, I don’t know what the answer is.’” (Wade et al., 2014: p.58)

The impact of cuts to public services on the availability of support was emphasised:

“Local authorities that had taken on Special Guardianship with enthusiasm were coming under strain from the scale of demands it had generated….Local authorities were therefore, perhaps understandably in the current climate, restricting the use of scarce resources to children for whom they had a legal and continuing obligation to provide support and services.” (Wade et al., 2014: p.59)

Therefore the importance of all agencies being aware of the needs of special guardianship families became more significant:

“Further work is needed to raise awareness of SG amongst the teaching profession. Virtual heads, designated special needs teachers in schools and education teams for looked-after children may have a valuable role to play
in helping school staff to recognise and respond to the particular needs of SG children.” (Wade et al., 2014: p.246)

**Special Guardianship (2015)**

In 2015, the Government commissioned further studies to explore these concerns, in order to “help inform any potential changes to the law”. (Bowyer et al., 2015: p.8) A qualitative analysis was conducted of 51 case files of children in five local authorities. Researchers found that in 47 cases, the child was looked after by the local authority prior to the special guardianship order being made and the remaining four children were known to social care. In 46 cases special guardians were relatives of the child “with grandparents comprising over half of these”. (Bowyer et al., 2015: p.41) However the study identified that:

> “although the majority of special guardians…were blood relatives, many of the children had not lived with the special guardian for very long and so had limited time to form a social relationship.” (Bowyer et al., 2015: p.43)

The researchers concluded that “in such instances, SGO assessment and support processes are being used in circumstances for which they were not originally intended” and that this “adapted use of the existing SGO process carries various risks.” (Bowyer et al., 2015: p.43) The study highlighted that children living in special guardianship families would likely need additional support due to the impact of early experiences:

> “Since children placed with special guardians, adopters and foster carers as an outcome of care proceedings come from similar backgrounds, typically with histories of neglect and abuse they are likely to need similar support throughout their minority”. (Bowyer et al., 2015: p.44)

However, social workers felt it was difficult to plan for and secure appropriate packages of support for families at this time, as their needs would change at different stages in their lives.
“Support plans are generally agreed and signed prior to the SGO being made, and in many cases before the child has lived with the special guardian for any length of time. For very young children, their needs may not be known until they are much older and needs and behaviours will change over developmental ages and stages.” (Bowyer et al., 2015: p.44)

The researchers suggest (Bowyer et al., 2015: p.47) that in light of these issues, there “may be merit in a final SGO decision not being made until the child has been living with the carer for a period of time” and refer to the adoptive process in which “the adoption order cannot be applied for until the child has lived with the adopter for a minimum of 10 weeks.”

The impacts of abuse and neglect on children (2017)

In 2017, the DfES published a review (Wilkinson and Bowyer, 2017) of U.K. studies (2000-2016) which provided evidence for the judiciary and social care of “comparative outcomes of different placement options” (2017: p.8) for children who had suffered neglect and/or abuse. This study was commissioned in response to “the increase in the number of children entering the care system” and to “ensure that factors known to be crucial to children's outcomes are considered when placement decisions are made.” (2017: p.8)

The research (Wilkinson and Bowyer, 2017: p.75) noted the “relatively high rates of breakdown for SGOs and ROs within two years of the order being made” and like previous studies, suggested this “raises questions about the assessments of carers, the making of the orders and the support provided to carers”. Drawing on the work of Wade et al. (2014) the review (Wilkinson and Bowyer, 2017: p.76) concluded “although there is no evidence to support this at present” granting “SGOs quickly, before relationships have been properly tested may carry some future risk of disruption”.

The study also pointed out this did not mean that local authorities should “necessarily rule out extended family members who have no established relationship with the child” as “in some cases such placements can be a positive outcome for a child”, but that “the
assessment for those without an existing relationship is more complex and requires more time.” (Wilkinson and Bowyer, 2017: p.76)

**Serious Case Reviews (2017)**

In 2017, the importance of these issues was highlighted in two serious case reviews in Birmingham (Wate, 2017) and Nottingham (Wiffin, 2017) following the deaths of two children living with family and friends carers under special guardianship orders. Although these occasions are rare and should not in any way be considered representative of kinship care, the issues these reviews bring to light require consideration. In both cases, the children had no relationship with their carer prior to the order and investigation into their deaths highlighted insufficient assessment of their carers.

**Prevalence**

Richards and Tapsfield (2003: p.5) estimated that in the UK, the number of “children under 18 being brought up by a grandparent, relative or friend…is likely to run into the 200,000 to 300,000 mark.” Although they note “this figure includes children who are living temporarily with family and friends and children who could live with their parents.” (Richards and Tapsfield 2003: p.5) More recent figures suggested that out of these children “less than 12,000 of them are looked-after children.” (Kinship Care Alliance, 2011: p.2). This may in part be accounted for by the introduction of special guardianship orders, which has led to more children leaving the care system.

“There has been a steady growth in the use of SGOs since their implementation in 2005, with 3,830 children (12 per cent) ceasing care due to an SGO in 2016; this represents an increase of eight per cent on 2015 and a cumulative increase of 78 per cent since 2012.” (Wilkinson and Bowyer, 2017: p.53)

However no official statistics exist on the total number of children living in kinship families as local authorities have only been required to keep records on children whom they are responsible for looking after. (Wade et al., 2014).
Kinship foster care

Broad (2004: p.211) reported that the numbers of looked-after children in kinship foster care in the UK was “increasing at a disproportionate rate”, citing an increase of 32% from 1996-2000 compared to “a 15% increase in all foster care placements over the same period.” (2004: p.212) By 2002, “12% of all children looked after were living in a family and friends foster placement.” (Broad, 2004: p.212)

Broad (2004: p.212) argues that it is important to consider an increased use of kinship placements within the context of a range of social and political factors. These include: “major scandals about and crises in residential care”, “poor outcomes for children leaving care”, “a shortage of foster carers” and “an over-representation of black/mixed race young people in public care”. Although there may have been developments in some of the issues raised by Broad over the last decade, for example improvements in the quality of residential care for children (Wilkinson and Bowyer, 2017: p.51), many concerns about outcomes for looked-after children remain. For example, recent government statistics on children’s educational attainment at Key Stage 2 found:

“For the headline measure reading, writing and mathematics, the percentage reaching the expected standard or above for children who left care through adoption, special guardianship order (SGO) or child arrangements order (CAO) is 30%, compared with 25% for looked-after children and 54% for non-looked-after children.” (DfES, 2017: p.1)

Although Broad (2004: p.212) acknowledges that there are some children in “largely unrecorded kinship care” his study focuses on children known to the local authority who are in receipt of some support, either as a looked-after child, or a child in need. However in recent years, there has been increased awareness of the need for more research to gather accurate statistics and better understanding of the circumstances of children in informal kinship care who may not be known to the local authority.
Informal Kinship Care

Researchers at the University of Bristol (Nandy and Selwyn, 2011) sought to investigate this by cross-referencing data from the last U.K. Census (2001), with local authority statistics on looked-after children. Analysis of census data identified 173,200 children in the U.K. were living with relatives. Local authority figures accounted for 9,004 children living with kinship foster carers, therefore the remaining 164,196 children (95%) were living in kinship care either under a legal order or informally by private arrangement between families. Using this method, it was not possible to distinguish between children in each of these categories. In order to calculate the extent of informal kinship care, these findings would need to be cross-referenced against statistics for the numbers of children placed with kinship carers under a special guardianship or child arrangements order. However this data was not available:

“At present, there is no single national statistical collection on use of Special Guardianship. Data provided by Department for Education has focused on children moving out of care into Special Guardianship. In addition, statistics provided by the Ministry of Justice have been unable to distinguish between looked-after and non-looked-after children.” (Wade et al. 2014: p.73)

Special Guardianship

As part of their investigation into special guardianship, Wade et al. (2014) conducted a survey of all local authorities in England to gather data on the numbers of special guardianship orders made between 2006-2012 including totals for looked-after and non-looked-after children. This data was “supplemented by analysis of national administrative data on looked-after children provided annually by local authorities to the Department for Education.” (Wade et al., 2014: p.25) The researchers (Wade et al., 2014: p.66) found most local authorities were “reasonably confident about numbers of SGOs that concerned looked-after children” however “much greater uncertainty was evident about SGOs for non-looked-after children.” They identified that “data on these cases was often not recorded and/or collated” and “was sometimes based on estimates linked to those receiving financial allowances.” (Wade et al., 2014: p.66) The researchers concluded:
“Despite limitations in the accuracy of some of the data that we received, we feel we can be fairly confident in the patterns of growth in Special Guardianship that have been presented. We estimate that there has been in excess of thirteen thousand SGOs granted since 2006, with a third of these being for non-looked-after children.” (Wade et al., 2014: p.73)

Wade et al. (2014: p.67) emphasise that having accurate data available on the numbers of children in special guardianship at a local and national level is “vital to the development of effective service planning and commissioning.” They argue that:

“A Department for Education requirement for local authorities to report annually on all SGOs (looked-after and non-looked-after) would not only encourage local authorities to comply but also provide for a single (more accurate) statistical collection on the national use being made of Special Guardianship for all children. (Wade et al., 2014: p.67)

Implications for policy

In Nandy and Selwyn’s (2011) study, the importance of gathering data on all children in kinship care was highlighted by findings on the circumstances of many kinship families. From analysis of census data they identified that “3 out of 4 family and friends carers experience severe financial hardship” and “rates of multiple deprivation among children in kinship care were consistently much higher than the national average.” (Nandy and Selwyn, 2011: p.18) As a result of these findings, the researchers concluded children in kinship care are “a group who face high risks of socio-economic disadvantage” and recommend “they should be recognised as a group with special needs” who are “likely to need additional help and services.” (Nandy and Selwyn, 2011: p.18) In their subsequent publication “Kinship Care and Poverty” Nandy and Selwyn (2013) argue:

“a lack of reliable quantitative data on children in kinship care has meant that their needs have not been reflected in consultations and proposals to tackle child poverty. In fact, children in kinship care are not mentioned at all in the Coalition government’s recent document A New Approach to Child
Poverty (2011). The document places a statutory duty on local authorities to lead local partnerships to develop child poverty needs assessments in their areas and to produce recommendations for reducing child poverty. However, children in kinship care continue to go unrecognised in local and national strategies. (Nandy and Selwyn, 2013: p.1662)

The relationship between local and national responsibilities for supporting kinship families is explored by Wade et al. (2014: p.60):

“Within local authorities and national agencies there is a general concern about where the boundary lies between local and central state responsibilities for providing income maintenance to families caring for the children of others…there is a feeling that these are being devolved on to local authorities that are not resourced to provide assistance to those for whom they have no legal obligation, even though the needs of children living in private kinship settings may in practice be very similar. Charities and organisations working in family and friends care have therefore long advocated for a national allowance to be paid to those providing substitute care for children who would otherwise be living within the care system and for changes to the tax and benefit system that would help to ease the financial burden on these families.”

Nandy and Selwyn (2013) cite research by Hannon, Bazalgette and Wood (2010: p.1663) which suggests “in 2010, the annual costs of a child being formally ‘looked after’ in England were estimated to vary between £23,000 and £56,000”. Therefore, they conclude;

“The price of failure of kinship arrangements is high, in terms of both the personal costs to children and carers, but also the significant costs if a child becomes formally looked after in foster or residential care. (Nandy and Selwyn, 2013: p.1663)"

The need for changes to policy in respect of the support available for kinship families was further highlighted in 2017, when the charity Grandparents Plus reported on the
findings of their survey of 671 kinship carers in England and Wales, of whom 83% were grandparents. (Grandparents Plus, 2017: p.3) Their research highlighted the challenging circumstances faced by many families, in terms of both the personal and financial situations of kinship carers, as well as their variable and often insufficient experiences of support.

This survey found that in terms of their personal circumstances, 40% of those surveyed were single carers, 43% had a disability or long term health condition, 41% were raising two or more children and 30% had additional caring responsibilities such as “helping to look after a disabled or elderly relative or friend” (Grandparents Plus, 2017: p.4).

With regards to employment, 51% of kinship care households were without a working adult. (Grandparents Plus, 2017: p.5) 85% of carers were of working age and 73% were working prior to becoming a kinship carer. Of these; 45% subsequently gave up their employment and 23% reduced their working hours with a “consequent impact on family income.” (Grandparents Plus, 2017: p.5) 81% of carers who left their job reported that this was to be more available to care for the children, with 21% reporting feeling under pressure to do so from social care. (Grandparents Plus, 2017: p.5) 60% of those surveyed were looking after children under a Special Guardianship Order (Grandparents Plus, 2017: p.4) and unlike adopters, were not entitled to take adoption leave from work when having a child placed permanently in their care. (Grandparents Plus, 2017: p.5)

Analysis of carers’ financial situations revealed that 65% of carers received financial support from their local authority, but 43% reported their income was not adequate to provide sufficiently for the children, with 50% of carers turning to their savings to supplement this. (Grandparents Plus, 2017: p.5) Overall, 47% of carers reported they were not receiving the financial support they needed. (Grandparents Plus, 2017: p.3)

Grandparents Plus conclude that their findings highlight a “growing financial divide among kinship carers” between those who feel that they do receive the financial support they need (33%) and “a comparable number (28%) [who] say they feel very poorly supported” (Grandparents Plus, 2017: p.6). They suggest that these statistics reflect the divergent situations of kinship carers who become foster carers, thereby receiving a statutory allowance from the local authority, and those who care for children informally
or under a Special Guardianship (or other legal order) where there is no statutory requirement for local authorities to provide them with financial assistance:

“We might speculate that this division reflects entitlements to financial support for kinship foster carers only, while support for Special Guardians is discretionary, means tested and variable from place to place.” (Grandparents Plus, 2017: p.6)

This survey also explored what other types of support were required and when these were most needed. 62% of carers wished for “more advice, information and practical support” (Grandparents Plus, 2017: p.6), especially at the point of considering taking on the care of children and needing help to understand the different legal options available (Grandparents Plus, 2017: p.7). 65% needed more emotional support once the children were living with them, as they needed help to “come to terms with their situation and the children’s needs” (Grandparents Plus, 2017: p.7). In this survey, carers reported that 52% of the children they were looking after had special needs:

“Of these children, the majority (82%) have emotional or behavioural issues, 36% have a learning difficulty/disability, 28% Autistic spectrum/Asperger’s, 14% have chronic health issues, 9% have foetal alcohol syndrome and 7% have a physical disability.” (Grandparents Plus, 2017: p.4)

20% of carers reported that children had received counselling and 24% said they had received support from Child and Adolescent Mental Health Services, however 19% had not received any help despite this being needed (Grandparents Plus, 2017: p.7). Some carers highlighted the difficulties they experienced in accessing support:

“Therapeutic services for children are difficult to access without a diagnosis. I have had to pay for theraplay and cognitive therapy etc.” (Grandparents Plus, 2017: p.7)

Managing contact with birth parents was also reported as a “major concern” for kinship carers, particularly for 27% of carers who felt that “contact was harmful or very
harmful” but had to support this where the Court had ordered that parental contact be maintained. (Grandparents Plus, 2017: p.6)

In light of these findings, Grandparents Plus advocate for changes to local authority policy and practice. These include; a “realistic assessment of financial and other needs” at the outset, so as to ensure that “kinship carers are not pushed into poverty, so reducing their ability to provide optimal care for children” (Grandparents Plus, 2017: p.8), the introduction of “a national minimum allowance to cover the costs of bringing up a kinship child, equivalent to the fostering allowance” (Grandparents Plus, 2017: p.9) and the right for all kinship children “irrespective of their legal status or the local authority’s involvement in the original arrangement” to request “an assessment of their support needs from the local authority at any time” (Grandparents Plus, 2017: p.8). Grandparents Plus emphasise the need for local authorities to work with voluntary organisations like theirs to provide “high quality, accessible and tailored support for kinship carers and their families” which can “help families avoid crisis and reduce the likelihood of future reliance on public services.” (Grandparents Plus, 2017: p.9)

The need for funding to be made available to support such services is emphasised by this study, alongside a requirement for local authorities to collect data on all children in kinship care “including those who were not previously looked after” so as to “help to inform the development of national and local policy and the planning of support services for children and young people in kinship care.” (Grandparents Plus, 2017: p.10)

1.5 Aim of Research

The research question I have posed myself is: what can we learn from interviews with kinship carers, teachers and therapists about the experiences of children in kinship care? To explore this question my thesis is structured as follows: In chapter 2, I review literature on kinship care from the fields of social work and mental health, including child psychotherapy. In chapter 3, I describe my research project including: study design, ethical considerations, recruitment, interview process and data analysis. In chapter 4, I present the findings from my research, exploring the key themes which emerged. In chapter 5, these themes are considered from a psychoanalytic perspective
in the context of other study findings and current debates, to enable a broader discussion about what can be learned about the experiences of children in kinship care. In the final chapter, I reflect on the limitations of my study and present my conclusions and recommendations.
CHAPTER 2
Literature Review

2.1 Search Methods

Initial searches were conducted of the Tavistock and Portman Library Catalogue and online databases using EBSCOhost for papers containing ‘kinship care’ in the title. Additional searches were undertaken in journals representing the core CAMHS professions: Clinical Psychology, Psychiatry, Family Therapy and Child Psychotherapy, in addition to the specialist journal Adoption and Fostering. Further papers of interest found in bibliographies, conferences and supervision were also collected.

2.2 Social Work Literature

Introduction

Within the U.K. and Ireland, most social work papers acknowledge the importance of exploring kinship placements as a first priority for children living away from parents and cite the strengths of kinship homes in providing children with a sense of continuity, familiarity and identity (Broad, 2004). However there is also recognition of potential concerns about keeping children within birth families who have struggled with intergenerational difficulties (Kroll, 2007). Other papers therefore focus on the task of assessing extended family members as potential carers (O’Brien, 2014), the pressure on social workers to undertake this work (Warren-Adamson, 2009) and the importance of support (Pitcher, 2002) and training (Sykes, 2002) being available to kinship carers.

As numbers of children in kinship families are increasing, some authors raise concern about the lack of adequate research in the U.K. (Holland, 2005). They identify the need for further studies to provide evidence as to whether outcomes for these children are better than for those living with unrelated foster carers, to ensure that changes in policy are informed by research. There are also calls for more studies to better understand the experiences and views of children living in kinship care (Burgess, 2010).
In America, where the “number of children being raised by kinship caregivers without biological parents’ involvement has increased over the previous two decades” (Littlewood, 2012: p.60) the literature base is far more extensive. With “more than 1.8 million children…being cared for solely by grandparents” (Littlewood, 2012: p.60), this “‘explosion’ in relation to kinship care” (Kroll, 2007: p.86) is attributed to:

“a rise in social problems, including parental substance abuse, incarceration, teen pregnancy, child abuse and neglect, HIV/AIDS, and parent death. In addition, there is an increasing trend in child protective agencies placing children with relative rather than non-relative caregivers based on a belief that children will do better when raised by family members than foster parents.” (Littlewood, 2012: p.60).

In a sample of 42 American journal papers written over the last two decades (1994-2014), twelve (29%) were on social policy reform and case management, ten (24%) on the experience of kinship carers (70% on grandparents, with one (Okagbue-Reaves, 2005) about grandfathers), six (14%) compared outcomes for kinship children with those in different types of placements, six (14%) explored the experience of African-American children who “are placed disproportionately in kinship foster care” (Shwartz, 2008), and three (7%) were longitudinal studies on permanency.

The remaining five papers (12%) were on other topics linked to the particular demographic and cultural context of kinship care in America. These included: Shin’s (2003) study on educational competence of youth in foster care which found that “placement in kinship care is the only factor in the placement experience domain that predicted educational attainment of youth in foster care” (2003: p.623), Naughton and Faye’s (2003) exploration of intercountry kinship placements, as the “number of foreign-born residents and children of immigrants is at the highest level in US history” (2003: p.31), and lastly, Smith et al. (2004) study entitled ‘Breaking Through the Bars’ exploring the experiences and views of addicted incarcerated parents of children living in kinship care.

For reasons of brevity, the following literature review is largely restricted to research in the UK and Ireland.
The value of kinship care


For carers, motivation for providing care was above all “their love for the young person and (in the case of grandparents) a love and desire to support the birth parent(s).” (Broad, 2004: p219). This was underpinned by a belief that “family is the best place to raise young people” (Broad, 2004: p.219) and concern that “they did not want the child to be cared for by the local authority” which they imagined would have “damaging results” (Broad, 2004: p.220).

Issues of culture were also pertinent. Just under half the children were of Caribbean heritage. With one exception “the ethnic origin of the kinship carers exactly matched those of the young people” (Broad, 2004: p.216). This showed that “kinship care can promote or maintain a young person’s racial and cultural heritage” (Broad, 2004: p.219) and the importance for children of belonging to a family identity and culture, which may also be linked to a local area or community.

“Both black and white young people and carers spoke of the importance of family love, being looked after by the whole family, and the importance of other relatives and friends being local.” (Broad, 2004: p.216)

Nearly all carers felt “the overall impact of the placement had been positive” in “establishing a family life and security for the young person” and that “maintaining links with the birth parents; improved behaviour of the young person; and educational achievements.” (Broad, 2004: p.219) They were also able to identify at least one benefit for themselves, such as “companionship, satisfaction in watching the young person develop and being introduced to new interests.” (Broad, 2004: p.220)

Carers also described disadvantages and challenges including;
“shortage of money, loss of freedom and independence, overcrowding, problems relating to old age and ill health, and problems relating to managing difficult behaviour.” (Broad, 2004: p.220)

Despite not wanting children to be looked after by children’s services, involvement with social care for advice and support was desired, indicating that the experience, expertise and impartiality of professionals from family dynamics was considered helpful.

“Kinship carers valued social work support and wanted more, not less, contact with social services to talk through family issues, especially about internal family relationship matters.” (Broad, 2004: p.220)

Interviews with young people (aged 11-25) highlighted that feeling “safe and settled in [their] current situation” was paramount but many also struggled with feelings of guilt, for “not living with their parents/siblings, or about being taken into care” (Broad, 2004: p.221). Broad concludes:

“these emotional burdens need to be more highly recognised by care agencies and young people might want the choice of having an appropriate person, probably not a social worker, perhaps a trained counsellor, to speak to about such matters.” (Broad, 2004: p.221)

The relationship between feelings of guilt and the difficult behaviour which many carers reported they were struggling to manage was not explored in this study.

**The impact of intergenerational family difficulties**

Feelings of guilt, responsibility, fear, blame and suspicion are discussed by Kroll (2007) in her exploration of family dynamics when grandparents become carers following a history of parental substance misuse. The interplay between intergenerational feelings, conflicts and solutions are examined to understand how this can impact on kinship families and type of support required. Kroll draws on attachment theory and
psychoanalytic concepts such as projective identification and splitting in her exploration of how feelings in the kinship family may originate from earlier family relationships.

Citing the findings of a study by Barnard (2003) in which 62 parents were interviewed, Kroll explores the ambivalent feelings that parents may experience towards grandparents offering support. For example, grandparental care of children could be helpful in enabling parents to attend rehabilitation centres, however;

“supportive kin were also seen as undermining parents’ motivation to tackle their substance problems. By freeing them from responsibilities and thus appearing to collude with a chaotic lifestyle, this provided a significant barrier to both change and a continuing attachment to their children.” (Kroll, 2007: p.87)

Grandparental support could therefore be welcome whilst also arousing anxieties in parents that their relationship to their child could be weakened: “relief can be tempered by guilt, fear of being replaced and loss of role and parent status” with grandmothers at times experienced as a “threat by their daughters, who feared their concerns might lead to official intervention” (Kroll, 2007: p.89). Feelings of uncertainty about role and responsibility were also present in children.

“There was an equal amount of evidence to suggest that grandparent involvement was not without its problems in terms of confusion for children about who was ‘in charge’ of them…” (Kroll, 2007: p.87)

In Barnard’s study, the feelings of guilt which parents may hold towards their children, and their parents for looking after them, may also co-exist with feelings of blame towards grandparents. This may be particularly in families where parents were themselves children of parents who misused substances or alcohol.

“a high proportion of parents reported dysfunctional family backgrounds, with 58% reporting parental alcohol abuse and a further four parents reporting parental drug dependency problems.” (Barnard, 2003: p.295)
Other difficulties such as marital conflict which affected parents during childhood, may also be held responsible for their turning to drugs to cope with painful family experiences.

“Many of the interviewed parents spoke of difficult childhoods. They reported parents whom they considered had been emotionally cold and uncaring and family homes marked by conflict and violence, most often between parents, but in some cases also directed at them as children.” (Barnard, 2003: p.295)

Barnard notes that in many families “a long-standing history of conflict between parents and grandparents” was indicated.

“Family dynamics that probably harked back to childhood underpinned or exacerbated the tensions currently centred on the parent’s drug problems and its impact on the children.” (Barnard, 2003: p.295)

Kroll draws on attachment theory to explore these intergenerational difficulties and question their potential impact on the capacity of grandparents to parent their grandchildren.

“It has been argued that substance misuse is based on an attachment relationship and if one’s primary attachment is to drugs, alcohol or both, this has significant implications for the ability to attach to others.” (Kroll, p.88)

Citing Barnard (2003), Kroll (2007: p.88) asks “if some grandparents have shaped the parent’s drug problem, is there a degree to which placing children in their care can compound the problem?” She considers “it is of course possible that grandparents could have resolved their substance use and their attachment issues by the time they become substitute carers” but questions whether “these may be re-activated in the face of their child’s inability to parent effectively.” (Kroll, 2007: p.88) She concludes; “this does not necessarily mean, however, that they cannot be managed effectively but that they may have practice implications if difficulties are identified.” (Kroll, 2007: p.88)
Due to the painful feelings which may resurface if intergenerational experiences were recognised, Kroll reflects on how defences such as secrecy or denial of knowledge about a parent’s drug use may operate within the family system. Where substance misuse is not consciously known or openly acknowledged by grandparents, but may be obvious to children, this can lead to complex dynamics within the kinship family and impact on children’s behaviour. Kroll suggests when this ‘elephant in the living room’ (2007: p.88) does become visible, a range of complicated feelings may be triggered and “contribute to grandparents’ motivation to assume care.” (2007: p.90)

“Parents may feel relief, guilt, shame; carers may feel resentment at having to parent once again, triumphant that ‘they were right all along’ or guilty for the part they may have played in the substance misuse itself or may be tempted to blame the parent in front of the child. Alternatively, they may be shocked at the discovery of drug - or alcohol-related behaviour and inclined to blame the other partner, the social worker or any other convenient repository for difficult feelings.” (Kroll, 2007: p.90)

Kroll also considers how children’s emotional experiences will impact on kinship family dynamics and the challenges this may bring. She suggests that due to the adult activity which accompanies obtaining and using drugs, children’s early experiences of caregiving may be “characterized by lack of emotional connectedness, multiple and randomly selected caretakers and inconsistent response to signals of distress” (Kroll, 2007: p.89) which may result in children developing a disorganised attachment. Consequently, children’s perception of themselves and their impact on others may be affected and these feelings carried into the new family situation.

“The world of attachment-disordered children is a frightened, frightening and troubled one. They see themselves as unlovable and unworthy but capable of evoking anger, rejection and violence in others. As a consequence, they feel both powerful and evil. Other people are perceived as frightening and dangerous, but also seem frightened of them, in their turn. The confusion evoked by this conflicting range of emotions leaves them feeling out of control, helpless and vulnerable and, as a result, it is hard to focus or concentrate on anything around them, from social relationships to
cognitive development, unable to make sense of or control their own emotions and reactions or understand anyone else’s. The impact of such a constellation of emotions and behaviours on a family is likely to be very powerful.” (Kroll, 2007: p.89)

Kroll turns to Shore’s (1994) idea of ‘imported pathology’ to explore this further. Acknowledging its roots in psychoanalytic concepts such as projective identification and splitting, ‘imported pathology’ attempts to:

“...understand the way in which a child’s unresolved grief and loss (and all the associated powerful feelings) together with the insecure, disorganized attachment patterns that have developed as defences against this, affect the workings of the family that they join.” (Kroll, 2007: p.89)

Kroll describes how a child may feel “relief at leaving what might have been a neglectful, chaotic, violent, impoverished and unpredictable environment” but “this may be complicated by guilt, anxiety about the parent(s) left behind and resentment that the degree of freedom they may have enjoyed…may be curtailed.” (2007: p.90)

The child’s projection of these feelings into the new family, which will have “developed its own systems of communication and management of pain/sorrow” (Kroll, 2007: p.90) can lead to tensions in the child-carer relationship, in situations where the carer may be unable or unwilling to be the recipient of such powerful and painful feelings.

“The child’s pain generates punitive, angry, defensive responses that are effectively reflections of the child’s projections. This can lead to the continued acting out of the child’s unconscious processes, resulting in the family being unable to manage the child, leading to further upheaval and change...For grandparents, committed to caring for and loving children for whom they represent what may be a major source of stability, this could pose a number of challenges as well as undermining confidence and encouraging blame and censure. Just because there is a biological link, it does not mean that this phenomenon will not occur and carers may need
considerable support and skilled help in order to enable the child to re-attach in a safe way.” (Kroll, 2007: p.90)

Kroll suggests the task of assessing and supporting kinship placements brings particular challenges as it “takes place within a context where secrecy, denial, conflicting loyalties and family tensions all play their part”. (2007: p.90) She concludes:

“Risks from within the placement may be related to the role and roots of substance use in the family system or to the threat posed to identity and parent/child attachment as a result of the attitudes and judgements of the carers concerned.” (Kroll, 2007: p.90)

Assessment and Support

Routes into Kinship Care

The forms of support kinship families receive is often linked with how the child came to live in their kinship placement, if local authority assessments were completed, and what legal framework, if any, is in place.

In a study by Pitcher (2002) on issues facing grandparents who care for grandchildren following abuse or neglect, 33 sets of grandparents were interviewed and their experience of and relationship to help explored. In almost two-thirds of families, drug use was a factor in the parents’ inability to care for their child. The second main reason was “the mother’s seeming inability to feel sufficient commitment to the child, leading to potential abuse and neglect…sometimes connected with mental health issues.” (Pitcher, 2002: p.7) Other reasons were “risk of violence to the child, one parent being a sex offender, and a parent in prison. (Pitcher, 2002: p.7)

Children came to live with their grandparents in different ways. In 36% of families grandparents reported they “approached social services requesting to take on the child/ren” whilst another 33% said “social services had sought them out and asked them to care.” (Pitcher, 2002: p.7) For the remaining 30% “the grandchild was already living or staying with the grandparents at the time the decision for the child to be placed with
them was made.” (Pitcher, 2002: p.7) These different routes into kinship care reflected in part the different relationships between parents and grandparents prior to kinship placement. 74% of grandparents “had regular contact with the grandchild, of whom 11 said that they were ‘almost caring’” but in five cases, grandparents had “barely seen their grandchild due to family estrangement.” (Pitcher, 2002: p.8) Knowledge of the extent and nature of the difficulties within the parental home therefore also varied.

“One in four of the grandparents was genuinely shocked to hear that their grandchild had suffered abuse. Twelve (36 per cent) said they had an idea that all was not well, but did not realise the full extent of the ill-treatment. However, thirteen (40 per cent) said they knew ‘everything’ or ‘almost everything’ and several of those described their difficulties in trying to get professional agencies to listen to their concerns….For the majority, even if they had suspected that they would need to step in at some time, starting to care for the child was a major adjustment.” (Pitcher, 2002: p.8)

Pitcher found that children’s different routes into kinship care greatly affected the level of support that families received.

“If social services were involved in making the placement, the carers were treated much like any other foster placement (at least until a residence order was made): they were assessed, given financial support, had regular contact with a social worker and often obtained a residence order as a final outcome of care proceedings. On the other hand, those who stepped in before social services became involved were viewed as having made a private arrangement and received no help. Thus there could be two virtually identical situations, but two completely different experiences of caring.” (Pitcher, 2002: p.8)

In Pitcher’s study, negative ideas about social care could impact on all stages of the process, from informal caregiving, through assessment, to post-order support.

“a number of the grandparents had negative assumptions of the public care system, whether from the media or from their own experiences as a child.
They saw themselves as saving their grandchild from this.” (Pitcher, 2002: p.9)

These concerns may contribute towards a grandparent offering care and later affect their willingness to approach the local authority for the support they need.

“For many, there was a high level of anxiety that if they appeared in any way ‘demanding’ of help, social services would judge that they could not manage and would place the child elsewhere. This led to a reluctance to ask for too much practical help at a time when it was desperately needed.” (Pitcher, 2002: p.8)

In situations where the local authority removed children from their parents and placed them in kinship care, most grandparents supported this but were then left with worries that social care could revoke their decision.

“All but one of the grandparents believed that social services were right in removing their grandchild from the parental home or refusing to allow the child to return. Criticism was more likely to be that social services took so long to respond to concerns, and fears were frequently expressed that social services would decide to return children home to an unsuitable parent.” (Pitcher, 2002: p.11)

Grandparents’ feelings of a lack of power and control - either to get social care to hear their concerns about parents, or be sure they will agree for their grandchild to remain in their care, seemed to culminate most strongly at the point of formal assessment. This might be heightened in situations where grandparents have already been offering informal care prior to social services involvement, and are then in the difficult situation of being assessed to care for children whom they have already been caring for.

“All but two of the grandparents believed that it was right in principle that grandparents should be assessed as to their suitability to care for their grandchild. Five grandparents said that they were surprised when they were not: ‘We could have been anybody, couldn’t we?’ However, they also
found the form the assessment took difficult to appreciate, at least initially. Typically, it seems, social workers had begun assessments with an historical profile, which had felt intrusive. Several thought this could have been better explained at the outset. Social workers may also have been unaware of the power they held in the grandparents’ mind, and of the fear this could inspire. Fear of losing their grandchild led some to give answers that were interpreted by the social worker as dishonest.” (Pitcher, 2002: p.12)

**Assessment of Kinship Carers**

The question of how best to assess and support kinship carers is the subject of O’Brien’s (2014) paper, in which she argues that traditional foster care assessments are inappropriate.

> “While relatives trying to help their extended family can appreciate the agency’s need to ensure safety, an extended investigation/assessment process can be an unwelcome, incomprehensible, intrusive and worrying intervention while they are adapting to the difficult task and changes involved in caring for their vulnerable relatives…” (O’Brien, 2014: p.356)

In order to grapple with the complexity of family dynamics, complete assessments within timescales and reduce anxiety for families, a new conceptual model is proposed. O’Brien (2014: p.357) identifies four key capacities required of kinship carers:

> “insight into self, understanding the child’s needs and be committed to meeting them, understanding and ability to deal with family dynamics, especially one’s own position in it, and allowing the agency to provide support to the child and family.”

O’Brien (2014: p.357) draws on systemic ideas to formulate a social constructionist approach to assessment in which social workers “enter a more dialogical and collaborative space with the family, to support families in identifying solutions”.
“A social constructionist position ensures that the social worker does not impose a view of ‘normality’ which families must measure up to, allowing social workers to be more transparent, spontaneous and creative. The author has found that these social constructivist, systemic and narrative ideas are particularly useful in dealing with the challenges of understanding and working with kinship care networks.” (O’Brien, 2014: p.358)

In Pitchers’ (2002) research, grandparents’ feeling of intrusion by social work assessments and worry the child could be removed from their care if assessments were not favourable, was also coupled with the contrasting impression that social workers were keen for children to remain with extended family as this was in the financial interests of the local authority:

“…many felt unrecognised and taken for granted by social services, who they said were liable to make decisions without consulting them. Others recognised that social services had less need to worry, or to supervise their grandchildren, than if they were with foster carers….One element that several grandparents mentioned was the desire of social services to ‘close the case’: ‘We got the distinct impression we were taking things off their hands.’” (Pitcher, 2002: p.11)

Therefore the relationship between kinship carers and social workers, particularly at the point of assessment, or when support is needed, seems to be a point of intersection within a complex matrix of desires, anxieties and defences (both conscious and unconscious). These exist at both an individual and organisational level, with kinship carers and social workers each representatives of a bigger system, be it the wider family or children’s services department responsible for managing its budget whilst meeting government targets for children in care.

**Organisational Factors**

Warren-Adamson (2009) explores some of these tensions between the individual and the system. Using practitioner-led collaborative enquiry within one local authority, his research aims to gain a better understanding of “the implications for practitioners of the
authority’s strong policy of encouraging kinship placement for looked-after children.” (Warren-Adamson, 2009: p.76)

Research involved regular meetings for a year between eight social work practitioners from different teams including: “assessment, protection, special needs, development and leaving care” (Warren-Adamson, 2009: p.77) along with two academic researchers. The group’s goals were “to report to the authority in one year on kinship practice, the authority’s practice strengths and what needed to change.” (Warren-Adamson, 2009: p.77) Warren-Adamson notes there was;

“nothing to suggest that the collaborative group members were more or less challenged or more or less capable than their counterparts elsewhere. On the contrary, there was much evidence of experienced practice and surges of great creativity. However, the narrative of this collaborative enquiry group resonates with a growing debate in the literature about the makings of disproportionate anxiety for children and family practitioners.” (2009: p.82)

The study found that at a personal level, social workers reported struggling with:


Work took place within a culture which “reflected an unfriendly terrain for practice” (2009: p78):

“Group members highlighted especially audit, bureaucracy, managerialism, a lessening belief in the professional roles and task, proceduralism, a competence-grievance-complaint-blame-telling-off culture, defensive practice, variable resources, an over-reliance on technical responses, and new messiahs and government initiatives. Valued practice… is largely short term, focused on rescue, a culture that counters dependence and long-term relationship intervention. Alongside these challenges are pendulum swings and the vagaries of practice fashion.” (Warren-Adamson, 2009: p79)
A predominant theme in social worker accounts was of ‘mindset’, describing the “fixed and boundaried state of mastering a sub-domain of practice.” (Warren-Adamson, 2009: p79) The development of expertise within an area, often linked with a particular part of the legal system, seemed to enable work within that area to be completed. However with different aspects of the social care system divided between different specialist teams, locations and decision-making forums, the study found a propensity for this to result in unhelpful splitting and lack of fluidity in service provision, which made the development and maintenance of professional relationships difficult. This “hostile environment” was considered “ill-suited to the complex world of kinship placement.” (Warren-Adamson, 2009: p79)

Warren-Adamson (2009: p.79) describes how workers need to become skilled at “operating in dynamic systems of criss-crossing territories.”

“Overall, my sense is that practitioners are challenged to equip themselves and gain experience for the elaborate dance they need to have within and between these sites, each with its particular imported purpose and culture. Initial training may have left them ill-equipped for such complexity.” (Warren-Adamson, 2009: p.80)

The study concluded:

“what is especially attractive about kinship care for practitioners is the instinctive claiming of the child by kinship carers, which is containing and normalising. What goes with it is likely to be economic impoverishment and inexperience in dealing with the agencies on which carers must rely for the special needs of their children. Their needs for support may well be as great as or greater than those of stranger carers.” (Warren-Adamson, 2009: p.82)

Warren-Adamson (2009: p.83) argues that:

“the complexity of kinship placement practice alongside the disempowerment of bureau-based practitioners, has become evident. Analysis of practitioner capacity and the sites from which they practise, set
against the complexity of their task, appear to be critical and poorly recognised variables in social work research.”

Warren-Adamson (2007: p.82) suggests that the “office or bureau-based site appears to be singularly unsafe and inappropriate for the development of kinship practice” and proposes “we should look to the more sophisticated examples of family centre or family support centre as more suitable bases.” He cites Hess et al’s (2003) account of the Center for Family Life in Brooklyn, New York which enables practitioners to support kinship families at different levels within a community setting.

Support

Aside from practical issues with finance and housing, in Pitcher’s study the main areas where kinship carers needed help was in managing parental contacts, understanding children’s behaviour and peer support. Discussing parental contact, a third of grandparents “described the difficulties caused by poor reliability” and children’s behavioural difficulties were often linked to contact sessions with “disruptive behaviour before and after visits”. (Pitcher, 2002: p.9) Concern about children’s behaviour brought two “commonly recurring worries” (Pitcher, 2002: p.10), that of:

“wild, destructive behaviour, which the grandparents could neither understand nor manage; and a child who is somehow ‘too good’ or ‘adult in their understanding’. In these cases…grandparents found themselves wondering whether this young person (most often a girl) was a ‘time bomb waiting to go off’. This was often connected with the question, “What if she turns out like her mother?”’ (Pitcher, 2002: p.10)

Carers’ feeling of coping with these difficulties on their own was also highlighted in the study:

“I asked the grandparents whether they knew anyone else in their situation. Only ten reported that they had even heard of anyone else caring for their grandchild and, of those, five did not know them to speak to. Further, over half (60 per cent) of the grandparents said that they had no one to talk to
independently of the children. Many did not feel that they could ‘burden’ family or friends. Thus, one significant element of this group’s experience was of isolation.” (Pitcher, 2002: p.11)

In order to address this, Pitcher describes the development of new local initiatives including:

“the provision of mediation for contact in kinship placements, a ‘listening line’ run by the support group, and a link with a team of psychotherapists to provide consultation for grandparents who are unsure how to understand their grandchildren’s behaviour.” (2002: p13)

Similarly, within her new assessment model, O’Brien proposes that therapeutic work is available from the outset to help families manage intergenerational dynamics which may affect the placement.

“The provision of a therapeutic service targeted at different configurations of relationships in the kinship network is an additional feature of this model. This aspect may involve working conjointly with the child and family worker to carry out therapeutic work that may be required to build up working relationship between birth parents and kinship carers and any other network configurations that may require therapeutic assistance.” (O’Brien, 2014: p.362)

Training

In Sykes et al. (2002) study, carers’ experiences of training were explored across seven local authorities in England. 944 foster carers were contacted by postal questionnaire of whom 13% were kinship carers. (Sykes et al. 2002: p.39)

Kinship foster carers varied in terms of how they reconciled the duality of their role as both relative and foster carer. This issue of personal/professional identity often determined their relationship to support.
“Some want to be treated as carers entitled to similar levels of financial reward, and in need of training. Others may see support from social services as ‘intrusive’ and regard themselves as qualified by experience to care as they do.” (Sykes et al. 2002: p38)

In terms of accessing training, the researchers found:

“One-third of the kinship carers…said they had turned down training. Their reasons included the lack of crèche or childcare facilities, clashes with work and inconvenient times of day. However, the most common reason given by just under half of this group was that the training was ‘not relevant to their needs’. Some saw training as unnecessary because they were caring for a family member and had previous experience of doing precisely that.” (Sykes et al. 2002: p.41)

The study found that this perspective contributed to differences in the levels of support received by unrelated foster carers and kinship carers.

“77% of kinship carers claimed they had received no training since they began fostering, compared with 21 per cent of non-relative foster carers.” (Sykes et al. 2002: p.41)

This finding is unfortunate since attending training would be a good way for kinship carers to meet others in their situation and potentially gain a better understanding of the challenging behaviours they may be struggling with.

“Kinship carers in our sample seemed less integrated into the support systems associated with foster care. They received less training and reported less support from other foster carers, groups for foster carers and relief breaks.” (Sykes et al. 2002: p.46)

The researchers also found that;
“kinship carers appeared to have lower levels of formal education and were much less likely to have an adult partner who was employed outside the home than other foster carers.” (Sykes et al. 2002: p.45)

This raises a question as to whether a dismissal of the need for training could also mask kinship carers’ anxieties about returning to an educational setting, which may feel very unfamiliar and exposing, particularly in front of social care professionals and peers.

As these findings indicate that kinship carers may be less well trained and supported than unrelated foster carers, how might this impact on kinship placements meeting children’s needs?

**Outcomes for Children in Kinship Care**

Assessing how successful kinship placements are in meeting children’s needs and how they compare with non-kin placements has been a growing area of interest as the use of kinship placements has increased. In the last few years, Lutman, Hunt, and Waterhouse (2009) and Farmer (2009) have sought to explore this further. Assessing outcomes for children in kinship care raises questions such as; what are meaningful outcomes? What factors can be assessed? How can these be measured and compared?

**Placement Duration**

Holland, Faulker and Perez-del-Aguila (2005) consider numbers of placements and placement duration as indicators of stability and therefore as a measurement of success. This links with an understanding that moving placements can be extremely unsettling and disruptive for children, particularly if the ending is as a result of placement breakdown, rather than a planned move to a longer term home.

Lutman, Hunt and Waterhouse (2009) seek to understand what factors may be associated with placement breakdown and what contributes to greater placement stability. In this government-funded study, data from social care case files was collected on 113 children in two local authorities who had been placed in kinship care following care proceedings. This was supplemented with semi-structured interviews with social
workers, carers and children. 90% of children were “believed to have experienced actual abuse or neglect rather than just being at risk” (Lutman, Hunt and Waterhouse, 2009: p.29) and 70% already displaying emotional and/or behavioural difficulties prior to kinship placement (2009: p.30). File data was also gathered on a small comparison group of 31 children placed with unrelated foster carers before their fifth birthday.

In this study, 31 out of 113 kinship placements (27%) were judged to have ended prematurely. On average this was three years after care proceedings ended and most often (in 29% of families) as a result of children’s behaviour. The second highest reason (26%) for placements terminating early was the child requesting to leave. This seemed to highlight how for many children the desire to return to birth parents despite their early experiences was so strong that “no other placement is likely to work”. (Lutman, Hunt and Waterhouse, 2009: p.32) In 13% placements ended early due to “alleged or substantiated abuse or neglect/child put at risk” and in another 13% due to “relationship difficulties between the child and either the carer or other children in the household.” (Lutman, Hunt and Waterhouse, 2009: p.32) In two families (6%) carers “concluded that they had made a mistake in offering to care” and “one was unable to carry on caring because of ill health.” (Lutman, Hunt and Waterhouse, 2009: p.32)

Research analysis identified the following four protective factors which were found to help limit the likelihood of placement disruption:

“if the child was young at the point of placement; if the carers were grandparents; if they had previously cared for the child full time; and if the child had never asked to live elsewhere.” (Lutman, Hunt and Waterhouse, 2009: p.32)

Findings revealed that of the 27% of placements that ended prematurely, the children were significantly older at the time of placement than those that were continuing. Given the two main reasons why placements were found to break down (children’s behaviour and desire to leave), the researchers concluded age was significant in two important ways:
“…children who were older at the end of the proceedings had experienced more adversities prior to placement and were more likely to have difficulties (e.g. emotional and behavioural problems) that pre-dated the placement. Older children are also more likely to vote with their feet about where they want to live.” (Lutman, Hunt and Waterhouse, 2009: p.33)

The researchers emphasised that whilst age at time of placement may be a contributing factor to placement duration, it was not the case that “all adolescent placements disrupted and not all placements of younger children lasted as long as needed.” (Lutman, Hunt and Waterhouse, 2009: p.33) Other factors such as level of involvement the child had with their kinship carer prior to placement also had a significant impact on stability:

“In cases where the carer had previously cared for the child full time, the children probably already knew their carers well and were likely to have an existing emotional bond (and perhaps as importantly, the carers knew them well and what they were taking on)… it seems likely that this can protect from disruption even when other factors, such as the age of the child, pose a risk.” (Lutman, Hunt and Waterhouse, 2009: p.34)

Type of kin relationship was also a significant factor in placement duration. “Placements with an aunt or uncle were less likely to last as long as needed than those with grandparents.” (Lutman, Hunt and Waterhouse, 2009: p.34) The researchers suggest this could be due to there usually being more children in the household with aunts and uncles than in grandparental homes, so resources would need to be shared. Another reason may be that “the grandparent–grandchild relationship involves a particularly special type of commitment.” (Lutman, Hunt and Waterhouse, 2009: p.34) In respect of the fourth protective factor (if the child had never asked to live elsewhere), researchers concluded this had “limited predictive value” as “the child’s wishes may reflect, rather than be a contributory factor to, placement breakdown.” (Lutman, Hunt and Waterhouse, 2009: p.34)
Relationship between social work support and placement disruption

In this study researchers found no evidence that where placements ended prematurely this was linked with a lack of social care support. Rather, that more support was given to placements which were failing than those which were going well.

“In almost all the placements which ended prematurely, children’s services had been involved throughout (94%) compared with only 40 per cent of other placements.” (Lutman, Hunt and Waterhouse, 2009: p.34)

Researchers suggest this indicated that “social workers were aware of the placements that were in difficulties, but that the support they were able to provide was not sufficient to maintain them.” (Lutman, Hunt and Waterhouse, 2009: p.34) In placements which disrupted due to children wanting to return to birth parents, it was concluded that “better provision would probably not have made a difference.” (Lutman, Hunt and Waterhouse, 2009: p.34) However in those which broke down as a consequence of carers being unable to manage children’s behaviour it was questioned whether they “might conceivably have been sustained with different or more consistent support.” (Lutman, Hunt and Waterhouse, 2009: p.34) In interviews with these carers about the type of support needed, “the common factor was help in dealing with the child’s behaviour and/or managing its impact on the rest of the family.” (Lutman, Hunt and Waterhouse, 2009: p.34) Researchers found that when placements did break down other relatives often stepped in to offer care.

“More than half of the children remained within their family networks, moving either to a parent or another relative and the original carers often retained a positive relationship with the child.” (Lutman, Hunt and Waterhouse, 2009: p.38)

Researchers reflected that the “extent to which some families rallied round to keep the child within the network was sometimes quite astonishing” (Lutman, Hunt and Waterhouse, 2009: p.34). They concluded;
“there is a strong argument that kinship care provides an enveloping supportive network for many children even when there are problems.”
(Lutman, Hunt and Waterhouse, 2009: p.38)

This may be quite a different experience from children living in non-kin placements who would be more likely to lose contact with carers following placement breakdown.

Comparison between kinship and foster care

Farmer (2009) compared placement outcomes for children living in kin and non-kin care. Research was conducted in four local authorities in England with a sample of 270 children, just over half of whom were living with family or friends, and just under half in unrelated foster care. Research consisted of case file analysis, interviews with adults and children, and some standardized measures. Children were followed up after two years to assess their progress.

Little difference was identified between the two groups of children in terms of age, gender, health conditions, special educational needs, types of previous adversity (e.g. abuse and neglect) and behavioural problems. However those in foster care were “significantly more likely to have been recorded as having experienced emotional difficulties, such as anxiety and depression”. (Farmer, 2009: p.333) It was unclear whether this was a real difference or “may be because social workers had more information about the children who went to unrelated foster carers, because…they had spent longer in care” (Farmer, 2009: p.333) before the current placement.

Children were less likely to be placed with kin if “one or both of the children’s parents had been in care themselves” which may suggest that “the relatives of these children were often either unavailable or considered unsuitable to care for the children.” (Farmer, 2009: p.333) If children suffered from multiple health difficulties, kinship care was also less likely.

“It may be that kin carers were less able or willing to offer the care needed by some of these children or that social workers were more inclined to place
these children with specially trained and equipped foster carers.” (Farmer, 2009: p.333)

Children living with foster carers were found to have spent a much longer period in care.

“42% of the children placed with kin had spent the majority of their lives with a relative or friend, whilst this was true for only 2% of those with unrelated foster carers.” (Farmer, 2009: p.335)

This finding suggested that “many of the family and friends had stepped in early to look after children who would otherwise have spent time in care.” (Farmer, 2009: p.335)

Care plans for the two groups of children also differed significantly.

“93% of those in kinship homes were expected to remain there until adulthood, whilst only 61% of the foster homes were intended to be long term placements.” (Farmer, 2009: p.335)

There were also differences between kinship and non-kin carers, with kinship carers far more likely to be struggling with poor health, overcrowded living conditions and financial hardship.

Placements were assessed after two years to measure quality, disruption and duration. It was noted that during this period, the kinship carers received significantly less support than the foster carers.

“…Whilst almost all of the unrelated foster carers (96%) had the benefit of a family placement worker, this was true for only four of the kin carers and few had access to training or foster carer groups.” (Farmer, 2009: p.338)

Placement quality was assessed by how far the placement was meeting the child’s needs, any concerns raised about the child’s wellbeing by professionals and the presence of any other negative factors such as bullying by other children in the placement. The study found that the foster placements were only slightly more
satisfactory than the kinship homes. Statistics on placement disruption found that outcomes for each group were largely the same.

“When placements disrupted, the reasons for this were broadly similar in the two groups, with most disruptions caused by the children’s behaviour, a relationship breakdown with the carers or other children in the family, or the child requesting a move.” (Farmer, 2009: p.338)

Analysis of placement duration identified that kinship placements lasted longer. However this was often because fewer of the foster homes were intended to be permanent placements. Subsequently, a higher percentage of children in these placements had planned moves to permanent homes with long-term foster or adoptive families. (Farmer, 2009: p.339)

Although placement continuation would usually be a positive outcome, this study found that where children were living in unsatisfactory placements, they often remained much longer if living in kinship homes:

“We found that when placements were unsatisfactory, social workers moved children out of unrelated care much more quickly than out of kin placements. As a result, unsatisfactory kin placements continued for significantly longer than poor unrelated foster placements. There seemed to be two reasons for this. Some kin placements continued when social work monitoring was infrequent and when referrals about concerns (often from other family members) were disregarded. In other situations, social workers allowed standards in kinship care to fall considerably below those that would be accepted for other children, either feeling that they could not intervene readily in kin placements or thinking that, for children, being with family trumped other difficulties.” (Farmer, 2009: p.339)

Furthermore, whilst kinship carers were “much more likely than unrelated foster carers to be struggling to cope with the children in their care” they also demonstrated “high levels of commitment…to the children they were looking after.” (Farmer, 2009: p.339) Subsequently, “many more of the placements where kin were under strain were
continuing at follow-up.” (Farmer, 2009: p.339) Therefore, despite receiving less professional support;

“These findings suggest that kin carers persevered beyond the point at which unrelated carers conceded defeat, even when they were under considerable strain.” (Farmer, 2009: p.340)

Overall, this study found that whilst children in kinship care may do equally well as those in foster care and have “the important advantage that their placements last longer…the good outcomes for these children are sometimes achieved at the expense of the kin carers themselves.” (Farmer, 2009: p.340)

In a recent review of research studies which compare outcomes for children placed in kin and non-kin care, Brown and Sen (2014) consider how factors such as placement duration and quality impact on children’s emotional and behavioural development.

“When compared to non-kin placements, kin placements are longer lasting and this is linked to the fact children tend to have developed meaningful relationships with carers before being placed away from their parents. Although relationship quality with kin carers is better, children are more likely to experience problematic parental contact, receive poorer quality care and live in more adverse environments… However, despite the continuation of kin placements of poorer quality, when a wide range of emotional and behavioural outcomes are examined children placed with kin do as well, or better, than non-kin placed children. These divergent findings appear to be explained by the fact that placement stability, more commonly achieved through placement with kin, is found to have a direct positive effect on children’s outcomes and pre-existing relationships with carers prior to placement positively affects emotional and behavioural child development directly and indirectly.” (Brown and Sen, 2014: p.174)
Children’s Views

Two research studies (Aldgate and McIntosh, 2006 and Burgess et al., 2010) explored children’s experiences of kinship care in Scotland. I will explore their findings on five key areas: children’s understanding of their situation, the challenges of adapting to kinship care, the benefits of living in kinship care, family contact and school life.

In Aldgate and McIntosh’s study 30 children aged 8-16 were interviewed. 90% had moved to their kinship placement from their parents’ home, although some had previous episodes in residential or foster care. Children’s histories included neglect, physical abuse, parents with mental health problems and substance misuse. Most carers were grandparents in their fifties and over half were living on state benefits.

In the study by Burgess et al. 12 young people aged 11-17 were interviewed. This study was designed with a higher minimum age with the idea that “their relative maturity would mean that they were more able to reflect on their experiences during interview.” (Burgess et al., 2010: p.299) Most had also experienced “the effects of living with problematic substance misusing parents and for some physical and emotional abuse” (Burgess et al., 2010: p.299) and were now cared for by grandparents.

Children’s understanding of their situation

Aldgate and McIntosh found that at “least two thirds of the children…had a sense of why they had come to stay with their kin and why the placement was continuing” but “almost a third had no sense of personal history about the significant transition they had experienced, often at an early age”. (2006 p.40) This was identified as an unexpected finding and an issue of concern.

“Since many children were also in contact with their parents, the finding suggests that any lack of communication was omission on the part of the adults, possibly because they took it for granted children understood their circumstances precisely because they were living in their families.” (Aldgate and McIntosh, 2006: p.40)
It may also be useful to consider how unconscious defences may play a part in this finding. For example, how might an omission of this kind enable families to avoid confronting with each other and within themselves the painful experiences which have led to this situation? Carers may also worry that discussion about the past will result in children becoming upset, which could lead to unsettled behaviour that may be hard for them to manage. Equally, children may protect themselves from emotional pain, by not asking questions or allowing themselves to absorb information which they may have been told, as the accompanying memories of early experiences which could be stirred might feel too overwhelming to bear. Aldgate and McIntosh conclude “whatever the reason, the finding raises questions about the kind of support children may need in order to understand the legacies of their past.” (2006: p.40)

Children’s understanding of the future was also an important issue in grandparental care.

“Most of the young people felt secure with their carers and felt there was no uncertainty about their future there. Many of the young people, however, did express worries about their carers’ health, especially if the carers were older relatives….Some young people were aware of contingency plans, or at least, could think of alternative relative carers who would step in if current arrangements came to an end. Other young people admitted that they just preferred not to think about it.” (Burgess et al., 2010 p.302)

The challenges of adapting to kinship care

When asked about the challenges of learning to live in kinship care, some children spoke of finding it hard to adapt to a different household:

“Moving from a small to a large multigenerational household brought difficulties of noise, lack of privacy, overcrowding and having to share resources. Five children found themselves having to share with younger siblings or cousins or, in eight cases, with adults in the households. Although some shared a room with others in their parents’ homes, at least
six children experienced the loss of privacy of their own rooms, with consequent disrupted sleep patterns.” (Aldgate and McIntosh, 2006: p.41)

The issue of “having to accept a different style of parenting” (Aldgate and McIntosh, 2006: p.42) was also raised. Older children spoke of “a heightened ‘generation gap’” in which they felt “older carers did not understand their needs and could behave in an embarrassing way.” (Aldgate and McIntosh, 2006: p.42) In addition, older children spoke of “having to adapt to…stricter regimes…Coming in early at night was a major issue, as was being able to go out with friends.” (Aldgate and McIntosh, 2006: p.42) This was also an issue raised by the children interviewed by Burgess et al.:

“At least half of the young people had been living with parents who had issues with problematic alcohol or substance misuse, negatively affecting their care. Once living within the kinship home, young people were, in general, expected to conform to stricter, or at least clearer, rules and routines in relation to home, school and being out with friends.” (Burgess et al., 2010: p.301)

It is hard to know how much these complaints may also be an expression of more ordinary teenage feelings of not being understood and of wanting more independence. These desires may conflict with carer’s concerns based on their children’s experiences about where adolescent behaviour might lead.

Another challenge raised by the children in Aldgate and McIntosh’s study was of moving to an unfamiliar location. This could provoke feelings of fear, anxiety and frustration. This finding would not be specific to children in kinship care but also relevant to children in foster and residential care.

“That three children who had moved to inner city urban areas were sometimes frightened by commotions outside late at night, which left them feeling unsafe in a strange place…Conversely, four children who had moved to a more rural area complained that there was nothing to do or it was difficult to get to town to see their friends.” (Aldgate and McIntosh, 2006: p.42)
The benefits of living in kinship care

Aldgate and McIntosh (2006: p.43) found that “although there were some adjustments to be made” kinship homes were felt to offer a safe sanctuary away from the violence, drug and alcohol misuse which many children had been exposed to. Children valued “the stable routines carers offered them” and “the thrill of the new ‘ordinary’ environment. Taking delight in sleeping in bunk beds or watching television in bed were two examples.” (Aldgate and McIntosh 2006: p.43) Similar feelings were reported by Burgess et al:

“The majority had no wish to return to the care of their parents and felt that their lives had vastly improved as a result of the move. There were a small number of exceptions; one young person was still experiencing feelings of loss and sometimes wished to be back with her parent.” (2010: p.301)

The most important benefit was the relationship between children and their kinship carers:

“All the children in the study felt loved, although one or two continued to struggle emotionally with the legacy of their experiences of neglect.” (Aldgate and McIntosh, 2006: p.44)

The researchers concluded:

“The reciprocal, loving relationship that the majority of children in the study had with their carers was reflected in the fact that, when children were asked who they would turn to if they had a problem or were worried about something, 21 children said they would turn to their carer.” (Aldgate and McIntosh, 2006: p.45)

This sentiment was echoed by children in the other study, most of whom felt that “their kinship carer understood them very well, took time to talk to them about their feelings and that this helped them to feel that they were wanted.” (Burgess et al., 2010: p.302)
Unlike the children in Aldgate and McIntosh’s study who had to adjust to living in new areas, for many children interviewed by Burgess et al., their kinship home was in the same area as their parents. This was often an advantage as it helped children to maintain connections:

“Many of the young people had moved just a short distance to stay with new carers, some remain within the same town, the same street or even as close as next door. This appeared to have assisted them in making an easy transition to their new living situation. People and places around them were familiar and most had not had to change schools and had been able to retain their friends.” (Burgess et al., 2010: p.301)

Family Contact

The issue of most importance to children was to have more contact with their parents:

“Of the 22 children who had contact with their mothers, 16 wanted to see more of them; only six were happy with the arrangements.” (Aldgate and McIntosh, 2006: p.58)

Far fewer children had paternal contact: “Well over half the children never saw their fathers” and of the twelve who did, “eight wanted to see more of them” (Aldgate and McIntosh, 2006: p.65). Whilst those children who had some paternal contact often wanted more, only two of the sixteen children who had no contact with their fathers wanted to see them. One was a boy who had never met his father and “held in his mind an image of a father figure whom he idolised and wished to meet.” (Aldgate and McIntosh, 2006: p.58)

This difference between meeting an unknown figure, compared to spending time with a parent with whom there is an existing relationship, may say something about the importance of contact in helping children to mourn the loss of an idealised absent parental figure, who in phantasy they may imagine could rescue or protect them. From a Kleinian perspective, this could be understood as the importance of reality testing in helping children to relinquish a dependence on paranoid-schizoid defences and facilitate
a more depressive state of mind in which they are able to come to terms with the truth of their parents’ capacities and limitations. In Aldgate and McIntosh’s study, there were several examples of where children who had contact with their parents were grappling with the painful aspects of this reality. This was particularly the case in situations where children visited their parents at home.

“Several children were beginning to recognise the differences between the surroundings and behaviour within the kinship households and their parents’ circumstances and behaviour. Visiting parents heightened the contrast between the homes. For example, one child described their parental house as: *It’s a bit of a tip – quite depressing – bottles of drink, he chains-smokes and there is the mess of the cat.*” (Aldgate and McIntosh, 2006: p.68)

Coping with feelings of disappointment and frustration about the impact of parents’ difficulties on the quality of time together during contact was reported by some children:

“I am happy to see mum but it annoys me ’cos I tell her something and she then asks me the same question. I just lie on the bed as she’s always not feeling well.” (Aldgate and McIntosh, 2006: p.68)

Contact in the community could also present particular challenges:

“Some children were irritated at what they perceived as the bizarre behaviour of their parents, induced by mental health problems or substance misuse. Children were especially embarrassed by the strange behaviour of the parents in public places…*I sometimes feel embarrassed as she shouts and still drinks a lot.*” (Aldgate and McIntosh, 2006: p.68)

Both studies highlight ways in which the experience of parental contact may be different for children in kinship care, compared to children who are looked-after. For example, contact is more likely to be arranged in a less formal way without intervention or supervision by social care and held within the home environment or community rather than a contact centre.
“Contact mainly took place at the home of either the parent or the carer. In a few cases, contact took place at a neutral venue and, in three cases, contact was supervised in the social work department.” (Aldgate and McIntosh, 2006: p.72)

Burgess et al. found these differences seemed to be reflected in the children’s terminology:

“Only a small number of young people referred to seeing their parent by using the term ‘contact’. These were young people for whom this was arranged by the local authority.” (Burgess et al., 2010: p302)

While seeing parents in a home environment may enable children to have a more normalised experience of spending time together, having contact in the home without the support of contact supervisors could be a challenge for kinship carers to manage:

“Carers felt there was a risk factor if children saw mothers in their homes and sometimes found themselves in the role of parent, having to tell their son or daughter that they could not come and visit their child when they were under the influence of drugs. Two carers barred the door to parents whom they considered not to be in a fit state to see the children. These carers felt that children’s behaviour was adversely affected by contact with parents.” (Aldgate and McIntosh, 2006: p.67)

When parents did not come when expected this was also challenging for carers to cope with:

“She keeps phoning and saying she’ll come and take them out but she never appears. She keeps letting them down, so I’ve told her not to bother phoning if she is going to do that.” (Aldgate and McIntosh, 2006: p.67)

For some children whose kinship homes were in the same vicinity as their birth parents, this also brought with it the challenge of how to manage seeing them at unplanned times.
“Living in a small community all four young people were regularly seeing one or both parent in the street and had devised strategies for dealing with this or gave the impression, at least, of having learned how to cope.” (Burgess et al., 2010: p302)

Seeing that parents had moved on in their absence, making new relationships and building new families, was also highlighted as a complicated and painful aspect of parental contact.

“The kinship children found it upsetting to visit these new families and sometimes could not understand why they could not be part of the new family. Ewan likes to see them [new family] but he gets sad as he cannot stay.” (Aldgate and McIntosh, 2006: p.68)

The emotional impact on some children of managing these situations is captured by descriptions of deterioration in concentration, health and behaviour following contact visits:

“I have communications with the school because they see quite a big difference, her concentration becomes way down…. Chloe has flaky skin which is bought on by seeing her mum, although she is dying to see her… The school can always tell if Ian has seen his mum because his behaviour goes right down.” (Aldgate and McIntosh, 2006: p.67)

Very few children in this study lived with all their siblings. “Out of the 24 children who had siblings, only three were placed with all their siblings” however “20 of the 24 children who had siblings elsewhere were in contact with them.” (Aldgate and McIntosh, 2006: p.71)

Similarly, children in the other study (Burgess et al. 2010: p303) reported “ongoing contact with non-resident siblings” and “almost all had contact with extended family members, usually on the side of the family within which they were living.” Burgess et al. note that a “small number wished they could see more of family members from the other side of the family.” (2010: p.303)
School Life

The role of schools, not only in monitoring children’s behaviour but also in providing a place of safety and routine is highlighted by Aldgate and McIntosh: “Positive experiences at school can…act as protective factors against adversity and promote resilience.” (2006: p.48) The researchers cite Berridge (1997) who states:

“…there is some evidence that children becoming looked after in kinship care are less likely to change schools than children in foster care.” (Aldgate and McIntosh, 2006: p.48)

In this study, 10 out of 16 school-aged children had moved schools but “gave the impression that moving school was not a major issue.” (Aldgate and McIntosh, 2006: p.48) The researchers concluded this:

“…may well be a reflection of the fact that children had moved at a younger age, when they were able to re-establish themselves more easily in a new peer group.” (Aldgate and McIntosh, 2006: p.48)

With one exception, all children attended mainstream schools and “over half…thought they were getting on well or very well at school, while nine said they were doing OK.” (Aldgate and McIntosh, 2006: p.49) Achieving in school was important to most of the children:

“Twenty-five children said that they thought it was important to get good marks at school. Only two children said that it was not very important and the rest did not have a view. This was an important finding. It was encouraging that children felt positively motivated to achieve at school. Some children linked doing well at school with their aspirations for a career. Their ambitions included becoming lawyers, beauticians, care assistants, teachers, mechanics and social workers.” (Aldgate and McIntosh, 2006: p.50)
The role of kinship carers in supporting children’s sense of pride in their achievements was highlighted by Burgess et al.

“All the young people felt that they were encouraged by their kinship carers to go to school more regularly and to do well at school. In addition to giving young people the opportunity to take part in leisure interests and activities, which increased their confidence, kinship carers appeared to be instilling in young people a feeling of self-belief and supporting them in striving towards their aspirations and ambitions. Almost all the young people were able to identify career ambitions, many of which were professional in nature…” (2010: p.303)

Five children interviewed by Aldgate and McIntosh (2006: p.50) reported being bullied at school and several “drew attention to the playground politics of discrimination against those who were seen as different.”

“Kinship children, whose parents were ‘junkies’ or who had no parents, were obvious targets. In two cases, children had been moved to new schools to get away from the bullying. This included a child whose mother had died and who was bullied because of this.” (Aldgate and McIntosh, 2006: p.50)

Given these worries about being seen as different, how children dealt with others knowing about their situation was an important issue:

“It was clear children had thought about this issue. Children developed four main tactics: dismissing the issue; defending themselves through aggression or refusal to respond; telling a cover story or giving partial information about their circumstances.” (Aldgate and McIntosh, 2006: p.51)

The researchers conclude that “although many were coping well at school and having some positive experiences, they were conscious of being ‘a kinship care child’ and that this marked them out from many of their peers.” (Aldgate and McIntosh, 2006: p.52)
Burgess et al. reported similar findings in terms of how children managed the issue of peers knowing the reasons why they were in kinship care: “Some felt that it was their own business and others that it was just too complicated to go into.” (2010: p.301) However, in contrast to the children interviewed by Aldgate and McIntosh, in this study children did not convey the same concern about feeling different due to their living with grandparents:

“None of the young people who were interviewed reported that they felt different from their peers because they were living with extended family relatives rather than with a parent. Most were extremely matter of fact about their living situation and were not worried about not living within a ‘normal’ nuclear family. They took the view that living with grandparents or other relatives was just one of a range of different family compositions, such as living with a single parent or in a household that included aunts and uncles.” (Burgess et al. 2010: p.301)

2.3 Clinical Literature

Introduction

Within the fields of child psychiatry and clinical psychology, literature reflects on the complex mental health needs of children with a history of maltreatment (Street and Davies, 2002), (Golding, 2010), issues of diagnosis (DeJong, 2010) and CAMHS provision (Minnis and Del Priore, 2001), (Callaghan, 2003), (Vostanis, 2010). The only research which looks specifically at the experience of kinship families in accessing mental health services is a study by Addy and MacKechnie (2006).

In order to explore research which considers the relationship between kinship placements and children’s mental health, I have reviewed two overseas studies, one from Norway (Holtan et al., 2005) and one from the U.S. (Stacks and Partridge, 2011) which compare the emotional and behavioural needs of children in kin and non-kin foster placements.
Exploration of clinical interventions with kinship families has been predominantly by family psychotherapists using a systemic approach. Very few studies have been published by child psychotherapists on psychoanalytic treatment with children in kinship care.

**Mental health needs of children with a history of maltreatment**

Golding (2010: p.573) notes the increased propensity for children in care to be diagnosed with mental health difficulties:

> “Ten per cent of children and young people within the general population in the UK will be diagnosed with a mental disorder…Figures for children and young people living in care in England are much higher, approaching 50% for those living in foster care and rising to nearly 70% for those in residential care.”

Street and Davies (2002: p.66) consider the types of problems which looked-after children may struggle with:

> “Attachment problems…depression and anxiety, post-traumatic stress disorder… sexualised and other disruptive behaviours, all have a more frequent occurrence in this group of children. In addition to mental health problems there is also a higher risk of organic health problems…including asthma (poorly controlled), injuries, speech and language delay, developmental delay, more risk of infectious disease, more smoking and substance abuse, child sexual exploitation…and higher rates of teenage pregnancy. All of these may impact on emotional well-being in a variety of ways.”

Dejong (2010: p.593) reflects on the sorts of life experiences which may lead to the development of these difficulties:

> “our patients are subjected to a very particular kind of adversity that relates directly to the primary caregiving relationship, often occurs at a formative
time in their development, and is likely to have very important neurobiological consequences…This is frequently compounded by the more usual kinds of adversity seen across the spectrum of disorders: parental mental illness, socioeconomic disadvantage, drug and alcohol abuse and criminality. However it is also characterized by highly unusual psychosocial experiences, such as removal from the care of biological parents, placement with alternative carers, and often, sadly, placement with multiple carers over time.”

Given the multi-layered nature of these factors which may contribute to children’s mental health needs, Dejong highlights the necessity for CAMHS clinicians to give consideration to all aspects of children’s experiences when considering their difficulties:

“Formulations of presenting problems need to consider pre-natal influences and genetic vulnerability…early infant development and attachment relationships, care giving experiences both within the biologic family and in alternative placements, as well as a range of psychosocial stressors.” (2010: p.593)

Dejong concludes “complexity is therefore the hallmark of maltreated children” (2010: p.593) but raises concern this can result in problems with diagnosis when children do not reach the severe end of the spectrum for individual mental health disorders, but present with difficulties across a range of conditions. Dejong (2010: p.590) argues that this is equally concerning but diagnostically far less well understood and could result in children not receiving the treatment they need:

“There may be considerable functional impairment associated with a sub-threshold presentation, which is not given proper weight by the lack of a diagnosis. The problem is compounded by the fact that many of the psychiatric disorders that we see frequently in this population, such as Conduct Disorder, ADHD, PTSD, Depression and Anxiety are part of a co-morbid picture. It is often the case that a child may be sub-threshold on a number of different diagnoses; the resulting impairment is far greater than would be indicated by the diagnostic profile. If clinics are organized around
diagnosis there is a danger that these children may not reach the threshold for treatment; an opportunity to reduce impairment and prevent further escalation may be lost.”

Dejong also reflects on the frequent presentation of autistic symptoms within the looked-after population. She suggests this has not yet been sufficiently understood by psychiatric research, but notes the significance of the caregiving relationship in facilitating symptom reduction:

“Quasi-autism”…has atypical autistic features, including more flexibility in communication and a more marked, if abnormal, social approach, which in some cases resembles the disinhibited social behaviour seen in Reactive Attachment Disorder. There was found to be a trend for quasi-autistic symptoms to diminish over time with appropriate care in an adoptive placement, unlike the natural history of idiopathic autism. The possible relationship between autistic and attachment disorders remains unclear.” (DeJong, 2010: p.592)

**Service provision**

Dejong suggests that these issues of diagnosis can have a detrimental impact on the experiences of families using CAMH services:

“The constraints imposed by our current classification system, as applied to the maltreatment field, are not only a source of frustration for clinicians, they have an important impact on service provision. Too often Child and Adolescent Mental Health Services (CAMHS) are organized around diagnosis-led clinics, leading to fragmentation of service provision and dissatisfaction amongst users…Caregivers, whether looking after children in fostering, kinship care or adoptive placements sense that the difficulties the children experience are not adequately recognized and poorly described by the usual diagnoses, such as ADHD or conduct disorder. The treatment may be similarly narrowly focused. The experience of caregivers is therefore one of fragmentation and of being poorly understood.” (2010: p.596)
Callaghan et al. (2003) undertook focus groups with foster carers, social workers and residential staff to explore experiences of accessing CAMH services for children in care, with a view to informing the development of a specialist mental health service for looked-after children. Difficulties in accessing provision were widely reported. These included issues such as “long waiting lists” and “obscure referral criteria” (Callaghan, 2003: p.53).

“The likelihood of accessing services was regarded as being influenced not so much by young people’s actual mental health need, but rather by the incidental knowledge and skill of their individual social worker in ‘playing the system’ to get the referral picked up.” (Callaghan, 2003: p.53)

Another barrier to accessing help was due to children’s reservations about attending a mental health service:

“Young people in care have often had considerable experience of multiple health and social care agencies. As a result, they are often fairly ‘wise’ to the stigma that can be associated with these types of organisations. It is likely that the discourses of abnormality and damage which surround young people are combined with their reflexive constructions of the accounts of mental health services that they hear from other young people, and that these in turn influence their own experience of referrals.” (Callaghan, 2003: p.54)

Other key themes included; the need for agencies to work together more collaboratively, to find a shared language for understanding children’s difficulties, and for carers to receive guidance from CAMHS, including information on “how best to support a child in therapy” (Callaghan, 2003: p.56).

This research was limited to thinking about looked-after children and the needs of the adults who support them. However Vostanis (2010: p.556) highlights the importance of also considering the mental health needs of other vulnerable groups such as; children in kinship care, homeless young people and unaccompanied minors, so that “solutions to
children’s welfare and mental health needs…can encompass a wide range of high risk populations, without being limited by legal constructs.” He argues;

“Understanding where looked-after and other vulnerable children fit in a national welfare and health system, and why their needs are often not met, is a good baseline for policy and service planning.” (Vostanis, 2010: p.561)

CAMHS access for children in kinship care

Addy and MacKechnie (2006: p15) highlight concerns that children living in kinship care may not be receiving adequate mental health provision and note the lack of existing research in this area:

“Recent commentaries have raised concern that children receiving kinship care may have less access to mental health services than children in non-kinship care. Despite this recognition of poor access to services, there are at present no studies looking at the challenges involved in kinship foster carers approaching mental health services.”

Using semi-structured interviews with kinship carers, they seek to investigate this further in the hope that “this insight will provide information on how mental health services can support this underrepresented group.” (Addy and MacKechnie, 2006: p.15)

Out of 52 possible carers identified by social care and invited to participate in the study, only three agreed, all of whom were grandparents. The researchers concluded “this apparent lack of interest may in itself reflect the degree of detachment and suspicion surrounding mental health services”. (Addy and MacKechnie, 2006: p15) Analysis of interview transcripts produced four key themes:

“‘Lack of understanding by others outside the kinship family’, ‘Carer’s personal feelings about being a kinship carer’, ‘Relationship with professional services’ and ‘Ways to improve carers’ current access to mental health services’. (Addy and MacKechnie, 2006: pgs. 16-17).
Anxiety about grandchildren feeling different due to not living with their parents resulted in a worry they could be bullied by their peers.

“I think there is a kind of stigma when you’ve been in care and others know... people think there must be something wrong with you…” (Addy and MacKechnie, 2006: p.16)

Worry about stigma associated with the idea of something being wrong with the child, also entered into grandparents feeling more comfortable to access mental health services if they were located in a less clinical setting:

“…getting away from a hospital setting, it can be off putting and implies you are ill, community centres would be better.” (Addy and MacKechnie, 2006: p.17)

Suggestions for ways to reduce stigma around mental health included “running teaching courses in schools and things talking about problems and how psychologists can help” (Addy and MacKechnie, 2006: p.17).

As only carers were interviewed in this study, to what extent this anxiety about stigma reflected the children’s concerns or was a projection of adults’ worries about mental illness is not clear, however for one participant there seemed to be a wish not to have to consider the child’s needs as a mental health issue:

“I reckon it would be better if it was developed as a different sector outside the...I mean you could have psychiatrists and people there but it wouldn’t be as a psychological problem.” (Addy and MacKechnie, 2006: p.17)

Grandparents also expressed confusion about different services’ roles, a lack of knowledge as to what services offer and a lack of engagement between different agencies:

“I mean it’s like the social services/medical/education areas although they are like different things and they all help in their own way they are all very
separate in their, the way they do things.” (Addy and MacKechnie, 2006: p.17)

Ideas for ways to improve carers’ understanding of services included; providing them with leaflets advising where to go for help and training sessions where clinicians could “explain the different options and agencies and how you help with stuff” (Addy and MacKechnie, 2006: p17).

Mental health and kinship care

Street and Davies (2002: p.72) highlight how for looked-after children, the issue of family contact can have a significant impact on a child’s psychological state:

“History is also an ongoing process and as well as dealing with the continuity of the past to the present, issues from family activity can still be present, the most common affecting the emotional welfare of children being the nature and extent of contact with birth parents and other birth family members. Undoubtedly looked-after children can often develop serious mental health problems when this issue is not dealt with in a way that gives due attention to a child’s self-conception or likely developmental pathway. Indeed it may well be that questions around contact will be the most important preventive mental health issues for many children.”

As children living in kinship care with relatives maintain a close connection with family, does this suggest that kinship placements may help to protect against the development of mental health difficulties in children? Norwegian researchers (Holtan et al., 2005) explored this question by comparing data on children in kinship and non-relative foster care.

Using a diagnostic measure (Child Behaviour Checklist), 214 children aged 4-13 living in kinship or non-kin foster placements were rated by their carers on a range of scales to assess emotional and behavioural difficulties. These included;

In addition, areas of competence were scored across different areas of their life including social activities and school. Data was also gathered on children’s histories, relationships, contact and various aspects of their current placement including details of caregiver and any support services received. The results found that “children in kinship care had fewer emotional and behavioural problems…than the non-kin group.” (Holtan et al. 2005: p204)

“The kinship group scored significantly higher…than the non-kinship group on Total Competence and School Competence scales and lower on… Total Problems, Withdrawn Behaviour, Social Problems, Attention Problems and Delinquent Behaviour scales.” (Holtan et al. 2005: p202)

The researchers conclude that “non-kinship placement is associated with higher level of problems than kinship placement” and that this finding “is consistent with previous research.” (Holtan et al. 2005: p204) In order to explore reasons for this, results were considered in light of information gathered about the children’s lives and current placement. Like many U.K. studies, Holtan et al. (2005: p.202) found that kinship carers were more disadvantaged than foster carers: “kinship foster parents were older and had lower social demographic status in terms of their income and education and were more often a single-parent household.” In addition they “received fewer child welfare services and psychiatric, pedagogical and medical services.” (Holtan et al. 2005: p204) The researchers highlight that “this combination of low social status and limited provision of professional assistance may be regarded as risk factors for the mental health of children in kinship foster care.” (Holtan et al. 2005: p204) However four areas of advantage were identified for children in kinship care:

“The kinship children had fewer previous out-of-home placements…more often had a foster home within their local community, had more contact with
biological parents and had parents who had less frequently appealed against the placement decision.” (Holtan et al. 2005: p202)

The researchers suggest that these continuity factors may help to protect the mental health of children living in kinship care:

“Studies have emphasized that one of the elements of well-being that is hardest to provide for children separated from their parents is to give them a sense of personal and cultural identity… Children in kinship care are placed within a social class and culture familiar to them. Living with relatives may reinforce the sense of identity and self-esteem that flows from knowing family history and culture, and may be one explanation for the lower association with psychiatric problems in the kinship placement group. Children in kinship placements may also be less stigmatized by peers… Stability and more frequent contacts with biological parents may compensate for the risk factors associated with the lower socio-economic status of kinship foster parents and lower rates of provision of professional assistance in kinship placements.” (Holtan et al. 2005: p204)

Identified limitations of this study include the fact that kinship carers often had less training and experience of fostering than the non-kin carers which may lessen “awareness of behavioural and clinical problems of the child, and may affect the scoring of the CBCL.” (Holtan et al. 2005: p206) Additionally, it was possible that the “non-kinship foster children were more traumatized on entry into foster care than the kinship foster children” (Holtan et al. 2005: p206), which they suggest requires further research.

A more recent U.S. study (Stacks and Partridge, 2011) investigates this question by focusing on the mental and emotional needs of infants placed with carers before their first birthday. Researchers investigate differences between kinship and non-kin foster placements in meeting the developmental needs of infants who have been removed from birth parents due to abuse or neglect. The focus of this research on the first year of life reflects concern in America about high numbers of infants and young children entering the care system.
“In 2008, just under ½ million children were in foster care, and 23% of all children entering care were under 2 years of age… Infants are overrepresented in the child welfare system. Compared to older children and teens, they are the most likely to be maltreated, the most likely to enter foster care, the least likely to be reunified with their parents and they spend the longest amount of time in foster care.” (Stacks and Partridge, 2011: p.489)

In this study, 457 infants from across 97 counties were included in the research. All were placed either in foster or kinship care within their first year. A range of tools were used to evaluate “initial developmental status, caregiving environments and length of stay in out-of-home care.” (Stacks and Partridge, 2011: p.500) Measures included “observation, direct assessment, and parent report” (Stacks and Partridge, 2011: p.493)

To gain a picture of the infant’s developmental status at time of placement, a range of areas were examined including; neurological functioning, cognitive processes, and socioemotional development assessed through semi-structured interviews with caregivers:

“How does the child react when a spoon of food is presented to him?… What kind of help do you give the child while he is drinking from a cup?...What does child do if his pants get wet or soiled?” (Stacks and Partridge, 2011: p.494)

Temperament was evaluated using scales to assess the infant’s responses to different situations:

“Activity (eager to explore in an environment outside the home, sit still in a car seat or stroller, how often the child plays quiet games), Fearfulness (afraid of strangers, child upset when you leave the room), Affect (smile or laugh during play), Friendliness (trouble soothing the child when upset, how often the child cries and fusses), and Attention (plays alone for 10 min or longer, becomes restless when watching television).” (Stacks and Partridge, 2011: p.494)
Interviews were also used to assess placements in terms of neighbourhood environment and caregivers’ capacity to provide infants with emotional support and stimulation. Questions included: “the number of times the child gets out of the house”, “how often the child is read to” and issues such as “spanking; physical affection; and telling the child that you love or appreciate him or her.” (Stacks and Partridge, 2011: p.495)

The researchers found that in terms of health and initial developmental status, “infants placed in kinship placements tend to have fewer risk factors” for example, “children in foster care were more likely to have required an extended stay in a NICU than were children in kin care.” (Stacks and Partridge, 2011: p.495) Children in foster care also “displayed significantly poorer scores on the expressive functions…and cognitive processes” which they suggest means “they are at higher risk for delay in motor development and neurocognitive development.” (Stacks and Partridge, 2011: p.496)

Analysis of temperament similarly revealed that infants in foster care had “more difficult temperaments, indicating more emotional reactivity and poorer emotion regulatory processes.” (Stacks and Partridge, 2011: p.496) These results were considered to be:

“consistent with other research that has demonstrated that children with greater socioemotional, cognitive, or health risk factors are placed in foster care at a higher rate than they are placed into kinship care.” (Stacks and Partridge, 2011: p.501)

The researchers suggest a possible explanation for this finding:

“the biological parents of infants who experienced more serious abuse were estranged from their own family for various reasons or that their family members were not deemed appropriate to care for infants; that is, these infants may be from higher risk families and maybe more difficult to care for.” (Stacks and Partridge, 2011: p.501)

Stacks and Partridge consider how the use of carer reports to assess children could have influenced their findings: “there may be differences between foster and kinship
caregivers’ in their ability to observe children or their expectations of typical development.” (2011: p.501)

Assessment of the caregiving environment and capacity of carers to support infants’ developmental needs, showed that “children in foster care were more likely to have a safe play environment” and were “in moderately more positive situations.” (Stacks and Partridge, 2011: p.498)

“52% percent of the foster care homes had at least ten books visible during the home observation compared to only 42% percent of kinship care homes…foster caregivers were more likely to read stories to the infants than were kinship caregivers…and reported the television being on less during the day than did kinship caregivers.” (Stacks and Partridge, 2011: p.499)

Analysis of caregiver parenting style and emotional capacity found:

“41% of kinship care respondents were observed to scold and criticize the infant, and 39% were either annoyed by or hostile to the infant during the home observation, compared to 32 and 30%, respectively, of foster parents displaying those behaviours.” (Stacks and Partridge, 2011: p.498)

Comparison of neighbourhood environments revealed;

“There were rather stark differences between the two placement types. Kinship caregivers reported that social disorder was significantly more problematic, as indexed by the number of assaults…presence of gang activity…and perceived neighbourhood safety.” (Stacks and Partridge, 2011: p.499)

The researchers raise concern about these findings and highlight that “environments in which maltreated infants and toddlers are placed are critical to their development.” (Stacks and Partridge, 2011: p.502) They also emphasise how responsive and sensitive caregiving is essential in helping children to build secure attachments and develop their
own capacity to regulate and express their emotions, which will help to reduce the likelihood of their turning to disruptive behaviour. The researchers conclude:

“Our findings with regard to the quality of foster and kinship homes suggest that foster homes provide a higher quality home environment than does kin care...These findings indicate that kinship caregivers are more likely to be single, less educated, and live in neighbourhoods characterized as unsafe...Stress associated with poverty and being a single parent while caring for a high-needs infant might impact a caregiver’s ability to attend to a child’s needs...and to provide a child with a cognitively stimulating and emotionally supportive home environment.” (Stacks and Partridge, 2011: p.502)

**Clinical Interventions**

In the U.S., Poehlmann *et al.* (2008) use story stem assessments to explore children’s representations of family relationships, in families where children are living with custodial grandparents often as a consequence of maternal incarceration. The study identifies links between grandparental depression and an increased likelihood of children including relationship violence in their portrayal of family relationships. In Israel, Lander’s (2011) case study describes the use of ‘Child-in-Family Therapy’ (CIFT) with a ten-year-old boy in grandparental care, experiencing severe behavioural difficulties after the traumatic loss of both parents at aged three due to political violence in the Middle East. The study highlights the “complexities of kinship care when caregivers are experiencing a parallel process of recovering from traumatic loss.” (Lander, 2011: p.275)

In the U.K., very little has been written exploring the practice and efficacy of different clinical interventions with kinship children and families. A few notable exceptions are; Granville and Antrobus’ (2006) description of running a Webster-Stratton parenting course for adoptive, foster and kinship carers, Barratt and Granville’s (2006) reflection on several years’ systemic work with kinship families within a Fostering, Adoption and Kinship Care CAMHS Team, and Ziminski’s (2007) research into systemic practice
with kinship families, in which she explores the types of dilemmas kinship families may struggle with.

In Ziminski’s study, video-taped therapy sessions with six kinship families in the middle stages of treatment are analysed using a discourse analysis to “examine the interactions and interrelationships of the therapy participants.” (2007: p.440) Ziminski’s interest is how meaning is constructed interpersonally, rather than focusing on intra-psychic processes.

> “the emphasis thus shifts away from the ‘inner world’ of the individual and towards a theory of social communication, with a person’s identity theorized not as a unified, consistent self, but rather as a multiplicity of selves, experienced through the positions he or she takes up in conversation.” (Ziminski, 2007: p.441)

Through her analysis of conversations in therapy sessions, Ziminski (2007: p.440) describes how this “provided an opportunity to hear the child’s voice alongside that of the carer”, see how different individuals in the family are positioned and identify key areas of conflict and confusion which they are struggling to reconcile. Her study highlights four key areas of tension between feelings of autonomy/authority, choice/responsibility, loss/entitlement and family belonging/identity. Examples of these include; the conflict created by an adolescent seeking independence at the same time as a carer is “struggling to establish authority…in a newly constructed kinship care family”, or how a carer can manage to “keep child and parent apart in order to safeguard the child, and yet also to acknowledge the importance of the child’s connection to the parent.” (Ziminski, 2007: p445)

Ziminski describes how for kinship families struggling with these sorts of dilemmas, the exploration of them in therapy could be “a step on the path towards the creation of coherent stories that provided individual family members with an ongoing sense of themselves and their family.” (2007: p.451)
The work of helping carers to enable children to have a realistic narrative of the family experiences which have resulted in their coming into kinship care is also highlighted by Barratt and Granville (2006: p.179):

“We try to enable carers to find a way to value aspects of the children’s relationship (sometimes idealized by the child) with the birth parent. This can be a difficult position to take, as carers are often very critical of the children’s care at the hands of the parents. Due to the past history of family relationships and complex web of loyalties, it is often hard for carers to help children construct a coherent account of their lived experience. Our position and work as “outsiders” provides the opportunity to work with different subsystems in the family in order to allow family members to give voice to their distress and concerns. These are then more able to be brought back into the conversations of the family sessions.”

Child Psychotherapy and Kinship Care

Psychoanalytic work with deprived children

Over the last forty years, much has been written about psychoanalytic work with deprived and traumatised children (Henry, 1974), (Boston and Szur, 1983), (Alvarez, 1992), (Canham, 2004). Lanyando (2000: p. 278) describes how the psychoanalytic approach has developed over time to take more into account the external worlds of the very vulnerable young children that are increasingly being treated in CAMHS settings:

“the psychoanalytic treatment of traumatisation children from the 1920s through to the 1970s emphasised the ‘internal world’ of the child, and what the trauma has meant to the child as influenced by his fantasies...it was rare at this time, to have a child referred for treatment because of sexual abuse or incest, or to work with a child who was known to come from a family in which generations of incestuous relationships were clearly established. In the 1990’s, this is sadly no longer the case.....During the 1980s adult sexual interferences with children became recognised as being much more widespread than had previously been thought probable....[this] stimulated
debate and a great deal of anxious soul searching within the Child and Family Mental Health services, where the verifiable external reality of actual sexual trauma had to be recognised, *in addition* to the internal reality of sexual fantasy. In the 1990s, services for the victims of trauma recognise the importance of fully acknowledging the reality of the traumatic events…as well as the internal world significance of the trauma.”

In response to these changes in patient population, new specialist areas of learning and clinical practice have developed, with more publications exploring the particular challenges and themes which emerge in psychoanalytic work with children in care, such as Canham’s (1999) exploration of distortions in children’s perception of time, Kenrick’s (2000) reflections on the impact on children of multiple placement moves, and Rustin’s (2001) investigation into the technical dilemmas and possibilities presented by once weekly work with looked-after children.

Literature on psychoanalytic work with children who have been adopted has also been a key area of development, notably; Rustin’s (1999) exploration of the internal worlds of children who have lived in multiple families, Bartram’s (2003) reflections on the prevalence of oedipal problems in psychotherapy with adopted children, and Fagan’s (2011) consideration of the mental challenges encountered by children who are adopted at a later age.

Other psychotherapists (Sprince, 2001), (Emanuel, 2002), (Rocco-Briggs, 2008) have focused their attention on the importance of providing reflective work with the professional networks around children who are removed from their parents’ care, which can be profoundly disturbed by the impact of the difficulties of the children whom they are responsible for looking after.

Alongside this, some clinicians (Emanuel 2004), (Music, 2009) have reflected on the ways in which developments in related fields such as developmental psychology and neuroscience can complement psychoanalytic formulations with an understanding of the physiological impact of states of terror and fear. The cross-fertilization of these ideas has resulted in the development of new constructions for clinical technique, in particular
Alvarez’s (2012) book ‘The Thinking Heart’ in which three levels of interpretation are conceptualized for psychoanalytic work with disturbed children.

**Child psychotherapy and kinship care**

Despite many children in kinship care and their families being seen by child psychotherapists, there is an absence of psychoanalytic literature on work with children in kinship care, which considers the impact of their particular experience of being separated from birth parents but remaining within their wider family network, with all the complexity which this brings.

Within the Journal of Child Psychotherapy there are no papers which (by title, abstract or keywords) are identifiably on kinship care. A hand search of the last twelve years of the journal (2005-2017), revealed three papers containing clinical case studies on psychoanalytic psychotherapy with children in the care of extended family members. Firstly, Strati’s (2010) paper entitled ‘Peek-a-boo. How can you be there?’ in which she reflects upon her intensive work with a little girl living with her maternal grandmother, following the murder of her maternal grandfather by her mother. Secondly, Franchi’s (2013) paper entitled ‘Thinking lest we be forced to remember’ in which Franchi describes the psychoanalytic treatment of a boy adopted by maternal grandparents along with his brother, following the murder of their mother by their father. Lastly, a paper by Bronstein (2014) entitled ‘I am not crying. I am rubbing my eyes’ in which the author explores her clinical work with a child who at approximately two years of age was taken into the care of her maternal aunt due to mother’s schizophrenic illness. These each provide thought provoking and emotive accounts of work with children who have experienced familial trauma. However, the focus of these papers is on the impact of past experiences on the child’s internal world and issues of clinical technique when working with traumatised children, as such little consideration is given to the current context of the child living in kinship care.

A recent child psychotherapy doctoral research study (Meehan, 2016) provides a further contribution to psychoanalytic thinking about clinical technique in work with traumatised children. Meehan uses grounded theory to analyse the first year of the intensive (three times weekly) treatment of an eight-year old girl living in kinship foster
care with her aunt and uncle in Northern Ireland. The child and her three brothers were placed in kinship care due to suffering neglect as a consequence of their parents’ mental health difficulties. The three youngest siblings were placed with their aunt and uncle and the eldest boy with his grandparents. Drawing on the findings of Nandy and Selwyn (2011), Meehan notes that in Northern Ireland, “while kinship care had increased in the last ten years, this region has the lowest rates compared to other UK nations” and that “unlike the rest of the UK, most children in kinship care in Northern Ireland are living with a sibling rather than with grandparents.” (Meehan, 2016: p.6)

This child was referred for psychotherapy by her social worker due to her need for constant attention and eruptions of rage when her aunt gave attention to her own children. Once their children were accommodated, the parents separated and the child’s contact with them terminated, due to father’s neglect of her health needs and mother’s “uncontained emotional states of distress” (Meehan, 2016: p.57) having a detrimental impact on her daughter during contact. Further familial trauma was subsequently revealed by the child who disclosed ongoing sexual abuse by one of her brothers. He denied these allegations, but was subsequently moved to live with his grandparents who “did not believe that the sexual abuse had happened.” (Meehan, 2016: p.57) Social care ceased contact between the siblings and Meehan notes the impact of this situation on family dynamics: “This disbelief created a divide between Lucy’s aunt and grandparents and contact between them was strained and infrequent.” (Meehan, 2016: p.57) When the child’s behaviour became increasingly violent, particularly towards her aunt following the removal of her brother, the kinship placement broke down and she was placed in a children’s home for two years whilst continuing intensive treatment. This situation seemed to provide a shocking example of the levels of disturbance which kinship families maybe managing, and in this case went beyond what could be contained within the family network at this time.

The aim of Meehan’s study is to explore “what facilitated recovery, reparation and developmental growth” (Meehan, 2016: p.2) in the child. Therefore much of her focus is on exploring the relationship between child and therapist and on the nature of transference interpretations. However attention is also given to the importance of parallel work with the carer and professional network:
“Findings from this study highlight the crucial need for parallel work with parents and/or the network of carers involved with the child undertaking intensive treatment.” (Meehan, 2016: p161)

This work involved regular network meetings attended by the aunt and residential staff, which helped “to contain the aunt's tendency to feel guilt and shame about her niece’s violence towards her” and enabled the possibility of thinking about “whether the child's violence towards her aunt derived from the child's unconscious experience of her aunt as a bad maternal object.” (Meehan, 2016: p.60) In her reflections on the suitability of a family placement for children like Lucy “whose internal worlds are extremely disturbed as a result of severe deprivation” Meehan (2016: p.160) concludes:

“The findings from this study significantly show that the intensity of family life was too much for Lucy and that she responded well to being placed in a residential setting for a two year period, while she continued to make developmental progress in psychoanalytic treatment. Although the breakdown of her kinship placement was distressing for all in the network and especially for Lucy and her kinship family, there also seemed a collective hope and even belief that the move was ultimately a positive one. No one in the network could foresee just how positive the move would prove to be, in that Lucy and her aunt gradually reclaimed their relationship during the two years Lucy lived in residential care, until her eventual and permanent return to her kinship family, where she remained.”

The only publication in which psychoanalytic work with children in kinship care and their families is the primary focus of the paper, is Music and Crehan’s (2014) chapter entitled ‘A psychoanalytic child psychotherapy approach to working with kinship care’ contained within a multi-disciplinary book. In his introduction, the editor (Pitcher, 2014: p.25) reflects:

“Much has been written about psychodynamic theory and its insights remain foundational. However, little has been written that links these insights to the complex world of kinship care.”
In their chapter, Music and Crehan illustrate how “psychoanalytic and developmental thinking can be applied in kinship care cases” (2014: p.90). This is undertaken through the presentation of a case study of a nine-year-old boy living in informal kinship care with his grandmother, following exposure to maternal substance abuse, domestic violence, suspected prostitution and paternal absence. The child was referred to their specialist CAMHS team by his social worker, who, like the social worker in Meehan’s study, was concerned about the child’s aggressive behaviour in school and need for constant attention. Music and Crehan note their observation of the propensity for splitting and blame between the adults involved in the child’s care and the importance of gathering the views of all involved parties in order to create a stable foundation for clinical work. This echoes Meehan’s finding of the importance of working with the network around the kinship child:

“…in complex cases any of us may become drawn into identifying with different emotions, feelings or positions represented within the case. For example, we may feel angry with the birth mother, or upset with a judgemental attitude from the school, or frustrated with the wariness of kinship carers. We may feel indignant that a social worker should do more, or maybe we would identify excessively with the child’s plight and his or her bad experiences. Such different perspectives somehow need to be contained and held together. When they are not, we often see different bits of the network at loggerheads.” (Music and Crehan, 2014: p.91)

In this case, the CAMHS assessment consisted of a series of individual meetings with the carer, joint meetings with the carer and social worker, a school observation and assessment of the child for individual psychotherapy. This resulted in the formulation of a treatment plan offering weekly therapy sessions for the child alongside regular work with the kinship carer and professional network. Music and Crehan (2014: p.93) consider the key issues which emerged in each strand of this work. In the therapy with Toby, key themes included; his “fear that we was unlovable” as “his mother had chosen drugs over him”, the “feelings of self-hate and self-blame” which he subsequently carried inside him and at times “projected angrily onto others, such as peers or teachers”, and his fearfulness of “feeling hope” as this would involve some emotional risk and “trust in his own capacities”.

81
Music and Crehan explore the psychological mechanisms Toby used to protect himself from contact with these more “vulnerable aspects of his personality” (2014: p.93). In particular his use of projective identification (Klein, 1946), such that his “experiences of feeling frightened and denigrated were frequently projected onto the therapist” who needed to “communicate gently an understanding of what is happening, both verbally and non-verbally” (Music and Crehan, 2014: p.93) so his feelings could gradually become thought about.

In work with the kinship carer and meetings with the professional network, key issues included: the grandmother’s initial feelings of “fear and suspicion” (Music and Crehan, 2014: p.91) about meeting with therapists, following her own past experiences of therapy which resulted in social services being alerted to her husband’s drinking and violence; differing views between the grandmother and social worker who wanted her to consider applying for a special guardianship order, which she felt would be a “betrayal of her daughter” (Music and Crehan, 2014: p.92), and the unconscious opportunities for emotional reparation which may have contributed to the grandmother’s motivation to become a kinship carer:

“In some ways, Julie’s willingness to care for Toby and her wish to be a loving grandmother was a reparative act that at an unconscious level may have been redressing the inadequacies of the parenting she received and the parenting she had been able to give.” (Music and Crehan, 2014: p.94)

In their conclusion, Music and Crehan reflect on ways in which a psychoanalytic approach to clinical work can be of help to kinship families, and highlight how for both children and carers, coming to terms with their reality as a kinship family will require engaging with feelings of loss:

“we have tried to portray how psychoanalytic understanding can contribute to therapeutic work in kinship care cases. We have described how bearing difficult to manage feelings, and facing warded off thoughts can lead to psychic integration, greater sense of ease and less likelihood of acting out…We continue to pay great attention to defensive processes and aim, in a compassionate way, to help clients find ways of facing those issues which
they defend against. Freud (1917) also wrote much on processes of mourning and much of the important internal work clients do is to mourn for what they have lost or never had. In Toby’s case this included facing and mourning the reality of what his mother was not capable of giving him, and in Julia’s case it included facing up to what she had not given her own daughter and also what she had not received from her own parents.” (2014: p94)

**Working in schools**

In their paper “From scapegoating to thinking and finding a home”, Music and Hall (2008: p.43) describe how changes in government policy have “necessitated a move towards delivering therapeutic work in community settings such as schools.”

“A central driver of the new policy has been the idea that all clinicians need to move out of their traditional clinics into the communities where people live and work, and of course, where teachers teach and pupils study. The aim is to intervene both effectively and early, and also to reach out and offer help to populations who have hitherto not managed to access clinic-based services. Whilst the traditional tier 3 clinics remain at the heart of CAMHS work, there is an increasing emphasis on delivering services in accessible local settings, and this is a challenge to which child psychotherapists have risen in many areas. Nonetheless, trying to define both who we are and what we do in these new contexts is complex and demanding.” (Music and Hall, 2008: p.46)

Music and Hall highlight the range of interventions child psychotherapists can offer in addition to individual therapy sessions, including; “detailed observations of children, work with whole families, with parents or with staff and networks, and we can also run therapeutic groups.” (2008: p.50) They also reflect on the benefits of working in an educational setting from where it may be possible to provide an intervention to families who would not attend a clinic and particular challenges clinicians may be confronted with when providing individual and group support within schools:
“Being a therapist in a school setting means managing complexities that we rarely encounter in clinics…For this reason there are good grounds for sending out our most experienced clinicians to work in such community settings, as it is not the case that such community work is in early interventions with less complex cases. In fact often it is the most complex cases (the cases that professionals are most desperate about) who might never make it to a clinic, which are referred in schools.” (Music and Hall, 2008: p.49)

Other interesting and varied contributions to the literature on working within educational settings, include Jackson’s (2008) paper on setting up work discussion groups for teaching staff, McLoughlin’s (2010) description of work in a pupil referral unit in which she notes that a traditional fifty-minute session is impossible “not only because the external environment is bound to be unpredictable, but also because the children’s states of mind are often too disturbed to be able to tolerate such a setting” (McCloughlin, 2010: p.235), and Argent’s (2015) poignant reflection on “child psychotherapeutic work with a primary school class facing the terminal illness of a classmate” (Argent, 2015: p.131). In all these papers, authors highlight the importance of clinicians being able to draw on internal resources gained from “a long and rigorous training”, “our analyses” and “our learning from supervisors, tutors and colleagues” (Argent, 2015: p140) when working in environments where external resources may be challenged:

“The containing framework in such settings only reveals itself in the therapist’s clear, calm and receptive attitude, rather than a reliance on a stable and consistent external setting.” (McCloughlin, 2010: p.235)
CHAPTER 3
Research Methods

3.1 Research Design

My initial idea was to identify children living in kinship care who had received treatment through the TOPS service at their school and examine clinical session notes written by the children’s therapists. It was hoped that examination of these using a method of data analysis such as Applied Thematic Analysis (Guest, MacQueen and Namey, 2011) would help to illuminate common themes or areas of difference between the therapy of different children living in kinship care. This would also be a way to investigate the sorts of themes which might be present in the children’s treatment, without needing to involve the actual children in my research.

However I had some concern as to whether there would be a sufficient amount of detail in these process notes to explore the area of enquiry which I was interested in, which was specifically about the experiences of children in kinship care as opposed to a child living in a foster or adoptive home. Given that children in all of these situations would likely have experienced neglect and/or abuse in their early lives, resulting in separation from their parents, how could examination of themes within therapy sessions of children in kinship care illuminate understanding of their particular experience, as opposed to more general ideas about the impact of early relational trauma? How could the particularity and complexity of a child remaining within their extended family network be captured?

In discussion with my teachers, it was proposed a solution might be to conduct interviews with the TOPS clinicians, rather than look at their process notes. This would help to focus my data collection on the areas of experience which I was particularly interested in. In consultation with the TOPS manager about the possibility of interviewing TOPS therapists, this idea was developed further; I could also interview the teacher at the school who referred the child for therapy and the child’s kinship carer. This would enable me to gain a better understanding from the teacher of the types of difficulties which the child was presenting in school, as well as ascertaining from the
carer whether they shared the school’s concerns. Interviewing the carer would also enable me to gather the carer’s perspective of the child’s experience of being in kinship care and of receiving therapy through the TOPS service.

Conducting interviews with three significant adults connected to a child, all of whom played a part in enabling the child to receive therapeutic treatment, it would be possible to explore the child’s experience from three different perspectives, known as triangulation. Cohen and Manion (2000: p.254) highlight the value of triangulation in qualitative research, describing it as an "attempt to map out, or explain more fully, the richness and complexity of human behaviour by studying it from more than one standpoint."

As a consequence of this decision to use interviews as my method of data collection, I decided a more appropriate method of analysis would be Interpretative Phenomenological Analysis, a methodology which is particularly well-suited to qualitative studies which gather data through semi-structured interviews:

“In terms of devising a data collection method, IPA is best suited to one which will invite participants to offer a rich, detailed, first person account of their experiences. In-depth interviews and diaries may be the best means of accessing such accounts.” (Smith, 2008: p.56)

**Interpretative Phenomenological Analysis (IPA)**

IPA is an approach to qualitative research which developed in the mid-1990’s (Smith, Flowers and Larking, 2009: p.4) and is informed by three main areas of philosophical study: phenomenology, hermeneutics and idiography.

Phenomenology is the study of human experience and considers how people perceive and reflect on their experiences. IPA draws on the ideas of key theorists in this field such as Husserl (1927), Heidegger (1962/1927), Merleau-Ponty (1962) and Sartre (1956/1943):
“...through the work of all of these writers, we have come to see that the complex understanding of ‘experience’ invokes a lived process, an unfurling of perspectives and meanings, which are unique to the person’s embodied and situated relationship to the world.” (Smith, Flowers and Larkin, 2009: p.21)

IPA is a phenomenological approach in that it is “concerned with an individual’s personal perception or account of an object or event, as opposed to an attempt to produce an objective statement of the object or event itself.” (Smith, 2008: p.53) The aim of the IPA researcher is to “explore in detail how participants are making sense of their personal and social world”. (Smith, 2008: p.53)

In order to understand how people make sense of their experiences and what meaning an event might hold for a particular individual, IPA draws on hermeneutics, the study of interpretation (originally of biblical texts), and in particular on the work of Schleiermacher (1998), Heidegger (1962/1927) and Gadamer (1990/1960). Smith, Flowers and Larkin (2009) highlight how the work of these theorists raises important questions which are integral to the interpretative aspect of IPA, about the relationship between the ideas of the researcher who is conducting the data analysis and the perceptions of the participant which are being explored.

“Although the primary concern of IPA is the lived experience of the participant and the meaning which the participant makes of this lived experience, the end result is always an account of how the analyst thinks the participant is thinking – this is the double hermeneutic… Thus the truth claims of an IPA analysis are always tentative and analysis is subjective.” (Smith, Flowers and Larkin, 2009: p.80)

Due to this subjectivity, they emphasise how it is important to ensure that data analysis is “systematic and rigorous in its applications and the results of it are available for the reader to check subsequently.” (Smith, Flowers and Larkin, 2009: p.80) In this respect, IPA draws on idiography, which focuses on understanding details which are specific and unique. Smith, Flowers and Larkin (2009: p.29) suggest that IPA is rooted in idiographic principles in two main ways; firstly, within its intention to understand
experience from the perspective of “particular people, in a particular context” and secondly, in the level of detail and depth of the data analysis which “must be thorough and systematic”. Therefore in order to capture the specificity, IPA studies typically consist of “small, purposively-selected and carefully-situated samples” (Smith, Flowers and Larkin, 2009: p.29). This fit well with my aim of exploring the particular experience of children living in kinship care, which would be different to those living in foster, residential or adoptive homes.

Smith, Flowers and Larkin also draw attention to the usefulness of triangulation in which investigation of “one phenomenon from multiple perspectives can help the IPA analyst to develop a more detailed and multifaceted account of that phenomenon.” (2009: p.52) This also resonated with my study design, in which the three adults connected to a child would each be asked to give their perspective of his/her experiences.

Sample Size

My sample size was largely decided upon for practical reasons, taking into account recommendations for student studies using IPA:

"Our current thinking is that, for students doing IPA for the first time, three is an extremely useful number for the sample. This allows sufficient in depth engagement with each individual case but also allows a detailed examination of similarity and difference, convergence and divergence. The danger for the newcomer is that if the sample size is too large they become overwhelmed by the vast amount of data generated by a qualitative study and are not able to produce a sufficiently penetrating analysis." (Smith, 2008: p.57)

I decided my project would focus on the experiences of three children living in kinship care (three cases) and I would interview three adults connected to key areas of each child’s life: home, school and therapy. This would not only help to provide a rounded view of each child’s experiences, but also enable me to explore differences and similarities between the feelings and perspectives of the three kinship carers, teachers and therapists alongside thinking about the experiences of the three children. At this
time the manager of the TOPS service was aware of four children in kinship care who had received therapy through the TOPS service and so this did not seem an unrealistic recruitment aim.

**Ethical Considerations**

In the process of formulating my study design, it was refined several times in consultation with my teachers and supervisors at the Tavistock Clinic, in response to recommendations by three separate Boards (within the Tavistock Centre and University of East London) who considered and then accepted my final doctoral research proposal. I then needed to apply for ethical approval from both the National Research Ethics Committee (through IRAS) and the NHS (through Noclor).

Preparing these applications ensured I considered carefully how best to design my study in a way which would be able to explore the areas which I was interested to research, whilst also considering how I could minimise any potential ethical difficulties. This led me to make the following decisions:

1) **Selection Criteria**
   I would only recruit participants connected to children whose therapeutic treatment had ended, to ensure my research would not interfere in any respect with a child’s therapy.

2) **Data Collection**
   Only broad statistical data would be collected from TOPS files to provide context, such as age, ethnicity and gender of the child, and relationship to carer e.g. grandparent.

3) **Participants**
   No children would be involved directly in my research. I would only have direct contact with connected adults to learn about their perception of the children's feelings and experiences.

4) **Confidentiality**
   All identifying details would be anonymised. However due to the nature of the study in investigating personal feelings and experiences related to kinship care, participants
would be made aware that some details which are important to understanding their experiences, such as the child's age, ethnicity, family structure and background would be included.

5) Recruitment
Participants would be recruited in liaison with the TOPS service based in the children's schools, so this provided a familiar and supportive structure around the participants, both in terms of recruitment and follow up of any post-research concerns or feelings for which they need support.

Participants and research setting

Participants

In order to ensure participants connected to each of the three children would be able to engage in a research project which gathers data through the use of interviews, the following inclusion and exclusion criteria were defined:

Inclusion criteria:
1. Participants must be adults.
2. They must be connected personally or professionally with a child in kinship care who received therapy through the TOPS project.
3. They must speak English to a level possible for them to communicate their feelings and experiences in an interview.
4. They must be able to understand the purpose of the research and be willing to talk about their feelings and experiences.

Exclusion criteria:
1. If the child they are connected to is still in therapeutic treatment.
2. If they cannot verbally express themselves sufficiently in English.
3. If they cannot travel to the child's school or Tavistock Centre to participate in the research.
Research Setting

In order to help participants feel able to share their personal feelings and experiences with me, it was important to ensure the interviews could take place in a quiet and safe space where we would not be interrupted. A therapy room felt an ideal location for this meeting. I therefore planned interviews could either be held in a therapy room at the Tavistock Clinic or at the child’s school in the room used for therapy sessions by the TOPS service. The choice of setting would depend on which was a more convenient location for the participant and I would reimburse any travel costs by public transport.

Data collection

I planned that the interviews would be conducted with one participant at a time, on one occasion and last for approximately one hour. This felt it would be enough time to hear about the views and experiences of each participant, without overwhelming them with too many questions, or myself with too much data. My supervisor recommended I conduct a trial interview with a colleague to test out my interview questions and how much data they would generate.

We agreed my interviews would be semi-structured. This would ensure I asked questions about the areas of experience which I was interested to explore, whilst also giving space for each participate to share their individual experiences and perspectives, as described by Smith (2008: p.59):

“The investigator has an idea of the area of interest and some questions to pursue. At the same time, there is a wish to try to enter, as far as possible, the psychological and social world of the respondent. Therefore, the respondent shares more closely in the direction the interview takes, and the respondent can introduce an issue the investigator had not thought of. In this relationship, the respondents can be perceived as the experiential expert on the subject and should therefore be allowed maximum opportunity to tell their own story.”
I devised the following six broad questions for all participants which outlined the areas of research I wanted to explore:

1) Could you give me a brief history as to how it came to be that this child came to live with you/their carer?
2) Can you tell me something about your impression of this child’s experiences of growing up in kinship care?
3) Can you explain what the difficulties were which led to this child being referred for therapy?
4) What feelings did you/the child/the carer have about the referral?
5) What were the main themes of the treatment? (‘treatment’ includes child’s therapy, work with carer and review meetings)
6) What do you think were the main changes during treatment and after? (e.g. for the carer, for the child, in school, at home etc)

All interviews would be recorded using a Dictaphone in order to aid accurate data collection. Interview data on audio files would then be translated into written electronic manuscripts with the aid of Dragon software.

Confidentiality

As part of my application for ethical approval it was important to consider how I would ensure that participants were aware of how information which they shared with me would be kept confidential. Participant Information Sheets were designed (Appendix A) to explain to participants what their participation in the research would involve and how data would be accessed, stored and disposed of. In particular, that audio files would be destroyed after completion of the project, electronic manuscripts would be anonymised and any contextual data gathered from TOPS files would not include any identifiable data on patients or their families e.g. names or contact details. Therefore it was agreed with the TOPS manager that any correspondence which I needed to send by post to participants would be sent through the TOPS service administrator at the Tavistock Centre. A consent form was also designed for participants to sign if they agreed to take part in the research (Appendix B).
3.2 Research Protocol

Completing my application for approval from the Research Ethics Committee (REC) helped me to make sure I thought through in detail the processes through which cases would be identified and participants recruited and supported to take part in the research. Although this was an independent doctoral study, it was conducted with the support of the TOPS service and this support was essential in order to identify cases, recruit participants and offer follow-up support. The clinical judgement of the TOPS manager and Lead Therapists was also highly valued and taking account of their clinical view about the suitability of families to be approached to take part in the research was built into the research protocol (Appendix C).

Identification of Research Subjects

To identify potential cases for my research, it was agreed that the TOPS manager in consultation with the Lead Clinicians at each of the five schools, would provide me with the number of children living in kinship care who had been seen by the project in the last academic year and whose treatment had now ended. The following statistical data on these cases would be gathered: age, gender and ethnicity of child, relationship to kinship carer, year the child was seen by the service and name of TOPS therapist. If three cases were not identified, the search would be widened to include the previous academic year(s).

Inclusion Process

With each case identified which met my selection criteria, the TOPS manager would give consideration as to any clinical reasons why it would not be appropriate for any of these cases to be included in my study. For example, we discussed in principle that if a family had several children, although the treatment of the child seen by TOPS may have concluded, there could be siblings who had been referred to the Tavistock Clinic whose treatment was ongoing. It would then need to be considered whether my interviewing the kinship carer could potentially have any impact on the therapy of other children who were looked after by the same carer.
Once it was agreed that a case was suitable for my research, I would then need to check that the kinship carer, therapist and teacher who referred the child for therapy all met my participant inclusion criteria. If they did, then I could proceed to the recruitment stage.

Recruitment of participants

My recruitment process was divided into 5 stages: 1) initial contact, 2) arranging introductory meeting, 3) introductory meeting, 4) interview and 5) follow-up.

1) Initial contact

Kinship carers:

I decided that the first contact made with kinship carers should be through the Lead Therapist who was already known by the family. This initial contact would be to inform them of the research and see whether they would be interested to meet with me to hear more. Carers would be assured that if they did not want to be involved, this would have no impact on their potential to access further support from TOPS in the future, nor would it affect relationships with their child’s school.

Therapists:

The Lead Therapist would also make the first contact with the therapist who treated the child and would be well known to them through their work in the same service. The Lead Therapist would inform them of the project and see whether they would be interested to meet with me to hear more. The therapist would be made aware that the TOPS manager permits their discussion of case material gathered through work for the service, but this did not mean they were expected to participate and if they chose not to this would not have any negative impact on their employment in the service, nor their relationship to the Lead Therapist or other colleagues.
School:

The Lead Therapist would initially approach the Head Teacher of the school attended by the child. This would be to explain the nature of the research and what the participation of the teacher (usually the Special Educational Needs Co-ordinator) would involve. The Head would be made aware that a decision not to permit the SENCO to participate in the research would not affect the relationship between the TOPS project and the school. If the Head teacher gave verbal consent, the Lead Therapist would then have an initial discussion directly with the SENCO who referred the child for therapy, to inform them of the research and see if they would be interested to meet with me to hear more. The SENCO would be informed that the Head had given permission for them to discuss their perceptions of the child and their kinship carer in a semi-structured interview, but there was no obligation for the SENCO to participate. If they chose not to, this would not affect their relationship with either the Head of their school, nor the TOPS clinicians working there.

2) Arranging introductory meeting

If participants were interested to meet with me, the Lead Therapist would facilitate arranging a time for us to meet and give them an Information Sheet to read in advance of our meeting.

3) Introductory meeting

Individual introductory meetings with participants would take place at the child’s school. The aim of this meeting would be for me to explain more about the nature and purpose of the research and discuss details contained in the Information Sheet to make sure they understood what their participation would involve.

If participants decided at this meeting that they were happy to proceed, they would be given a consent form to sign (Appendix B) and a date for the interview would be scheduled. If they wished to have further time to consider their decision I would arrange to contact them a week later. If they then decided to proceed, a date for the interview would be arranged and the consent form could be signed when we next met,
before the interview commenced. If consent was not given by one or more of the kinship carers, a smaller project could continue without this data, with consideration given as to the reasons for their decision not to participate.

4) Interview

The interviews would be conducted individually, either in a designated therapy room at the child's school or in a therapy room at the Tavistock Clinic.

5) Follow-up

After the interviews, an optional debrief meeting would be offered with the Lead Therapist who had been involved in the initial stages of recruitment. This was to ensure that participants had support for any personal feelings which had been stirred through the interview process which they would like to talk through with a qualified therapist in confidence. It was not expected this would be needed for the SENCO or therapist, as the interviews would be a discussion of their work and therefore they would likely already had opportunities for case discussion/supervision within the organisational structures of the TOPS service/school. However this was a pertinent concern for the kinship carers who would be discussing personal experiences.

Once all the interviews were completed, I would write to all participants to thank them for taking part and provide some feedback on my findings. An individual follow-up meeting with me would be offered should they wish to talk over their participation in the research, address any questions or concerns they might have, or if they wished for some feedback from me in person. Participants would also be advised that a copy of the final thesis would be held by the TOPS Manager whom they could contact should they wish to see a copy.
3.3 Research Process

Ethical approval

In my application for ethical approval, the REC raised concern that I needed to make sure participants did not give consent to take part in the research before taking sufficient time (at least 24 hours) to read the Information Sheet and think about it carefully. Therefore this section of my Information Sheets was amended to include the following paragraphs:

You will have been given this information sheet by the Lead Therapist from the TOPS project who is based at your child’s school. If you would be happy to take part, please contact her using the details provided below to let her know you are interested and she will arrange for us to meet at the school.

It is important that all participants take at least 24 hours to consider participating in the study. A week after you have been given this sheet, if she has not heard from you, the Lead Therapist will give you a courtesy call to see if you have had a chance to consider taking part or if you have any queries you would like to discuss with her.

The REC also requested that in addition to the offer of a debrief meeting with the Lead Therapist, kinship carers also needed to be provided with details of an external agency through which they could receive emotional support in the event of distress. The TOPS manager advised me of a free local counselling service for carers of children attending schools within the borough. I made contact with the co-ordinator of this service who agreed they could help and sent me leaflets giving details of their service which I could give to carers after the interview (Appendix D). Leaflets were also distributed to the Lead Therapists to retain should additional copies later be required.

Lastly, it was recommended I make some revisions to my Information Sheet and Consent Form (Appendix E). Once these changes were made, ethical approval was granted by both the REC and NHS (Appendix F and G respectively).
Recruitment Process

Meeting with TOPS team

Once the project had received ethical approval, I met with the TOPS Manager and Lead Therapists from each of the five participating primary schools to inform them of my project and enlist their support in identifying possible cases at each of their schools. By this time, one of the participating primary schools had left the TOPS service and a new school had joined.

In order to prepare for this meeting, I made an Information Pack (Appendix H) to give to each of the Lead Therapists containing details of the study which they could keep for reference when contacting potential participants. Packs also included Participant Information Sheets which they could give out and copies of the Parent and Carer Counselling Service leaflet. I found making these packs a worthwhile task, as it helped me to ensure I had all the stages of the recruitment process clear in my mind.

Initial responses

When I met with the team I received a range of responses. One voiced worry about having the time/capacity to take on any extra work and what my research would require, another expressed interest in the subject of the research, and there was also concern raised that in some cases carers might feel suspicious of professionals and this could hinder their wish to get involved. I encouraged that therapists could highlight the importance for carers of having an opportunity to have their views and feelings heard.

All of these reactions felt important in considering the sorts of feelings which research can generate and required further reflection. For example, I noticed that the clinician who responded in the most interested way was the only one who had worked there when I was an honorary therapist in the service. Although we did not know each other well, she had known me over several years and this made me wonder whether this link had been important in how she responded to hearing about the project. If so, this seemed to lend weight to the idea that participants are recruited by the Lead Therapist
who knows the family, as this personal link might help participants to be open to hearing about what the project involves.

The idea that a professional wanting to meet with a carer could give rise to feelings of suspicion was also important to consider. TOPS clinicians had experience of working with families who’d had involvement with social care, and for whom the idea of a professional wanting to ask them questions could be associated with an assessment of their parenting capacity, rather than an interest in their views and experiences. This may well have been the case with many ‘hard to reach’ families who would not have attended a clinic-based service to meet with unknown professionals, but were able to be engaged by the TOPS service within the ‘safety’ and familiarity of the school setting. However given that any carer I recruited would have been seen by a TOPS clinician who could introduce me as a colleague, rather than an unknown professional, this didn’t seem to fully capture the therapists’ concerns. Was it possible that these feelings of suspicion about what questions might be asked and what could be seen might also reflect the therapists’ feelings of discomfort about being involved in clinical research?

**Implementation of protocol**

In our meeting we had a discussion about how Lead Therapists would make the initial contact with carers to inform them of the research and what they would say. We agreed it would be different for each case depending on the relationship between each particular carer and therapist e.g. how well they knew each other/how long they had worked together. However I raised my concern that if the initial contact was via a telephone call and the information sheet sent by post, this may be less likely to lead to participation, than if they spoke with the carer in person and gave them the sheet, as this would be a more personal and supportive approach.

**Interview questions**

We discussed my preliminary interview questions. The therapists suggested I needed a gentler opening question to put the participant at ease, rather than starting with their family history. It was also suggested I consider having separate questions for the carers,
therapists and teachers. This was useful feedback which helped me to revise my questions.

Identifying cases

I was surprised at this meeting to find that most of the Lead Therapists could not think of any children living in kinship care who had been seen by the TOPS service in their primary school. I was informed that there were three kinship children currently receiving therapy (2014-15), however as their treatment was ongoing they did not meet my selection criteria at this time. The therapists suggested that if I could wait for six months until the end of the academic year when the treatment of two of these children was expected to finish, they would then meet my criteria. None of the clinicians could recall any kinship children seen for treatment in the previous academic year.

It was not clear whether this initial finding reflected low numbers of children living in kinship care within these primary schools, or whether these children had just not been seen by the service. If they had not, this raised interesting questions as to why this was. Had they not displayed significant enough difficulties in school to result in a referral for treatment? Did this indicate a positive finding that children in kinship care were managing well enough? Or was it the opposite, that kinship families had instead been referred to the Tavistock Clinic as their difficulties were considered too complex to be held within an outreach service? In discussion with the TOPS manager, I understood that this could be the case for some families where there was ongoing social work involvement and a high level of complexity such that the case needed to be held within a multidisciplinary team which had the capacity to work with the professional network around a child. However there were still many families where a high level of complexity was held by the TOPS service including those with social care involvement so this would need more exploration.

As a result of this initial finding, I requested if the TOPS team could provide me with details (age, gender, ethnicity, school, relationship to carer, type of intervention) of any kinship children who they could recall receiving therapeutic support from their service since 2010 (so that my data covered the last five years). Information was collected from clinician recollection, therefore it was useful as a basis for recruitment, but details
would need to be gathered in a more systematic way if used as statistical data for a quantitative study. Part of the difficulty of collecting this data was that it was not a statistic which the project collected routinely. Therefore in order to check for accuracy of clinician recollection, all patient files within the service would have to be checked by hand, as case files during this timeframe were not stored electronically. This was beyond the scope of my research and ethical consent. However, as a result of this initial finding that very few children in kinship care were being seen by the service, the TOPS manager suggested they would raise awareness of this with the schools, in order to make sure that these children were not being overlooked in the referral process.

From clinician recollection and annual reports which detailed the numbers of families seen each year by the service, I was able to compile the following statistics. These provide a general picture of how many families were seen and how many of these were children in kinship families. However as the details of kinship children were calculated by academic year (September-July) and the overall service data by financial year (April-March) this meant that the numbers would only be comparable at certain times of the year when the data would overlap.

In total, twelve children (two children are counted in two separate years) living in kinship care received support from the TOPS service over the previous five years:

<table>
<thead>
<tr>
<th>Year</th>
<th>Total number of TOPS open cases</th>
<th>Number of kinship children seen</th>
<th>Approx. % of kinship cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010-2011</td>
<td>54</td>
<td>6</td>
<td>11%</td>
</tr>
<tr>
<td>2011-2012</td>
<td>107</td>
<td>3</td>
<td>3%</td>
</tr>
<tr>
<td>2012-2013</td>
<td>95</td>
<td>1</td>
<td>1%</td>
</tr>
<tr>
<td>2013-2014</td>
<td>93</td>
<td>1</td>
<td>1%</td>
</tr>
<tr>
<td>2014-2015</td>
<td>105</td>
<td>3</td>
<td>3%</td>
</tr>
</tbody>
</table>

[Figure 1: Percentage of kinship cases seen by TOPS per year]

Of these twelve children, ten were seen individually, eight for therapeutic treatment and two for assessment only. Both of the children seen just for an assessment then transferred to the Tavistock Clinic for treatment (one for family work and the other due to moving to a new school outside of the TOPS service). Four out of the twelve
children attended group therapy sessions, two of whom then went on to receive individual therapy in a subsequent year. Of the twelve children, five were male and seven female, nine were in grandparental care (details of the carers for the remaining three children were not available) and one had a significant health condition.

Recruitment

Out of the eight children who were seen for therapeutic treatment, I was only able to recruit the following participants for one case:

**Kinship Carer:**

The child had received treatment which had ended a few years before and now left the primary school, however his carer was still connected to the TOPS project as she had a younger kinship child still in primary school now receiving individual therapy. As a result, she was having regular meetings with the Lead Therapist. I discussed with the TOPS manager (who also happened to be the Lead Therapist on this case) whether this would be suitable for my research as there was a younger child in the family still in treatment. The manager was confident from her knowledge of the family that carer participation would not have a negative impact on the treatment of the younger sibling and therefore was fine for me to recruit. The Lead Therapist informed the carer of my project and set up an introductory meeting for us at the school where she introduced us in person. The grandmother subsequently agreed to participate in the research and was happy for me to also approach the SENCO and therapist.

**SENCO:**

The Lead Therapist advised me that the SENCO was now working at a local secondary school. However she returned to the primary school one day a week, so they still had contact and she would be able to inform her of my research. After their initial conversation, a follow-up email was sent by the Lead Therapist giving the SENCO my contact details and an information sheet. The SENCO agreed to meet with me and we arranged to have an introductory meeting at the secondary school where she now worked.
Therapist:

The child’s therapist no longer worked for the TOPS service and so was initially contacted by the Lead Therapist via email and sent an information sheet. She agreed to have an introductory meeting with me to hear more which we arranged would take place at the Tavistock Clinic.

Factors affecting recruitment

Different factors affected the recruitment of the other seven cases:

1) Recollection

The therapists of two children who received individual therapy a few years before raised concern that the sessions were a long time ago and it would be hard to remember the details. One of these therapists also reported that the carer of the child had not engaged with the service at the time and therefore would be unlikely to participate in the research or recall the work in an interview.

2) Change of circumstances

One therapist was on long term sick leave and the work had taken place at a school which was no longer part of the TOPS service.

3) Reluctance

Another child had now left the primary school and so no longer had any contact with the TOPS service. Therefore the child’s grandmother was initially approached via a telephone call from the Lead Therapist who had worked with her in the past. I was advised she was happy to meet with me to hear more about the research and it was arranged we would meet at the secondary school which her child now attended. I made four attempts to meet with her on days/times which were convenient for her over a three month period. However although we spoke on the telephone to arrange these meetings,
none were attended. As a result, this case was not pursued further. As this was the carer of a child with a significant health condition, it is possible she might have felt overburdened and reluctant to take on any further commitments on her time. However as she had not declined outrightly, I wondered whether the feelings of suspicion which had been raised by the Lead Therapists, could also have played a part in the difficulty of recruiting this carer.

4) Open cases

As a result of my difficulties with recruitment, I decided to see if I could amend my initial criteria, to include cases where therapy was ongoing, in situations where the therapist was confident that participation in my research would not have a negative impact on the treatment that the child was receiving. This was considered a minor amendment by the ethics committee and as such was able to be agreed by Noclir with the approval of my University Sponsor. This enabled consideration of the three cases currently being seen in 2014-15. As one of these children was the sibling of the case I had managed to recruit, this was not a suitable case, as it would mean that two of the three cases explored in the research would be from the same kinship home and school.

5) Child Protection concerns

Of the remaining two open cases, one carer was approached and had agreed to meet with me to hear more about the research, when child protection concerns were raised and Children’s Services became involved. As a consequence it was not considered a suitable case for my research at this time. The Lead Therapist of the remaining open case was just about to approach the carer to tell her about my study when child protection concerns were also raised on this case. As a result, it was also not considered suitable for my research at this time. Once these child protection concerns had been investigated and social care closed the case, the Lead Therapist asked if I would like to try again with this case, however by this time it was far outside my timescales for recruiting and interviewing participants.
6) Lack of kinship children seen

The TOPS manager suggested that in order to try to identify any further cases, I make enquiries with therapists who were based at a nursery which was attached to one of the TOPS primary schools. However the therapists at this nursery also could not recall seeing any children who were living in kinship care.

Reflecting on this recruitment process, it was interesting to notice that in the one case I was able to recruit, there was an ongoing link between the kinship carer and the TOPS service due to her younger kinship child now being seen. It is possible that this current link with the service may have contributed to her willingness to meet with me, in contrast to the other grandmother I spoke with who no longer had any contact with the Lead Therapist. This was an interesting initial finding that this ongoing link may have been valuable in supporting my research rather than considering this a reason not to recruit out of a worry about impacting on the child’s therapy.

Revision of Interview Questions

New interview questions were created for each type of participant and revised several times in consultation with my supervisor (Appendix I). Questions were divided between areas which were applicable to all three e.g. why the referral was made to TOPS and their view of the effectiveness of the treatment, and questions which were specific to their particular experience in their role as a SENCO, kinship carer or therapist. For example; perceptions of kinship care within the school (SENCO), how family relationships had changed as a consequence of becoming a kinship carer (carer) and themes which emerged in the treatment (therapist).

Consideration was given to how to start the interview with the kinship carer and how to ask about family history. I decided that it in order to help the carer feel at ease, it would be best to start with talking about the current situation i.e. what it was like being a kinship carer, including both the positive aspects and challenges. I would then go back to asking about the past and why the child had come into kinship care, which I anticipated might be a more sensitive area as it would relate to difficulties within the family. Therefore this question was designed in a very open way:
“Thinking about why (child) came to live with you, what would be the important things for me to understand?” (Kinship Carer interview question: no. 12)

At the end of the interviews, all participants would be given the opportunity in the final question to tell me about any other issues which they felt we had not sufficiently covered in the interview.

I then presented my final version of the Therapist and SENCO interview questions to the former manager of TOPS for her perspective on the questions for these professionals. She queried whether attitudes towards children being in kinship care may differ for children from different countries and cultures. This led to the formulation of a more specific question on how pupils’ ideas about children living in different sorts of families may be shaped by cultural differences:

“In what ways, if any, do you think that the cultural and ethnic backgrounds of the children who attend your school shapes/affects this? (SENCO interview question, no.10)

In this meeting it was also suggested that as the therapy may have taken place some years before, it would be a good idea for therapists to review their session notes on TOPS files in advance of the interview. This gave me the idea that it may be helpful to give each of the participants in the introductory meeting, a list of general areas of enquiry which we would be covering in the interview so they had time to think a little about them in advance (Appendix J).

**Pilot interview**

A pilot interview was conducted with a colleague who had many years’ experience of working with kinship families as a social worker/family therapist. In this trial, I asked her the interview questions for the kinship carer, which she responded to in the role of a carer, keeping a grandmother that she had worked with in mind so answers were based on real experience. I found my questions generated a lot of relevant material, some of which was quite moving to listen to. This raised an interesting question for me about
how to conduct a semi-structured interview as a clinical researcher. For example, when
the responses I received described events which had been quite painful for the
participant, how much could I respond as I would in a clinical role by giving space to
acknowledging the feelings generated by an emotional experience and when should I
move on to the next question so that I remained on task in the role of a researcher? The
feedback I received from my colleague after the interview confirmed that she felt I had
maintained an appropriate balance of these two aspects, in that she felt that the
emotionality of her experiences was received by me within an interview setting.

**Introductory meetings**

I had expected the introductory meetings would be largely focused on practical
concerns. That they would consist of a discussion about the purpose of the research and
be an opportunity to talk through the details contained within the information sheet and
consent form to make sure it was clear what participation would involve. Also that I
would give the participants an Interview Areas sheet which outlined the areas I would
be asking them about in the interview, so they had an idea of what to expect if they
agreed to take part.

In reality, I found that the introductory meetings consisted of far more personal
discussions than I had expected to occur at this stage. This generated material which I
had not anticipated, thereby making it harder to draw a clear distinction between my
research process and findings. Details of the findings from these introductory meetings
are presented in Chapter 4.

In the introductory meetings, all participants confirmed they would be able to travel to
the Tavistock Clinic for the interview.

**Interviews and Transcription**

All the interviews lasted approximately one and a quarter hours which was a little
longer than I had expected. I found that all participants really engaged with the
questions and I felt very appreciative of their time and generosity in sharing with me
their feelings, views and experiences. I got the sense in the interview with the carer that
she was happy to talk about the child’s experiences and his relationship to her and his mother, but there were other areas of family experience which were not available for our discussion, and it felt important to be respectful of these boundaries.

Once all the interviews had been completed, the recordings were transcribed into manuscripts with all names removed. Using Dragon software, the audio data could be converted into electronic text in a Microsoft Word document. However in order to enable accurate transcription, I found the interviews needed to firstly be re-recorded in my own voice which I had programmed the software to recognise. Following this, significant adjustments to the text and layout were needed to capture the interview format and therefore it was not clear how much time this saved compared to typing the interviews myself. It seemed likely that with more use and experience of the software this would improve the accuracy of the transcription and less time making adjustments would be required.

Follow-up

Following the interview, the carer opened up more about her own story, describing tragic losses and a lack of openness and transparency within her family system which created the potential for further ongoing confusion and uncertainty. As these details were revealed after the recorded interview was finished and related to her own experiences, not those of the child, this was not information which I had consent to include in my study. In many ways this was a shame as with many kinship families, there were striking aspects of intergenerational repetition which it would have been helpful to consider as a means to explore the complexity of kinship care and unconscious mechanisms through which experiences may be passed down through generations.

Following the interview, I gave the carer details of the free parent and carer counselling service which she had not been aware of and was interested to receive. In a follow-up discussion with the Lead Therapist, I understood she already had sessions arranged with the carer and so her offering a debrief meeting was not required.
On completion of my research I wrote to the participants to share my findings and thank them for taking part. An optional follow-up meeting was offered should they wish to receive further details of my research.

3.4 Data Analysis

IPA: Process

Smith, Flowers and Larkin (2009:p.79) highlight that there is not a “prescribed single ‘method’” for conducting data analysis using IPA but rather the approach is “characterized by a set of common processes”. They suggest these include “moving from the particular to the shared, and from the descriptive to the interpretative” (Smith, Flowers and Larkin, 2009: p.79). In order to offer guidance to those undertaking IPA for the first time, they outline a framework with six key steps for analysis:

1) Reading and re-reading, 2) Initial noting, 3) Developing emergent themes, 4) Searching for connections across emergent themes, 5) Moving to the next case and 6) Looking for patterns across cases (Smith, Flowers and Larkin, 2009: pgs.82-103)

The aim of the first step is for the researcher to familiarise themselves with the data by reading over it several times. It is recommended that the analyst’s initial ideas and responses to the material are noted and set aside. This ensures the analyst’s thoughts and feelings are available for later consideration but do not obstruct their task of focusing on understanding the participant’s experience. This step seemed to be much like the psychoanalytic task of taking note of countertransference responses whilst remaining receptive to hearing what the patient is saying.

In the second step, the data is engaged with in close detail, with exploratory comments written in the right hand margin against each line of the interview transcript. It is suggested that the text is considered from the following three perspectives:

“Descriptive comments focused on describing the content of what the participant has said, the subject of the talk within the transcript. Linguistic comments focused upon exploring the specific use of language by the
participant. Conceptual comments focused on engaging at a more interrogative and conceptual level.” (Smith, Flowers and Larkin, 2009: p.84)

In the third step of the analysis, these exploratory notes are summarised into short statements to create emergent themes which are recorded in the left hand margin of the transcript. In the fourth stage, these themes are then gathered together with the aim of exploring any links and commonalities between them. Where groups of related themes develop, these groups are given a title known as a super-ordinate theme. These super-ordinate themes may be new titles which are constructed to describe the material contained within the group, or could be the name of one of the original themes which now comes to represent all of the themes within the group.

Once all these steps have been undertaken with one interview transcript, they are then repeated with data from the next case. Once data from each case has been examined, the final step of the process involves looking at the relationship between the data from each of the cases to explore the relationships between them.
CHAPTER 4
Findings

4.1 Introductory Meetings

Kinship Carer

My first introductory meeting was with the carer. I found her to be quite happy to talk and willing to participate in the research. In addition to discussing the practicalities of when the interview would take place and details in the consent form, she shared information about her experience of being a kinship carer, the sorts of issues which affected her grandchildren and described the moment she realised her daughter was using drugs. She mentioned how alone she used to feel until joining a carer’s group and meeting others in her situation. This made me wonder whether the research appealed to this aspect of her experience, giving her an opportunity to share her story in the hope that it would help other people to be more aware of the challenges which kinship families can face. She also gave me a picture of how her grandson was doing, now that he was in secondary school, and her recent exploration of what further support she could get for him. She mentioned it would have been helpful to have a follow-up appointment with TOPS six months after his therapy ended to discuss how he was getting on, which sounded useful service user feedback.

Details about her family history were also shared voluntarily. This involved some reflection on ancestry and intergenerational experiences of relocating to a different country which connected with thoughts about difference and identity. From her descriptions, her own history seemed to have involved some painful experiences of loss, separation and confusion/secrecy related to her parents such that when confronted with family truths as a young adolescent (the same age her grandson was now) her experience was one of shock. Without help for these experiences to be metabolised, this seemed to have manifested in psychosomatic conditions which originated at this time of her life and continued to trouble her.
A key issue which came up in the introductory meeting with the therapist was the question of recollection. This fitted with concerns that some Lead Therapists had raised about it being difficult to recall details of therapy sessions which had taken place a few years before. This therapist suggested this was particularly difficult in this case due to the fact that the child did not behave in a way which caused him or particular sessions to stand out. Before our meeting, she had already looked over her clinical notes to remind herself of details of the treatment and mentioned several key themes in the work which were subsequently discussed more fully in the interview. Many of these later appeared as prominent themes in my findings such as ‘a good enough carer/therapist’, ‘lost babies’, ‘keeping a low profile’ and the child’s keenness for individual time.

In thinking about this child, the therapist raised her recollection of his grandmother having some health issues and this was connected to thoughts about fragility. This led to a general conversation about some of the challenges of children being brought up by older caregivers and questions about availability of younger family members such as aunts/uncles becoming kinship carers. This was an interesting point given that all the kinship carers I had details of for children seen by the TOPS service were grandparents.

In this initial meeting, we also discussed the question of professional development, particularly since many therapists in TOPS were in honorary posts, developing clinical experience prior to undertaking a full clinical training. In the years since working with TOPS, this therapist had gone on to gain clinical experience of working with parents of children in care, which she felt had helped to further her understanding of working with families where parents and children had been separated. She wondered if she had this experience at the time of treating this child in what ways she might have thought about things or responded differently? This raised an interesting consideration for the interview; would she be responding to questions about this case with the knowledge she had at the time or informed by further experience and understanding which she had gained since? In many ways this question seemed linked to the fact that I was exploring a case where treatment had occurred a few years before. The therapist also raised the point that increased insight and understanding was also often accompanied by more contact with the depths of a patient’s pain, and the importance of there being places e.g.
work discussion groups, where therapists could reflect on the emotional impact on the worker. I thought this issue of support and supervision was important, particularly for therapists working with complex patient populations who were not on/yet had a clinical training in which their own psychoanalysis was compulsory.

**SENCO**

The SENCO was an extremely experienced teacher who had worked at the primary school for over a decade and seemed to have a very comprehensive knowledge of the school population which totalled over 300 children. She reported there had been very few children in kinship care within the school over the years, but also highlighted that this was not a statistic which the school was required to collect, as they were with children looked after by the local authority - unless there was ongoing social work involvement with the family. She expressed that she was pleased I was doing this study as she felt it was an under-researched area and her experience was that kinship carers were not in receipt of sufficient support.

Recalling her involvement with this kinship family, it became apparent how important her presence was in the school as a regular point of contact over many years and that this stability, familiarity and knowledge of the children’s history provided an important containing function to the grandmother.

**4.2 IPA: Results**

As details given in the introductory meetings (as outlined above) were shared outside the main interviews, this material was not included in my data analysis. However much of what was shared in these initial meetings was subsequently repeated and elaborated on within the actual interviews and so was then included within the analysis of my interview data.

From the interview data gathered, I decided to exclude from my analysis the introductory parts of the interviews with the two professionals, which gave the context of their work but did not relate specifically to the child, such as the role of the SENCO in the school and details of the therapeutic setting.
As a new researcher, I decided to follow the six steps of data analysis proposed by Smith, Flowers and Larkin (2009) to guide me through the process.

**Step 1: Reading and re-reading**

Reading over the interview with the SENCO, the importance of her role in creating a link between school, home and therapy was particularly striking to me, as well as the level of knowledge she held about the child and his family circumstances. In the kinship carer’s interview, the complexity of her role and responsibilities as a grandparental carer and her proactive approach to seeking appropriate support for her grandson stood out to me. From the interview with the therapist, I found myself thinking about the clinical challenge of how to work with the child’s internal world whilst keeping in mind the ongoing challenges experienced in their external world.

**Step 2: Initial noting**

In order to identify the three types of comments (descriptive, linguistic and conceptual) contained within the dialogue, I used different colours to highlight each of these elements. In the SENCO’s interview, this process led to the creation of four levels of analysis, in order to capture both her own understanding (‘we’) and her perception of other people’s experience (‘she’) as illustrated in Figure 2 in which there are two levels of descriptive comments:

1. **Descriptive:** SENCO’s knowledge, understanding and recollection of the ‘facts’ of the child’s story, often told from the perspective of the school as an organisation - ‘we’.
2. **Descriptive:** SENCO’s perceptions of other people’s (e.g. the grandmother’s) feelings, views and experiences - ‘her’ or ‘she’.
3. **Linguistic/Conceptual:** SENCO’s own views, experiences, reflections, analysis and conclusions about the kinship carer, child and TOPS treatment - ‘I’.
4. **Conceptual/Interrogatory:** My own thoughts about the SENCO’s feelings and ideas about the child’s unconscious functioning

[Figure 2: Four levels of interview data analysis: SENCO]
Analysis of the therapist’s interview also contained four levels as illustrated below. Here the linguistic comments were more pronounced. This seemed to relate to the difficulty of her feeling confident to recall the details of the treatment which had taken place a few years before, as raised in the introductory meeting.

1. **Descriptive:** Therapist’s perception and understanding of the child’s feelings and difficulties as learned from the case file, lead therapist, school and carer.

2. **Linguistic:** (e.g. “what I recall was that I think…”) the issue of recollection.

3. **Conceptual:** Therapist’s feelings, analysis and interpretation of what was going on for the child (and his grandmother) and his unconscious functioning.

4. **Conceptual:** My own analysis and interpretation of what was happening for the child and therapist.

   [Figure 3: Four levels of interview data analysis: therapist]

Although the SENCO had provided her own reflections and analysis (Figure 2, no.3) this aspect was less pronounced, with her own view mostly emerging at the end of the interview once she had shared her professional recollections and thoughts on the family’s experiences. Whereas in the interview with the therapist, the conceptual comments were more prominent, as would be expected, as reflection at a conceptual level was a key aspect of her role as a psychotherapist and therefore was more central throughout the interview.

Analysis of the interview with the kinship carer did not produce this additional fourth level, due to there not being a distinction between herself as an individual and herself in a professional role. However the complexity of her experience of being a grandparent who is also in a parental role was explored within the findings.
Step 3: Developing emergent themes

In the interview with the SENCO, emergent themes included: the SENCO as a key figure providing support for the kinship carer, the SENCO having a grandparental function within the school and the SENCO’s hopes for and feelings about the therapeutic intervention. In the interview with the kinship carer, key themes included: oedipal feelings and father figures, feelings of embarrassment at being seen as different, worry about the future, and feelings of isolation as a kinship carer. In the interview with the therapist, emergent themes included: splitting: presenting a likeable side of himself, keeping a low profile as a defence against being cast out, identification with a lost baby and undertaking therapy in schools.

Step 4: Searching for connections across emergent themes

Once I had compiled a list of emergent themes for a participant, my next task was to explore the relationship between these different themes, so as to create groups of themes. These groups were then given a heading (a super-ordinate theme) which described the properties which all themes within the group had in common. This is illustrated in Figure 4 (p.117) which gives an example of four groups of themes which emerged from the interview with the kinship carer.

Step 5: Moving to the next case (participant)

As I only had one case, in my study this step involved moving on to looking at data from the next participant and repeating steps 1-4 as described above with each interview transcript.
<table>
<thead>
<tr>
<th>Super-ordinate theme:</th>
<th>Super-ordinate theme:</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Being/having a grandparental kinship carer</em></td>
<td><em>Worries about history repeating itself</em></td>
</tr>
<tr>
<td>GM’s age: he feels she can be out of touch (18.1)</td>
<td>Worry he will follow same path as his mother (18.3)</td>
</tr>
<tr>
<td>Re-parenting: are GM’s stricter 2nd time round? (18.13)</td>
<td>Worry of past repeating itself (18.25)</td>
</tr>
<tr>
<td>GM keen to be a good parent to grandchildren (18.22)</td>
<td>Approaching adolescence, what will this bring? (19.3)</td>
</tr>
<tr>
<td>Things GM enjoys about being a kinship carer (18.27)</td>
<td>Lies and truth (24.2)</td>
</tr>
<tr>
<td>Feels not good enough if he needs a therapist too (29.9)</td>
<td>Negative influence of others, particularly men? (24.4)</td>
</tr>
<tr>
<td>The importance of having a GM who understands his experience with his mother (38.15)</td>
<td>Worries about the future: teenage behaviour (37.3)</td>
</tr>
<tr>
<td>The isolation of being a kinship carer (42.1)</td>
<td>Splitting: idea of good and bad people and paths (38.24)</td>
</tr>
<tr>
<td>The need for positive influences: (40.5)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Super-ordinate theme:</th>
<th>Super-ordinate theme:</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Feelings of difference and embarrassment</em></td>
<td><em>Growing up male</em></td>
</tr>
<tr>
<td>Home life: unfairness and difference to friends (18.15)</td>
<td>Oedipal feelings and father figures (19.4), (19.6), (19.7)</td>
</tr>
<tr>
<td>Fights at school connected to mum’s behaviour (18.17)</td>
<td>Having and losing a brother (24.7)</td>
</tr>
<tr>
<td>Therapy as embarrassing (29.1)</td>
<td>The only male in a female household (28.5), (37.11)</td>
</tr>
<tr>
<td>Therapy highlighting child has a ‘problem’ (29.2)</td>
<td>Fragile relationship to father figures in the wider family (37.13)</td>
</tr>
<tr>
<td>Feelings of embarrassment at being seen as different (29.2)</td>
<td>Need for fatherly input: no father’s first priority (37.15)</td>
</tr>
<tr>
<td>Public humiliation: issues of racial identity (38.8)</td>
<td>Police as representation of good paternal figures (38.16)</td>
</tr>
<tr>
<td>The value of a kinship carer group in alleviating feelings of difference (42.1)</td>
<td>Worry of adolescence: bigger boys/being tough? (38.22)</td>
</tr>
<tr>
<td></td>
<td>Police cadets versus gangs filling a paternal void (38.19)</td>
</tr>
</tbody>
</table>

Figure 4. Examples of groups of themes: Kinship carer
Step 6: Looking for patterns across cases (participants)

Once I had identified super-ordinate themes from data from each of the three participants, it was then possible to explore connections between them, as well as to identify where there were areas of difference in relation to specific participant’s feelings and experiences.

In the first stage of this process, all the super-ordinate themes from the three participants were collated to see if and how each of the different participants related to them. This helped to identify which themes affected all of the participants and which were only relevant to some. For example, different aspects of the theme *Feelings of difference and embarrassment* which presented itself strongly in the interview with the kinship carer, were also present in the interviews with the SENCO and therapist:

<table>
<thead>
<tr>
<th>THEME</th>
<th>SENCO</th>
<th>CARER</th>
<th>THERAPIST</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feelings of difference and embarrassment</td>
<td>In school the nuclear family was the exception not the rule, so the child would not have stood out as being different due to living with his grandmother.</td>
<td>During contact, their mother might sometimes behave in a way which they found very embarrassing. Having therapy was felt to be embarrassing for both the child and grandmother.</td>
<td>He feels himself to be different to other TOPS patients who he sees as being ‘more disturbed’. What does it mean about him if he has therapy too?</td>
</tr>
</tbody>
</table>

[Figure 5: Example of a theme which related to all participants]

Themes which were not relevant to all the participants, tended to be themes which related to a specific professional role, e.g. the *SENCO having a grandparental function in the school* and the *child’s relationship to his therapist in reality and in the transference*. It was interesting to notice that this latter theme did not enter into the interview with the kinship carer. This seemed to highlight that as long as the child was receiving therapeutic support, the grandmother did not intrude into the details of their work or relationship and therefore this did not become a subject of discussion in the interview with the carer. This seemed to indicate her respect of the child’s privacy, but
the absence of curiosity about this surfaced in other themes such as *Keeping a low profile* and *Treatment*.

Notes were then made of connections between different themes. For example, worries about whether the child would become susceptible to negative influences in the future which were captured in the theme *History repeating itself* also linked to the theme *Having a grandparental kinship carer* in which concerns were raised about the grandmother’s health and what would happen to the child in the future if she was not able to look after him.

Related themes were then grouped together into clusters. Due to the structure of the interview, in which all participants were specifically asked for their views and experience of the TOPS intervention in terms of the referral, treatment and outcomes, these aspects of the interview data naturally came together to form a cluster.

Initially five clusters were formed under new super-ordinate headings which gathered the related themes together: 1) Feeling (e.g. difference and embarrassment), 2) Managing (e.g. keeping a low profile), 3) Understanding (e.g. family history), 4) Helping (e.g. TOPS treatment) and 5) Grieving (e.g. loss of sibling). This final cluster was then incorporated into the first, so that the *Feeling* cluster included the feelings of anger and grief which the child experienced as a consequence of the losses in his life. The name of the fourth super-ordinate theme was later changed to ‘Engaging’ so that the title of each of the clusters reflected the experience of the child.

Themes within each of the four super-ordinate groups were organised, with three key themes emerging within each group. The relationship between the four groups and the themes within them were also considered, as demonstrated in Figure 6 (p.120) in which the horizontal arrows highlight the relationship between themes.
Read horizontally, the arrows in this diagram show three strands which ran through the data and connected the four groups in terms of key aspects of the child’s experience:

**Strand 1:**
The first strand shows how the child’s feeling of difference are managed by keeping a low profile. These difficult feelings and his way of responding to them relate to his understanding of why his mother is not able to parent him. As a consequence of his family experiences and the impact they have on him a referral is made to the TOPS service in his school.

**Strand 2:**
The second strand beneath this relates to his experiences as a boy who is struggling with feelings of anger as a result of the losses he has endured, in particular the loss of his brother and his difficulty in understanding why his family allowed him to be adopted. These feelings of loss emerge as key themes within his therapeutic treatment.

**Strand 3:**
The third strand explores how his experiences of caregiving in the past shape how he manages his relationships with adults in the present and his underlying concerns about caregiving arrangements in the future.
4.3 **Analysis of Themes**

**FEELING**

This category refers to key feelings which were experienced by the child, as understood by his SENCO, grandmother and therapist. At times, particularly in respect of the third sub-ordinate theme ‘having/being a good enough parent’, the ‘being’ aspect might not relate to the child’s feelings, but to the grandmother’s feelings about herself in her role as a kinship carer.

The question of what feelings were and were not shared with me in a research interview at this particular time, would likely be dependent on a variety of factors such as; what was most present in the participant’s mind at this time as a consequence of their current situation and concerns, what feelings were most memorable from this period of treatment and what feelings participants felt comfortable enough to share with me as an individual and as a qualified clinician in a recorded interview setting.

**Theme 1: Difference/standing out/embarrassment**

In this theme, difference is connected to adverse experience(s) which are not, or not consciously felt to be, as a result of the subject’s making or choosing. Consequently, the subject may experience feelings of hurt and embarrassment that these aspects of their experience make them stand out as being different from others in a negative way and/or anxiety about what this means about them as a person and their capacities. Where anxiety is felt, this could indicate unconscious anxiety that the adverse experiences are as a result of the subject, due to something they have or have not done, either in reality or in phantasy.

In the interview with the SENCO, this theme was present in concern that the school felt for a child whose learning capacities may have been disadvantaged from the start of life and wanted to do what they could to help him to catch up, so he could be on an equal footing with his peers.
“(Grandmother) said that she had advice from when he was born that because of the drugs that mum had been taking that might have affected him. So we were always aware that because of that there could be issues over his concentration. We didn't know about his development and Grandmother didn't know about his development, you know, whether that would be an issue. He was quite slow to pick up his academic skills, he was quite slow to pick up reading and writing. So he was flagged up for that and he had quite a number of support systems in place all through Key Stage I until he was 7, to ensure that he was keeping up with his peers but he was always below average in quite a lot of things. So he was always in a maths support group, in a handwriting group, in a reading group, you know, additional reading group...so that was done to support him.” (SENCO: 19.2)

In discussions with the kinship carer, this theme emerged strongly in relation to two aspects of the child’s experience; his mother’s drug use and behaviours associated with this and having therapy. Issues of ‘standing out’ were also present in terms of racial identity, in respect of one of his siblings who had a black father becoming aware of her own feelings of difference from her otherwise all white kinship family.

**Mother’s drug use and associated behaviours**

Feelings of acute embarrassment were present in public situations where the child and kinship family felt exposed and hurt by mother’s behaviour during contact, such that they felt they stood out in a negative way. The tone and unpredictability of this behaviour indicated to the grandmother that it may well be associated with drug use:

“once in a while she’s loud, she’s really, really loud. She’ll talk on the bus about anything, and everybody’s listening and everybody’s looking and we all sort of wanna, just die, really it’s horrible…and she can’t see it. ‘I’ll talk about what I bloody want to whoever I want, I don’t care who’s listening.’ And we’re all sort of, sat there going bright red and yeah...things like that, it is embarrassing, it really is. He talked about his girlfriend, this is two years ago...what was it she said, it was really horrible. She asked her name and he said ‘....’ (a non-English sounding name). ‘What bloody colour is she?’
that’s how she…and I thought, excuse me you’ve got a mixed-race child sitting next to you and you’re going on about colour? I felt…and he just looked at her…I don’t think he could believe she actually said it. I had a friend with me as well who – her mouth was hanging open, so things like that she comes out with…” (KC: 38.14)

Having therapy

Feelings of embarrassment about his having therapy were described by the grandmother both in respect of her own feelings as a carer and her understanding of how her grandson felt. The issue of his ‘standing out’ from his peers was a key concern, arising in practical terms from the fact that TOPS therapists would collect the children from their classroom and take them to the therapy room for their session. Underpinning this concern was the more troubling question of what it meant that he needed therapy. For the grandmother this raised worries about her own capacity as a caregiver:

“C: I found it embarrassing at first…to be quite honest yeah. Because they’d go to the classroom and take them out of the classroom and everybody knows who it is and why they’re…

R: So you felt embarrassed on his behalf?

C: Yeah and for myself…I just thought I’m doing something wrong if they need therapy.” (KC: 29.9)

For the child, it seemed to suggest both to himself and others that he was a boy who had difficulties. The idea of thinking this about himself, or being thought of in this way by others, perturbed him:

“R: How do you think it was for him having therapy?

C: He felt embarrassed…It’s the same reason…the fact that the actual woman comes to the class…

R: Because the other children in the school all know that’s the therapist?

C: Yeah…Because there’s quite a few kids in the school see somebody, so…”
R: So then it shows that he’s having therapy
C: Mmm. I think that was the embarrassing part.” (KC: 36.8)

In examples such as this, where the grandmother’s own feelings and her perceptions of the child’s feelings echo each other, this raises a question as to whether; grandmother and child independently each felt embarrassed, grandmother’s perceptions of the child’s feelings could be unconsciously coloured by her own feelings either experienced now as an adult, or in relation to her own feelings as a child, or whether the feelings of embarrassment which exist in each of them might be as a consequence of unconscious projective processes, such that the child comes to share his grandmother’s feelings or vice versa.

In interview with the therapist, the issue of his embarrassment was raised when asked if she felt he understood the concerns that the adults had about him, which led to his being referred for therapy. The therapist described having explained to him they would meet together three times (a child psychotherapy assessment) and then there would be a review meeting with his grandmother to make a decision as to whether they would carry on (with weekly treatment). From the outset he had been keen and expressed confidence that his grandmother would agree “its fine, it will be fine, my grandma, you know, it will be fine everyone would say.” (TH: 11.1) However in the review meeting, more worried feelings about what it meant to have therapy were expressed:

“what was interesting is the third session, I kept reminding him then we wouldn’t meet the following week as I was meeting his grandmother, I remember asking him whether there was anything you know, he thought I could say and he was very quiet. And then I was..I remember being quite surprised because when I met her she wasn’t sure about the work, she said that he, erm, he was a bit concerned that children that went for therapy were often quite sort of disturbed and sort of… perhaps children who were seen to have quite a lot of behaviour problems, you know. I tried to say, you know, there were all kinds of reasons why, so there was some embarrassment on his part about being pulled out… and I remember then saying that I would look into the fact that maybe I wouldn’t have to pick him up from his class,
that he could come... And I remember having that conversation with... that... No, they’d like me to do what they do for everyone.” (TH: 11.5)

In this extract, the sensitivity of this issue (presumably because it touches so acutely on other aspects of his experience as described above), is highlighted by the powerful counter-transference response experienced by the therapist, who, feeling moved by how difficult it is for him to have to bear these embarrassing feelings, explores with the Lead Therapist the possibility of making different arrangements for this child which would spare him from these feelings. Ironically, were different arrangements to have been agreed for this child, this _would_ have made him different to all other children receiving therapy in the school and would likely have resulted in these same concerns about difference returning though a different situation. It therefore seems important that the Lead Therapist makes a decision not to do something differently for this child in order to circumvent these difficult feelings, but rather to allow them to surface in order to enable them to be explored as part of the therapeutic work. This is likely to be important not only for this child, but also to challenge within the school environment an idea that needing therapeutic help with troubling feelings is something to feel embarrassed about. The importance for this child of grappling with questions of inclusion, difference, vulnerability and capacity is also highlighted in descriptions of his awareness of other children receiving therapy within the school:

> “I’d work alongside another therapist and she sometimes would see a child, so sometimes there would be a kind of traffic jam... there was that with him that he tended to see which other children were going and thinking I’m not in that group, should I be? What does that mean? Who am I? That confusion, you know what does that make me? ... I mean not every child would worry about that. But he’s quite a sensitive child.” (TH: 33.4)

Interestingly, the question of feeling different due to living within a kinship family was not considered to be an issue either by the SENCO or by the grandmother, despite the numbers of children living in kinship care in the school being very low whilst the level of intergenerational difficulty within these families was high:
“In terms of the school I was at, it was quite a rarity. I was there 12 years. I think there were three families where children were being looked after by family members, normally it tended to be the grandparents….two of the three families, all the children had very complex needs and it was a family that was well known I think to the social services… there’d been quite a history actually with both families over quite a number of years, almost to when the parents had been children themselves and they’d also been looked after by grandparents.” (SENCO: 6)

From the SENCO’s perspective, the reason for this not being an issue was due to the fact that pupils attending the school lived in a wide variety of family constellations such that “the nuclear family was the exception rather than the rule” (SENCO: 23.2). Consequently in her view, children generally had “quite a high awareness” (SENCO: 9) of the fact that pupils live in many different sorts of families including with; single parents, same-sex parents and step-families. There were also several looked-after children living with foster families at the school. Work commitments and financial pressures on families also often resulted in children being cared for by extended family members:

“there were lots of people living with all sorts of, either relatives or whatever or sometimes didn't see their parents because it was very common for some of the parents to work in the catering business, so as the children came home from school they would go off to work. So although they were with their parents it was quite often Grandma that was looking after them anyway and making them their tea and putting them to bed. So although they were not looked after in kinship care, actually they were, because parents worked very long hours and didn't see much of their children.” (SENCO: 23.2)

In addition, the school was very culturally diverse and family arrangements particular to different ethnic groups were described within the school. For example, within the Bangladeshi community “two or three families could be living at the same address” (SENCO: 10) and parents would support each other with care of the children.
“I think we identified there were 23 different languages being spoken at school. So every time we had international evening, whatever, it was amazing. We had the flags from every country, you know, all over the hall and people came in national costume, and music, and bought food in and it was quite a celebration actually.” (SENCO: 3)

It therefore seems likely that despite the low numbers of children living in kinship care, within this diverse environment and within a school culture in which different family backgrounds and identities were celebrated, this enabled any negative feelings of difference not to be felt in relation to living within a kinship family.

For the kinship carer, feelings of difference and accompanying isolation due to not knowing anyone else in her situation were alleviated upon finding a group for those with Special Guardianship Orders.

“C: I think erm… for both of us I think probably not having anybody to talk to about it, not knowing that, because erm, up until then I didn’t realise so many people had grandchildren, you know, up until I went to that meetings and I didn’t realise so many did, it’s now so nice to actually… One of the mum’s doesn’t live far from me, and erm, we actually went to another meeting, she picked me up in her car and we went to another one this week….It’s just so different to know…

R: That there are other people….

C: For the kids I think, they met…one of the girls and they know two of the boys and they all live with grandmother or father and it’s nice for them to know that they’re not that different.” (KC: 42.3)

If as perceived by both the SENCO and carer, that this child did not feel different on account of living in a kinship family, it is interesting then to notice that his more negative feelings of difference were connected to the reasons why he was living in kinship care and these were mostly, at a conscious level, mentally located outside of the kinship home. However, in interview with the therapist a different perception was expressed:
“he thought he was the only one in the class who wasn’t living with his mother. There’s a lot of single families, but usually children with their mothers, so I think it must have been, quite a lot of difficult feelings…” (TH: 30.3)

It is possible therefore that the SENCO and carer’s perceptions of his not feeling different in this respect could have been to some extent a projection of their own positive feelings about the inclusivity of the school environment and reassurance gained from attending the carer’s group.

**Theme 2: Anger (underpinned by feelings of loss)**

Feelings of anger featured prominently throughout as a consequence of there being several aspects of this child’s life experiences which caused him a great deal of upset. All of these situations, which connected in different ways to his mother, were events he was powerless to have any influence or control over, resulting in feelings of hurt and frustration being expressed through angry behaviour:

1) His mother not attending contact
2) The adoption of his younger brother
3) Children calling his mother names on account of her drug use

All of these situations could also be seen to involve a loss; of time with his mother and of the experience of having a mother who is able to respond to her children’s needs, the loss of his brother to a new family and of contact with him, and the loss of an idea/ideal of how a mother should be.

**Mother not attending contact**

In the interview with the SENCO, the connection between his angry behaviour in school and events affecting him in his family life is made through communication with his kinship carer, resulting in a referral to the TOPS service (all the siblings were then seen by the Lead Therapist as a group):
“I think he was about Year 3 when TOPS was involved and the reason that we involved them was, because he, uncharacteristically, then became quite aggressive in the playground. He was getting into a lot of fights and then he was having tantrums. He became quite angry, you know, became quite angry and it took us time to calm him down. We spoke to Grandmother about it and yes there was things going on like, so mum was back on the scene again and wanted to see her children but then wouldn't turn up. So it was agreed that she would come on a certain time after school or on a Sunday, and then just wouldn't turn up and that caused the children quite a lot of upset. So, it was those sorts of things that were going on.” (SENCO: 19.2)

The issue of missed contacts as a significant source of upset and angry feelings was also highlighted by the grandmother in descriptions of what this was like for the children to experience, leading to her eventually seeking a reduction in planned contacts from weekly to fortnightly:

“C: out of say 16, 17 times she only turned up about half of them. So we’d be in the park or wherever it was we were meant to meet and be sat there for hours and erm, particularly the ‘….’ Festival that was the worse one, the kids picked it because their friends would be there, their mum’s friends would be there, but quarter past six she still hadn’t turned up and we’d been there since two.

R: And was it an idea that it would be nice for them to have their mum there when their friends have got their mums as well?

C: Well, she doesn’t really know their mums, but I think (granddaughter’s) attitude was, if things are getting a bit…she doesn’t like, she can just go and talk to her friends… So they worked it out that way and erm, it didn’t work out at all ’cause she didn’t turn up. And (child) asked one of the mum’s friends could she phone the mum and she picked up for her, and he went mad. And erm, she says ‘oh she was asleep’ and ‘stay there I’ll be coming now’, but no, we’re going. So we stayed for about half an hour with their friends there and then we left.” (KC: 9)
Adoption of younger brother

The adoption of the child’s younger brother who had been living in foster care is described by all three participants as a significant life event which resulted in increased feelings of anger, which had otherwise largely dissipated with the support of the TOPS sibling group intervention.

“When (brother) got adopted, which, I think went through when he was four properly, he took that really hard. All of them did. But him worse…. He got angrier and erm, yeah he was, the only way he could sort of cope with it I think was having a go at people.” (KC: 27.5)

In her interview, the kinship carer describes discussing her concerns about this with the SENCO, which resulted in a subsequent referral to the TOPS service, this time for him to receive individual support. In her interview the therapist highlights the fact that his mother had also recently had another child and this raised concern for the grandmother about him forming an attachment to this new sibling which he could then potentially lose as well.

“T: Specifically when he was referred to me what I understand is he was, he’d been living with his grandmother with his two sisters. There had been a baby that his mother had, that was then adopted which caused the children, particularly him upset, I think about that baby which he’d come to know and before he was referred to me his mother had… there’d been another sibling born

R: a fifth one?  
T: and I think they were a little concerned about the impact of that on him and so I think the other areas had improved a little bit, but they were a bit worried about this setting something off, yeah, and there still were some of, you know, the issues of him being angry I think, but less so than before the previous therapy.” (TH: 4.2)

In her interview, the therapist reflects on how understandable it is for a child who has experienced such significant loss to feel angry about it:
“The fact that he’s actually… has a, you know, luckily has a very nice disposition, the fact that he has angry feelings is not really surprising, you know where do they go?” (TH: 24.30)

Her response could be seen to highlight how feeling anger is a developmentally ordinary response to feelings of loss and as such is an appropriate part of a grieving process, not a sign of mental ill-health, unless it were to become a more permanent defence against any feelings of vulnerability or dependency. This did not seem to be the case for this child who, according to his grandmother, was able to cry and express upset feelings at home. It is possible that this distinction could be felt unconsciously by the child, when comparing himself to other children that he saw receiving therapy in school and perceived as being more “disturbed” (TH: 11.5) than him.

In his individual treatment, the opportunity to work through some of these feelings within the safety of the therapeutic relationship, are present in descriptions of his play as the work is coming to an end and the impending loss of the therapy and his therapist stirs up angry feelings, which in this situation he is tentatively able to express towards the person that he feels is responsible:

“T: Some of the play, with the ball play, you know, was when he’d throw it really hard, especially towards the end perhaps because we were coming to the end. I know there was one where he wanted to play football and I was in defence but it was like, you know…
R: You are going to get it with the ball?
T: Yeah, yeah. You are sort of under attack so, and that’s when, I mean you know, the gentle side of him would, you know, some of this aggression would come through that play.” (TH: 22.4)

Children calling his mother names on account of her drug use

In primary school, angry feelings at playtime were attributed to his mother not attending contacts. There might have been clinical ideas at this time about sibling rivalry at home being heightened in response to feelings of maternal deprivation which were then enacted with peers at school. However, now in secondary school, fighting with peers
was described by the kinship carer as a response to provocation by children whose mothers were friends with his mother saying disparaging things about her:

“it was two weeks ago somebody said to him ‘your mother takes her knickers off to get money for drugs’. He come back really upset about that, so… he does get an awful lot of stick for it…” (KC: 9)

It is likely that this additional aspect now present in secondary school would have been stirred up as a consequence of pubertal development and the accompanying sexual feelings and oedipal phantasies arising within the peer group at this time. Due to his circumstances, this child would likely be an easy receptacle for locating difficult feelings about maternal sexuality within the group.

“C: He was constantly erm, getting into fights at school because of people calling his mum names and things and erm, one time he, he was really badly hurt, his shirt ripped, he’d marks on his stomach. Lumps on his back and big lumps on his head... Somebody had said something to him, in class, he’d said something back, I think the teacher stopped it and thought that was it finished, but seemingly four boys caught him in the street halfway up the road from school.

R: And attacked him?

C: Yeah, he was a real mess. I rang up the school and said I’m gonna get the police involved, I was really mad, and erm, somebody from his school rang back and said he was equally to blame. I says well he can’t, if there’s four of them... one was beating him up while the other three stood and watched and erm, then the policeman phoned me and said erm, it might be a good idea for him to come Police Cadets…” (KC: 38.19)

**Theme 3: Having/Being a good enough parent**

Feelings about good enough parenting featured as a key theme in all three interviews. Ideas on this subject fell into two categories:
1) ‘Having a good enough parent’ in which the participants reflected on the child’s experiences of being parented, firstly by his mother and then by his grandmother.

2) ‘Being a good enough parent’ in which the participants reflected on the parental task, what being a ‘good’ parent involves and whether they feel they were sufficiently able and equipped to provide this parental function within their role.

1. Having a good enough parent

Within this category, reflections on the child’s experiences were related to his past, present and future care.

The Past:

In the interview with the SENCO, concerns around the impact of parental neglect and harm to the child from the very start of his life, are captured by an image of a destructive feeding relationship, with a mother who is unable to take good care of herself or her child, feeding them both bad ‘food’ (drugs).

“… very, very slight boy, very frail looking. Because he was quite short and very thin. So there were always issues over his eating, whether he was eating enough and that sort of thing… Grandmother was quite concerned about him as well… because of the drugs that mum had been taking that might have affected him.” (SENCO: 19.2)

In the interview with the kinship carer, descriptions of neglectful parental care continue during his infancy, resulting in the involvement of social care:

“She was taking him out and he’d come back and he smelt really not nice and she wasn’t bathing him and you know, that sort of stuff. And erm, so there was lots and lots of stuff with the social worker that if she wanted to go out, I agreed to have him if she wanted to go out for a couple of hours, erm, and she’d go out and not come back for days and things like that, so, yeah, that how it all started.” (KC: 12)
In her interview, the therapist reflects on the emotional impact of these early experiences and what this might have been like for him.

“that’s something that touched me and stuck in my mind... how does it feel to really have a mother that isn’t a good enough mother at all, it’s quite, you know, hasn’t really managed?” (TH: 24.30)

She also raises the question of how hard it might be for him to make sense of why his mother has these difficulties and didn’t/wasn’t able to care for him differently. Thoughts about an intergenerational aspect to his mother’s difficulties are alluded to but not explored. The difficulty of how to broach this subject sensitively might reflect how difficult it would be for the child himself to be able to wonder about this aspect whilst being cared for by his grandmother:

“I would think that the children felt very loved by their grandmother, very cherished by her. But you know a lot of mixed feelings...I just think they must have a lot of unresolved upset about having a mother with so many difficulties and what that means to them. I mean not really being mothered and being exposed to very difficult situations... But I mean he has got somebody who’s caring for him, so from that point of view they are very lucky.” (TH: 28.1)

The Present:

In terms of his current experience of being parented by his grandmother, this was considered to have a positive impact on his life. One aspect of this was because being in kinship care enabled him to have ongoing contact with extended family members in an ordinary way.

“I think for him the good thing is at least he sees most of his family, and cousins and aunties and things like that.” (KC: 24.1)

Having extended family members around to help grandmother with looking after the children was also highlighted by the SENCO as making a significant positive
contribution to the children’s experiences of being looked after when they were young. This was important as a result of grandmother at times suffering from poor health.

“one of her daughters lived with them and I think she was a trained nursery nurse and helped a great deal with the children. Because although Grandmother wasn’t old, she had a number of health problems herself. So there were days that she didn’t have the energy to run around after them. So her daughter would collect them from school, take them to the park, would help with homework, would help her with the cooking at home. So, she was a great support for them and I think that the children liked having, older auntie there as well, who was young and able or whatever… So the children in my view were always very happy.” (SENCO: 23.2)

In her interview, the kinship carer described how occasionally her grandson would express some frustration with her on account of her age, although his tone, as enacted here by his grandmother, appears good humoured:

“sometimes he… I say something to him and ‘(sigh) I shouldn’t be living here with you, you’re too old’ (laughs).” (KC: 18.1)

Here the child’s frustration is described as being on account of her being out of touch with “all these slang words and things like that.” (KC: 8.3) In this way, the child seems to have a phantasy that were he to be looked after by a younger parental figure (or by his mother), they would be better able to understand him, as they would have more knowledge of the cultural and social phenomena which are a part of his world. Although to some extent this might be true, the phantasy here seems to be of closeness in a parent-child relationship such that each can easily understand the other, without the need for limitations and differences between them to be negotiated. Another aspect of home life in which these feelings seem to arise, is in respect of his grandmother’s parenting style “he says I’m a bit strict sometimes” (KC: 18.16). In the extract below, he is again confronted with boundaries which he (at least in that moment) would rather weren’t there, and seems to feel that there are differences between how his grandmother and a mother (like his friends have) would parent him.
“His friends get to keep their phone in their bedroom all night long and my cut-off time is 9 o’clock. You don’t need a phone if you’re going to bed. Cause at first I let him, but he’d be up at 12 o’clock playing games. I said no. I give you a chance you’ve lost it now and that was it.” (KC: 18.16)

The future:

The most serious implication of what it might mean for this child to be looked after by an older parental figure was in respect of his future care. In her interview the therapist raises this issue; however her reluctance to believe that such worries would be a conscious concern for this child is perhaps a communication of quite how painful it is to consider that he might one day be faced with another loss of primary carer.

“having this mother that hadn’t been able to look after him and his sisters, is huge. And the grandmother, I felt you know, she really cared but she had some health issues and she seemed vulnerable herself to more ill-health, ‘cause that’s quite a strain, and so one wonders what might happen should she be unable to look after them. But whether a young person of that age would be worried about that, I think probably not, so much. I don’t know. Maybe on some level.” (TH: 23.2)

In her interview, the kinship carer describes how the child is very much aware of this worry and has been able to bring it to her directly. His capacity to do so and her recognition of the need to make contingency plans so as to lessen the children’s (and her) anxiety, seems to lend weight to the positive view of the parental relationship between grandmother and child.

“He says if I die what’s going to happen to him? And my youngest daughter said she’d have them all anyway, so that’s okay, she fosters as well, so… but she did say if anything happened, her and her boyfriend would have all three of them.” (KC: 4b)
2. Being a good enough parent

Within this category two key areas were raised: the complexity of simultaneously having parental responsibility towards children and grandchildren, and feelings about parental capacity.

Intergenerational Parenting:

In the interview with the kinship carer, the complexity of her position as a parent to both her children and grandchildren is communicated in descriptions of situations in which difficult choices must be made if she is to ensure her grandchildren are looked after safely. As demonstrated in the following example when the child was a few months old, being a ‘good enough’ parent entails grappling with questions such as ‘what is the ‘right’ thing to do as a parent?’ and ‘to whom do one’s foremost parental responsibilities lie?’

“I took him to the doctors, cause, I saw there was something wrong and the doctor wanted to know why the mum hadn’t taken him and that’s how it all started… And that caused a big argument as well, I should have left… My son said if I hadn’t bothered that, you know, she might have stopped taking drugs and things, but if I hadn’t bothered take him to hospital he’d have been really ill, he could have died, cause you know, he just was vomiting, diarrhoea…” (KC: 12)

In this example, as it is presented by the grandmother, despite the importance of the baby receiving medical attention, individual family members may have different views on what they feel is the ‘right’ thing to do and whose needs the grandmother should prioritise:

“My son’s never forgiven me for getting anybody involved because she [child’s mother] might have been fine if I hadn’t. But I thought no, she had plenty of chances anyway, so… I don’t feel guilty about that at all.” (KC: 12)
The varied responses of family members as to how best to respond to mother’s difficulties and the impact on her children, highlights the complex nature of family relationships and the individual motivations, concerns and loyalties which shape family dynamics.

“Some of them [children] don’t talk to me because they think I’m being too tough on the mum, others think I’m being too soft on her, you can’t win.”

(KC: 9)

The individual perspectives which different adults in the family hold towards the grandmother taking up this parental role, would likely be as a consequence of their own experiences of being parented, gender, role and position within the family. Sensitivities may also be heightened in response to an unconscious resurrection of old feelings of sibling rivalry now directed towards the new babies in the family who are occupying their mother’s attention:

“My son says I care more about my grandchildren than…what was it? I got a text: ‘you care more about your grandchildren than you do of your own children.’” (KC: 9)

In families where there may have been intergenerational difficulties and children not felt that their emotional needs were sufficiently attended to, it may be very hard to allow new children in the family to have a different experience than the generation before.

In the interview with the kinship carer, grandmother’s perception of her daughter’s mixed feelings towards her for having taken on the care of her children are described:

“Sometimes I think she is and other times no. It depends on the mood she’s in. She’ll say, you know if I say something, she’ll say that ‘they’re my f-ing children, not yours’ and stuff like that.” (KC: 15)

Here it seems as if at times the mother might feel gratitude towards her mother for enabling the children to remain within the family, whilst at other times the kinship
arrangement provokes rivalrous feelings between mother and daughter which can lead to feelings of powerlessness, resentment and anger:

“she gets very...aggressive with me, bad tempered and, erm, yeah if I make arrangements to do something and I haven’t told her... I got used to not telling her because she was never interested.” (KC: 14)

It is likely that such feelings would become heightened in relation to contact sessions, when the mother would be confronted by her own mother’s (legal) authority in relation to her children. This could help to explain why a mother struggling with these sorts of feelings might turn to the avoidant behaviours described by this grandmother such as; not attending contacts “they’d all be sat there waiting and she just, not even a phone call” (KC: 13); attending but not engaging with her children when she is there “even in contact she doesn’t spend time with them... when they’re in the park playing she’s sitting down on the bench” (KC: 15); or using drugs to avoid being in touch with the pain of this reality “half the time she’d come and she was totally out of it on drugs.” (KC: 7) Such feelings might also result in a retaliatory desire to undermine grandmother’s control by evading contact plans altogether, but such actions could also communicate in part a more depressive wish to spend time alone with her children so that she can feel like their mother again.

“we had to put the phone on loud-speak... because I could hear what she was telling the kids... because she was asking him to meet her and ‘don’t tell your nan’ and things like that.” (KC: 8)

**Parental Capacity:**

In her interview, the therapist wonders how demanding it might be for the grandmother to take on parental responsibility for young children again and the strain that managing this might have on her:

“she had maybe from stress, stress-related physical things. I know that she suffered from eczema or psoriasis and she talked quite a lot about that, or, that was quite visible... so maybe that’s why I had the feeling of she’s
struggling, somewhat. So one had the feeling that although she did show a lot of concern for the children, that it wasn’t so easy for her really.” (TH: 27.1)

Similar feelings were also articulated by the SENCO who recalled encouraging the grandmother to attend ‘parent-work’ sessions with the TOPS Lead Therapist in order to support her.

“She would say ‘look, you know, I've now got…’ There was a problem with her heart after all this and she had physical problems with her back and this, that and the other, and the doctors felt it was because of stress and everything that was going on, and I said ‘look, so therefore it’s really good that you have this to help you’. ‘But I don't need it, I'm absolutely fine’.” (SENCO: 34.1)

The SENCO hypothesises that Grandmother’s reticence to engage with therapeutic support for herself could also result from a worry that her parenting style and capacity could be challenged by a professional figure who she imagined might advise her to do things differently:

“she didn't want to be drawn into anything which may result in her eyes as some sort of criticism of her parenting, or having to make changes to her parenting, at some point.” (SENCO: 25.1)

The SENCO suggests that grandmother’s experience of involvement with children’s services may well have contributed to a more generalised perception of what engagement with professional support would be like:

“I think she needed a lot of convincing. She had so much dealings with social services that she didn't want people intruding into their lives, which was the way that she saw it, really.” (SENCO: 25.1)

One would imagine that this transference, which seems to result at this time in a perception of the Lead Therapist as an intrusive and critical figure, would also be a
product of grandmother’s own unconscious anxieties about her parental capacity and a worry that if anyone looked into her too deeply, such worries might be found to exist in relation to her daughter’s difficulties.

In her interview, the grandmother is able to reflect on how her parental capacity has developed through experience and that looking after her grandchildren provides an opportunity to parent differently, this time equipped with the benefit of experience:

“You do things differently than you did the first time and you know what to look for as well. You know, problems you can see coming before… things are just different, I don’t know…. it’s more fun as well, in a way.” (KC: 10)

In the interview with the therapist, who had acquired further experience of working with vulnerable children in the years since treating this child, we see how similar ideas around the benefit of parenting experience were also alive in the transference:

“I kind of worry that maybe I didn’t do so well, you know, I didn’t have the thinking to do as well for him…. Maybe if I’d had more insight into children in that situation and I feel I have a bit more now, I might have been able to be a bit more… perhaps to try and name some things?” (TH: 32.1)

Although the therapist’s concerns here in part reflect the reality that clinical understanding is gained through experience, her subsequent conclusion “but I don't know if that would have helped him because… I don’t know if he was at that stage?” (TH: 32.1) illustrates the sensitive work undertaken with this child in which clinical interpretations are pitched at a digestible level. With only two terms of individual work, concern that it would have been premature to name the child’s unconscious anxieties too explicitly seems appropriate. As such, this highlights how the therapist’s worries as to whether she had the internal resources to ‘feed’ him enough of the right kind of ‘food’ and was thereby equipped to be a good enough parent/therapist seems to be a powerful countertransference response to working with a child whose mother was unable to provide him with the quality of care that he needed.
MANAGING

This superordinate category explores ways in which the feelings which were described in the first superordinate category are managed by the child. There is also some reflection on how the grandmother manages her own worries about him. Within the three sub-ordinate themes: ‘Keeping a low profile’, ‘Growing up male’ and ‘Special/proud/eager to please’ hypotheses are made as to why feelings might be managed in a particular way and how these responses could be shaped by unconscious anxieties and phantasies.

Theme 1: Keeping a low profile

This theme relates to interview material which suggests the child responds to feelings such as difference and embarrassment by ‘keeping a low profile’ i.e. avoids drawing attention to those aspects of himself and his experience which he feels could be viewed negatively by others. This way of managing only relates to those aspects which he feels are negative, in contrast to the positive aspects of himself which he is keen for adults to see (see theme 3).

In the interview with the SENCO, who describes hearing about the child’s difficult start in life from his kinship carer: “Grandmother was very open, wanted the school to know all the background of the children” (SENCO: 19.1) we get a picture of a child who aside from needing support with his learning, did not draw attention to himself for his first few years at school “emotionally he was fairly okay” (SENCO: 19.2) and of the SENCO therefore routinely checking up on how he is getting on, to ensure he doesn’t fall out of people’s minds:

“…at these termly meetings, if his name wasn't mentioned I would bring up with his class teacher ‘everything okay? Has he said anything?’ and, you know…” (SENCO: 19.2)

In this way, the SENCO could be seen to hold a grandparental function within the school, keeping an eye on how the child is managing. In interview with the therapist, similar feelings are expressed, that unless someone specifically asks about this child (as
I did for the research), he is not a child who would be at the forefront of an adult’s mind due to his not doing anything that would make him stand out.

“When you mentioned to me this child and we met I said… he wasn’t a child that… ‘stuck out’ in, in your mind. Like sometimes when you’ve worked with other children there’s a very strong feeling, a sense of how things were in the beginning and how things changed… sometimes there’s even a session that you really, something happens and you know that it’s… So there’s more of an even keel here, so it doesn’t stand out like that. So, if someone said, you know, think about a case and bring it, this probably wouldn’t be the case.” (TH: 20.1)

When the adoption of his brother and erratic contact with mother lead to feelings of upset being expressed in school, it is noticeable that angry behaviour is reported to have occurred at playtime and his aggression “wasn’t directed towards himself or adults.” (SENCO: 21.3) In this way, it could be considered that he attempts to keep angry feelings outside of the classroom away from his class teacher.

Similarly, the kinship carer reports that at home “his anger had got so bad that I don’t think it could have got worse” (KC: 37.2) and yet when struggling with such angry feelings, aggression is never directed towards her or his sisters, nor is he destructive towards her property. Grandmother describes that he would “just scream and shout and bang doors and refuse to come out of his room” (KC: 37.3), behaviours which she associates with being like “teenage things but he was too young” (KC: 37.3). It is possible that the appearance of these ‘teenage’ behaviours might be particularly concerning for grandmother if they remind her of how his mother behaved during her adolescence.

From these descriptions, an image is created of a child who as a consequence of events in his family life, finds himself overtaken by feelings which are too powerful for him to manage and which break through his ordinary defence of keeping a low profile. However even in moments of heightened emotion, he protects adults from his anger by remaining in his bedroom or waiting until playtime. In this way, there is still evidence of a desire to keep the aspects of himself which he feels might be viewed negatively
away from the adults whom he is dependent on. In therapy, this could make it harder for his therapist to know what was on his mind “with this child I found it harder in a way, he was a child that didn’t reveal so much so easily.” (TH: 25a.1)

His therapist hypothesises that this way of managing would likely be as a consequence of worry that were he to direct his feelings towards the adults who care for him, it could result in him being ‘cast out’ of home, school or therapy:

“I’ve been thinking a bit about…this child and you know how it is that things seem to have to be calmer...or not to be too visible, or maybe I suppose then I thought maybe not to be visible in a negative way that you then get cast out, because that must be, I suppose a very big fear of a child like that, to be cast out, or not taken in, or not held….and not managed.” (TH: 20.2)

Although having an older carer (and therapist) might exacerbate such worries “he presents as someone perhaps that doesn’t want to make too many waves in case you wouldn’t manage” (TH: 20.2), one might imagine that his fear of being too much for his objects is the product of an unconscious phantasy that it is because of him and how he behaved as a baby that his mother couldn’t manage to care for him and perhaps that had he been a less demanding baby she might have been able to cope. He may well also imagine that he is responsible for her turning to drugs as a way to escape. In her interview, the therapist recalls that his grandmother reported in a review meeting that he had been asking her about what he was like as an infant:

“she said he’d asked her about his mother and how he was as a baby…. Because I think it was ten or coming to that age where children actually begin to make links and work out and be…. so you know he’s probably wondering… why, why, was I too difficult, why?” (TH: 30.3)

Given the descriptions of his mother’s ‘high profile’ reputation and behaviour (e.g. on the bus) there may also be a wish to show (himself and others) that he is different from his mother and so by keeping a low profile is able to separate himself from this aspect of his identity which may greatly trouble him. It is these feelings which perhaps become
located in other ‘high profile’ children at the school who are receiving therapy, whom he perceives as being more disturbed than him and doesn’t want to be connected with:

“he presents as someone… being perhaps quite self-conscious, I mean the fact that right at the beginning he had the thought about, should I be going to this as there are other people that go that are known, perhaps in the school - you know flagged up a bit with a higher profile.” (TH: 30.1)

**Theme 2: Growing up male: brothers, fathers and sons**

This subordinate theme considers how this child and his grandmother manage their feelings in relation to his particular experience of growing up as; the only male in the kinship family, a boy who has lost his brother and a son without his father.

**Brothers**

In her interview, the carer considers why the loss of his younger brother who became adopted might have particularly affected this child due to his being the only male in the kinship home:

“I think he was just, lost his brother and that was it, you know, so… probably two, well, three women in the house and him, it must be awkward for him.” (KC: 37.11)

The therapist considers that his position as the eldest of the siblings might also have played a part in his carrying a lot of the worry “he seems to have taken it, he’s the oldest.” (TH: 23.3)

The grandmother describes how the child first got to know his brother during visits to his mother’s home “we used to go there once a month” (KC: 24.6) until he was placed in foster care “once she [mother] wasn’t allowed to see him he’d come to us, foster parents would drop him off at us.” (KC: 24.6) The carer conveys the child’s pleasure in spending time with his brother and building a relationship with him:
“they would play up the garden a lot, and you know, they really did have a great time, they spent every minute that he was there with him.” (KC: 37.12)

She communicates how painful it was for this child to then cope with the loss of a brother that he had become very attached to:

“His third birthday was the last time he saw him, or any of us saw him. So he was really upset, he was teaching him how to play football and he loved having his brother there, it was terrific so…” (KC: 24.7)

In this description, there is a sense of an important relationship for this child being severed prematurely and just at a time when his brother was developing new abilities which were enabling them to spend time together in a way which was rewarding and enjoyable for both of them. It could be considered that a part of the positive feelings attached to their relationship, in addition to the love for his brother in reality, was that in their play together, as an older brother he could take on the role of a paternal figure towards him. This would offer him an opportunity in phantasy to experience the feelings of a positive father-son relationship which he had missed out on as a little boy growing up without a father to guide and nurture his development. In this way, their play could be considered to have an important restorative quality for this child and the loss of this function, in addition to the actual loss of his brother, could mean that his loss would be experienced as doubly hard in a way which he might feel but be unable to articulate, resulting in descriptions of his “having tantrums” (SENCO: 19.2), which would usually be associated with a much younger child.

The dislocation of his brother to a new permanent family and feelings of shock associated with the finality of adoption are captured by the SENCO “then he was adopted and there was no contact with him, whatsoever.” (SENCO: 29.1) It is possible that his brother’s experience of loss and separation from his family which was very visible, might also highlight for this child his own experiences of loss and separation from his parents, which may be felt but harder to see when he has remained living within the same home and family network he was born in. The fact that he has been
able to stay with his birth family when his brother has not could also lead to feelings of guilt which might help to explain this recollection by his therapist:

“I remember writing one thing that he said… that he wasn’t so happy with his birthday anymore because it was close to the birthday of the sibling that was adopted.” (TH: 22.1)

One would imagine that birthdays would not only evoke feelings of loss for this child having last seen his brother on his birthday, but may also stir feelings of guilt that whilst he can celebrate the day of his birth with his relatives, his brother no longer has access to the family he was born into and has now started life with another.

When his mother has a further child, his grandmother is understood to have managed her worries about how he would cope with the potential loss of another brother by limiting their contact with him until it was clearer whether he would be remaining in the family:

“They only met that baby every five or six weeks because she was very worried that they would become attached and that baby would go. But the mother was going through a programme and she was free of drugs at the time which, she seemed to manage to get through, and I think baby did go back to her, but whether or not she managed to sustain that I don’t know.” (TH: 14.2)

In therapy, the child seems to make use of this space to work though some of his feelings about loss and separation through hide and seek games with a teddy:

“He played a lot with this teddy. I remember in one supervision we said whether… some parts of himself might be in the teddy. But part of me thought that this teddy was also about these babies and he didn’t know where they were because he had to hide the teddy and look…He did that with other animals…hiding and finding, so very important to be found, which I found quite poignant with this child.” (TH: 22.1)
As the treatment comes to an end, this provides a further opportunity for exploration of the feelings stirred in him by final goodbyes, bringing forth ideas about death and being forgotten.

“towards the end… the teddy started being hid in the fridge and got forgotten one time and then it was freezing, it became something that died.”

(TH: 22.2)

Alongside more ordinary worries about whether he will be remembered by his therapist after they have said goodbye, this also seems to capture the particular challenge facing a child who has lost a sibling to adoption. How can he mourn the loss of his brother so he can move forward with his own life, without fear that in the process of letting go he will forget about him altogether? How can he keep his brother alive in his mind into adulthood when he may wish to find him again, when in his memories his brother is frozen in time at aged three?

“The teddy ended up in the fridge and in the freezer. I mean that was quite remarkable to me that this teddy froze to death and was, right near the end, was a dead body which was quite shocking…so this teddy that was kind of loved and in the end was abandoned, and that is interesting really about, you know, him…” (TH: 25b.4)

This description seems to highlight the different levels at which this child is using his therapy sessions to grapple with feelings about the loss of: the relationship with his therapist, the loved brother that has gone, and an idea of himself as an infant that was ‘kind of loved’ by his mother but ‘in the end was abandoned’.

Fathers

In the interview with the kinship carer, a negative view of the child’s father is presented:
“I only met the dad once and he was nasty so… he already… [daughter] was pregnant and another girl was pregnant by the same man at the same time. So, yeah. I don’t particularly like men like that.” (KC: 10)

The grandmother conveys that a difficult part of her role as a kinship carer is knowing how to talk to the children about their fathers, particularly when there were issues of unclear paternity of the child’s siblings. “It’s hard trying to explain to the kids how, you know, why they don’t know their dads and things like that.” (KC: 10) In contrast, she reports that during contact sessions, the child’s mother would speak freely about her negative experiences of their fathers “she’d come out with things like ‘your dad used to hit me, he was really nasty when he was drunk’” (KC: 8) despite having “been asked not to discuss things like that.” (KC: 10) The grandmother expresses her concern about the emotional impact of these remarks on the children “they don’t need to hear that, and I think that…makes them feel a bit bad.” (KC: 8)

In her interview, the SENCO describes her understanding of the grandmother’s worry in the past that the boy’s father could make an unexpected reappearance in their lives:

“he was in and out of prison, and he hadn't shown any interest in the children. Then she heard that he was living locally and she was petrified. That he would just come and stumble across the children, or meet them when she was out shopping.” (SENCO: 22.1)

At this time, the worry seemed to be that an unplanned meeting could lead to a desire for further contact between father and son.

“that he would just come into contact with them and say ‘I'm your dad’ and want to see them and she, you know, was terrified of that. You know, would it happen? I don't know if it ever did, you know, that I don't know. But I'm sure that her anxieties over this must have been picked up by the children as well.” (SENCO: 22.2)

In the interview with the kinship carer, the concern presented was not just that the father might wish to build a relationship with his children, but that as the son reaches
adolescence and becomes more independent, he might also want to get to know his father:

“she [mother] tells the kids that their dad is…. because he’s saying that he’s clean now, he lives somewhere around […]… and she keeps talking about him all the time and I get a bit worried in case he gets it in his head to…to get the train to […] one of the days. He knows how to get there because, we go, won’t be anymore, but we used to go a lot.” (KC: 10)

Grandmother’s wish to prevent contact between them and her anxiety that this could occur, seems to be her way to manage her fears of the negative influence that she imagines the father could have over his son, as she feels he once had over her daughter:

“She didn't want them to have any contact, for obvious reasons. I mean she blamed their Dad for actually involving her daughter in drugs in the first place.” (SENCO: 22.1)

In this view of Grandmother’s feelings, as understood by the SENCO, there is a real worry of ‘history repeating itself’. That all of her hard work in protecting and parenting the children to give them a positive future could be undermined by a man who she feels has the power to lead them off-track “This daughter had, you know, in her words, ‘gone off the rails’.” (SENCO: 23.2) In this picture there is little belief that an adult could change, nor consideration of the part that the young person has taken in allowing themselves to be led down a more destructive and rebellious path and why they might wish to do so. It is also possible that the child’s father could at an unconscious level come to represent the kinship carer’s feelings about fathers in general, both her own as well as the father of her children who was not a part of his grandchildren’s lives.

In the absence of a ‘positive’ biological father or father figure in the kinship home, the child’s relationship with his uncle seems to fulfil this role. This relationship is felt to be helpful and is supported by his grandmother. However in the example given, the situation described in which the uncle’s attention needs to be given to his foster child, seems to be a painful reminder of how this child’s needs never get to be a father’s first priority:
“he gets on really well with [aunt’s] other half… sometimes if he’s got a homework problem that I haven’t the faintest idea what it is, erm, he just gets on the train and [uncle] meets him at the other end and he’ll stay there the night so… But erm, that hasn’t happened for a while because the boy she’s got, is bit of a problem….He’s hard work, so, yeah.” (KC: 37.16)

Sons

In her interview, the kinship carer describes some situations which had occurred more recently and led to him feeling angry or upset. The carer connected his way of managing these feelings to the onset of puberty:

“he gets moody but I think that’s his age anyway, he has got a bit of a temper. But usually he’ll storm up to his room and come back down half an hour later and he’s fine.” (KC: 19.3)

It is possible that as he enters adolescence, ordinary oedipal conflicts may be complicated by his situation as the oldest sibling and only male in the kinship family. This may well invite an omnipotent phantasy that he can take up the role of ‘man of the house’ and perhaps by doing so defend against having to feel the absence of a real father who can set boundaries for his son “it’s just his attitude ‘you can’t tell me what to do, I’m 13 now’ you know.” (KC: 19.7)

In the following example, this phantasy, which may be enjoyed through feelings of potency in his play, seems to collapse when confronted by the reality of his vulnerability and powerlessness in relation to an adult male figure who can impose limits on him:

“My youngest son upset him… He was bouncing a ball going up the street and I said stop, so he stopped for two minutes and then started again and my son had a real go at him and he said ‘you can’t tell me what to do’ and so he started bouncing it again. And my son took the ball off him and put it in the bin in the street. And the way he [son] started shouting at him [child] was really upset, really, really upset about that. When we went home he went
upstairs crying. He didn’t do it in front of [son], he wouldn’t let him see, but he went upstairs crying. And I says ‘well you shouldn’t have bounced the ball when you were asked not to and he shouldn’t have shouted so you’re both wrong’. And erm, he just says ‘no, I wasn’t wrong’.” (KC: 19.4)

In this example, the shock of the abrupt loss of his object seems to contribute to the child’s upset, which may connect at a symbolic level with the loss of his maternal object in infancy. The extent of the son’s anger which also leads to the child’s distress could suggest that at the level of intergenerational experience, something is powerfully enacted here by the son about feelings of shock and sudden loss within the family which cannot be processed.

Having his ball taken off him and discarded in the bin, could be experienced by the child as a devaluation of his object and the significance it holds for him, as well as resonate with his own insecurities of being discarded by his mother. Similar feelings of being discarded might also be felt at an infantile level by the son, who becomes protective over his mother and rivalrous towards the child who he feels has taken her from him, perhaps resulting in this wish to remove the object from him and put it somewhere where he can’t have it anymore.

**Theme 3: Special/Proud/Eager to please**

This subordinate theme considers how the child can feel keen to present the positive aspects of himself to others so that he is experienced by them as a likeable, capable and willing boy who they will want to continue to spend time with. It is suggested that this is another aspect of his way to manage unconscious anxieties of being ‘cast out’ as explored in Theme 1. This theme relates to the third theme of the first superordinate category ‘having/being a good enough parent’ resulting in counterpart feelings in him of needing to be ‘a good enough child’.

**Special**

From her descriptions of working with him, it is possible to see how this way of managing was enacted in the transference towards his therapist, who recalls how
surprised and pleased he was to hear that he was going to be offered individual therapy with her (unlike his previous experience of sessions with his siblings).

“It was explained that he’d have it and I remember that he went ‘just me?’ and he seemed quite excited at the thought that it would be just for him.” (TH: 9.2)

Being selected as the only sibling to spend time individually with a therapist seems to make him feel quite special that he has been chosen and perhaps also communicates how much he desires to have some individual time with an adult.

“I think that he quite enjoyed the opportunity to really have some time focused just on him.” (SENCO: 30.1)

His therapist recalls how after this plan was explained to him in an initial meeting, he had to wait until after a holiday break to begin his sessions:

“…he had to wait to come to me and he’d written this, the first time he’d written this list which was kind of unusual…he said he didn’t want to forget, he wanted to remember things that he wanted me to know… which was really poignant… It was things he liked, a lot of sports, football…” (TH: 11.4)

In this description it is clear that the idea of a special person for him has stayed in his mind over the holiday and it feels very important to him that she should know about the positive aspects of his life. It also seems important that she see he is an ordinary and likeable boy who is functioning well unlike some of the other children in school that receive therapy.

“He was…a pleasant looking young boy…quite a pleasant nature, so he didn’t seem… he felt quite compliant… came across as a child who seemed very polite.” (TH: 10.1)
His pleasure at having his need for some individual attention responded to by a maternal figure and his wish for closeness with her is conveyed in a description of how he would greet his therapist and walk alongside her perhaps in phantasy as if they were one.

“…he would come and he’d often greet me with a smile and he’d walk in synch with me very often.” (TH: 24.2)

Connecting himself to her in this way might be particularly important in helping him to feel securely held during the transition to the therapy room.

Proud

Another way in which he seems to try to make himself an appealing child, is to show that he has skills and talents that might make a parent feel proud. This desire is captured by the grandmother’s description of his working hard at Police Cadets and his pleasure when his achievements are recognised.

“He does want to be…because at the end of each session they pick a cadet of the week and he’s had it four, five times maybe… and erm, he’s really proud of himself. You get a bar of chocolate and, you know, a lot of praise so erm, yeah he likes it.” (KC: 38.22)

In therapy, he is similarly keen at the start to make a good impression on his therapist by showing her his skills:

“He wasn’t a child to talk direct a lot and then he’d like to sometimes show me things he could do. In the very first session he did drawing and told me he liked drawing and he told me he could do mirror writing, which was, he could do beautiful mirror writing and he seemed to be very good at art, you know, he was very careful and could make things very neat and quite beautiful.” (TH: 24.1)
However his therapist hypothesises that this way of managing can result in him putting a lot of pressure on himself to do well, which at times can be overwhelming and paralysing:

“Right near the beginning at the first review she [grandmother] mentioned that he’d handed in a project - because that was a concern for her that he wouldn’t sit and do the homework. And it may have been partly anxiety about not being able to do it well, because I think he had this big thing about not being good enough and not managing, and so then he’d leave it.…. I remember she said he’d leave it too late and then, you know, it was hard to get it finished.” (TH: 31.2)

She also highlights a competitive aspect of his desire to do well so that he stands out from other children as being ‘the best’:

“There was something at school, they were doing this bleep test or something for their heart in sports and he was a bit upset because he, he wasn’t right at the end, so he wasn’t the very best. But when I managed to tease it out of him I think he was one of the last three, so he did really well. So I think I picked up from him then, that was always that it was really important for him to be one of the best, to be special, not to be a loser… and that came out really early on…” (TH: 16.1)

In his sessions similar feelings are evoked in play with his therapist, where the fragile nature of this omnipotent defence becomes evident in how quickly he can feel dismayed with himself when he is not as capable in reality as he would like to be:

“Winning - to be the winner it came up all the time, right at the beginning and all the way through. He liked to play games. He’d make up rules very often and he was quite good at ‘I’m the champion’ and then if he sort of missed something, you know, ‘why am I a loser?’ ‘why did that happen?’ It was really quite strong, or you know, he’d say to me sometimes ‘you flopped’ if I didn’t catch a ball. So there were adjectives for being a loser
and for being a winner and it seemed really important to him, the winning.””

(TH: 22.1)

As his mother’s first child and son, he might attach particular significance to the specialness of being first, whilst in reality his early experience seems to be of his needs coming second to his mother’s and of not being a father’s first priority. Seeing that his mother has kept another son whilst she was unable to care for him, might also stir competitive feelings towards other children and a drive to recreate through his relationships with other adults such as his therapist, the feeling of having a special parent-child bond in which he is the chosen child and not the one who lost out.

“…what’s the meaning of losing? And maybe not as consciously…because a child whose lost out in some ways… that was all the way through and I think that feeling of the need to be good enough… was really important for this child…he had a need to show me he could do things, and he was good at this and good at that and although, I mean any child can enjoy showing you, it seemed to be more of an urgency and more.. you know, really strong feeling attached to that, he had to be good at things…” (TH: 22.1)

Eager to please

His desire to be a likeable and wanted child, who is willing to do things to please others, seems to lie behind worries voiced by the kinship carer about his vulnerability to being manipulated by people who have negative intentions.

“He’s really, really easily led by naughty, really naughty kids. When the, even the police [cadets] noticed when they went camping. This one boy, whatever he wanted [child] to do, he would do it and that is really worrying, because that’s how you end up getting in big problems, stealing and drugs and stuff. And hopefully he wouldn’t but… I don’t know… I was talking to one of the policeman, [child] doesn’t know we talk, but, and he did say to me ‘Granny worries about him still’ and I says yeah, because he’s really easily led.” (KC: 38.16)
When the parallels between these worries about her grandson and descriptions she had given of his mother were raised in the interview, the kinship carer readily acknowledged that in this respect he was very much like his mother and this was of great concern to her for his future.

“R: Is there a feeling that he’s a little bit like…like was his mum also? That… he’s somebody who could be easily influenced is that the worry for you?

KC: Yeah. Definitely. Yeah you can see it in [sister] as well, so… Actually you can see it in all of them…. [Each of] the children you can see a bit of mum… With…him I think he’d do anything that anybody says even if he knows it’s wrong. And that’s the bit I want stopped.” (KC: 38.25)

His grandmother’s perception that “he’s actually quite truthful most the time” (KC: 18.3) seemed to offer her some relief, perhaps that at least she would know if he was getting himself into difficulty, for example with drugs, which she had felt unaware of with his mother:

“…she smokes cigarettes but she smelt funny a few times and I didn’t know what it was. And one day she had holes in her tracksuit bottoms and somebody says ‘oh she’s smoking roll-ups’ and I says ‘oh, well maybe ‘cause they’re cheaper than cigarettes’ and this person says ‘no, not that sort of roll-ups’. I was quite ignorant…” (KC: 12)

Her uncertainty as to what path he would choose for himself in the future seemed to be symbolised by her description of his two best friends, one whom was a ‘well behaved’ child and the other more ‘badly behaved’.

“he does worry me, he really does because he’s, like I say he’s very, very easily led. [One] is a really nice child. [The other] is, a bit of a tearaway.” (KC: 38.24)
This concern about which aspects of his identity may predominate in the future was also expressed by his therapist:

“I think…we put at the end that he was a vulnerable child and as he grows and tries to make sense of all of this he could certainly, he would need an eye kept on him about which way that might take him.” (TH: 31.3)

UNDERSTANDING

In this superordinate category understanding of key aspects of his experience of being a child in kinship care are explored. These are: why his mother is not able to parent him, why his sibling is adopted and the legal arrangements under which he is cared for by his grandmother. In the first two of these subordinate themes, the child’s understanding is considered in the context of the feelings of the adults around him. The third subordinate theme explores the understanding of the research participants, with a view to considering how their perspectives might help to illuminate the child’s experience.

Theme 1: Why his mother is not able to parent him

The SENCO describes how the school had a good understanding of the child’s situation as the grandmother would talk frequently to the SENCO about difficulties she was experiencing.

“[Grandmother] was actually very keen to always stand and talk about things. So it was very common first thing in the morning when the children would line up to go into school that she and I would have quite a long discussion about what had been going on generally. It tended to be that she wanted to talk about, you know, the issue with her daughter and her daughter’s partner and, sometimes it was about neighbours that were causing her lots of hassle or whatever, there was always a story to be told so there was always lots of opportunities to talk to her informally at the beginning and the end of the day. So, we were aware of the background of the family.” (SENCO: 19.1)
The grandmother’s desire to talk regularly with the SENCO seems to highlight the challenge of being a kinship carer to children who are no longer in the social care system, as this results in there being limited ongoing professional support and guidance:

“the first year you get a social worker coming, I think maybe three times in the year, after that you don’t see a soul, so you’ve, if there’s any problems you’ve not really got anybody to talk to, so yeah, I found that quite hard.” (KC: 8)

Although in other ways the grandmother is ambivalent about wanting continued social work involvement, when in need of practical support she makes contact with social care to ask for help in reducing the frequency of contact due to their mother’s low attendance.

“My youngest son stopped talking to me when he found out I’d gone to Social Services and, erm, it was the only way I could do it. I spoke to somebody at the school about it and I just didn’t know what to do. I mean I didn’t particularly want social workers involved, but if that was the only way to get her [mother] to listen, that the kids wanted less contact, you know, she just won’t listen…” (KC: 9)

She describes how as a consequence of this, she is advised that she needs to explain to the children the nature of their mother’s difficulties:

“The social worker said that I have to… explain to the kids about drugs, which I’d just never done, I just said she hadn’t been well.” (KC: 9)

She recalls subsequently having this conversation with the children and how it then enables the child to make sense of other experiences which he has had:

“KC: I sat down, after Christmas it was…and explained to them. He [child] got a tablet out, you know a Kindle, looked up the drugs that was mentioned and I was talking to [his sisters] about it, erm, and we were all
sat there talking and he said ‘that was the first fight I had in ‘[Secondary School]’ because somebody had called his mum a junkie.

R: And had he understand what it meant at that time?
KC: No.
R: And now he understood.
KC: Yeah.” (KC: 9)

The carer describes how well the child manages this discussion and his interest in trying to understand the facts:

“He was really good, really adult about it actually and… I can’t remember what drugs we discussed, but he looked up each one.” (KC: 9)

When asked what she thinks the child understands about why he is living with her, there is a sense of relief that this conversation has taken place “I probably should’ve done it before, but I didn’t quite know how to” (KC: 17.2) and that the child feels he now understands:

“all of it, mostly, yeah everything now…when I told them about the drugs and that he says ‘yeah that explains a lot’.” (KC: 17.2)

The carer’s observation that he responds to hearing this information in an “adult” way in part suggests that he is now at a time of his life (adolescence) when he can absorb this information and is interested to learn more about his family and the world around him. However this very pragmatic response to hearing about his mother’s addiction, may also indicate a defence against the painfulness of this information and what it means to him, by focusing on the factual information about different drugs and what they do which he can find clear answers to online. This response seems to mirror the carer’s (and possibly social worker’s) focus on the symptoms of mother’s difficulties (i.e. her drug use), rather than helping them to understand why their mother turned to drugs. In this way the split within the child here seems to replicate a defence within the family in which the underlying difficulties might be much harder to think about and share (especially within an interview setting), as this would mean that the troubles are not all
located within the mother but within an intergenerational family experience which she has responded to in a particular way.

Given this, the responsibility on the kinship carer to have this conversation with the children on her own, without any support for her feelings, would be an understandably hard task. For any carer to manage this, it would require them to not only be able to reflect on themselves and their experiences, but also to be able to share information in a way which enables the children to remain open to parents who they themselves may feel very angry and disappointed with.

Without the underlying aspects of their parents’ difficulties being explored, it is questionable how much the children do really feel they understand, or what further conversations might need to be had as they grow up and become more curious. In the absence of a more comprehensive understanding, the children might be left with doubts and unanswered questions which they could then create their own answers to, shaped by unconscious phantasies about their role in why their parents do not care for them:

“…issues were around knowing you had a mum but not living with mum and trying to build up some sort of resilience, that when she sort of let them down, it wasn't because she didn't love them, or they weren't lovable, it wasn't their fault.” (SENCO: 29.3)

It is perhaps this level of understanding and openness which would be required in order to prevent the same difficulties from being enacted by the next generation.

**Theme 2: Why his sibling is adopted**

The child’s desire to understand why his sibling has been adopted, seems at times when he is struggling with this loss, to be fuelled by a need to know who is responsible for this happening so that he can know who he can be angry with about it. The grandmother reports that when he asked his mother, she said it was his grandmother’s fault:
“…when he asked his mum why his brother got adopted she said ‘cause your f-ing nan wouldn’t have him’.” (KC: 27.4)

When he asks his grandmother why she wouldn’t have him, his grandmother refers to the original recommendation by the Court, which perhaps in this moment represents a helpful paternal figure who can set some protective limits:

“‘why couldn’t you have him?’ and I did explain to him that I was fifty-something, I was too old to take another child and plus the courts only actually wanted me to have two, so me having [his youngest sister] was… having an extra.” (KC: 27.8)

In this situation, as it is reported by the grandmother, the mother does not acknowledge her (or his sibling’s father’s) contribution to this outcome. As a result, the child’s angry feelings are diverted from his mother to his grandmother who is then the recipient of his upset:

“…he really did resent the fact and I says ‘I’m too old’ you know… I wouldn’t have coped with four children… it’s hard with three, four would have been impossible, so no. And I did feel bad, but, just had to get over that didn’t they?” (KC: 27.4).

In this family dynamic, as it is described by the kinship carer, the child seems to become a medium through which the mother can voice her own complaints towards her mother. It is not known to what extent the mother really feels the grandmother is culpable for her fourth child being adopted, or whether the loss of her child represents a more general feeling of blame towards her mother for how her life has turned out. Given her ambivalent feelings towards her mother parenting her children, there may be an unconscious wish to create difficulty in the kinship care relationship, so the grandmother is deprived of the satisfaction of having a good relationship with her children and succeeding in parenting them when she has failed. There may also be a phantasy that her mother has not taken on this child as a way to punish her for her behaviour.
In this situation, the kinship carer describes having to manage both her own feelings of loss and upset, as well as the children’s:

“I did feel rotten as he’s such a lovely child as well, and we saw him every couple of weeks. In the end, somebody just dropped him off at us and left him there and come back a few hours later so they got to spend time on his own with nobody else around.” (KC: 27.10)

She reflects on how for the child this situation is “hard for him to understand it” (KC: 27.9) but expresses some feelings of comfort that at least the child has been adopted into a good home: “the people who adopted him are really nice, I met them.” (KC: 27.12)

**Theme 3: Legal arrangements**

In her interview, the SENCO reflects on how difficult it was to fully grasp the different care arrangements within the kinship family.

“It was quite complex, I’m still not sure I absolutely understood, because each of the children came to her through different…local authorities.” (SENCO: 19.1)

The Grandmother also conveys a sense of feeling ill-informed about what arrangements might have been possible when she was granted a residence order for her grandson. This was particularly in relation to contact frequency which, since attending a kinship carer’s group, she discovered had been set unusually high.

“Myself and [another kinship carer] are the only two that mother sees them so often. Even the social worker said it, they’ve never known people… and I thought oh if I’d known that years ago I could have stopped it.” (KC: 42.11)
She also describes a lack of knowledge of any interventions and support which might have been available to help her, such as life story work; “No. Nothing. I don’t think they did in those days, maybe. I don’t know” (KC: 17.8) and support groups:

“My friend’s sister…she fostered for years and she got custody of her niece or something. And she started going to meetings and I didn’t know they existed. I think there should be… If somebody gets Special Guardianship or Residence Order or something, then they should send letters to people saying there is meetings…” (KC: 42.5)

This feeling of uncertainty and confusion connected with the legal arrangements also seems to become transmitted into the TOPS service which was under the impression that the child was adopted by his grandmother.

“that’s quite, interesting the way, you know, why somewhere along the line was an assumption that was probably… kind of carried through, and erm… how that does sort of impact on this particular family? With the kind of uncertainty, it just added layers of uncertainty which, you know, one thinks they have had enough uncertainty and they don’t need any more really.” (TH: 35.4)

As suggested by the therapist, the difficulty of having to tolerate feelings of uncertainty seems to result in a phantasy that the child is cared for under an adoption order, thereby offering a greater sense of certainty about the child’s future care.

“I was quite taken when I realised, but it is in the notes from our review meetings, near the end that it was thought that he was adopted and he wasn’t…and I’m not quite sure how that was and then the implications for that and the grandmother beginning to worry that possibly her daughter would want to…have the children in her care at some point, but I mean that wasn’t, you know she would have to be clear of drugs for quite a long time…” (TH: 35.1)
ENGAGING

This superordinate category reviews the child’s (and his grandmother’s) engagement with the therapeutic provision offered through the TOPS service at his school. Participants’ views on the effectiveness of the individual treatment for this particular child are explored, in terms of how much the work was able to help him with the difficulties for which he was referred.

Theme 1: Referral

As a consequence of continued upsetting experiences within his family life, it was felt that this child would benefit from individual treatment further to the work already undertaken by the TOPS service with the sibling group. His presenting difficulties included: “issues with anger and anxiety” (TH: 4.2), his “self-esteem was not high” (TH: 19.3) and “academically he wasn’t doing as well as he could be” (TH: 4.2). The therapist describes the aim of the therapy as being “to try and see if that kind of work could alleviate some of those feelings.” (TH: 19.4)

In addition to these difficulties, the SENCO also articulates concerns about the child’s low weight:

“Generally he had a really, really good appetite. A really, really good appetite. So it wasn't that he wasn't, he wasn't eating in class, but he wasn't really gaining weight. So there were concerns about that.” (SENCO: 21.5)

The fact that the TOPS service could undertake individual work within the school was highlighted by the SENCO as an advantage:

“she [Grandmother] could see the benefits of it, you know, she didn't have to take them anywhere else, it was there on site. She was concerned about him getting very emotional, upset, angry and getting into conflict with his peers, so she wanted him to have support for that.” (SENCO 25.1)
The SENCO reflects that without this service being available in the school, the child may well not have been able to access therapeutic help, as it would have been very hard for the kinship carer to take the child for weekly sessions at a clinic whilst managing the care of three children.

“had TOPS not been there, I think it would have been tricky, because we could have made a CAMHS referral but I doubt whether Grandmother would have taken them there, because she had so much on her plate, that to try to get them to the Tavistock [clinic]…I don't think that would have worked.” (SENCO 34.2)

From her perspective of offering treatment in a school setting, the therapist outlines the benefits as well as some of the challenges:

“I think school, school is a familiar place…There are…pros and cons with that because they are pulled out of, so it’s more visible to their peers that something’s happening perhaps… On the other hand you’re not reliant on adults being reliable enough to bring them to a clinic and, you know, have to be there and bring them back. So my experience of working in a school is often that…the children actually get to be seen more quickly than if it goes through a clinic, as there’s often different processes and waiting lists, and I think that can be very positive. I do think overall a familiar surrounding is positive but there are a few other sides to it… You know that it isn’t as private perhaps and this particular room [in the school used for therapy sessions]… [posed specific challenges]” (TH: 33.1)

**Theme 2: Treatment**

**Treatment Package**

The individual treatment consisting of weekly psychotherapy sessions for the child lasted for two academic terms. In addition there were review meetings between the kinship carer and therapist “we would have review meetings usually I think it was once a half term.” (TH: 17.1)
In the interviews with the three participants, there are mixed recollections as to what, if any, individual support was offered to the kinship carer at this time, alongside the child being seen for treatment, as is a typical model of psychoanalytic work. In the interview with the SENCO, there is a strong recollection of the service trying to engage the grandmother to attend ‘parent work’ sessions with the lead therapist.

“As long as she felt that it was for the children's benefit and that she wouldn't be part of it, I think she was very comfortable with it.... I think where she felt a little uncomfortable was when the team wanted to involve her as well into it. And she would say to me like, things such as, ‘I don't know why they want me there because I don't need any counselling, I'm absolutely fine’. And I'd say ‘no it's not counselling for you, it’s helping you to then help the children’. ‘But I don't need that, I'm perfectly fine, I just want them to deal with the children’.” (SENCO: 25.1)

In the interview with the kinship carer, when asked about support offered to her by the service, the kinship carer recalled attending regular review meetings “Sometimes you go after a couple of months and just have a quick chat, a review sort of thing.” (KC: 30.1) but did not bring the same recollections as the SENCO about being offered parent work sessions. The therapist could also not recall this aspect clearly, concluding that “it might be because she [the Lead Therapist] worked with...the grandmother the previous year...and then it was felt she didn’t need it so much.” (TH: 17.5)

This was the only area of the research where there was a considerable disparity in the recollections between the three participants. This may in part be due to the length of time since the work took place and of the service having offered more than one period of intervention to different children within the family, such that the details of this particular period were harder to distinguish and recall. This also related to work which may have been offered by the Lead Therapist who was not a research participant, therefore leaving a gap in the knowledge of this particular aspect of the therapeutic package offered by the TOPS service at this time. This was potentially a shortcoming of the research design, although was intentionally not included as the focus of the research was on the child’s experiences and not those of the carer. However, given the strength of recollection by the SENCO “I think it was a shame that Grandma herself wouldn't
engage to the same extent. I think that would have helped further, to have helped her deal with all the stresses and strains” (SENCO: 34.1), this might suggest that this aspect of the treatment package was not available for recollection in the interview with the kinship carer, due to her own wish to keep the focus of our discussions on the child’s feelings and experiences rather than her own, such that the research interview became a replication of the original situation.

However an aspect of the broader intervention offered by the service outside of the child’s individual therapy sessions which was felt to have been helpful, was an idea of the Lead Therapist working with school staff to devise strategies for moments when the child was struggling to manage his behaviour:

“I didn’t know if the teachers worked it out or if it was worked out by [the Lead Therapist] that he had…a card, a red card and if he was getting, really getting enough state he just had to show the teacher the card and he could disappear to his classroom or something, for a calm down… and that actually did work. We’ve still got that card somewhere… He’s kept it.” (KC: 34.5)

Clinical Work

Across all three interviews there is a shared belief that the child engaged with his therapy, however the confidential nature of the work seems to lead to different ideas about how he engages in his sessions. In particular the question of whether he uses them as a place where he can talk about his feelings towards his mother. In the interview with the SENCO there is an idea that the individual work has enabled this to be possible:

“I think that he was able to talk, but I don’t think it was when it was in a group session. I think when he had one-to-one he was able to talk about how he felt about his mum not being there. And, those sort of discussions came out of those sessions.” (SENCO: 29.1)
In the interview with the therapist, she remembers the kinship carer asking her this question directly “I recall there in one of the reviews…his grandma asked me whether he’d spoken about his mother…” (TH: 25a.1) There seems to be a hope from both the SENCO and carer that the child would be able to talk to his therapist about the absence of his mother and how he feels about this, presumably based on an idea that it would help him to do so, however the therapist reports that this was not the case:

“I said he didn’t speak but sometimes I would wonder from his sort of mood and play whether something had happened, you know, whether he’d actually seen mother that weekend…” (TH: 25a.1)

Although this poses a challenge to the therapist who (between review meetings) can be unaware of the events occurring in his life which might be impacting on his state of mind at that time “it was just that perhaps I could feel more of an agitated state that was coming out” (TH: 25a.5) this lack of knowledge of external events might also enable the therapist to focus her attention on his internal world, such that his preoccupations are not overdetermined and feelings can be explored at the level of unconscious phantasy through his play.

“I would say that some of the time when I was with him, I suppose one thinks about the work and so it wasn’t always in my mind I’m with this child who’s in kinship care and all those things… So you forget, and so some of me feels a bit guilty for forgetting. But maybe that, I shouldn’t, you know, maybe that he wouldn’t want me, he wouldn’t want to go through life with everyone thinking about that…but at the reviews of course you’re very much brought back to it.” (TH: 28.4)

Over the duration of the work, the therapist notes some subtle developments which occur in how the child becomes able to engage with her in a less guarded way, bringing to her a wider range of feelings, which could be viewed as clinical evidence that the child is working through his feelings towards his primary maternal object in the transference:
“I think he was more able to sometimes be bolder, be an attacker, be... you know, whereas the very initial stages he really wanted to be the good boy, nice boy and he could show me perhaps more facets.” (TH: 25b.1)

At the ends of sessions, when faced with feelings about separation from her, this could result in a wish to protect himself from these feelings by either suggesting that he feels nothing, or wishing to keep going so as to avoid the moment of leaving all together:

“towards the end he’d often say suddenly ‘I’m bored’ and I’d say well you know maybe sometimes it’s hard to know what to do with the time and then he’d think of something and sometimes after saying he was bored we’d then run over, but then I think that was also more coming further on in the year and I think part of that is also knowing that it’s going to end.” (TH: 24.2)

Reflecting on the treatment and how it ended, a feeling of hope is also present for the therapist that the child has managed to engage with the work and internalised something positive from this experience which will help him if he faces difficulties in the future:

“I remember right at the end he did manage to think about, you know, why am I here and worked it out, sort of, and you know, I tried to say how will it be when we don’t meet? He didn’t know and, you know, I was saying do you think I can think about you in my head? And I remember he smiled, so he... then he played some play of an animal getting stuck, but then there was a way out...which I then commented back to him, that this helps, help’s around...so that was near the end. But it was a nice way to end that perhaps he had picked up that, you know, people can be in situations but there are others around to offer some help and, so that was hopeful.” (TH: 35.7)

Theme 3: Outcomes

The Present

In her interview, the SENCO expresses confidence that the decision to refer this child to the TOPS service for individual work was a good decision:
“I think it was absolutely the right thing to do, to make the referral. I mean there is no doubt that it had a very positive effect on the family.” (SENCO: 34.1)

She reports that he became better able to apply himself in his lessons and subsequently made academic progress.

“Certainly he settled down in school. Certainly his ability to attend and concentrate and to write approved. His grades improved. Grandmother was really, really pleased about that, that he did a lot of catching up between Years 3 and 4. It was a combination we felt of the TOPS therapy and the fact that he was maturing as well, because he grew, physically, and actually emotionally, he grew and he settled down as well and he was able to really, concentrate to a much higher degree in class and actually challenge himself, whereas before he’d been very uncomfortable about being out of his comfort zone with any work that was being presented to him. He then was able to actually do that, so I think that the TOPS intervention certainly was very beneficial.” (SENCO: 29.1)

Compared to her earlier description of the child having a big appetite but not putting on weight, here it is interesting to note the parallel processes described of his growing physically, mentally and emotionally during this period. This seems to connect to the idea of a deficit in the early feeding relationship which left him feeling hungry and unable to absorb the nourishment he needed in order to grow. Having individual time with a therapist seems to have helped to attend to this need and supported him to be in a better position to be able to internalise the good experiences available to him, which enables him to develop his own capacities. In her interview the therapist recalls that this development was not only recognised by the school but also by his kinship carer:

“I know overall the school felt he was doing better… and that definitely in the review, his grandmother thought that things had improved, he was able to apply himself.” (TH: 25c.2)

In her interview, the kinship carer also reports that his anger had lessened:
“He started getting a lot calmer, I do remember that much. He was getting a lot calmer and he didn’t erm, bang doors and things as much, and, all that sort of thing yeah, it was a big difference.” (KC: 37.1)

She similarly attributes this to a combination of the therapeutic work and his increased maturity:

“…whether that was the therapy and growing up at the same time – probably a mixture of both of the things.” (KC: 39.5)

In addition, the SENCO suggests that the therapeutic work helped him to be better equipped to manage his transition to secondary school:

“I know that when he did transition to secondary school, he made a good transition, you know… Had TOPS not been involved and to have helped him deal with his emotions, I'm not sure it would have been as successful as it was.” (SENCO 33.1)

Reflecting on these positive developments, the SENCO conveys her view that this was possible due to the treatment being accessible within the school:

“I'm not sure that they would have had the same outcome without the service being available in the school. You know, I can, I can very clearly say that I think.” (SENCO: 34.2)

However, limitations are also recognised. Firstly in terms of the allocation of these resources within the school and decisions which needed to be taken about how much input could be invested in any one child:

“although I think its recognised that this child, you know is vulnerable, there were others waiting, on the waiting list that they felt was more acute at the time and he’d had a fair, you know sibling therapy and this, so I think for the moment…” (TH: 32.3)
Secondly, in terms of the limitations of what the treatment at this time could help with:

“I think, problems are complex and you know might become more complicated with some other… I don't know where it is, whether that baby is still with her, whether baby has had to leave her?” (TH: 32.1)

Perhaps due to this concern that the child could experience further significant loss, the therapist recalls that although it was felt he had received a sufficient input at this time, the carer was advised that she could always speak with the school again if further support was needed:

“They did say that if, to grandmother, if she had concerns she should approach the SENCO again, so it wasn’t left without any, you know just this is it, you can’t have any more, it wasn’t that way.” (TH: 32.4)

The future

The therapist also suggests that a positive outcome of the treatment was that it gave the child a good enough first experience of therapy that were he to need further help in future, he may be more willing to seek support:

“it was a piece of work that he managed to do from the beginning to end and he got something out of it and completed it and I feel that can be helpful for the future if you’re thinking of looking for help, to think, well, that as an experience…” (TH: 32.1)

In the interview with the kinship carer, a few years following this treatment and after her discussion with him about his mother’s use of drugs, there was an idea he would benefit from further support, possibly through a mentoring scheme:

“I think he’s getting to the point where he does need to talk to somebody now, now he knows about the drugs and things like that as well, I think he…somebody like that might be able to help him talk it through that…” (KC: 38.3)
The grandmother’s capacity and willingness to find appropriate support for her grandson at different stages of his life, resonated with the recommendations of the therapist when concluding her work with him:

“we put at the end that he was a vulnerable child and as he grows and tries to make sense of all of this he could certainly…he would need an eye kept on him about which way that might take him.” (TH: 31.3)
Chapter 5
Discussion

“Belonging is what human children crave. Without belonging we hardly know who we are, we scarcely know where to begin.” (Hunter, 2001: p.106)

5.1 Belonging

In her paper Where do I belong? Rustin (2006: p.107) suggests “the idea of belonging somewhere is an ordinary and fundamental building-block of a sense of personal identity.” She writes:

“The somewhere that we belong starts off as our family of origin in which we are accorded a place defined by relationships. Around this will be concentric circles in which we belong in some fashion to wider social groups: extended family, school, local community, city, region, country.” (Rustin, 2006: p.107)

Rustin describes how “children who cannot be brought up in their families of origin suffer a basic disruption in this sense of membership, of knowing where they belong.” (2006: p.107) This feeling is poignantly captured by Hunter’s recollection of psychotherapy with a child living in a temporary foster home who had a recurrent dream in which she was “always lost, running everywhere, trying to find someone to whom she belonged.” (2001: p106)

Aside from any accompanying financial incentives what makes kinship care such a desirable placement choice for children who cannot live with their parents is the chance to provide them with a continued sense of belonging to the family which they were born into, as expressed by the grandmother in my study:

“I think for him the good thing is at least he sees most of his family, and cousins and aunties and things like that.” (KC: 24.1)
It is the recognition of the importance of maintaining these connections which is captured by the Children Act 1989, confirming that where possible children are best cared for within their family of origin. This is further evidenced by studies which show that where children are able to maintain family ties through being placed with kin, the feelings of belonging, identity and emotional security this provides are protective factors in supporting children’s mental health:

“Children in kinship care are placed within a social class and culture familiar to them. Living with relatives may reinforce the sense of identity and self-esteem that flows from knowing family history and culture, and may be one explanation for the lower association with psychiatric problems in the kinship placement group.” (Holtan et al. 2005: p.205)

For many, although not all children, in addition to remaining within their family of origin, kinship care may also be more likely than other forms of care, to provide children with the possibility of remaining within their existing school and local community, as found by Burgess et al.:

“Many of the young people had moved just a short distance…some remain within the same town, the same street or even as close as next door… People and places around them were familiar and most had not had to change schools and had been able to retain their friends.” (Burgess et al., 2010: p.301)

Although as for the child in my study, remaining within the same locality as birth parents may bring its own significant challenges, retaining their location within these ‘concentric circles’ perhaps cannot be underestimated in enabling children to feel anchored within a time (Canham, 1999) and place. This may help to protect against feelings of disorientation, anxiety and loss of a sense of self and of one’s place in the world as may be experienced by some looked-after or adopted children - “I would perhaps summarize his mental state as being frequently almost totally lost in time and space” (Rustin, 2006: p.111), who have been separated, sometimes repeatedly from all that is familiar to them, in often “bewildering, incomprehensible, or frightening circumstances” (Rustin, 2006: p.109):
The markers of familiar places, so important to young children, may be confused or lacking. Sounds, smells, the view out of the window may have changed unpredictably as did the humans in view.” (Rustin, 1999: p.53)

The child who was the subject of my study, seemed to have benefitted from all the protective aspects of caregiving which studies suggest promote the best outcomes for children in kinship care. He had remained living in the same home from birth (when his mother moved out he remained there in his grandmother’s care), had siblings living with him which enabled further close family connections to be maintained, had contact with his mother and extended family, remained at the same school throughout his primary years, had access to therapeutic services in his school and a grandmother who was resourceful in seeking support for him. It is possible that it is the benefit of these aspects which resulted in perceptions of him as having “a very nice disposition” (TH: 24.30) perhaps indicating that he is a boy who has experiences of feeling loved and cared for.

Lutman, Hunt and Waterhouse (2009: p.35) note that in situations where a kinship placement breaks down, other family members will often step in: “the extent to which some families rallied round to keep the child within the network was sometimes quite astonishing.” This sense of wider family responsibility also seems to be evident in this family in descriptions of an aunt who helps her mother with providing care, and thereby perhaps prevents the likelihood of the placement breaking down due to strain on the grandmother’s health:

“Although Grandmother wasn’t old, she had a number of health problems herself. So there were days that she didn’t have the energy to run around after them. So her daughter would collect them from school, take them to the park, would help with homework, would help her with the cooking at home. So, she was a great support for them.” (SECO: 23.2)

The “high levels of commitment” noted by Farmer (2009: p.339) seemed to be evident in this family with a grandmother who decided to offer care to a third grandchild despite the court’s recommendation that she only take two (KC: 27.8). This picture fits with Farmer’s finding that kinship carers will often go ‘the extra mile’ despite this resulting
in themselves being under considerable strain: “the good outcomes for these children are sometimes achieved at the expense of the kin carers themselves.” (Farmer 2009: p.340)

The feeling of belonging to a kinship family, along perhaps with recollections of neglectful and/or abusive parental care may account for Farmer, Selwyn and Meakings’ (2013: p.28) finding that 73% of children who were asked “where they would most like to be living now, if they could choose” replied “with their kinship carer”. However 13% of children (the second largest group) replied that they would like to be living with a parent. Similarly, Lutman, Hunt and Waterhouse (2009: p.32) found that “the second highest reason for kinship placements breaking down was the child requesting to leave” which they concluded was an indication of how “for many children the desire to return to birth parents despite their early experience was so strong that “no other placement is likely to work”.

This seems to highlight that in spite of the extent to which kinship care may be able to mitigate against some feelings of loss by providing important aspects of continuity, it of course cannot remove or replace a more primitive sense of belonging, in terms of a longing to be with the primary maternal object. This desire to be with birth parents may be complicated by feelings of guilt about “being taken into care” (Broad, 2004: p.221) or anxiety about “having betrayed or abandoned a mother who needed her baby’s love.” (Rustin, 2006: p.108)

It is possible this aspect of children’s feelings could be easier for foster carers to hold in mind when they are unrelated to the parent, than when a child has remained living with extended family, as this could obscure the child’s feelings of loss and separation (see subsequent section on ‘invisibility’). Additionally, due to the likelihood of kinship carers having their own conflicted feelings toward the child’s parent, which children would likely be aware of, this could make it harder for children to feel able to voice feelings of longing to be with parents out of worry about appearing ungrateful or upsetting the family member who has taken them in, particularly when it may be evident that carers are fragile or struggling to cope. This may play a part in the high percentages of children in Farmer, Selwyn and Meakings’ (2013) study who reported that they wanted to remain living with their carer, when interviewed within their kinship home. The struggle to reconcile feelings of divided loyalty between carers and parents is
captured by a child in Aldgate and McIntosh’s study who concludes: “I want to stay at my mum’s for one week and then at my gran’s for the next week.” (2006: p.59)

As the child who was the subject of my study had difficult experiences of contact with his mother, it may be hard for his carer to be able to retain within herself an openness to the possibility that feelings of longing to be with his mother may nevertheless remain. This insight may be additionally hampered by unconscious projective processes as a consequence of the grandmother’s difficult experiences in the relationship with her own mother as a child.

One area where such feelings may have been present was in relation to the child visiting his mother’s home, where she lived along with her new infant son. Aldgate and McIntosh (2006: p.68) found that where “some parents had established new households” kinship children “found it upsetting to visit these new families and sometimes could not understand why they could not be part of the new family”. In her interview, this grandmother recounts asking her grandson if he wanted to go to his mother’s house (KC: 18.5) and so appears to be open to supporting the possibility of this, yet at the same time seems to accept his confirmation that “he just doesn’t want to” (KC 18.4) rather readily: “we went once for [brother’s] birthday party. And, they didn’t want to go back…they didn’t like it, said it was too bare and boring.” (KC: 18.5).

It is of course possible that the ‘bareness’ of his mother’s flat compared to the ‘fullness’ of his grandmother’s house, may well have put him in touch with unbearable feelings of emptiness, reminding him of the neglectful aspects of his mother and her treatment of him, such that he didn’t want to return and may well have felt protected by his grandmother supporting him in this decision. However it is also possible that the grandmother’s readiness to accept this answer is because this perspective supports her own unconscious position in relation to the child and his mother:

“These placements often rely on an unacknowledged split between the ‘bad abusive parents’ and the ‘good rescuing relatives’.” (Emanuel, 2002: p.166)

By accepting the explanation that ‘it was boring’, other sorts of painful feelings which might have been stirred, such as envy of the celebrated little brother who remained
living with his mother, may then remain unprocessed in phantasies of “being a child who was so dreadful that he could not inspire affection in his mother” (Rustin, 2006: p.109). Within Farmer, Selwyn and Meakings’ study (2013: p.28), such feelings seem to come to light within descriptions of the bullying taunts of other children: “(The bullies say) I’m not wanted…I’m used to it.” or “It’s a bit weird you don’t live with your parents. Do they hate you?” It is possible that these bullying voices might also represent the internal voices of kinship children who hold such worries and in some cases where there has been emotional abuse, may well have experienced parents telling them exactly this.

The question of to whom a child belongs is a pertinent question in kinship care resulting in tensions at different levels in the ‘system’. Within families this tension may exist between different generations “they’re my f-ing children, not yours” (KC:15), and/or between maternal and paternal sides “one part of the family wanted to write out another part as having no or negative importance in a child’s life.” (Ziminski, 2007: p.446). In the relationship between families and the state, this tension may be manifested in worries about approaching social care “they did not want the child to be cared for by the local authority” (Broad, 2004: p.220), and at a national level, played out in debates about funding and responsibility:

“There is a long legacy of reluctance to help family members to do what many think should be done out of a sense of kinship affection and obligation.” (Farmer, Selwyn and Meakings, 2013: p.32)

In this way the idea of belonging could be used not only out of love to claim a child, but also defensively, to avoid the cost of responsibility.
“...all the information pointing to the seriousness of the situation is available and we seem to have to avoid drawing the unhappy conclusions which a realistic appraisal would demand. We can only carry on our lives as normal by turning a blind eye.” (Steiner, 1985: p.170)

5.2 Invisibility

The idea of something not being seen seems to permeate several aspects of the kinship experience. At a national level, researchers and family rights campaigners have repeatedly called for legislative change which acknowledges and responds to experiences of hidden struggle, particularly in respect of informal kinship care, the scale of which is now known (Nandy and Selwyn, 2011). Following their investigation into informal kinship care, Farmer, Selwyn and Meakings (2013: p.32) conclude:

“We had expected this to be an invisible population of children whose needs were not known to Children’s Services. Instead, we found that almost three-quarters (73%) of the kin carers had asked Children’s Services for help or advice (including almost all [92%] the carers without a legal order)….and we found that only one-quarter (23%) received the help they had requested. Carers were often told that they were expected to manage without state assistance. The attitudes the carers encountered are likely to be under-pinned by attempts to contain costs.”

This finding makes an important distinction between something that is invisible and something which is seen but responded to by ‘turning a blind eye’ (Steiner, 1985) as a defence against having to respond to a situation which would be overwhelming, in this case due to the level of need:

“Local authorities that had taken on Special Guardianship with enthusiasm were coming under strain from the scale of demands it had generated.”
(Wade, 2014: p.59)

The lack of a national statistic gathering data on all children in kinship care could therefore be considered another way for the level of need to not be seen so as ‘to avoid
drawing the unhappy conclusions which a realistic appraisal would demand’ (Steiner, 1985: p.170)

“a lack of reliable quantitative data on children in kinship care has meant that their needs have not been reflected in consultations and proposals to tackle child poverty….children in kinship care continue to go unrecognised in local and national strategies.” (Nandy and Selwyn, 2013: p.1662)

At a local level, the repercussions of this ‘strategy’ were present in my interview with the SENCO who raised the issue that as a school they were only required to report on looked-after children:

“There were a number of families that were in foster care and had social services involvement, but there were these families, as it happens in each case there was social service involvement, but they were not put on any sort of data to be tracked and monitored, because Camden like all authorities have responsibility for children in care to really monitor and supervise, and whenever an Education Psychologist would come in to do a planning meeting, always on the agenda was…I need to identify the children who were in care and…I need to track their progress and emotional needs. But actually when we said what about children…living with grandparents…They said, ‘oh, right, well they’re not on our list. Are there any issues?’ And invariably there were.” (SENCO: 5)

At the level of the kinship child and family, issues of visibility emerged in my study in the following areas: parental separation, parental contact and engagement with professionals.

**Parental separation**

Unlike for looked-after or adopted children where the point of separation from parents is clearly visible by the physical removal of the child from the family, for children in kinship families and particularly in situations where relatives have stepped in to prevent a child from becoming looked-after, the child’s experience of loss and separation may
be harder to see. For the child in my study who had always lived in his grandmother’s house it may be particularly hard to see that the child has suffered a profound loss without a more defined moment of separation within which to locate this experience. When I asked this grandmother about her grandson’s experience of separation from his mother and whether she noticed any particular changes in his mood or behaviour around that time, it felt as if my question didn’t make any sense to the carer who reminded me that “he was only a few months old” (KC: 19.1) as if it was not possible to imagine that such a small infant would have registered and reacted to the experience of the loss of his mother. This is very much at odds with a Kleinian model of development, in which the infant’s awareness of the mother as “a whole person” (Klein, 1935: p.286) towards whom powerful and conflictual feelings are held, occurs within the first few months of life.

At a practical level this may be in part because the mother’s neglectful care of her infant meant the child had often been left in the care of his grandmother, such that she might have felt herself to be frequently in the position of his primary carer. However at an unconscious level the difficulty in contemplating the child’s experience of separation may be in part due to the presence of a wishful phantasy on the part of the grandmother that her continued presence and intervention has protected the child from an experience of loss and the pain associated with this. If he was bottle rather than breast fed, this could also have contributed to an unconscious denial of the significance of the mother’s unique capacity in relation to her son. This position may be compounded by feelings of anger towards the daughter on account of her behaviour, making it harder for the grandmother to consider the mother’s absence as a source of loss to the child.

The lack of visibility of a child’s experience of separation when remaining in a family placement seems to correspond with the absence of an expectation that social workers undertake life story work for children placed in kinship families, as if within the professional system, there is also a lack of willingness to see and respond to the child’s experience of trauma and loss as they would for those in foster or adoptive homes. Aldgate and McIntosh (2006: p.40) found that out of thirty children interviewed in their study “almost a third has no sense of personal history about the significant transition they had experienced, often at an early age”, whilst Farmer, Selwyn and Meakings (2013: p.28) found that out of eighty children “one in five children had unanswered
questions about why they had not been able to stay with their parents or were troubled by events that they did not understand.” In my study, the grandmother was not sure if life story work existed at the time her grandson was legally placed within her care, and was only offered this at a much later stage after contacting social care for help in reducing parental contact.

Palacios and Jimenez (2009: p.71) found that when children remain within families it may be “taken for granted…that the child is aware of the family situation”, whilst Farmer, Selwyn and Meakings (2013: p.32) suggest “there is a long legacy of reluctance to help family members to do what many think should be done out of a sense of kinship affection and obligation”. It could be argued that adopting either of these perspectives which locate the responsibility of explaining to the child the reason why their parents were unable to look after them with their kinship carer, could be another way of ‘turning a blind eye’ to this issue, due to the level of resources it would require of local authorities to offer this type of input to kinship families, in addition to those who are fostered and adopted. Family rights campaigners are lobbying the government on this issue, calling on them to “place a new duty on local authorities to establish and commission family and friends care support services, including…life story work…for family and friends carers.” (Kinship Care Alliance, 2017)

**Parental Contact**

Within kinship placements, the area of parental contact also raises significant questions about what is seen. For looked-after children, the complexities of contact are usually far more visible due to the involvement of a range of professionals including contact supervisors, social workers and independent reviewing officers who all have an ongoing role in monitoring contact arrangements between children and their parents. In contrast, in kinship families there is often a lack of visibility outside the family of the sorts of ongoing challenges involved in managing parental contact and the powerful feelings this may stir in all members of the family. Some studies note that schools may be the place where these feelings do become visible: “The school can always tell if Ian has seen his mum because his behaviour goes right down.” (Aldgate and McIntosh, 2006: p.67)
Recent studies into special guardianship (Bowyer et al., 2015, Harwin, 2017) have noted an increased use of supervision orders being granted by the Courts alongside special guardianship orders, giving the local authority a responsibility for monitoring the placement which would likely include oversight of contact arrangements. However this would usually only be for the first year of placement and therefore special guardians may not gain access to any support in managing contact arrangements after this period, although the challenge of managing parental contacts would likely be ongoing and change as the child grows older. This feeling of support ending after the first year mirrors the experience of the grandmother in my study:

“the first year you get a social worker coming, I think maybe three times in the year, after that you don’t see a soul, so you’ve, if there’s any problems you’ve not really got anybody to talk to, so yeah, I found that quite hard.” (KC: 8)

For children and carers, contact is likely to be the time when family difficulties are most visible, particularly, as for the child in my study, when contact takes place within the community, resulting in private family dynamics being played out in public settings. The distress this can cause emerged as a strong theme in my research, with descriptions of the child’s feelings of embarrassment and wish to avoid difficulties being seen captured within the theme ‘keeping a low profile’. This finding matched those of other studies in which similar feelings of humiliation were expressed:

“some children were irritated by what they perceived as the bizarre behaviour of their parents, induced by mental health problems or substance misuse. Children were especially embarrassed by the strange behaviour of the parents in public places.” (Aldgate and McIntosh, 2006: p.68)

Farmer, Selwyn and Meaking (2013: p.28) emphasise how such situations may present particular challenges for children who have remained living with the same locality, where parents’ difficulties may be well known within the local community:
“Children sometimes taunted kinship children about their parents when they had a local reputation because, for example, of their drug-taking, involvement in prostitution or time in prison.”

This was very much the case for this child who was “constantly…getting into fights at school because of people calling his mum names” (KC: 38.19):

“It was two weeks ago somebody said to him ‘your mother takes her knickers off to get money for drugs’. He come back really upset about that, so… he does get an awful lot of stick for it…” (KC: 9)

**Engagement with professionals**

Similar feelings of wishing to keep family difficulties out of sight also seemed likely to underlie ambivalent feelings towards involvement by professionals. Although on the one hand many kinship carers, including the grandmother in my study, reported feelings of isolation, studies such as Sykes et al. (2002: p.41) found that offers of support from professionals were often not taken up: “one-third of the kinship carers…said they had turned down training”. This is an unfortunate finding since this could provide an opportunity to meet others in their situation and discuss areas of difficulty. In Pitcher’s study into the experience of grandparental carers, reluctance to involve professionals is understood as a worry about what they might see (and do) if carers were open about their need for support:

“For many, there was a high level of anxiety that if they appeared in any way ‘demanding’ of help, social services would judge that they could not manage and would place the child elsewhere. This led to reluctance to ask for too much practical help at a time when it was desperately needed.” (Pitcher, 2002: p.18)

In my research, this tension was raised by the SENCO who felt the grandmother would have benefitted from engaging in ‘parent work’ sessions with the TOPS service at this time:
“she didn't want to be drawn into anything which may result in her eyes as some sort of criticism of her parenting, or having to make changes to her parenting, at some point.” (SENCO: 25.1)

Emanuel (2002: p.166) reflects on how anxieties about what might be seen if professionals look too closely seemed to be stirred in her meeting with kinship foster carers of a boy referred to her for child psychotherapy:

“The very idea of attending the child guidance clinic may have felt threatening to this family, as if they sensed that, if we scratched beneath the surface, we could discover more similarities than differences between the birth and foster-carers.”

It is likely that worry about what difficulties might be seen if professionals begin looking ‘beneath the surface’ also contributed to the problems I encountered in recruitment for my study.
“...it seems in many cases that areas of hidden or denied parental devastation becomes a burden that may have to be carried unconsciously by the children, even grandchildren of survivors.” (Garland, 2002: p.4)

5.3 Learning from experience

In his seminal paper *Attacks on linking*, Bion (1959) revisits Freud’s idea of psychoanalysis as being like an archaeological investigation and suggests the following reframing of this idea:

“Freud’s analogy of an archaeological investigation with a psychoanalysis was helpful if it were considered that we were exposing evidence not so much of a primitive civilisation as of a primitive disaster...we are confronted not so much with a static situation that permits leisurely study, but with a catastrophe that remains at one and the same moment actively vital and yet incapable of resolution into quiescence. This lack of progress in any direction must be attributed in part to the destruction of a capacity for curiosity and the consequent inability to learn.” (Bion, 1959: in Bott Spillius, 1988: p.94)

The language Bion uses to describe this ‘primitive disaster’ brings to mind the image of an active volcano, which lies dormant, but not extinct and is predicted to erupt again. This could also provide a helpful metaphor for thinking about the transmission of intergenerational trauma in kinship families, where a ‘catastrophe’ which has occurred within the history of a family is not a ‘static situation’ in the past, but remains ‘actively vital’ in families in the present, often bringing anxiety about the potential for a re-eruption of these difficulties in children in the future.

In the family who were the subject of my study, it was possible to see how experiences of relational trauma which had affected the grandmother as a child and become manifest in psychosomatic symptoms, were alive in the present through the impact of her health difficulties on her capacity as a kinship carer and the subsequent worries this brought to her grandson about who would care for him in the future. In this way, there seemed to be an intergenerational transmission of the impact of this experience at an unconscious
level, as Garland (2002: p.4) describes: “areas of hidden or denied parental devastation becomes a burden that may have to be carried unconsciously by the children, even grandchildren of survivors.”

It was not possible in this study to explore the relationship between the grandmother’s experiences of childhood and parenthood with those of her daughter, in whom an eruption of difficult feelings became expressed through drug use and drug-related behaviour. However in other studies such as Barnard (2003: p.295) in which interviews were conducted with 62 parents whose drug use affected the care of their children, it was found that a “high proportion of parents reported dysfunctional family backgrounds” and many “spoke of difficult childhoods” with “family homes marked by conflict and violence”. It is also beyond the scope of this study to explore how and why the same family histories may be responded to in different ways within a sibling group.

In her interview, the grandmother reflects that she learned through her experiences of being a mother and this helped to inform her parenting as a kinship carer: “You do things differently than you did the first time and you know what to look for as well.” (KC: 38.16) However worry that the behaviours of her daughter could resurface in her grandson were very much apparent, revealing the grandmother’s concern that despite all her efforts to protect her grandchildren, history could repeat itself:

“He’s really, really easily led by naughty, really naughty kids…and that is really worrying, because that’s how you end up getting in big problems, stealing and drugs and stuff.” (KC: 38.16)

Bion describes how the capacity to learn from experience is dependent upon access to a receptive mind in which the ability to be interested and curious enables links to be made between feelings and experiences. The prototype for this is the early relationship between mother and baby, in which in ordinary circumstances the mother is able to receive the feelings projected into her by her infant and through her capacity for reverie give meaning to his experiences:
“Projective identification makes it possible for him to investigate his own feelings in a personality powerful enough to contain them.” (Bion, 1959: in Bott Spillius, 1988: p.98)

Bion highlights how in situations where this maternal function is not accessible, this could result in “the destruction of a capacity for curiosity and the consequent inability to learn.” (Bott Spillius, 1988: p.94)

“Denial of the use of this mechanism, either by the refusal of the mother to serve as a repository for the infant's feelings, or by the hatred and envy of the patient who cannot allow the mother to exercise this function, leads to a destruction of the link between infant and breast and consequently to a severe disorder of the impulse to be curious on which all learning depends.” (Bion, 1959: in Bott Spillius, 1988: p.98)

Within the theme ‘Understanding’, examples of this ‘destruction of a link’ seem to occur in my findings when the child seeks to understand why his mother cannot care for him and why his sibling is adopted. In both situations, the child is provided with answers by his grandmother “I told them about the drugs” (KC: 17.2) and mother “your f-ing nan wouldn’t have him” (KC: 27.4) about what had taken place. These answers seem to have the effect of closing down his investigation, rather than supporting the development of further curiosity, thought and understanding about these very serious and complex issues. Bion notes that “attacks on the link originate in what Melanie Klein calls the paranoid-schizoid phase” which is “dominated by part-object relationships” (Bott Spillius, 1988: p.94). Here we can see how when dealing with such painful experiences within a family, paranoid-schizoid defences such as splitting and blame may predominate, resulting in the child receiving explanations which only respond to an aspect of what is in reality a much bigger and more complicated picture which involves the family as a whole. The real question of why these things have happened within the family, such as why his mother started using drugs or turned to destructive relationships with men, cannot be explored:
“The problem that has to be solved...must be stated...by the question, ‘What is something?’ and not the question ‘Why is something?’ because 'why' has, through guilt, been split off. Problems, the solution of which depends upon an awareness of causation, cannot therefore be stated, let alone solved.” (Bion, 1959, in Bott Spillius, 1988: p.95)

For many kinship carers, there may well be a wish to protect the child from exposure to information which they may find upsetting or inappropriate for their age. However unless children are helped to understand the links between past and present relationships, feelings, actions and reactions, it is unlikely they will be able to learn from the experiences of their family and may consequently be more likely to resort to the same way of coping with these issues as the generations before. This may lead to an increased likelihood of children acting out feelings of confusion or curiosity in an effort to try to gain an understanding of and connection with their parents in order to understand their own experiences.

In this family, the grandmother was keen to prevent a repetition of intergenerational difficulties by being proactive in seeking therapeutic support for her grandson. However it is questionable how effective any clinical intervention with a child can be, unless carers are also able to do the work of making links between the child’s relational experiences in the present, with the experiences of the family in the past:

“When it comes to treatment, to attempt to understand the creature of the present without regard to his or her past may sometimes work, but for most patients it achieves at best a temporary and chronically unstable quiescence of the more acute after-effects of the immediate trauma. Increasingly, clinical findings indicate that events have to be remembered, rather than forgotten or put out of one's mind.” (Garland, 2002: p.4)

A finding of this study was that there may be a presumption that due to links in biology, that help to make links between experiences within a family is not needed in kinship care. On the contrary, this may be particularly important in order to help children have different outcomes and support families to learn from their experiences.
“Children and special guardians are entitled to services from practitioners who understand special guardianship.” (Tapsfield, 2017)

5.4 Access to services

Issues of access to clinical services for kinship families, particularly those under special guardianship orders or in informal kinship arrangements have been raised in many studies. Wade et al. (2014: p. 245) found that for special guardianship families, “access to CAMHS and other therapeutic services…was often difficult” however “where they were accessed, they were generally found to be helpful.” The authors suggest:

“Further consideration should be given to how these services can be made more comprehensive and more easily accessible to special guardians and their children.” (Wade et al., 2014: p.245)

A further finding of their study identified that:

“Most local authority practitioners felt that Special Guardianship had become more established, as you would hope it would seven years on, and more firmly embedded in the procedures and practices of the local authority. Considerable activity was now directed towards encouraging movement from care to Special Guardianship for looked-after children, most successfully for those in kinship foster care settings.” (Wade et al. 2014, p.45)

This raises important questions for mental health services. For example, how might this movement impact on CAMHS provision? As looked-after children with a social worker, it may be more likely that children in kinship foster care would be referred to and receive a service from a looked-after children (LAC) CAMHS team connected to the local authority. If these children were moved to special guardianship orders and ceased to be looked-after, they would instead need to be referred to generic CAMHS teams which may have higher thresholds, resulting in it being harder for these children to access psychotherapeutic input. Therefore as the numbers of special guardianship orders
increase, this raises the question of where best should children with a looked-after history be seen?

One solution to this difficulty could be for LAC CAMH services not to be limited to children currently in care, but also to be able to see children who were previously in care, or been separated from their parents due to the same early experiences of children who enter care. This would be in accordance with the findings from Callaghan et al. (2003: p.57) in which the need for service flexibility and continuity of therapeutic relationships was highlighted:

“Participants argued that mental health practitioners needed a better understanding of the difficulties of working with looked-after children, and that more patience and flexibility were required. They also highlighted the importance of continuity of mental health input. Given the fragmented nature of many children’s experiences, a stable and trusting relationship with the mental health professional is an important aspect of the therapeutic process.”

This would position CAMH services in line with recommendations by charitable organisations (Grandparents Plus, 2017) and family rights groups (Kinship Care Alliance, 2017) that children living in kinship care as a result of being unable to live with their parents, should have access to the same range of support provision as children who are, or were, looked-after. This would also meet recommendations by the Department for Education that support should not be determined by a child’s legal status:

“Local authorities and their partners should make sure that family and friends carers are aware of relevant support services, and that these can be readily accessed by those caring for children whether or not these are looked after by the local authority. Whilst recognising the requirements which may go with a particular legal status, it is essential that services are not allocated solely on the basis of the child’s legal status, and that commissioners and providers of services are aware that many children in family and friends care have experienced multiple adversities similar to those of children who are
looked after by local authorities. Where support services are identified as necessary to meet the child’s needs, these should not be withheld merely because the child is living with a carer under an informal arrangement rather than in a placement with a foster carer or with a person with a residence or special guardianship order or an adopter.” (DfE, 2010: 2.12)

Enabling all children who are in kinship care to be able to access a specialist mental health service (like the Tavistock Clinic model of a fostering, adoption and kinship care team and other services designed like this), would fit with Golding’s view that:

“It is now widely recognized that these children are best served by dedicated services provided by professionals with expertise in meeting the needs of looked-after and adopted children.” (2010: p. 573)

This may also particularly help children living in kinship families in other boroughs, who may not meet the diagnostic thresholds of local generic services, to gain access to treatment. As LAC CAMH services are commissioned by local authorities who would be unlikely to (have resources to) fund clinical services for children who are not in local authority care, this would likely require NHS commissioners and local authorities to work together to design larger specialist services which enable different funding pathways based on the child’s experiences and needs “without being limited by legal constructs.” (Vostanis, 2010: p.556) This could be linked with the Adoption Support Fund which in 2016 became available to children living in special guardianship homes who were previously in care.

As LAC CAMH services are often co-located in social care to help facilitate inter-agency working between social workers and mental health professionals, to ensure easier access to clinical services, this may prevent some kinship families from accessing a service, if they feel they have worked hard to keep children out of local authority care and may not wish to attend a local authority building for mental health support.

This might suggest that a solution to this issue is not to bring kinship children within LAC clinical services, but highlights the need for generic CAMH services to be able to offer a more comprehensive service than may currently be offered in some clinics:
“The constraints imposed by our current classification system, as applied to the maltreatment field, are not only a source of frustration for clinicians, they have an important impact on service provision. Too often Child and Adolescent Mental Health Services (CAMHS) are organized around diagnosis-led clinics, leading to fragmentation of service provision and dissatisfaction amongst users…Caregivers, whether looking after children in fostering, kinship care or adoptive placements sense that the difficulties the children experience are not adequately recognized and poorly described by the usual diagnoses, such as ADHD or conduct disorder. The treatment may be similarly narrowly focused. The experience of caregivers is therefore one of fragmentation and of being poorly understood.” (DeJong, 2010: p.596)

This would enable clinicians to gain wider experience of working with children living in a range of situations and could provide opportunities for further learning. For example, Continuing Professional Development (CPD) training on working with children in kinship care, so the particular issues which may accompany these families’ circumstances, including; intergenerational trauma, contact issues, poverty, legal arrangements and outcomes for children in kinship care become more broadly known and understood. This would support Tapsfield’s assertion that: “Children and special guardians are entitled to services from practitioners who understand special guardianship.” (Tapsfield, 2017)

Other studies found that kinship carers, particularly those with a history of involvement with social care, were often reluctant to attend mental health clinics due to ambivalent feelings towards professionals:

“Our experience is that, in many kinship care cases, there is a long-standing history of suspicion of professionals, sometimes going back several generations.” (Music and Crehan, 2014: p.167)

Families may also be worried about children being further stigmatised by attending a mental health setting: “it can be off putting and implies you are ill, community centres would be better” (Addy and MacKechnie, 2006: p.17). The perception that it would be
difficult for the kinship carer to bring her grandchild to a clinic for therapy was also highlighted by the SENCO in my study:

“Had TOPS not been there, I think it would have been tricky, because we could have made a CAMHS referral but I doubt whether Grandmother would have taken them there, because she had so much on her plate, that to try to get them to the Tavistock [clinic]...I don't think that would have worked.” (SENCO 34.2)

Schools may therefore be a good place for children in kinship care to be seen, as the intervention would be focused around the needs of the child, rather than legal status or diagnosis.

“Schools have been increasingly acknowledged as centrally important to local communities, places that are accessible and trusted and which have fewer stigmas than traditional, ‘out of the way’ clinics.” (Music and Hall, 2008: p.46)

Child psychotherapists may also be well positioned to help schools with thinking about the emotional needs of children in kinship care, who may find themselves to be the unwitting recipients of unprocessed family trauma, feelings which they in turn may evacuate through unconscious mechanisms such as projective identification:

“Our understanding of projective processes might come into play to manage painful affects. For example, in the situation of a pupil wanting to belittle another child to assuage their own hurt feelings, the child psychotherapist can help teachers and management to not only process their own powerful reactions to what they often initially see as ‘misbehaviour’, but also help them find some sympathy for a child who had hitherto aroused only distaste or anger...these and other kinds of understandings...can form a potent toolbox to take into the world of school.” (Music and Hall, 2008: p.47)

It seemed from my research that where kinship cases were more complex they may need to be referred to a multidisciplinary CAMHS team which could provide an intervention
by a range of clinicians and have greater capacity (for example, TOPS clinicians may only work in schools one or two days a week). Additionally, being seen in school also raises issues of visibility which children in kinship care may feel particularly sensitive about due to existing feelings of difference. This was identified in my findings within the theme ‘difference/standing out/embarrassment’ and summarised by the therapist in my study:

“I think school, school is a familiar place…There are…pros and cons with that because they are pulled out of, so it’s more visible to their peers that something’s happening perhaps… So my experience of working in a school is often that…the children actually get to be seen more quickly than if it goes through a clinic, as there’s often different processes and waiting lists, and I think that can be very positive. I do think overall a familiar surrounding is positive but there are a few other sides to it… You know that it isn’t as private perhaps and this particular room [in the school used for therapy sessions]… [posed specific challenges].” (TH:33.1)

Another response to the need to make services “more easily accessible to special guardians and their children” (Wade et al., 2014: p.245) could be to establish a community centre for kinship care where families could access a range of services under one roof including; child psychotherapy, carer support groups, family support/social work providing life story work and contact support, training courses and legal and financial advice (an idea which I have been giving some thought to!). This would fit with Warren-Adamson’s (2009: p.82) suggestion that “we should look to the more sophisticated examples of family centre or family support centre as more suitable bases”, citing Hess et al's (2003) account of the Center for Family Life in Brooklyn, New York which “combines community rootedness with a clinical sophistication” enabling practitioners to offer a “multi-levelled response” which “appears to make sense to families.” (2009: p83)
Chapter 6

Limitations, Conclusions and Recommendations

6.1 Limitations

Over the last twelve years, many authors (Holland, Faulker and Perez-del-Aguila, 2005), (Kroll, 2007) have drawn attention to the limited research into kinship care in the U.K., compared, for example, to the U.S. where the literature base is more extensive. However more studies have now begun to emerge investigating children’s views and experiences of being in kinship care (Aldgate and McIntosh, 2006), (Burgess et al., 2010), (Farmer, Selwyn and Meakings, 2013) and reviewing findings on the increasing use and application of special guardianship orders (Wade et al., 2014), (Bowyer et al., 2015), (Harwin, 2017).

Despite repeated assertions in many of these studies that due to their early experiences, many children in kinship care (and their carers) may require therapeutic support, there has been little clinical enquiry into therapeutic treatment offered to children in kinship care. In a recent U.K. national survey of child psychotherapists’ working practices with looked-after and adopted children (Robinson, Luyten and Midgley, 2017), work undertaken with kinship children and/or their carers was not included within any of the research measures, although clinical work with looked-after children would likely include those in kinship foster care, as explored by Meehan’s (2016) doctoral case study.

Given this paucity of clinical data, it was a disappointing outcome of my research that I was only able to recruit one case out of three, as although in such a small-scale study it would not have been possible to generalise from my findings, it would have been interesting to explore areas of commonality and difference in the experiences of three children in kinship care who had all received therapy in their schools and gain the perspectives of three sets of carers, teachers and therapists on the interventions offered.

Despite this limitation, within my research I felt I was able to bring to light many of the key issues which kinship families negotiate and the sorts of feelings children may be struggling with as a result of their experiences and those of the generations before. I
found it helpful to have three interviews bringing together different perspectives on the child’s experiences which raised questions for me to think about. In this way, only having one case was also a strength of my research, as it enabled me to focus on the interview material with a level of detail which would not have been possible with three cases.

6.2 Conclusions

Recruitment

The difficulties I experienced in recruitment was itself an interesting finding, both in terms of the low numbers of cases which fit my recruitment criteria and the difficulty I experienced in recruiting those who did. The very low numbers of children in kinship care in the school (as reported by the SENCO) was a surprise, as descriptions of the demographic of the five primary schools where the TOPS service was located (Cioeta and Geater, 2014a) seemed to match the profile of many kinship families as described by researchers such as Nandy and Selwyn (2011).

Having worked in the Fostering, Adoption and Kinship Care Team at the Tavistock Clinic during my training which also offered clinical work to families from within the same borough, I had experience of seeing kinship families coming for treatment. Reports by the team (Barratt and Granville, 2006) suggested that referrals to the service for children in kinship care had risen over recent years, whilst national statistics showed that the numbers of children placed under Special Guardianship Orders were increasing (Wilkinson and Bowyer, 2017). Consequently my assumption was that there would be higher numbers of kinship families within the school and due to community-based services often being better placed to engage ‘hard to reach’ families who would not access a clinic, that the TOPS service would also have seen an increase in referrals for children who were in kinship care. It therefore wasn’t clear to me whether the low numbers of children in kinship families at this school reflected an ordinary statistic or there were coincidentally fewer children in kinship care at this particular school. Had I been able to recruit three cases and interview SENCO’s from two other primary schools within the same borough this would have helped to shed more light on this finding by providing comparative data.
According to TOPS annual reports (Cioeta and Geater, 2014b), children seen by the service across the five schools, typically included a high proportion of children who had current or past involvement with social care. This would indicate that children in kinship care would likely be referred to the service and yet the numbers of children in kinship care seen in recent years also seemed very low (e.g. in 2014-15 three kinship children were seen out of 105 families overall). One possibility was that children in kinship families were managing well enough (for example compared to looked-after children) and so had not been referred to TOPS, or conversely that due to intergenerational family difficulties, the level of complexity might have meant these families were instead referred to the Tavistock Clinic. Clarification of this would require further investigation to track and calculate referrals for kinship families within the borough to see which services were being accessed and what factors had an influence on referral pathways.

As a consequence of my findings, the TOPS service highlighted the need for thinking about children in kinship care with each of the five primary schools, to ensure that this group of children were not being overlooked within the referral process. A two-year follow up was conducted to see whether referrals for children in kinship care had subsequently increased.

In the current academic year (2016-17) five children in kinship care were being seen by the service out of 55 children overall. This meant a total of 9% of children seen by the service were in kinship care. This was noticeably higher than in the previous five years, with the exception of 2010-2011 when several children from one kinship family were seen resulting in a higher statistic for that year. It is therefore possible that due to my initial finding and the subsequent work undertaken by TOPS to raise awareness of the needs of children in kinship care within the schools, this may have resulted in more referrals being made for these children to the service.

Of the eight children who fit my inclusion criteria, the difficulties I experienced with being able to recruit more than one set of participants for my study, also raised important questions about the sorts of feelings which might be generated by research. In their investigation into whether children in kinship care were receiving adequate mental health provision, Addy and MacKechnie (2006: p.15) who were only able to
interview three out of fifty-two kinship carers concluded that “this apparent lack of interest may in itself reflect the degree of detachment and suspicion surrounding mental health services”. This finding seemed to highlight a striking and unfortunate irony that the families who may be in most need of support, could prevent themselves from receiving it, due to concerns about where opening up a dialogue with professionals could lead.

It seemed likely that feelings of wariness about who I was, why I was asking questions, what conclusions I would draw and what I was going to do with this information were also present in my recruitment process. Awareness of the possibility of such feelings being stirred was initially raised by the TOPS clinicians when I discussed my project with them. This seemed to be enacted most powerfully with one kinship carer who I was unable to recruit and communicated her strong ambivalence about meeting with me, such that I felt if I continued to persist in trying to recruit her I was in danger of becoming the persecutory figure she might have imagined me to be.

On reflection, I wondered whether my awareness of the potential for my position as a researcher to generate feelings of suspicion, could have unwittingly contributed to my difficulties in recruitment? For example, when presented with reasons why cases were not suitable for my research such as due to a child protection investigation or length of time since treatment had occurred, could I, in a wish to avoid being experienced as a persecutory figure, have agreed too readily that these were not suitable circumstances for my research? Should I have questioned this assumption further and wondered about the feelings of anxiety which might be underlying it? Rather than maintaining a position that there would be value to asking questions with a view to understanding how kinship families manage difficult feelings and what support might be helpful, is it possible I could have unconsciously colluded with an idea that my interviewing carers at this time could be detrimental to the delicate work being undertaken by clinicians who were carefully managing the tension between the responsibility to report safeguarding concerns and maintaining a collaborative working relationship with families of children receiving treatment?
Findings and experience of research

Findings

The aim of my research was to see what I could learn about the experiences of children in kinship care, by conducting interviews with three separate adults who each represented a different aspect of a child’s life: home, school and ‘internal world’. These were: the child’s kinship carer, the teacher (SENCO) who referred them to TOPS due to concerns about their emotional wellbeing, and the child’s therapist.

The data from these three interviews was analysed using Interpretative Phenomenological Analysis, to see areas of commonality and difference in the perceptions and views of these three adults, and to see what key themes emerged. As I only had one case, it seemed likely that some themes would be specific to the experiences of this individual child within his particular family and school context, whilst others might be typical of the sorts of experiences which many kinship children and families may face.

I found that his position of being the only boy and oldest child of a sibling group within a kinship family was significant to understanding his individual feelings and experiences. This emerged most strongly within the second strand of my findings and in particular within the theme ‘Growing up male: brothers/fathers/sons’ in which his relationship to his lost brother (and to the ‘lost boy’ aspects of himself) were explored. Alongside the individual nature of his experiences, the absence of a father and loss of a sibling to another family are sadly not uncommon experiences for children in kinship care.

Within the theme ‘Feelings’, the upset, anger and embarrassment aroused for this child as a result of his mother’s actions, both in a direct way through her absence from or behaviour during contact and indirectly through the bullying taunts of other children, were also feelings highlighted in other studies which explored children’s views of kinship care.
Concerns about the future both in respect of the child’s worry about who would look after him if his grandmother wasn’t able to and her concern about ‘history repeating itself’ were particular to the individuals within this study, but were again typical of the sorts of concerns which studies show are felt by many kinship children and their carers, particularly those in grandparental care. This finding also matched with my own clinical experience of working with kinship families where such concerns are present.

In terms of areas of commonality and difference in the perspectives of the three participants, I found that their views were mostly congruent with the exception of the issue of therapeutic support for the carer where this was less clear.

One area which arose in my findings, which I was unable to explore sufficiently, was the role of the SENCO. It was clear she was particularly significant to this grandmother, someone she regularly confided in and was an enormous source of support. The SENCO provided a pivotal link between the carer’s concerns about the impact of family experiences on the child, the observations of class teachers who noticed changes in the child’s emotional state and behaviour, and the TOPS Lead Therapist who organised treatment for the child. This linking up between home, school and mental health services appeared to work extremely smoothly and provided an excellent example of how agencies can work together to support vulnerable children and their families.

Due to her many years’ experience which enabled her to hold both the history of the family and the school in mind (and likely also due to individual characteristics of age and gender), the SENCO seemed to have a grandparental function within the school, containing the concerns of the carer and teachers who occupied a parental role:

“Traditionally, grandparents have played a fundamental role in family life as sources of wisdom, stability and family identity, as well as babysitters, mediators, friends and listeners.” (Downie et al., 2010: p.8)

When she left the school after many years, this loss was noted by the carer:

“it was easy when [SENCO] was there – she had to leave, I can’t forgive her for that. She erm, I just spoke to her about it… you know, you can actually
talk to… even when you might be talking crap she knows what I’m talking about.” (KC: 41.3)

This resonates with Warren-Adamson’s (2009: p.83) finding on the significance of a positive transference towards a local institution which has existed over time and may result in families being more willing to access support:

“History and memory, continuity of staff and containment are striking features….Kinship families see the centre as an extension of the supportive network and appear to appreciate the knowledge of and memory of the building itself.”

The overall findings from my data analysis were then considered in the context of other research findings leading to the formulation of four key areas of discussion: belonging, invisibility, learning from experience and access to services. I propose that these are key areas for consideration when thinking about the experiences of children in kinship care.

Experience of research

Initially I was concerned whether there would be enough data provided by this one case when the therapist reflected that “he wasn’t a child that…‘stuck out’… in your mind” (TH:21). This countertransference response turned out to be an important finding in understanding how this child managed feelings associated with his experiences as a child in kinship care.

This was my first experience of research and conducting semi-structured interviews. I was impressed at the capacity of the participants to share their thoughts and recollections in this setting and learn of this grandmother’s resourcefulness in seeking support for her grandchildren. It was saddening to hear about ongoing instances where her grandson had to contend with painful family experiences being the subject of derision.
Undertaking a review of the literature and of current concerns raised by family rights campaigners helped me to think about how developments in other services, including the impact of legislative change, will impact on children accessing therapeutic provision. Questions need to be raised about how CAMHS can respond to these changes. At a recent conference on the future of special guardianship (CoramBAAF, 2017), I was the only delegate from the NHS, leaving me feeling that there is, as of yet, not enough linking up between agencies to think together about these children and families and how they navigate access to the services they need. Equally, there was little mention of CAMHS by speakers at the conference. When I questioned this absence and what it might mean, I was advised by the Chair that although it wasn’t the focus of discussion on this occasion, “you couldn’t get a group of kinship carers together in a room without them raising CAMHS”.

6.3 Recommendations

Implications for practice

In her paper ‘Where we live’ Kenrick (2005: p.24) asks:

“What are some of the particular characteristics of looked-after and adopted children; what are the particular dilemmas for therapist and child? And, most particularly, how do we speak to the child about them in the session? In other words, as child psychotherapists, how do we maintain our psychoanalytic stance in work with children whose development and lives have been greatly impinged on, not just in the past but possibly still, in a continuing way, in the present?”

As a consequence of this study, I recommend that as a profession we need to be asking these questions and thinking together in the same way about our work with children in kinship care. Although in many ways children who are able to remain within their extended family networks may be comparatively fortunate, research shows that there are many ways in which their lives may be “greatly impinged on, not just in the past but…in a continuing way, in the present”. (Kenrick, 2005: p.24)
As with all psychoanalytic work with children who have suffered deprivation the need for supervision is vital. From my own clinical experience and reflecting on this therapist’s account, the feelings of guilt stirred by ending the work in situations where loss and deprivation are an ongoing reality of the child’s external world, may be particularly hard to bear.

Further thought also needs to be given to the nature of parent work with kinship carers of children in therapy. What issues need to be considered? How can kinship carers help children to understand their situation? What is the impact on treatment and on the child’s relationship to their therapist if this work does not occur in parallel?

**Dissemination of ideas**

There is likely to be much experience of working with kinship families within the discipline, yet an absence of clinical literature. An explanation might be that concerns about confidentiality and gaining permission have restricted publication. One way for therapists to learn from each other’s experience could be if there was a request for papers on work with kinship families by the Journal of Child Psychotherapy to help develop this resource.

Thinking about the needs and experiences of children in kinship care could also be given more space as a specialist topic within clinical trainings and/or offered as a Continuing Professional Development event.

Child psychotherapists based in schools are also well positioned to be thinking with teaching staff about the needs of kinship families.

**Recommendations for future research**

There are two areas of kinship experience where I recommend further research is needed: access to services and sibling relationships.
Access to services

It is clear from informal discussions with colleagues that many child psychotherapists based in CAMHS are working with kinship families, but there are currently no studies which have gathered data on this work. A survey of members of the Association of Child Psychotherapists, as conducted by Robinson, Luyten and Midgley (2017) for work with looked-after and adopted children, would enable data to be gathered. For example; the number of clinicians working with kinship families, the types of services where this work is undertaken (generic or specialist teams), the type of work offered and patient data (age of child at referral, reasons for referral, length of time in kinship care, numbers of previous placements, clinical attendance rate, key themes of the work).

Gathering data on kinship families within one borough could also enable a better understanding of the factors which affect referral pathways and families accessing services. For example, in the London Borough of Camden data could be gathered from: the local authority on numbers of special guardianship families known to and receiving support from children’s services, local schools for numbers of children in kinship care within each school, the Tavistock Clinic for numbers of kinship families receiving a CAMH service in different teams within the clinic and in community-based services including TOPS. In addition, data might also be gathered from charities based within the borough such as PAC-UK which offer therapeutic services for families with children placed permanently in their care. Compiling and cross-referencing data from a range of sources, should make it possible to assess the overall numbers of children in (formal and informal) kinship care within the borough, the proportion of these known to social care and the percentage who have been referred to CAMHS or other therapeutic services. It would then be possible to investigate the factors which affect referral pathways. For example, what issues might result in a family receiving a school or clinic-based service? How might issues of culture or ethnicity be a contributing factor in families accessing treatment? Are children from some communities more likely to be referred or families more willing to accept support from a mental health professional?
Sibling Relationships

In 2011, the Family Rights Group published findings from a research study on sibling carers. Key issues raised included; the impact on sibling carers of “changing their role from older sibling to caregiver and rule maker”, the “experience they have already of caring for younger siblings and how this may have prepared them for becoming a full-time carer”, managing “potential difficulties from parental contact” and “their own feelings about events in the family which have led to them becoming a sibling carer” (Roth, Lindley and Ashley, 2011: p.92). In the same year, findings from Nandy and Selwyn’s analysis of the 2001 U.K. census identified that 38% of all children in kinship care in England were being brought up by an older sibling. This figure rose to 49% in Northern Ireland (Nandy and Selwyn, 2011: p.9). The Family Rights Group note that:

“This is far more than anyone had suspected, and shows how important it is that young people who take on the task of bringing up their siblings should get the recognition, respect and support that they deserve.” (www.frg.org.uk/big-bruv-lil-sis)

Given these figures, I recommend further research is needed on understanding the impact on relationships when siblings become kinship carers and that a psychoanalytic perspective would enable consideration of the unconscious aspects of these dynamics.

In my study, the child initially attended a therapy group with his sisters who were living together in kinship care. He was then referred for individual work due to concerns about the impact of the loss of his brother to adoption and birth of a new sibling. Drawing on Lee-Messner and Stevenson’s (2014) account of group work with five siblings moving to different adoptive homes, further research could also be undertaken on sibling groups in kinship care and the experience of loss of siblings who are placed outside the family. Consideration could be given to the role of CAMHS in offering consultation to professional networks to help with thinking about issues of sibling separation and contact, the emotional impact of these decisions on kinship families and how plans are communicated to children.
References


Department for Education (2014) Court orders and pre-proceedings. London: Department for Education


Roth D., Lindley B., and Ashley C., (2011) *Big Bruv, Lil Sis.* Available at: http://www.frg.org.uk/big-bruv-lil-sis


APPENDIX A

PARTICIPANT INFORMATION SHEET
for Kinship Carers

Title: What can we learn from interviews with kinship carers, teachers and therapists about the experiences of children in kinship care?

I would like to invite you to take part in my research study. Before you decide, it is important you know why this research is being done and what it would involve for you. Please take the time to read this information sheet carefully and discuss it with others if you wish. If anything is not clear or you would like more information please do contact me on the number above, or speak with the Lead Therapist from the TOPS project who has given you this sheet. Their contact details are on page 3.

What is this research for?
The aim of this research is to learn more about the experiences of children living in kinship care.

Why is this important?
It is estimated there are currently over 143,000 children living in kinship care in England,¹ but there is very little research into understanding the experiences of these children and their kinship families. How does this arrangement impact on family relationships? How do families manage? What is difficult and what can help?

Who is doing the research?
My name is Mel Serlin. I am a qualified child psychotherapist and this project is part of my Doctorate at the Tavistock Clinic. I am the Chief Investigator for this study which I am doing independently, but with the support of the Tavistock Outreach in Primary Schools (TOPS) service.

Why have I been given this leaflet?
You have been identified by the TOPS project manager as someone who fits the criteria for my research project. This means, you are a kinship carer, and you and your child will have received support in the past from the TOPS therapists based at your child’s school.

¹ Nandy and Selwyn (2011) Spotlight on kinship care. Using Census microdata to examine the extent and nature of kinship care in the UK. University of Bristol.
**What will taking part involve?**

I would like to invite you to tell me about your experience of being a kinship carer in a one-off interview.

**What will the interview be like?**

The interview will be for one hour and will be at your child’s school in a room used by the TOPS therapists. (During the interview, you can take a break any time you want to). You will also later be offered a further meeting with me if you would like one, to discuss how you found the interview and to receive some general feedback.

**How many people are you interviewing?**

My research will focus on three (unconnected) children living in kinship care. As well as interviewing their carers, I will also be interviewing their therapists and the teachers who referred them to TOPS. Together, these nine interviews should provide a rounded picture of the sorts of experiences and feelings which shape the lives of children living in kinship care.

**Will it cost me to take part?**

No. If you need to take public transport to get to your child’s school for the interview, your fare will be refunded. As there is no funding for this study, it won’t be possible to pay participants for taking part.

**Will it be confidential?**

Yes. All information gathered will be kept strictly confidential at all times.

**Interviews**

All interviews will be tape-recorded and only I will hear them. Recordings will be stored securely until completion of the project and then destroyed. Recordings will be typed into manuscripts and all identifying details (e.g. names of participants, family members, school) will be anonymised. All electronic data will be stored securely in password-protected files.

**Manuscripts**

I will analyse the anonymised manuscripts to explore what themes come to light. I may find many participants share the same feelings and experiences, but there may also be very unique differences. In order to research this, it will be vital that whilst any identifying details about you are anonymised, I do still include important details which are specific to you, for example; your family structure, why this child came to live with you, how you feel kinship care affects your family relationships etc, as this information will be central to understanding your individual experiences, feelings and views.

**Research Findings**

My analysis will be overseen by two supervisors from the Tavistock Clinic who are both child psychotherapists unconnected to the TOPS project. My findings will then be written up into a thesis. If this research brings to light important issues which would be valuable to share, it is possible the findings could be published, for example, in an academic journal.

**Why might I want to take part?**

...and what happens if I choose not to?

If you choose not to take part, this will not impact in any way on your relationship with your child’s school, or with the TOPS project. It will also not prevent you or your child from receiving further support from TOPS in the future should you need to.

**What will I get from taking part?**

As a kinship carer, you may have views on your experiences which you would like to be more widely heard! Participating in the project will be an opportunity for you to do so.
Will it help others?
By contributing your experiences and views to this project, it could help to highlight issues which are important for professionals to be aware of, when working with other kinship families in circumstances similar to yours. This project might also show where there are areas which need more understanding and research, and why funding for community-based therapeutic services like TOPS might be important in supporting the needs of local families.

Yes, I’d be interested in taking part, what happens next...?
You will have been given this information sheet by the Lead Therapist from the TOPS project who is based at your child’s school. If you would be happy to take part, please contact her using the details provided below to let her know you are interested and she will arrange for us to meet at the school.

When we meet, this will give you a chance to ask me any further questions you may have. If you are then happy to go ahead, I will give you a consent form to sign and we will arrange a date for the interview. If you would rather take more time to think about it, I will arrange to call you a week later.

It is important that all participants take at least 24 hours to consider participating in the study. A week after you have been given this sheet, if she has not heard from you, the Lead Therapist will give you a courtesy call to see if you have had a chance to consider taking part or if you have any queries you would like to discuss with her. If you do decide to take part, you can always contact either myself (Chief Investigator) or the Lead Therapist at any time if you have any concerns about the study.

Contact Details for TOPS Lead Therapists

Carlton Primary School and Beckford Primary School

Marta Cioeta
Lead Therapist
TOPS
Child and Family Department
Tavistock Clinic
120 Belsize Lane
London
NW3 5BA
TOPSadmin@tavi-port.nhs.uk

Work mobile: (provided)

Gospel Oak Primary School

Shira Jacobs
Lead Therapist
TOPS
Child and Family Department
Tavistock Clinic
120 Belsize Lane
London
NW3 5BA
TOPSadmin@tavi-port.nhs.uk

Work mobile: (provided)

Brookfield Primary School

Isobel Pick
Lead Therapist
TOPS
Child and Family Department
Tavistock Clinic
120 Belsize Lane
London
NW3 5BA
TOPSadmin@tavi-port.nhs.uk

Work mobile: (provided)

Brecknock Primary School

Ilana Inspector
Lead Therapist
TOPS
Child and Family Department
Tavistock Clinic
120 Belsize Lane
London
NW3 5BA
TOPSadmin@tavi-port.nhs.uk

Work Mobile: (provided)
**Support for Participants**

**Practical Support**

If at any time you feel unhappy with your involvement in the research project or how you have been treated and wish to speak to somebody unconnected to either the research study or the TOPS project, you can contact the Patient Advice and Liaison Service (PALS) at the following address:

**Patient Advice and Liaison Service (PALS)**
Tavistock Centre
120 Belsize Lane
London
NW3 5BA
Tel: 020 8938 2523
Email: PALS@tavi-port.nhs.uk

**Emotional Support**

If following the interview, you feel left with any difficult emotions as a result of talking about your personal experiences, we can arrange for you to have a debrief meeting with the TOPS Lead Therapist.

Alternatively, if you wish to speak confidentially to someone neutral, you can contact the Parent and Carer Counselling Service, who will be able to offer you up to 12 free counselling sessions with a counsellor who will meet with you privately at the school. To access this free service, please contact:

**Miranda Clifford**
Parent and Carer Counselling Service Co-ordinator
SEN and Psychology Services
Children, Schools and Families
Camden Council
Crowndale Centre
218 Eversholt Street
London
NW1 1BD
Tel: 020 7974 6500
Email: pccs@camden.gov.uk

**Further Information**

All research in the NHS is examined by an independent group of people called a Research Ethics Committee. This is to protect your interests. This study has been reviewed and given a favourable opinion by the Proportionate Review Sub-Committee of the Wales REC 4.

---

*Thank you for taking the time to read this information sheet and consider taking part.*
CONSENT FORM
Kinship Carer

Title: What can we learn from interviews with kinship carers, teachers and therapists about the experiences of children in kinship care?

Please initial box

1. I confirm that I have read and understood the information sheet dated 7th November 2014 (version 2) for the above study, I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

2. I understand that my participation in this research is voluntary and will not have any bearing on my relationships with the teaching or therapy staff at my child’s school.

3. I understand that the researcher will be accessing TOPS file data to gather basic statistical information on the child I care for and on our family structure.

4. I understand that all information collected in the research study will be held securely and in confidence. Any information that is published will be written in such a way that I, the child I care for and our family cannot be identified. However I am aware it will be evident that my child attends/attended one of the TOPS primary schools in Camden.

5. I am aware that the final thesis will be held by the TOPS Project Manager and I am welcome to contact the Lead Therapist at my child’s school if I would like them to arrange for me to see it.

6. I agree to take part in the above study by participating in a one-off interview with the researcher and for what I speak about to be used anonymously as material for the research project.

Name of Participant (Kinship Carer) __________________________ Date __________________________ Signature __________________________

Name of Person taking consent __________________________ Date __________________________ Signature __________________________

2 copies: 1 copy for participant; 1 for research file
Step 1: Identification of Research Subjects

Meeting with TOPS team to identify 3 cases.

Selection Criteria:
1. Child lives in kinship care
2. Child seen by TOPS in last academic year
3. Treatment has now ended.

[If 3 cases not found, search is widened to include previous academic years]

Step 2: Inclusion Process

Case identified by TOPS Lead Therapist which meets my selection criteria

TOPS Manager to consider any reasons why the identified case may not be suitable? (e.g. if child has a sibling still in treatment).

Unsuitable → Suitable

Case not pursued further.

Do the 3 participants connected to the child meet my inclusion criteria?

Inclusion Criteria:
1. Participants must be adults.
2. Participants must be connected personally or professionally with a child in kinship care who received therapy through the TOPS project.
3. Participants must speak English to a level possible for them to communicate their feelings and experiences in an interview.
4. Participants must be able to understand the purpose of the research and be willing to talk about their feelings and experiences.
5. Participants must be able to travel to the interview setting (child’s school or Tavistock Centre)

No → Case not pursued further.

Yes → Continue to Step 3
**Step 3: Recruitment of Participants**

**Initial Contact**
Lead Therapist based at child’s school to approach the Kinship carer, Therapist and SENCO (with permission of School Head) to inform them of the project and give them an Information Sheet.

**Arranging Introductory Meeting**
After 24 hours, potential participants (PP’s) to contact Lead Therapist (LT) if willing to attend an introductory meeting with the researcher.

After a week if the LT has not received a response, then LT to give PP’s a courtesy call to see if they would be happy to have an introductory meeting with the researcher.

If they don’t wish to take part, LT to thank them for their time and update researcher.

If they are, then LT to help co-ordinate setting up introductory meeting at the child’s school between PP and researcher.

**Introductory Meeting**
Researcher to explain more about the project and what participation would involve. Opportunity for PP to have any questions answered.

If PP happy to proceed they are given a consent form to sign and an interview date is arranged.

**Interview**
Interviews to take place either at child’s school in room used for TOPS therapy sessions, or at the Tavistock Centre. Interviews to be semi-structured, last approximately one hour and are recorded.

**Follow Up**
Participants to be offered an optional debrief meeting with the LT should they feel left with any difficult emotions as a result of talking about their feelings and experiences in the interview.

Kinship carers to be given a leaflet for a free local parent and carer counselling service which they can access confidentially.

Participants to be sent a letter thanking them for taking part and offering an optional follow-up meeting if they would like to receive feedback on the research and discuss their experience of taking part.

Copy of thesis to be held by TOPS manager which participants can arrange to see via the LT.
Parent and carer counselling service

A free confidential counselling service for all parents and carers of children in Camden schools and children’s centres
Parent and carer counselling service

Being a parent or carer is a uniquely demanding and important task. Most parents and carers have times when they are troubled by personal or family problems. Counselling sessions are a private space to talk and think about worries and move towards finding solutions.

The parent and carer counselling service offers 12 counselling sessions which take place in a confidential room in your child’s school or children’s centre. A counsellor from the service comes into the school to meet with you there. The service is free.

What is counselling?

Life is complicated and it can sometimes feel like an uphill struggle. We may turn to friends and family to support us, but sometimes we need more than this. That’s when it may help to talk to a counsellor.

Your counsellor will listen to you and help you untangle your feelings and thoughts. Some people say counselling helps because they can talk about anything they want in a safe and non-judgemental environment. When people talk with their counsellor over time about the things that feel overwhelming they often find things feel more manageable.

Each counselling session lasts 50 minutes and sessions take place once a week during the school term in a private room in your child’s school, usually during school hours. Regular attendance is important to get the most out of counselling.

Who uses the parent and carer counselling service?

Mothers, fathers, foster carers and other carers of children in Camden schools and children’s centres use the service.
Who will I see?

Counsellors are carefully selected for their experience and counselling qualifications and they are professionally managed and supervised. All of our counsellors work within the code of ethics and practice set out by the British Association for Counselling and Psychotherapy. Counsellors are trained to listen without judging. They can help you sort out your thoughts and feelings about what is worrying you.

Who will be told about what I say in the sessions?

Our counsellors are not part of the school and are separate from the school’s counselling service. What is discussed during counselling sessions isn’t shared with school staff or other agencies. However, if your counsellor thinks that you or someone else may be at risk or in danger there may be a need to get help from others to keep you safe. If this happens your counsellor will talk with you about this.

The school receptionist and headteacher or link person in the school will know that you’re seeing a counsellor but we won’t tell them any other details.

What happens next?

Within two weeks of receiving your application form for counselling we will send you a letter with the name of your counsellor. Your counsellor will contact you by telephone to find out when you can meet for counselling sessions.
Application form for counselling continued...

Please tick ☑ your ethnic group below (this information is requested to ensure we are working within our equal opportunities policy):

White:
- White British
- White Irish
- Any other white background (please specify):

Mixed:
- White and black Caribbean
- White and black African
- White and Asian
- Any other mixed background (please specify):

Asian or Asian British:
- Indian
- Pakistani
- Bangladeshi
- Any other Asian background (please specify):

Black or black British:
- Caribbean
- Somali
- Any other black African background (please specify):
- Any other black background (please specify):

Chinese or other ethnic group:
- Chinese
- Any other group (please specify):

Do you consider yourself to have a disability?
- Yes
- No

If you would like to have this leaflet or application form in another language, large print or Braille, please call 020 7974 6649.

Post to: PCCS co-ordinator
SEN and psychology services
Children, schools and families
Camden Council
Crowndale Centre
218 Eversholt Street
London NW1 1BD

Or email: pccs@camden.gov.uk
# Application form for counselling

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of parent or carer:</td>
<td></td>
</tr>
<tr>
<td>Date form completed:</td>
<td></td>
</tr>
<tr>
<td>Telephone numbers:</td>
<td></td>
</tr>
<tr>
<td>Home address:</td>
<td></td>
</tr>
<tr>
<td>Where you heard about the counselling service (e.g. I picked up a leaflet in school):</td>
<td></td>
</tr>
<tr>
<td>Child’s school or children’s centre:</td>
<td></td>
</tr>
<tr>
<td>Link contact in school or children’s centre:</td>
<td></td>
</tr>
<tr>
<td>Days and times you are available for counselling sessions:</td>
<td></td>
</tr>
</tbody>
</table>

Please use this space to tell us about the main issues you’d like to discuss with your counsellor:

The service has male and female counsellors. You will be allocated to a male or female counsellor with a current vacancy. Please state only if you have a particularly strong preference for a male or female counsellor:

Please turn over
The kind of things you might talk about

You can use your counselling sessions to talk about whatever is on your mind: problems, decisions, worries or changes in any area of your life. Talking about your worries and problems can be the start of sorting them out.

How do I arrange to start seeing a counsellor?

By completing the application form at the end of this leaflet (either on your own or with a member of staff) and sending it to:

PCCS co-ordinator
SEN and psychology services
Children, schools and families
Camden Council
Crowndale Centre
218 Eversholt Street
London NW1 1BD

or you can contact us by telephone on 0207 974 6500
or email pccs@camden.gov.uk
APPENDIX E

Mrs Tracy Biggs
REC Manager
Wales REC 4
G1/G2 Croesnewydd Hall
Croesnewydd Road
Wrexham Technology Park
Wrexham
LL13 7YP

7th November 2014

Dear Tracy,

Apologies for the delay in re-submitting my documents to the Sub-Committee. In response to the recommendations stated in your letter on 28th August 2014, I have made the following changes to the documentation for study participants:

i. **Confirmation that at least 24 hours will be provided to consider participation prior to consent.**

1) I have added an initial paragraph at the start of all Participant Information Sheets which encourages potential participants to “take the time to read this information sheet carefully and discuss it with others if you wish.” This should encourage the idea that this is something that participants need to give sufficient time to think about before deciding.

2) On page 3, I have also rewritten the section entitled “Yes, I’d be interested in taking part, what happens next?” so that it explicitly states that “it is important that all participants take at least 24 hours to consider participating in the study”.

3) On page 3, I have also provided contact details for the Lead Therapists at each school and advised potential participants in the first paragraph on this page that “if you would be happy to take part, please contact her using the details provided below…” This should also make it clear to participants that they will need to make contact with the Lead Therapist outside of the time when she gives them the information sheet, in order to communicate a decision to participate in the study. This should help to encourage the idea that they take some time for themselves to think about it.

4) Lastly, I have added into the 3rd paragraph on page 3 that the Lead Therapist will make a courtesy call to potential participants a week after she has given them the information sheet to see if they have had a chance to consider participating and to help if they have any queries they would like to discuss with her. This should help to indicate a timeframe around decision making and help to give support if needed to potential participants who may have questions which they would like an answer to before deciding whether to meet with me.
ii) Please reconsider and provide an appropriate mechanism in the event of distress. Referral to the GP is not adequate.

1) I have added an additional section to all Participant Information Sheets on page 4 entitled “Support for Participants”. This is divided into two sections entitled “Practical Support” and “Emotional Support”.

2) Under Practical Support, on all three information sheets I have provided the contact details for the Patient Advice and Liaison Service, should they be unhappy with their involvement in the study and wish to speak to someone unconnected with the project.

3) Under Emotional Support, on the Information Sheets for the SENCO and TOPS Therapists, I have stated that they can receive a debrief meeting with the Lead Therapist should they feel left with any difficult emotions as a result of participating in the interview. This will give them a time where they can speak to a qualified therapist in private about any upset they may be feeling as a result of reflecting on their work. I have not provided a further additional mechanism in the event of distress for these participants, as unlike the kinship carers, they will be not be discussing personal matters, and although discussing children they work with may evoke strong feelings, they will already have systems in place via the school/therapy project for supporting them in their work.

4) Under Emotional Support for Kinship Carers, in addition to the offer of a debrief meeting with the TOPS Lead Therapist, I have also provided details of a separate local counselling service in the event of distress. This service offers 12 free counselling sessions to any parents or carers of children who attend a London Borough of Camden school. I have made contact with Miranda Clifford who runs this psychology service and explained the nature of my project. She has confirmed that they will be able to offer support to the kinship carers who participate in my study, as the TOPS primary schools are all within their catchment area. She has sent me some leaflets which I can give out to participants when they meet with me. (Please see attached electronic version on my IRAS checklist). These leaflets are also always available in the schools.

5) Lastly, I have added into the third paragraph on page 3 that participants can “always contact either myself or the Lead Therapist at any time if you have any concerns about the study” and added my contact details to the front page. This should help participants to feel able to get in touch with someone at any time should they need to access further information or support.

iii) The Committee suggest that the Participant Information Sheet and Consent form may benefit from revision.

1) I have added University/NHS logos and contact details to the front of all forms.

2) I have added a header to all forms giving the name of the form, REC submission details and page number.

3) I have added a footer to all Information Sheets with contact details should the pages become separated.

4) I have changed the font style and size (to Arial 10 on advice from Noclor).
5) I have added a Further Information section to the bottom of page 4 on the Information Sheets, giving the details of the REC committee and explaining the purpose of this.

6) I have added a footer to the Consent Form stating that two copies are to be signed.

7) I have reordered the points on the Consent Form and removed two which were not relevant for a consent form (previous points 6 & 7).

Additionally, I have now been able to provide updated insurance documents valid until July 2015.

I hope that these changes adequately attend to the concerns of the Sub Committee.

Yours sincerely,

Mel Serlin
Child Psychotherapist

cc. Tumi Kaminskas, Assistant Research Facilitator, Noclor.
26 November 2014

Ms Mel Seilin

Dear Ms Seilin

Study title: What can we learn from interviews with kinship carers, teachers and psychotherapists about the experiences of children in kinship care?

REC reference: 14/WA/1126
IRAS project ID: 139283

Thank you for your letter of 07 November 2014, responding to the Proportionate Review Sub-Committee’s request for changes to the documentation for the above study.

The revised documentation has been reviewed and approved by the sub-committee.

We plan to publish your research summary wording for the above study on the NRES website, together with your contact details, unless you expressly withhold permission to do so. Publication will be no earlier than three months from the date of this favourable opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to withhold permission to publish, please contact the REC Manager Mrs Tracy Biggs, Tracy.Biggs@wales.nhs.uk.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised.

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission (‘R&D approval’) should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at http://www.research.nihr.ac.uk.

North Wales REC (Central & East)
01/02 Cremorne Hall
Cromorne Road
Wrexham Technology Park
Wrexham LL13 7YP
Telephone: 01978 723377
E-mail: tracy.biggs@wales.nhs.uk
Website: www.nres.nhs.uk
Where a NHS organisation’s role in the study is limited to identifying and referring potential participants to research sites (“participant identification centre”), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of approvals from host organisations.

Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publicly accessible database within 8 weeks of recruitment of the first participant (for medical device studies, within the timeline determined by the current registration and publication trees).

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g. when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non-clinical trials this is not currently mandatory.

If a sponsor wishes to contest the need for registration they should contact Catherine Blewett (catherineblewett@nhs.net), the HRA does not, however, expect exceptions to be made. Guidance on where to register is provided within IRAS.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Ethical review of research sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see ‘Conditions of the favourable opinion’ above).

Approved documents

The documents reviewed and approved by the Committee are:

<table>
<thead>
<tr>
<th>Document</th>
<th>Version</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covering letter on headed paper</td>
<td></td>
<td>21 August 2014</td>
</tr>
<tr>
<td>Covering letter on headed paper (Covering Letter for Revised Documentation)</td>
<td>2</td>
<td>07 November 2014</td>
</tr>
<tr>
<td>Evidence of Sponsor insurance or indemnity (non NHS Sponsors only)</td>
<td>2</td>
<td>01 August 2014</td>
</tr>
<tr>
<td>IRAS Checklist XML [Checklist_21082014]</td>
<td></td>
<td>21 August 2014</td>
</tr>
<tr>
<td>IRAS Checklist XML [Checklist_11122014]</td>
<td></td>
<td>11 November 2014</td>
</tr>
<tr>
<td>Non-validated questionnaire (Non-validated questionnaire)</td>
<td>1</td>
<td>10 April 2014</td>
</tr>
<tr>
<td>Other [Project Proposal Signature Page]</td>
<td></td>
<td>16 January 2013</td>
</tr>
<tr>
<td>Other [Employers Liability Insurance]</td>
<td>2</td>
<td>13 June 2014</td>
</tr>
<tr>
<td>Other [Parent and Carer Counselling Service Leaflet]</td>
<td>1</td>
<td>07 November 2014</td>
</tr>
<tr>
<td>Participant consent form [Consent Form for Kinship Carer]</td>
<td>2</td>
<td>07 November 2014</td>
</tr>
<tr>
<td>Participant consent form [Consent form for SENCO]</td>
<td>2</td>
<td>07 November 2014</td>
</tr>
<tr>
<td>Participant consent form [Consent form for Therapist]</td>
<td>2</td>
<td>07 November 2014</td>
</tr>
<tr>
<td>Participant information sheet (PIS) [Info Sheet for Kinship Carers]</td>
<td>2</td>
<td>07 November 2014</td>
</tr>
<tr>
<td>Participant information sheet (PIS) [Info Sheet for SENCOs]</td>
<td>2</td>
<td>07 November 2014</td>
</tr>
<tr>
<td>Participant information sheet (PIS) [Info Sheet for Therapists]</td>
<td>2</td>
<td>07 November 2014</td>
</tr>
</tbody>
</table>
Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document “After ethical review – guidance for researchers” gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The HRA website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

Feedback

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website: [http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance](http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance)

We are pleased to welcome researchers and R & D staff at our NRES committee members’ training days – see details at [http://www.hra.nhs.uk/hra-training/](http://www.hra.nhs.uk/hra-training/)

14/WA/1126 Please quote this number on all correspondence

With the Committee’s best wishes for the success of this project.

Yours sincerely

Professor Alex Carson
Chair

E-mail: tracy.bingo@wales.nhs.uk

Enclosures: “After ethical review – guidance for researchers”

Copy to: Sponsor contact - Prof Neville Punchard

Lead NHS R&D lead - Ms Angela Williams, NOCLOR
APPENDIX G

Ms Mei Serlin

Dear Ms Serlin

I am pleased to confirm that the following study has now received R&D approval, and you may now start your research in the trust(s) identified below:

Study Title: What can we learn from interviews with kinship carers, teachers and psychotherapists about the experiences of children in kinship care?
R&D reference: 15/0293
REC reference: 14/WA/1125

This NHS Permission is based on the REC favourable opinion given on 26 November 2014.

<table>
<thead>
<tr>
<th>Name of the trust</th>
<th>Name of current PILC</th>
<th>Date of permission issue(d)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tavistock &amp; Portman NHS Foundation</td>
<td>Ms Mei Serlin</td>
<td>16 December 2014</td>
</tr>
</tbody>
</table>

If any information on this document is altered after the date of issue, this document will be deemed INVALID

Specific Conditions of Permission (if applicable)

If any information on this document is altered after the date of issue, this document will be deemed INVALID

Yours sincerely,

Pushpa Joshi
Research Operations Manager

Cc: Dr Janifer Wakelyn jwakelyn@tavi-port.nhs.uk, Mrs Margaret Rustin mmrustn@tavi-port.rh.org.uk, Professor Neville Purchard n.purchard@uel.ac.uk
What can we learn from interviews with kinship carers, teachers and therapists about the experiences of children in kinship care?

Contents

Study Aim and Design (p.2)
Identifying Research Subjects (p.4)
Recruitment of Participants (p.6)
Interviews, Follow-up and Support for Participants (p.9)
Confidentiality (p.10)

Appendix 1: Information Sheets for Kinship Carer, SENCO and Therapists
Appendix 2: Consent Forms for Kinship Carer, SENCO and Therapists
(Consent forms for reference only – not to be given out)
Appendix 3: Interview Questions (for reference only – not to be given out)
Appendix 4: Parent and Carer Counselling Service Leaflet

Mel Serlin, Child Psychotherapist
(contact details provided)
Study Aim and Design

Research Aim

The aim of my investigation is to learn more about the experiences of children who grow up in kinship care, as perceived by their carers, teachers and therapists. I am interested to understand what it may be like for children to be living with extended family members who have their own history and relationship with the child’s parent(s) who have been unable to continue parenting them.

I will be exploring the relational dynamics and feelings of the children and their carers, as they manage a new family structure together which is likely to have been proceeded by loss, trauma, neglect and/or abuse. I will be seeking to find out more about the experiences of this group of children and how it affects them, which will be different to children growing up with birth parents, adopted parents or looked after children.

My research will be done with the support of the Tavistock Outreach in Primary Schools (TOPS) project. This is a psychotherapeutic service which has therapists based in five primary schools within the London Borough of Camden. I will be selecting three children living in kinship care who received therapeutic treatment through the TOPS project.

Methodology

My research will consist of nine semi-structured interviews in total, with the Kinship Carer, Teacher (SENCO) and Therapist connected with each of the three children. All interviewees will be asked the same few questions, which will be intentionally broad so as to encourage participants to share their individual feelings, experiences and views. Interviews will be tape recorded and then transcribed.

Interview data will then be coded and analysed using Interpretative Phenomenological Analysis. Coding will enable themes to be teased out and I will then analyse these themes using a psychoanalytic understanding to explore the issues which come to light.

Research Literature

In thinking about the specific needs and difficulties of children living in kinship care, most of the relevant literature comes from social work. The focus is on thinking about the emotional benefit on children of remaining within their family network so that they maintain a sense of identity and belonging, as well as the complexities of this decision and the specific skills required of social workers to assess suitability of relatives to become carers e.g. Broad (2001) and Greeff (1999).

In other disciplines such as family therapy, there is some research e.g. Ziminski (2007) which focuses on the complex dynamics within families that surround children in kinship homes. However within child psychotherapy there is no literature focused specifically on this population of children, although there is a wide range of literature on relevant themes, such as loss and separation, the impact of trauma and neglect on mental and emotional life, and on working therapeutically with children who have been deprived and abused.
Given that the Children Act 1989 sets out a legal imperative for children to be accommodated with family and friends wherever possible, and according to a study by Nandy and Selwyn (2011) there are now over 143,000 children in England living with relatives (1 in every 77 children), it is important to find out more about the experiences of these children and I am interested in how psychoanalytic thinking can contribute to understanding the needs of this group and how they can best be supported.

Findings

As there has been very little research into kinship care in the UK, this project will likely highlight the need for more research in this area. Accessing data about the therapeutic treatment of young children and their carers, will provide a unique opportunity to gain insight into the emotional impact of these arrangements and experiences on young children and their families.

The project may also lead to further understanding about how much schools are aware of the complexities of home life for their pupils who are living in kinship care arrangements, and in what ways school-based therapy projects like TOPS may be helpful to children and families in providing more specialist and community based services in the future.
Identifying Research Subjects

Research Subjects

The three children who will be the focus of my study will all have been referred to the TOPS project by their school due to concerns they are exhibiting signs that they need some support. This may be symptoms such as: being unable to concentrate on tasks, organise themselves appropriately, disruptive behaviour in class or lack of ability to socialise with their peers.

In consultation with the child’s carer, the school Special Educational Needs Co-ordinator will have made a referral to the project. The treatment which will have taken place in the child’s school would have involved individual psychotherapy for the child in question, usually for one academic year approximately, regular sessions with the kinship carer to help them with understanding and parenting this particular child, and termly reviews with the SENCO.

My research will consist of one-off semi-structured interviews with the kinship carer, SENCO and therapist connected with each of these three children. I will not be having any direct contact with the children themselves.

Selection Criteria

For the purposes of my research, I am looking to identify three children who fit the following criteria:

1) The child lives (or lived during TOPS treatment) in kinship care.
2) They received TOPS treatment in the last academic year. (If three children are not found, the search will then be widened to include the previous academic year).
3) Therapeutic treatment has now ended.

Issues for consideration

Once three children have been identified who meet these criteria, there should be consideration by the Lead Therapist who knows the identified child and their family, along with the TOPS Project Leader, as to any reasons why it may not be clinically suitable to include this child as a subject in my research study. For example, if the child has a sibling who is currently receiving therapeutic treatment with TOPS or the Tavistock Clinic and there is concern that the carer’s involvement in my study could negatively impact on the treatment of the sibling. Consideration should also be given as to whether there is any reason why it would not be appropriate for me to interview the Honorary Therapist who treated the child.

Potential Participants Criteria

In order to be interviewed for the research project, the three adults connected with each of the three identified children must fit the following criteria:

1) Participants must be adults.
2) They must be connected personally or professionally with a child in kinship care who received therapy through the TOPS project and whose treatment has now ended.
3) They must speak English to a level possible for them to communicate their feelings and experiences in an interview.
4) They must be able to understand the purpose of the research and be willing to talk about their feelings and experiences.
5) They must be able to travel to the school (or if not, to the Tavistock Clinic) to participate in the research.
Recruitment of Participants

Research participants will be recruited in collaboration with the TOPS Lead Therapists, in order to provide a familiar and supportive structure around participants at every stage, from recruitment through to obtaining support for any difficult feelings or concerns that participants may be left with following the interview.

Once a) three children who meet the selection criteria have been identified, b) it is agreed with the TOPS Project Leader that the three adults around each of these children also meet the criteria for Potential Participants and c) there are no clinical reasons why they should not be invited to participate in my research, the recruitment process can begin.

Step 1 – Initial Contact

Kinship Carers:

The Lead Therapist based at the identified child's school will first approach the kinship carer to inform them of the project and give them an Information Sheet.

Potential participants should be assured that a decision to decline to participate in this research will have no impact on their potential to access further support from TOPS in the future, nor will it affect relationships with their child’s school.

SENCO’s:

The Lead Therapist based at the identified child’s school will initially approach the Head Teacher to explain the nature of the project and what the participation of the school SENCO would involve. Permission will be sought from the Head Teacher to approach the SENCO directly to invite them to meet with the researcher and consider participating in the study. The Head Teacher should be made aware that a decision not to permit the SENCO to participate in the research will not affect the relationship between the TOPS project and the school.

If the Head Teacher gives consent for the SENCO to be approached, the SENCO would then be approached by the Lead Therapist and given an Information Sheet.

The SENCO should be informed that the Head has given permission for them to discuss their perceptions of the child and their kinship carer in a semi-structured interview, but that there is no obligation for the SENCO to participate and that if they decline to do so, this will not affect their relationship with either the Head Teacher or the TOPS project staff working there.

Therapists:

The TOPS Lead Therapist will approach the therapists who treated the identified children to explain the nature of the research project and give them an Information Sheet.

The therapists should be made aware that the TOPS Project Leader permits their discussion of case material gathered through therapeutic work for the TOPS project with the researcher in an interview, but that this does not mean they are expected to participate in the research and that if they choose not to, this will not have any negative impact on their employment in the TOPS project, nor their relationship to the Lead Therapist or other colleagues.
Step 2 – Arranging Introductory Meeting with the Researcher

1. Once they have been told about the project and given the Information Sheet, Potential Participants (PPs) to think about it for at least 24 hours.

2. PPs then to contact the Lead Therapist (LT) via the contact details on page 3 of the Information Sheet with their decision as to whether they would be happy to have an introductory meeting with the Researcher. [Meeting with the Researcher does not commit them to participating further in the study, if they then decide not to.]

3. If after 1 week, the LT has not heard back from the PP, LT to give a courtesy call to the PP to see if they have had a chance to consider participating, or if there are any queries/concerns they would like to discuss with the LT, in order to help them decide whether to progress on to having an introductory meeting with the Researcher. LT to answer any queries/concerns where possible and ascertain the PP’s decision.

If their decision is NO:

a) LT to ask PP if they are happy to share their reasons why they have chosen not to e.g. feels too personal, don’t have time, too nervous, as this will be helpful data to gather.
b) LT to thank PP for taking the time to consider participating. No further research contact with this PP.
c) LT to email the Researcher with the PP’s decision and any reasons given.

If their decision is YES:

a) LT to thank PP for agreeing to participate in the research.
b) LT to remind PP that the next step will be for them to have an introductory meeting with the Researcher at the school (or Tavistock if needed).
c) LT to ask PP if there are any times/days which would be better for them. (N.B. Fridays are best for the Researcher!)
d) LT’s to email the Researcher the PP’s decision and help co-ordinate setting up the introductory meeting at the school in the TOPS therapy room.

If they are UNSURE:

a) LT to encourage PP to have an initial meeting with the researcher so that any concerns/uncertainties can be explored. If the PP wishes for the LT to be present at the introductory meeting for support, this will be at the discretion of the LT to offer if they feel it would be helpful and if they have the time to offer this. LT presence at the introductory meeting is not expected.
b) If the PP agrees to have an introductory meeting with the Researcher, LT to help arrange this as outlined above.
c) If the PP is still not sure and wants more time to think about it and/or discuss it with family, LT to arrange a time to call back (e.g. a week later) to see what they have decided.
Step 3 – Introductory Meeting with the Researcher

1. At this meeting, PP’s will be able to talk more with the Researcher about what to expect in the interview and ask any further questions they may have.

2. If, at the end of this meeting, they are happy to agree to participate in the interview, they will be given a consent form to sign and a date will be arranged for the interview.

3. If they decide they want more time to think about it then the researcher will arrange to call them a week later to see what they have decided.

4. If they decide not to participate any further, this will be the end of their involvement in the research project.
Interviews, Follow-up and Support for Participants

1. Interviews will take place in the room used for TOPS therapy sessions at the school, or if easier, e.g. for TOPS therapists to get to, in a therapy room at the Tavistock Clinic. Interviews will last approximately 1 hour.

2. Following the interview, all participants will be sent a letter thanking them for participating and offering them an optional follow-up meeting with the Researcher at the school, if they wish to discuss the interview experience and receive preliminary feedback.

3. They will also be offered an optional debrief meeting with the Lead Therapist, should they feel left with any difficult emotions as a result of talking about their feelings and experiences in the interview.

4. If participants need to take public transport to get to the school for the interview or meetings with the Researcher or Lead Therapist, these travel costs will be refunded.

5. Along with the thank you letter, kinship carers will be sent a leaflet with details of a free local Parent and Carer Counselling Service which they can access confidentially, should they wish to receive further support. Lead Therapists have copies of this leaflet in this pack, should they feel in the debrief meeting that the carer would benefit from some support in accessing this service.

6. Participants will be aware from the Consent Form, that a copy of the final thesis will be held by the TOPS Project Leader and that they are welcome to contact the Lead Therapist who will be able to arrange for them to see it.
Confidentiality

1. Participants will be aware from the Information Sheet and Consent Form that the Researcher will be accessing TOPS file data to gather basic statistical information on the selected children and their family e.g. age, ethnicity, gender, family structure, reason for referral to TOPS etc. Permission for the Researcher to access this clinical data has been agreed with the TOPS Project Leader.

2. All identifying details of participants will be anonymised by the Researcher, however it will be evident that all participants either worked for, in partnership with, or received treatment through one of the 5 TOPS Primary Schools in Camden – although which one will not be disclosed so as to maintain confidentiality.

3. In order that all identifiable patient details are only held securely in TOPS files at the Tavistock Clinic, the Researcher will only use initials when storing electronic data (e.g. when typing up the interview manuscripts) and any letters sent to participants by the Researcher will be sent via the TOPS Project Administrator who has secure electronic access to patient names and addresses.
APPENDIX I

Kinship Carer Interview Questions

Current Situation

1. So you’re the grandmother for (child)? And you are his maternal grandmother?
2. How old was he when he came to live with you?
3. And the plan is for him to remain living with you. Is there a legal Order?
4. Do you think he is clear that he’s going to be staying with you? Does he ask about the future?
5. What does he call you? (Has he always called you that? Or has it changed? Who initiated the change? Are you happy with that name?)
6. Can you tell me who else is currently living in your home?

Kinship Care

7. What’s it been like for you, becoming a kinship carer?
8. Is this how you imagined it would be?
9. In what ways are things different for you and your family now?
10. What are the positive things that having him living with you has brought to you and what are the things that are now more difficult?
11. Do you feel a different kind of family? (to other families)

His relationship with his parents

12. Thinking about why he came to live with you, what would be the important things for me to understand?
13. Can you tell me a bit about the contact arrangements between him and his parents?

Your relationship with his parents

14. Has your relationship with your daughter changed by your becoming a kinship carer?
15. What does she feel about him coming to live with you? (Has this changed over time?)
16. Can you tell me a bit about the relationship between the maternal and paternal families? (Are there grandparents on his dad side? Do they offer any support?)

Kinship Care

17. What do you think he understands about his coming to live with you? (What gives you this impression? Does he talk to you about it? Who has helped him to make sense of this? e.g. you, social worker, life story work etc)
18. How do you think he feels about living with you?
19. What was his mood and behaviour like when he first came to live with you? (Did you notice any changes in him around this time? e.g. compared to how he was before he came to live with you?)
20. What did you think about these? (e.g. what did they indicate to you about how he was feeling?)
21. Once he had been settled with you for a little while, did these behaviours/moods stay the same, or did they change at all?
Contact

22. How do you think he feels about contact? (Father too?)
23. What gives you this impression? e.g. change in behaviour?/talks about it?

Overall

24. What do you think has been the good things for him about being in a kinship family and what’s been the most difficult for him to manage?
   (Sense of belonging, family identity, living away from parents, contact with parents, feelings of conflicted loyalty, moving school, separation from sibling(s)…)

TOPS therapy

Referral

25. How long had he been living with you when he got referred for therapy?
26. What did you understand about why he was referred by the school?
27. Were you a part of that decision?
28. Were any of the behaviours you noticed at home a part of the reason for the referral? Or were the school’s concerns very different?

Your experience of the TOPS work

29. What was it like for you having him being in therapy? How did it feel for you?
30. When he was having therapy, did you also have your own separate meetings?
31. Were there particular things that you found you used these sessions to talk about?
32. Was this helpful?

Review Meetings

33. Did you get invited to review meetings along the way? (How often were they? Who was present at these?)
34. Do you remember what sorts of things were talked about?
   (i.e. what things the therapist thought he was struggling with? What things the therapist was working on with him in their sessions?)
35. Were these review meetings helpful? (if school present, did she feel these meetings helped the school to understand and work with his behaviour better?)

His Treatment

36. How do you think he felt about having therapy sessions?
37. Can you tell me about any changes you noticed in him during the treatment?
38. Are there any changes you have noticed in him since treatment has ended?
39. Did you feel that the treatment ended at the right time? Or there was more support that you would have liked, or felt that he needed?
40. What further support would you have liked?
41. Would you know how to get more help for him if needed? (e.g. at secondary school?)

42. Is there anything else you feel is important for me to understand about what it’s been like for you or him being in kinship care? (e.g. housing, financial, work, social work, support etc?)
SENCO Role in the school

1. You’re the Special Educational Needs Co-coordinator at your School. Do you also have other responsibilities in the school – i.e. class teacher/head of year?
2. Do you usually know before a child joins your school, whether they are likely to need support from a SENCO?
3. Are there any factors/criteria which immediately highlight for the school that this is a child who may at some stage need additional support?
4. How much is a child’s home life/family circumstances a part of this?

Thinking about children living in kinship care

5. Can you tell me from your experience as a SENCO what are the things you think of, when you think about children living in kinship care?
6. In the school as a whole, how much of a perception amongst the staff do you think there is of children living in kinship care as being a particular group of children - who may have specific needs which will be different from looked after children or those who have been adopted?
7. Do you feel that this is in the school’s mind as an issue of inclusion e.g. in classroom discussion and language used, or in relation to ‘parents’ evenings.
8. Are there any (other) areas of school policy which recognise any needs which are specific to this group of children?
9. How much do you think children in the school generally have an awareness of pupils living in different sorts of families?
10. In what ways, if any, do you think that the cultural and ethnic backgrounds of the children who attend your school shapes/affects this?

Support for emotional and behavioural difficulties in School

11. If difficulties emerge once a child is in your school, how do individual children usually come to your attention?
12. What are the different supports available within the school for emotional/behavioural needs? (e.g. TOPS, nurture groups etc.)
13. How do you decide what intervention(s) would be best?
14. What factors influence your decision? (e.g funding issues, age of child, severity of difficulty? 
15. Does a child’s family life or situation in anyway influence which intervention you feel would be most suitable for this child? (i.e. some interventions in school might be just for the child, whereas TOPS also involves the family?)
16. Are there particular criteria you have for deciding if a child is suitable for a TOPS referral?
17. What might prompt you to refer to TOPS and what might lead you not to?
18. Once it’s agreed that a TOPS referral is appropriate, can you tell me about the TOPS referrals process? Are families involved?
Referral

19. How did he come to your attention?
20. How long had he been at the school at the point you referred him to TOPS?
21. What were the concerns you had and difficulties identified that he needed help with?
22. What did you think were the reasons for this behaviour?
23. How do you think he felt about himself and his situation? (e.g. did he feel different to be living with a grandparent not a parent like his peers?)
24. What were your hopes for him from TOPS involvement?
25. How did his grandmother (and other family members) feel about the referral?
26. How involved was she along the way?

Review Meetings

27. What was your involvement along the way – e.g. review meetings?
28. Did you find the review meetings helpful? In what ways? e.g. understanding his behaviour better, being able to advise teachers on how to help him manage him in the classroom? Building a better relationship with the family?
29. Are there particular things you remember being discussed? Themes of the work? Issues which came to light for him during treatment?

Treatment

30. How do you think he felt about going to therapy? (e.g. feelings of difference to leave his class?
31. Did you/the school notice any changes in him during treatment?
32. Are there any changes you noticed after treatment?
33. Did you feel that the treatment ended at the right time or was there further input you would have liked from the TOPS service?

34. Is there anything else you feel would be important for me to understand about his experience of being in kinship care? Or about the treatment he received, or the TOPS service in general for helping children in kinship care?
Setting

1. Can you tell me a bit about the setting where you see the children? (Is it a designated room in the school just for TOPS therapy? Or is it a multipurpose room that the child would also go in at other times?)
2. How do the children get to and from their sessions, do you collect them?
3. Thinking about this child in particular, is there anything about his prior relationship to the project, to you or the setting that would be helpful for me to know?

Referral

4. So thinking back to the start when he got referred to TOPS. Can you remember the reasons why he was referred?
5. Were the difficulties the same at home and school, or did he present differently in different places?
6. When did you first meet his kinship carer?
7. Were the school’s concerns shared by his kinship carer at the time?
8. What did you understand about how the carer felt about the referral?
9. When did you first meet with the child?
10. What were your first impressions of him?
11. Did he recognise the difficulties the adults were concerned about?
12. How was his coming to see you explained to him?
13. How do you think he felt about the idea of coming to see you for therapy?
14. What would you say were the important things for you to understand about his history and current circumstances?

Setting up the work

15. Can you tell me a bit about how the therapy was set up?
16. If there was an assessment, can you remember what the key things were which came to light?
17. Re: treatment, how was it set up in terms of timescales, other support, (e.g. meeting for the kinship carer, reviews etc?)
18. Were there any important factors in terms of what time he was seen for therapy?
19. What were the main treatment aims at the start?

Treatment

20. Can you describe what you recollect of the experience of the work as a whole with this child and this family? Any predominant impressions you had?
21. Did you feel that there were any distinctive situations in the work as a whole which wouldn’t have come up with a child living with their parents or in foster care?
22. Thinking now just about this child’s treatment, can you tell me about the main themes which emerged in the work?

23. In what ways do you feel these themes may have been connected to:
   a) early life experiences
   b) current living arrangements
   c) other events or circumstances particular to this child’s life and identity?

24. Can you say something about the way that the child communicated their difficulties and feelings with you in the sessions, and what sense you made of this using your psychoanalytic understanding?

25. Were there any periods of the therapy that you felt were of particular significance in terms of:
   a) your reaching an understanding how this child functions and the nature of his difficulties?
   b) the development of his relationship with you?
   c) making progress in his treatment?

Review meetings

26. What was your experience of the carer in terms of her engagement in the work?

27. To what extent do you feel the carer was able to understand his difficulties and the reasons for this?

Kinship Care

28. From your work with this child and his family, how do you feel he experiences living in kinship care?

29. Can you comment on the child’s relationship with his kinship carer? What are the strengths and challenges?

30. Can you say something about feelings that he has? (e.g. feelings of difference, feelings of belonging, identity, shame, pride, hopes for the future, feelings about parents and contact with parents?)

Outcomes

31. In what ways do you feel the treatment was successful in helping him with the difficulties which he was referred for and achieving the treatment aims?

32. In what ways do you feel the treatment was unable to be successful in helping him to overcome these difficulties? What would have helped to achieve this?

33. What was the impact of seeing him within their school (rather than a CAMHS clinic) and in what ways do you feel this helped or hindered the treatment?

34. Has he been referred on for any further support and if so where/what kind of intervention?

35. Is there anything else you feel is important for me to understand or you want to talk about with me today?
APPENDIX J

Interview Areas
for kinship carers

1. Your kinship family

2. Why this child came to live with you

3. What it’s been like for you becoming a kinship carer

4. How you think your child feels about living with you and what they understand.

5. The difficulties your child was having which led them to be referred to TOPS.

6. What you remember about the TOPS work and how you found it.

7. Your views on whether the therapy was helpful.
APPENDIX J

Interview Areas
for SENCO’s

1. Your role as a SENCO

2. Thinking about children living in kinship care – general perceptions in the school.

3. Support for emotional and behavioural difficulties in school – how do children come to your attention? What different support is available? Making referrals to TOPS.

4. Thinking about this child - your concerns about the child, your thoughts about this, your hopes for TOPS treatment, your understanding of key issues which were explored in the work with the child and their carer, in what ways, if any, you feel the treatment helped.
APPENDIX J

Interview Areas
for TOPS Therapist

1. Setting

2. Referral – reasons for referral, first impressions

3. Setting up the work as a whole – e.g. was there an assessment? Overall structure of treatment e.g. review meetings, carer work, treatment aims/goals.

4. Treatment of Child – main themes of the work, how child responded to you and what sense you made of this, key therapy periods/turning points in your understanding or in their progress.

5. Review Meetings with carer

6. Your thoughts about child’s experiences of kinship care

7. Outcomes of treatment