THE STORIES OF WOMEN WHO PROVIDE LONG-TERM FOSTER CARE IN AUSTRALIA

© Stacy Blythe RN BN (Hons)

A thesis submitted to fulfil the requirements for the degree of

Doctor of Philosophy

School of Nursing & Midwifery

University of Western Sydney

December 2012
Dedication

This work is dedicated to my amazing children: Caitlin, Aiden, Connor, Bryce, Bianca, Byren, Kyra and Taylor. Adopted, fostered or born from my body – you are mine.
Acknowledgements

I would like to thank my supervisors Associate Professor Elizabeth Halcomb and Professor Lesley Wilkes for their ongoing guidance, support and encouragement during my candidature. I would also like to thank Professor Debra Jackson for her contribution to the beginning of this project.

Importantly, I would like to express my gratitude to the women who shared their stories for the purpose of this research. Without their participation, this thesis would not have been possible.

I would also like to extend my gratitude to my colleagues and friends in the School of Nursing and Midwifery on the Hawkesbury campus of the University of Western Sydney. Their support and encouragement throughout my candidature was invaluable – especially Mary Goldsmith, Kathleen Dixon and Kylie Docker. Similarly, the friendships I developed with other doctoral candidates have been a source of strength – especially Tamara Power, who began and completed this journey with me. A very special mention must go to Debbie Irwin and Ruth Smyth – you two are the best!

Finally, I would like to acknowledge my husband, John. Thank you for all your practical help; the flowers, the wine, and the willingness to play both “mum & dad” on the weekends so I could write. Thank you for reading and discussing this research with me – so many times. Mostly, thank you for sharing this journey with me.
Statement of Authentication

The work presented in this thesis is, to the best of my knowledge and belief, original except as acknowledged in the text. I hereby declare that I have not submitted this material, either in full or in part, for a degree at this or any other institution.

________________________________________

Stacy L. Blythe
TABLE OF CONTENTS

ABSTRACT ................................................................................................................................. iv
ANTHOLOGY OF DISSEMINATION ............................................................................................ vi
  Peer reviewed publications .................................................................................................... vi
  Presentations ........................................................................................................................ vii
LIST OF TABLES ........................................................................................................................ viii
ABBREVIATIONS .................................................................................................................... viii
TRANSCRIPTION KEY ............................................................................................................. ix
CHAPTER ONE: Introduction .................................................................................................... 1
  Introduction ........................................................................................................................... 1
    Positioning of self .............................................................................................................. 2
  Child protection ................................................................................................................. 3
  The Australian context ....................................................................................................... 4
    Out-of-home care ............................................................................................................. 5
    Foster carers .................................................................................................................... 6
  Aim of the study ............................................................................................................... 7
  Significance of the study ................................................................................................. 7
  Thesis structure ............................................................................................................... 8
CHAPTER TWO: Literature review .......................................................................................... 10
  Publication ........................................................................................................................ 10
  Relevance to thesis ......................................................................................................... 10
CHAPTER THREE: Methodology ............................................................................................ 33
  Introduction ....................................................................................................................... 33
  Qualitative research ....................................................................................................... 33
  Characteristics of stories and storytelling ....................................................................... 34
  Storytelling as research ................................................................................................. 35
  Feminist perspectives informing this study ...................................................................... 36
  Data collection ................................................................................................................ 37
    Participant eligibility ...................................................................................................... 37
    Recruitment ..................................................................................................................... 37
    Interviews ......................................................................................................................... 38
  Data analysis ................................................................................................................... 38
  Ethical considerations .................................................................................................... 41
    Autonomy ........................................................................................................................ 42
Consent ............................................................................................................. 42
Confidentiality .................................................................................................. 42
Beneficence ...................................................................................................... 43
Rigour ................................................................................................................... 44
Credibility ......................................................................................................... 44
Transferability .................................................................................................. 45
Dependability ................................................................................................... 46
Confirmability .................................................................................................... 46
CHAPTER FOUR: The challenges of insider research ........................................ 47
Publication........................................................................................................... 47
Relevance to thesis ......................................................................................... 47
CHAPTER FIVE: Findings .................................................................................... 64
Introduction ....................................................................................................... 64
Participants ........................................................................................................ 64
Overview of the themes ..................................................................................... 69
CHAPTER SIX: Mothering revealed .................................................................... 71
Publication........................................................................................................... 71
Relevance to thesis ......................................................................................... 71
CHAPTER SEVEN: Seeking recognition: stigma and misconceptions .............. 89
Publication........................................................................................................... 89
Relevance to thesis ......................................................................................... 89
CHAPTER EIGHT: Mothering in the system .................................................... 117
Publication........................................................................................................... 117
Relevance to thesis ......................................................................................... 117
CHAPTER NINE: Discussion and conclusion .................................................... 139
Introduction ....................................................................................................... 139
Becoming a mother ......................................................................................... 139
Motherhood denied ......................................................................................... 142
Mothering in the system .................................................................................. 144
Implications of findings ................................................................................... 145
Strengths and limitations of this study ............................................................ 147
Strengths of this study .................................................................................... 147
Limitations of this study .................................................................................. 148
Recommendations for future research ............................................................ 149
Conclusion ......................................................................................................... 150
ABSTRACT

The Australian child protection system is responsible for promoting the health and well-being of children. However, despite early involvement to support and maintain vulnerable families, a significant number of children are unable to remain with their biological families and are placed into foster care. These children are known to experience an increased incidence of health related issues compared to the general population and are thus likely to have frequent contact with the health care system. As the day-to-day care providers for these children, foster carers are an essential component of the child protection system. Despite their importance, literature investigating the experiences of foster carers is scarce. This paucity of literature provides limited guidance to health and social service professionals in understanding the experiences, challenges and needs of this important group. To address this gap, this study sought to explore women’s experiences of providing long-term foster care in Australia.

Twenty women participated in interviews that were conducting using a storytelling design informed by feminist principles. Data were collected using face-to-face, telephone and online interviews. Verbatim transcripts were subject to thematic analysis using a feminist narrative technique.

Three main themes emerged from the data. A number of sub-themes were also identified. In the first theme; Mothering revealed the women reveal that they identify themselves as mothers, not foster carers, when caring for a child on a long-term basis. They justify this on the depth of their commitment to and emotional investment in the children. The second theme; Seeking recognition: Stigma and misconceptions explains how the women’s maternal identity was challenged and negated by the widely held belief that only the woman who gives birth is the "true" mother. As a result, the women felt stigmatised. The third theme; Mothering in the system, illuminates the women’s attempt to resolve the discontinuity between their perceived maternal identity and their social and legal limitations as foster carers.

The findings of this study have revealed women providing long-term foster care are a vulnerable population. The data has provided insight into the women’s perception of self and the detrimental impact of having that perception challenged or
unrecognised by others. Further, this research has revealed women providing foster care experience social isolation, to varying degrees, particularly when unable to develop friendships with other long-term foster carers.

The findings of this study suggest current policy and practice which privileges biological identity over socially constructed filial ties should be reviewed. Further, greater insight has emerged into the difficulties long-term foster carers experience negotiating their role in foster children’s lives. Factors which can mitigate the experience of stigma, such as the development of friendships with other long-term foster carers, have been identified. The findings of this study are useful for the retention and recruitment of foster carers.
ANTHOLOGY OF DISSEMINATION

PEER REVIEWED PUBLICATIONS


Throughout this document, these papers will be referred to by their corresponding number (eg. In Paper 1 it was noted...). Evidence of each papers acceptance for publication can be found in Appendix A (pg. 161).
PRESENTATIONS


LIST OF TABLES

Table 1: Themes and Sub-themes.................................................................70
Table 2. Theme one: Mothering Revealed......................................................71
Table 3. Theme two: Seeking Recognition: Stigma and Misconceptions........89
Table 4. Theme three: Mothering in the System..........................................117

ABBREVIATIONS

AFCA    Australian Foster Care Association
AIHW    Australian Institute of Health and Welfare
HREC    Human Research Ethics Committee
NHMRC   National Health and Medical Research Council
UN      United Nations
US      United States
UWS     University of Western Sydney
Pseudonyms have been used to ensure participants’ confidentiality.

The presentation of direct quotes from interview transcriptions varies according to the publishing journal’s editorial requirements. Generally, quotation marks or indentation indicate a direct quote (see examples below).

“I’m in it for the long haul” (Jodi).

OR

It didn’t happen as we kind of just thought it would, you really have to work at it. You seem to be forever looking for it and hoping it is reciprocated and it takes a long time for that to happen (Uma).

Symbols used within direct quotes:

[ ] square brackets contain words or phrases which have been included to provide clarity or conceal identity.

... three dots indicate data was omitted between sentences and paragraphs.
CHAPTER ONE: INTRODUCTION

“There is an instinct in a woman to love most her own child – and an instinct to make any child who needs her love, her own.”

~Robert Brault

INTRODUCTION

Imagine the transformation in a woman’s life, as she gives birth and becomes a mother to her child. Day by day she discovers how to become the primary source of her child’s comfort, support, nurture, and protection. Now imagine the transformation of a woman who opens her home and her heart to become the primary source of comfort, support, nurture and protection to a child born of another woman’s body, and in this process, discovers she has become a mother. This thesis explores the experiences of women who provide long-term foster care to children who are unable to live with their biological mothers in the Australian context.

This chapter begins by positioning the researcher as an ‘insider’ in relation to this study. It then provides a background for the reader with an overview of foster care within the context of the Australian child protection system. The aims and significance of the study are also presented. The chapter concludes with an overview of the thesis structure.

POSITIONING OF SELF

This research has been undertaken to fulfil the requirements for the degree Doctor of Philosophy (PhD) at the University of Western Sydney (UWS). However, I bring to it my own personal perspectives and life experiences. As such, I approach this research as woman, a wife, a biological mother, a long-term foster carer and a registered nurse. It is the combination of these life experiences that has motivated and enabled this Doctoral project.

In 1992 I experienced the joy of becoming a mother for the first time as I gave birth to my first daughter. Like many women, I found this experience humbling and life changing. As I held my daughter for the first time I was overwhelmed by her complete dependence upon and subsequent trust in me. In those first moments I vowed to love, nurture and protect her and determined to be a woman of whom she could be proud. In 1993 I met my husband. We married a year later and he became our daughter’s legally adopted father. Our family grew over the next few years as I conceived and gave birth to our two sons.

In 2000 I started a Bachelor of Nursing program, and commenced work as a Registered Nurse in 2003. During this time my husband became a Registered Child Psychologist. Although we were both working in “helping professions”, my husband and I felt we had more to give. After long discussions with each other and our three children, the decision was made to open our home to children in need.

In 2005 we welcomed two precious foster children, a two year old boy and his six month old sister, into our lives and our hearts. They were joined by their younger biological brother in 2006. Although it was never our intention to have such a large family, we felt it important to keep this sibling group together.

Since commencing my PhD studies in 2009, two more children have joined our family. Although quite unplanned, I gave birth to a beautiful baby girl in 2009. In 2011 another beautiful baby girl, full sibling to the children in my long-term care, was born and within months became the youngest child in our family. Our family is now made up of eight children; four girls and four boys; ranging in age from one to 20 years.
The motivation for this study stems from reflection on my own experience of providing long-term foster care. Since becoming a foster carer I have been variously praised, criticised and questioned by professionals, acquaintances, colleagues, friends and family regarding my motivation for and commitment to caring for the children in my care. I believe that this represents a common societal lack of understanding regarding foster care and the experiences of foster carers.

As a registered nurse, I have a duty and desire to provide optimal care to individuals and families. I understand that care-giving is not unique to nursing, but occurs in a variety of contexts and is known to have positive and negative effects on both the provider and recipient of care. From a research perspective, I felt there were care-giving contexts that were yet to be fully explored and understood, including the provision of foster care. As a result of my personal experiences and professional education I have found myself uniquely positioned to influence both social and health care policy and practice through research. The study presented in this thesis is the beginning of what I hope will be a lifetime of research that will contribute to the health and well-being of children and their families.

**CHILD PROTECTION**

In response to the atrocities of World War II the United Nations (UN) established The International Declaration of Human Rights (UN, 1948). The 30 articles within this document emphasise the inherent dignity and value of every human being and detail the inalienable rights to which all members of society are entitled. Among these is the right to live in a safe environment conducive to one’s health and well-being (UN, 1948). Expansion on article 25, which recognised children’s need for additional assistance, resulted in The Declaration of the Rights of the Child, which states:

> the child, by reason of his physical and mental immaturity, needs special safeguards and care, including appropriate legal protection, before as well as after birth (UN, 1959).

In 1990, delegates of 193 countries ratified the Convention on the Rights of the Child (UN, 1990). This Convention requires signatory governments to be bound by
international law, and accountable for protecting the civil, political, economic, social, health and cultural rights of children within their country.

Child protection systems serve to uphold and preserve the rights of children. Although political and legislative differences exist between countries, there are many similarities in the endeavours to protect children’s rights internationally (Colton & Williams, 2006; Maluccio, Canali, & Vecchiato, 2006). Historically, Australian child protection policy and practice has been shown to evolve in line with other western countries, particularly the United States and the United Kingdom (Scott & Swain, 2002). The current emphasis of this system is on multidisciplinary collaboration, integrated services and early intervention (Buckley, Carr, & Whelan, 2011; Council of Australian Governments, 2009; Rowse, 2009b; Vincent, Daniel, & Jackson, 2010).

THE AUSTRALIAN CONTEXT

The Australian child protection system is complex and multifaceted, comprising numerous government departments and private organisations that share a common duty of care for vulnerable children (Council of Australian Governments, 2009). With the recent introduction of a national framework, the focus of Australian child protection has shifted from one of response to abuse and/or neglect to the promotion of children’s health and well-being (Council of Australian Governments, 2009). The implementation of this framework has resulted in increased responsibilities for those working in the welfare, justice, education and health sectors (Council of Australian Governments, 2009).

Although unified under this new national framework, each of the six states and two territories in Australia has statutory responsibility for child protection (Bromfield & Higgins, 2005; Council of Australian Governments, 2009). A common feature of child protection policy across Australia is early involvement to support families with the least intrusive interventions as possible (Australian Institute of Health and Welfare (AIHW), 2012). Despite this support, a significant number of children are unable to remain with their birth families and require out-of-home care. Recognised as an intervention of last resort, out-of-home care requires legal authorisation and is
the physical removal of a child from an unsafe living situation to an alternate safe environment (AIHW, 2012).

OUT-OF-HOME CARE

In Australia, the number of children on entering out-of-home care has increased by 33% over the last five years (AIHW, 2012). In 2011 it was reported that 37,648 Australian children resided in out-of-home care, a 5% rise from the previous year. The national rate of children in out-of-home care in Australia is 7.3 per 1,000, approximately half of these children are in foster care (AIHW, 2012). These trends are similar to other western countries (Colton, Roberts, & Williams, 2008; Cox, Buehler, & Orme, 2002; Grimm & Darwall, 2005; McHugh, 2005). In 2009, the national rate of children entering foster care in the United States of America was 3.4 per 1,000 (US Department of Health and Human Services, 2009). In 2011, the United Kingdom reported 5.9 per 1000 children were residing in foster care (Department for Education, 2012; Department of Health and Children, 2010).

The majority of children (93%) in out-of-home care in Australia reside in home-based care (AIHW, 2012). Home-based care is defined as children living in the private home of an adult carer who is entitled to financial recompense for the costs incurred caring for the children (AIHW, 2012). Nearly half of the children in home based care (46%) are in kinship care; and live with a biological/legal family member or person with whom they had a pre-existing relationship. Almost another half of the children in out-of-home care (45%) are residing in long or short term foster care (AIHW, 2012). The remaining children (9%) reside in group homes subsidised by a government or private agency or some other form of home-based care (AIHW, 2012).

Foster care can be differentiated according to the children’s care and protection orders which are determined by the judicial system. Although there is variability in legislation from one jurisdiction to the next (Bromfield & Higgins, 2005), in Australia, generally, crisis foster care refers to children’s immediate need for care under a provisional order (AIHW, 2012; Colton & Williams, 2006). Short-term foster care typically coincides with interim orders and applies when children require care for a longer amount of time while their biological or adoptive families attend to the issues initiating the need for foster care (AIHW, 2012; Sellick, 2006). Finalised
guardianship or custody orders are ordinarily granted when children’s reunification with their biological or adoptive family is not possible (AIHW, 2012; Schofield, 2002). When this occurs, children may be placed in out-of-home care until they reach 18 years of age. Nearly three quarters (73%) of the 39,058 Australian children on care and protection orders in 2011, were on finalised guardianship or custody orders. This demonstrates a significant number of children requiring long-term foster care (AIHW, 2012).

**Foster Carers**

Foster carers are subject to stringent screening processes and training prior to being authorised as a carer (AIHW, 2012). Once authorised, foster carers assume the responsibility of providing a safe, stable and nurturing environment for the foster children, but are not considered their legal guardians (AIHW, 2012). Consequently, foster carers are accountable to the authorising government department or private agency, the child and family law courts, and the biological families of the children in foster care (Marcellus, 2008). Although the resources vary between foster agencies, foster carers receive ongoing training, support and supervision and varying degrees of financial reimbursement for the costs incurred in caring for foster children (AIHW, 2012).

Central to their care-giving role is the foster carers’ responsibility for the health and well-being of the children in their care (Pasztor, Hollinger, Inkelas, & Halfon, 2006). Foster carers are responsible for identifying children’s health issues, seeking professional assessment and treatment and negotiating access to resources accordingly (Bonfield, Collins, Guishard-Pine, & Langdon, 2010; Kaltner & Rissel, 2011). Research has also demonstrated that foster carers can promote resilience in children recovering from maltreatment by providing a sense of belonging (Riggs, Augoustinos, & Delfabbro, 2009a; Schofield, 2002). As such, foster carers have the potential to have a direct impact upon a range of health and social outcomes of the children in their care (Cashmore & Paxman, 2006; Henderson & Scannapieco, 2006).

As the day-to-day care providers for foster children, foster carers are an essential component of the child protection system. As such, their recruitment and retention is a high-priority across Australia (Council of Australian Governments, 2009). In 2011, there were 8,449 Australian households providing foster care, with just over half of
these (51%) caring for multiple children (AIHW, 2012). The female foster carer, married or single, has most often been identified as the primary care giver in this context (Grimm & Darwall, 2005; Rodger, Cummings, & Leschied, 2006; Siminski, Chalmers, & McHugh, 2005). Despite the evidence for the important role of the female foster carer, to date there has been limited attention in the literature given to the female perspective of providing long-term foster care.

**AIM OF THE STUDY**

The aim of this study is to explore women’s experiences of providing long-term foster care in Australia.

**SIGNIFICANCE OF THE STUDY**

Out of home care plays a significant role in providing a safe and nurturing environment for children who are unable to reside with their biological parents. Foster carers provide a vital contribution to the children welfare system by providing day-to-day care. Despite their importance, foster carers’ experiences have been minimally explored in the literature (Blythe, Wilkes, & Halcomb, In press-b). Gaining an understanding of foster carers’ experiences will inform both strategies for the recruitment and retention of foster carers and health care professionals who provide health care to the foster carers and their children.

There is potential for the findings of this study to influence societal understanding of what constitutes a family and how the roles within families are defined. Such an understanding can reduce marginalization of those living in families subsequently improving their health and well-being (Blythe, Jackson, Halcomb, & Wilkes, 2012c).

By enhancing knowledge and awareness of the emotional, physical and psychosocial impact providing long-term foster care has on female foster carers’ lives, the findings from this study have the potential to inform future social and health care policy. This can ensure the needs of female foster carers are met, subsequently improving the quality of care that they can provide to children in long-term foster care.

There is scant research regarding health and social service providers’ responsibilities for, relationship with or understanding of foster carers and their role in the child
protection system. Rather, literature emphasises these professionals’ capacity to support vulnerable families (Cohen, Mulroy, Tull, White, & Crowley, 2004; Kelleher & Johnson, 2004), their ability to assess and identify children at risk (Armitage, Taylor, & Ashley, 2012; Nayda, 2002), or their experiences as mandatory reporters (Rowse, 2009a, 2009b; Vulliamy & Sullivan, 2000). These studies reflect professionals’ responsibilities prior to and at the point of the children’s entry into the out-of-home care system. The findings of this study can inform practice for those professionals coming into contact with children, and their foster carers, already living in the out-of-home care system.

Involvement in this study had personal significance for each woman as it afforded her the opportunity to be heard and help to facilitate change in the policies and practices which influence her daily life. Moreover, foster care essentially occurs in seclusion. Issues of confidentiality, stigma and social isolation often prohibit women who provide foster care from sharing their experiences. This study provided a safe, non-judgemental environment for participants to share their experiences thereby enabling them to feel connected with and valued by others.

THESIS STRUCTURE

This document fulfils the requirement of a “Thesis as a series of papers” as defined by the University of Western Sydney Doctor of Philosophy Policy (2012). It consists of nine chapters and contains five papers that have been accepted for publication in peer-reviewed journals (see anthology of dissemination; pg. vi). These papers have been placed within the thesis to maintain logical flow of the document. Each paper is formatted according to individual journal requirements and contains its own tables and figures. Evidence of each paper’s acceptance can be found in Appendix A (pg. 161). As the first author, the doctoral candidate was responsible for preparing the initial literature review; the collection, analysis and presentation of the data; and composing the first draft of the discussion section of each publication. The co-authors (doctoral supervision panel) provided critical review of the manuscripts, input into the study methodology and design, and confirmation of the analytic processes used. In addition to the published papers, the thesis’s text provides more detail on the methodology and discussion of findings as outlined below.
This introductory Chapter has provided an insight into the position of the doctoral candidate in relation to the research. It has also provided an overview of foster care in the Australian child protection system. This chapter has demonstrated the significance of the problem and outlined the study aim, significance and outline of the thesis.

The second chapter contains a literature review titled: *The foster carer’s experience: an integrative review* (Paper 1) that was published in Collegian. This paper identifies recurring themes within the literature and reveals the gap in the literature that this study seeks to fill.

Chapter three outlines the qualitative design used to underpin this study. Discussion regarding the methods used for data collection and analysis is provided. The ethical issues pertaining to this study are addressed, and the strategies used to ensure rigour are identified.

Chapter four contains the second peer-reviewed publication resulting from this study titled: *The challenges of being an insider in story-telling research* (Paper 2) that has been published in Nurse Researcher. This methodological paper describes the challenges associated with undertaking insider research and identifies strategies implemented in this study to overcome these challenges.

Chapters five through eight present the findings of this study. Chapter five contains a brief discussion of the study participants and identifies the three main themes that arose from the data. Chapters six, seven and eight each present a peer-reviewed publication addressing one of the major themes (Papers 3, 4, and 5).

The final chapter provides a discussion and compares the findings of this study to the existing literature. This discussion highlights and elaborates on the new knowledge that this study has generated. Implications for social and health care policy, practice and education are discussed and suggestions for future research are presented.
CHAPTER TWO: LITERATURE REVIEW

PUBLICAION

Paper 1:


RELEVANCE TO THESIS

This paper establishes the importance of the study undertaken as part of this thesis. The review of literature introduces the reader to the positive and negative challenges associated with providing foster care. The 18 studies reviewed are examined in light of what could be achieved by undertaking the proposed thesis.
The foster carer’s experience: an integrative review

Abstract

Background: Foster carers have a significant responsibility in caring for children who are unable to live with their birth families and represent a key determinant in child outcomes. Difficulties in recruiting and retaining quality foster carers have resulted in an increase in research investigating foster carers and their experiences in recent years.

Aim: To synthesise current literature investigating foster carers and their experiences to enable a better understanding of their unique care-giving context.

Method: The electronic databases CINAHL, Health Source, MEDLINE, PsycARTICLES, PsycINFO and sociINDEX were searched using the key terms; ‘foster carer’, ‘foster parent’, ‘foster mother’ and ‘foster father’. Articles were included if they reported primary data about foster carers experiences in the English language. Papers published prior to 2000 were excluded in order to provide a contemporary perspective of the foster carer experience. Data was extracted, tabulated and thematically analysed.

Findings: The findings from this review revealed the provision of foster care to have both positive and negative effects on foster carers’ personal well-being. These effects are largely reliant of foster carers perception of their role as either parental or professional, the nature of their relationships with child welfare personnel, and their ability to manage children’s difficult behaviours.

Conclusion: It is important for nurses to understand caregiving as it occurs in a variety of contexts. Nurses need to have an awareness and understanding of the value and role foster carers have in the lives of vulnerable children. In so doing, nurses are well positioned to assist foster carers to identify and express their needs in relation to their important caregiving role.

Keywords - Foster care; children; nursing; family health; child well-being.
Introduction

Internationally, the health and well-being of children living in foster care is a matter of concern (Council of Australian Governments, 2009; Galehouse, Herrick, & Raphel, 2010; Raghavan, Inoue, Ettner, Hamilton, & Landsverk, 2010; Woods, 2008). In Australia, a National Framework for child welfare provides opportunities for collaboration between government and non-government organisations within health, justice, education and welfare sectors to protect and promote the health and well-being of Australia’s children (Council of Australian Governments, 2009). As health professionals, nurses play a vital role within this framework and are variously responsible, within their diverse roles, for monitoring, maintaining and managing the health and well-being of children in foster care.

It is well recognised fact that the children living in foster care experience an increased incidence of physical, mental and developmental health issues compared to the general population (Carbone, Sawyer, Searle, & Robinson, 2007; Nathanson & Tzioumi, 2007). Accordingly, children in foster care likely have more frequent interactions than other children with the health care system, and subsequently, nurses. In order to provide optimal care, it is imperative that nurses recognise and understand the context in which these children live and develop (Jackson & Borbasi, 2000).

Foster carers have a significant responsibility in caring for children who are unable to live with their birth families, many of whom experience significant behavioural, emotional and developmental problems (Orme & Buehler, 2001). In this caring capacity, foster carers represent a key determinant in child outcomes (Cashmore, Paxman, & Townsend, 2007; Cole, 2005; Leathers, 2006). Difficulties in recruiting and retaining quality foster carers, internationally and within Australia, have resulted in an increase in research investigating foster carers and their experiences in recent years (Ciarrochi, Randle, Miller, & Dolnicar, 2011; Colton, Roberts, & Williams, 2008; Smyth & McHugh, 2006). It is now timely to synthesise these studies to evaluate what is currently known about foster carers and their experiences of providing foster care. Such a review can serve to increase nurses’ awareness and

---

2 “A child is defined as a person 0-17 years” (Australian Institute of Health and Welfare, 2011)
understanding of this important care-giving context, identify amenable factors contributing to foster carer attrition, and highlight areas for further research.

**Purpose**

This paper seeks to synthesise the peer reviewed literature describing the experiences of foster carers published between January 2000 and March 2012.

**Method**

As a summary of extant literature, integrative reviews have the potential to contribute to evidence based practice and are therefore subject to methodological standards regarding clarity, rigour and replication. Using the integrative literature review method outlined by Whittemore and Knafl (2005), a comprehensive search of the literature was conducted for papers published between January 2000 to March 2012 using: CINAHL, Health Source, MEDLINE, PsycH-articles, PsycINFO and sociINDEX. Key search terms included foster carer, foster parent, foster mother and foster father. Articles were included if they reported primary data about foster carers’ experiences in the English language. Papers published prior to 2000 were excluded in order to provide a contemporary perspective of the foster carer experience.

The initial search yielded 1214 articles (Figure 1). Following the removal of duplicates, opinion pieces, discussion papers, reviews and case studies; articles were assessed based on the relevance of the title and/or abstract. Articles using multiple data sources were excluded if the findings relevant to foster carers were not separately presented. Articles focussing on the psychological construct of attachment between foster carers and children and articles measuring the effectiveness of foster carer training programs were excluded as these largely focus on child outcomes. This resulted in 77 articles which were independently considered for possible inclusion by three reviewers. Articles were excluded at this stage if they investigated specific sub-groups of carers or children or did not report foster carers’ experiences. A detailed list of excluded articles can be obtained, upon request, from the corresponding author. Studies which met the inclusion criteria were assessed for methodological rigour as described by Whittemore and Knafl (2005). As Whittemore and Knafl (2005) recommend, given the small number of relevant studies, none were excluded based on methodological standards.
Data analysis was an iterative process. Using a standardised form designed to enable the accurate and consistent extraction of data from individual studies, the first author compiled relevant study elements to facilitate analysis. Data was further reduced and entered into a table. Given the predominately qualitative nature of included studies, thematic analysis was used to identify commonalities between study findings.

Results

In total, 18 articles met the inclusion criteria (Table 1). Studies were conducted in several countries, namely; the United Kingdom/Ireland (n=6; 33.3%), the United States of America (n=4; 22.2%), Canada (n=4; 22.2%), Australia (n=3; 16.6%) and New Zealand (n=1; 5.5%). The majority of studies were qualitative (56%; n=10), whilst 4 (22%) used quantitative methods and 4 (22%) employed mixed methods. Given the diversity of methodologies, the findings of this review are presented in a descriptive summary (Whittemore & Knafl, 2005). Three major themes emerged from analysis of the included papers: 1) The foster carer, 2) The foster carer and the system, and 3) The foster carer’s well-being. Each of these consisted of two sub-themes which are discussed below (Table 2).
<table>
<thead>
<tr>
<th>Article</th>
<th>Country</th>
<th>Study Aim</th>
<th>Sample</th>
<th>Data Collection</th>
<th>The foster carer</th>
<th>The foster carer and the system</th>
<th>The foster carer’s well-being</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Broady, Stoyles, McMullan, Caputi, &amp; Crittenden, 2010)</td>
<td>Australia</td>
<td>To investigate the experiences of foster parents to provide to explore the implications of inadequate training procedures and the need for ongoing support</td>
<td>12 foster parents; 11 female, 1 male</td>
<td>Focus group (7 participants); 5 individual interviews</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>(Brown &amp; Calder, 2000)</td>
<td>Canada</td>
<td>To describe the needs of foster parents.</td>
<td>30 foster families; 27 females, 22 males</td>
<td>Telephone interviews &amp; concept mapping</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>(Brown &amp; Campbell, 2007)</td>
<td>Canada</td>
<td>To determine how foster parents define successful foster care.</td>
<td>61 foster parents; 51 female, 10 male</td>
<td>Telephone interviews &amp; concept mapping</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>(Buehler, Cox, &amp; Cuddeback, 2003)</td>
<td>USA</td>
<td>To investigate familial and parental factors which promote or inhibit successful fostering.</td>
<td>22 foster parents; 14 female, 8 male</td>
<td>Semi-structured interviews</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>(Farmer, Lipscombe, &amp; Moyers, 2005)</td>
<td>UK</td>
<td>To examine the extent of strain on the foster carers of adolescents, its influence on parenting practices and the overall impact on placement outcomes.</td>
<td>68 foster families; 47 couples, 19 single females, 2 single males</td>
<td>GHQ, SDQ, interviews</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>(Hendrix &amp; Ford, 2003)</td>
<td>USA</td>
<td>To explore the impact of hardness on foster carers</td>
<td>82 foster families</td>
<td>Survey, FHI</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Article</td>
<td>Country</td>
<td>Study Aim</td>
<td>Sample</td>
<td>Data Collection</td>
<td>The foster carer</td>
<td>The foster carer and the system</td>
<td>The foster carer’s well-being</td>
</tr>
<tr>
<td>---------</td>
<td>---------</td>
<td>-----------</td>
<td>--------</td>
<td>----------------</td>
<td>----------------</td>
<td>-------------------------------</td>
<td>-------------------------------</td>
</tr>
<tr>
<td>(Hudson &amp; Levasseur, 2002)</td>
<td>Canada</td>
<td>To identify supports needed to maintain the caring role of foster parents.</td>
<td>66 foster parents; 58 female, 8 male</td>
<td>Postal questionnaire</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>(Kirton, 2001)</td>
<td>England</td>
<td>The impact of payment upon foster carers</td>
<td>20 female foster carers</td>
<td>Interviews</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>(MacGregor, Rodger, Cummings, &amp; Leschied, 2006)</td>
<td>Canada</td>
<td>To examine motivation, support, and retention of foster parents.</td>
<td>54 foster parents; 49 female, 5 male</td>
<td>Focus groups</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>(Morgan &amp; Baron, 2011)</td>
<td>UK</td>
<td>To explore the relationship between foster children's behavioural difficulties and the stress, anxiety and depression experienced by their carers.</td>
<td>58 foster carers; 40 female, 16 male</td>
<td>Survey (SDQ, PSI-SF, HADS, DBSES)</td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>(Murray, Tarren-Sweeney, &amp; France, 2011)</td>
<td>New Zealand</td>
<td>To explore foster carers’ perceived need for support and training.</td>
<td>17 foster carers; 14 female, 3 male</td>
<td>PSI, CBEI, semi-structured interviews</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>(Orme, Cherry, &amp; Rhodes, 2006)</td>
<td>USA</td>
<td>To measure the impact of support on foster carers</td>
<td>304 foster mothers, 111 foster fathers</td>
<td>Survey (CHAP-SR, CFAI-II)</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Pickin, Brunsden, &amp; Hill, 2011)</td>
<td>UK</td>
<td>To investigate the everyday experiences of foster carers</td>
<td>5 foster carers; 4 female, 1 male</td>
<td>Photographs and interviews (Phenomenology)</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Article</td>
<td>Country</td>
<td>Study Aim</td>
<td>Sample</td>
<td>Data Collection</td>
<td>The foster carer</td>
<td>The foster carer and the system</td>
<td>The foster carer’s well-being</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>---------</td>
<td>---------------------------------------------------------------------------</td>
<td>-------------------------</td>
<td>----------------------------------------------</td>
<td>------------------</td>
<td>-------------------------------</td>
<td>-----------------------------</td>
</tr>
<tr>
<td>(Riggs, Delfabbro, &amp; Augoustinos, 2009)</td>
<td>Australia</td>
<td>To explore how foster parents play out their role as carers.</td>
<td>80 participants; 49 female, 31 male</td>
<td>Interviews, focus groups</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>(Rosenwald &amp; Bronstein, 2008)</td>
<td>USA</td>
<td>To understand the characteristics of foster children that foster parents both preferred and not preferred.</td>
<td>13 foster parents</td>
<td>Focus groups</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>(Samrai, Beinart, &amp; Harper, 2011)</td>
<td>UK</td>
<td>To explore foster carers' experiences and expectations in relation to placement outcome, current support and what support systems may contribute to positive placement outcome.</td>
<td>8 foster carers; 7 female, 1 male</td>
<td>Semi-structured interviews (Grounded Theory)</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>(Thomson &amp; McArthur, 2009)</td>
<td>Australia</td>
<td>To develop understanding about foster carers experiences using the theory of family boundary ambiguity and ambiguous loss.</td>
<td>90 surveys, 12 interviews</td>
<td>Surveys, interviews</td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Wilson, Sinclair, &amp; Gibbs, 2000)</td>
<td>UK</td>
<td>To investigate carers reactions to the stressful events</td>
<td>932 foster carers</td>
<td>Surveys, GHQ</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Theme</td>
<td>Sub-theme</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-------------------------------</td>
<td>----------------------</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The foster carer</td>
<td>Parent vs. Professional</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Personal Characteristics</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The foster carer and the system</td>
<td>Relationships</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Resources and support</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The foster carer’s well-being</td>
<td>Positive effects</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Negative effects</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**The foster carer**

For several decades, the literature has described the foster carer’s role as both ambiguous and arduous (Colton, et al., 2008). The ambiguity largely arises from the unique characteristic of foster care spanning both the public and private domains (Kirton, 2001). The responsibility for daily care-giving, nurturing and behaviour management is difficult as foster children often have complex social, emotional, behavioural, educational and physical needs (Teicher et al., 2003). Discussions aimed at resolving the ambiguity and minimizing the complexity associated with providing foster care have largely focussed on the development of professionally recognised skills and identity (Kirton, 2007; Wilson & Evetts, 2006). Several studies included highlight that despite considerable debate, these two features significantly impact on the foster carer’s experience and may even influence their personal well-being (Broady, Stoyles, McMullan, Caputi, & Crittenden, 2010; Hudson & Levasseur, 2002; Kirton, 2001; Pickin, Brunsden, & Hill, 2011; Riggs, Delfabbro, & Augoustinos, 2009; Rosenwald & Bronstein, 2008; Samrai, Beinart, & Harper, 2011; Thomson & McArthur, 2009).
Parent vs professional

Included studies reveal that collectively, foster carers struggle to define their role. The majority of foster carers either identify themselves as parents to the children in foster care (Broady, et al., 2010; Hudson & Levasseur, 2002; Kirton, 2001; Pickin, et al., 2011; Riggs, Delfabbro, et al., 2009), as professional service providers working together with the child welfare system (Hudson & Levasseur, 2002; Kirton, 2001; Rosenwald & Bronstein, 2008; Samrai, et al., 2011) or as a hybrid of the two (Kirton, 2001; Thomson & McArthur, 2009). Examination of these studies provides insight into factors influencing foster carers’ perception of their role.

Kirton’s (2001) interviews with 20 female foster carers revealed that their perceptions of their role can vary between individual placements, with some categorised as “work and others as parenting” (p. 207). Pickin et al. (2011) found that individual foster carers struggle within themselves to reconcile their “transitory parental role” (p. 67). Generally, a parental role is conceptualised as permanent. However, foster care is often required or provided on a temporary basis. The length of time a child resides, or is likely to reside, within the foster home impacts on how foster carers characterise their role (Broady, et al., 2010; Kirton, 2001; Riggs, Delfabbro, et al., 2009). Broady et al. (2010) concluded that the attachment between foster carers and children in care is strengthened with the passage of time. As attachment developed and deepened, they determined that foster carers were more likely to adopt a parental identity (Broady, et al., 2010). Similarly, Kirton (2001) identified that foster carers differentiate their role according to the type of foster care being provided. They describes short-term foster care akin to a job, whereas long-term foster care enabled carers to identify as parents (Kirton, 2001). The literature demonstrated that this parental role was a fundamental part of the foster carer’s individual identity and had negative implications for carers’ self-esteem and emotional well-being when not duly acknowledged (Broady, et al., 2010; Riggs, Delfabbro, et al., 2009).

Personal characteristics

Personal characteristics associated with being an effective foster carer were identified within several included studies (Broady, et al., 2010; Brown & Calder,
Love, understanding and patience were described as attributes which facilitate positive child outcomes (Brown & Calder, 2000; Buehler, et al., 2003; MacGregor, et al., 2006). Many foster carers describe the importance of being altruistically motivated and child focussed (Broady, et al., 2010; Brown & Calder, 2000; Buehler, et al., 2003; MacGregor, et al., 2006; Pickin, et al., 2011). A deep, heartfelt concern for children was variously articulated as the incentive to provide foster care. Such motivation was described as intrinsically rewarding and viewed as a sustaining factor during times of stress and frustration (Buehler, et al., 2003).

Foster carers’ demonstrated capacity to identify their own personal limitations enabled them to seek solace and respite when needed. Several studies highlight the importance of foster carers developing and maintaining individual personal support networks independent from child welfare systems (Brown & Calder, 2000; Buehler, et al., 2003; Farmer, et al., 2005; Murray, Tarren-Sweeney, & France, 2011; Orme, et al., 2006; Pickin, et al., 2011; Samrai, et al., 2011). The ability to develop such networks is described as essential as a strategy for mitigating foster carer strain (Farmer, et al., 2005; Samrai, et al., 2011). Orme et al. (2006) found that the composition of these networks influenced the length of time women provided foster care. Specifically, women who received support from only their own extended biological family were found to foster 26% fewer years compared to women whose networks comprised unrelated professionals or a religious group (Orme, et al., 2006).

The diversity of personal characteristics reportedly required by foster carers is somewhat contradictory. Carers are described as needing to be both: flexible and structured; easy-going and possess stress coping skills; calm and assertive; able to work with and tolerate the system (Brown & Calder, 2000; Buehler, et al., 2003). This range of personal characteristics may be reflective of the variety of study participants, their individual experiences or the respective types of foster care provided. Alternatively, this dichotomy may reflect foster carers’ individual capacity to possess and exercise disparate personal characteristics.
Hendrix et al. (2003) used the family hardiness index (FHI) to measure the impact of the characteristic on caring. This study demonstrated that foster families who plan to continue fostering demonstrate higher levels of hardiness compared to both families who do not provide foster care and foster families who do not intend to continue fostering.

**The foster carer and the system**

Despite the variation in the policies, procedures and goals of child welfare systems between various countries and in each locality (Bromfield & Higgins, 2005; Maluccio, Canali, & Vecchiato, 2006), foster carers identify that working with and navigating child welfare systems is more stressful than caring for foster children (Buehler, et al., 2003; Farmer, et al., 2005; Rosenwald & Bronstein, 2008). Foster carers’ experiences of the child welfare system are generally articulated in terms of their relationships with system personnel and their ability to access the required resources and support.

**Relationships**

Several studies revealed foster carers relationships with child welfare personnel had a significant impact on the carers (Broady, et al., 2010; Brown & Calder, 2000; Brown & Campbell, 2007; Farmer, et al., 2005; Hudson & Levasseur, 2002; MacGregor, et al., 2006; Murray, et al., 2011; Pickin, et al., 2011; Riggs, Delfabbro, et al., 2009; Rosenwald & Bronstein, 2008; Samrai, et al., 2011). In their study of 932 foster carers, Wilson et al. (2000) found that nearly 20% (n=182) had experienced significant disagreements with child welfare personnel. Yet having a good relationship with child welfare personnel is essential to effective foster care and optimising child outcomes (Brown & Calder, 2000; Brown & Campbell, 2007; Murray, et al., 2011; Samrai, et al., 2011). Good relationships are characterised as having effective communication which enables information sharing, conveys mutual respect and encourages foster carer input into decision making (MacGregor, et al., 2006; Rosenwald & Bronstein, 2008). When good relationships are experienced, foster carers feel valued, involved and encouraged to continue providing foster care (Broady, et al., 2010; MacGregor, et al., 2006; Samrai, et al., 2011). Conversely, poor relationships with child welfare personnel impede optimal fostering (Buehler, et
relationships are deemed problematic when communication is poor (Samrai, et al., 2011). Child welfare personnel are perceived to be unresponsive to and dismissive of foster carers when their calls are not returned, information is not relayed and foster carers are not involved in decision making (Hudson & Levasseur, 2002; MacGregor, et al., 2006; Murray, et al., 2011). Foster carers within this relational milieu reportedly feel frustrated, undervalued and disrespected (Hudson & Levasseur, 2002; MacGregor, et al., 2006; Murray, et al., 2011; Pickin, et al., 2011; Riggs, Delfabbro, et al., 2009; Rosenwald & Bronstein, 2008; Samrai, et al., 2011).

Factors impacting poor relationships with child welfare personnel are elucidated within several studies (Broady, et al., 2010; Buehler, et al., 2003; MacGregor, et al., 2006; Murray, et al., 2011; Rosenwald & Bronstein, 2008; Samrai, et al., 2011). High levels of child welfare personnel turnover is seen to contribute to poor communication, as well as foster carers confidence in both the system and themselves (Broady, et al., 2010; Buehler, et al., 2003; MacGregor, et al., 2006; Murray, et al., 2011). Farmer et al. (2005) reported a significant correlation between changing the allocated child welfare worker and foster carer strain. The inexperienced personnel (Buehler, et al., 2003) and heavy caseloads (Rosenwald & Bronstein, 2008) resulting from high staff turnover as well as the complexities of individual personalities (Samrai, et al., 2011) are also ascribing factors.

**Resources and support**

Foster carers reportedly seek both emotional and practical support from the child welfare system (Brown & Calder, 2000; Brown & Campbell, 2007; Hudson & Levasseur, 2002; Kirton, 2001; MacGregor, et al., 2006; Murray, et al., 2011; Rosenwald & Bronstein, 2008; Samrai, et al., 2011). Such supports are deemed essential for effective foster care, the maintenance of foster carers health and well-being and carer retention (Brown & Campbell, 2007; MacGregor, et al., 2006). Emotional support is largely reliant on foster carers’ relationship with child welfare personnel (Hudson & Levasseur, 2002; Murray, et al., 2011). As has been described, when this relationship is viewed positively foster carers feel emotionally supported (Hudson & Levasseur, 2002; MacGregor, et al., 2006).
Brown et al. (2000) characterised child welfare personnel as the gatekeepers to practical supports and resources. Thus, it would seem positive relationships with child welfare personnel convey emotional support and enable access to practical support. The practical supports foster carers expect from the child welfare system primarily include; finance, respite and training. Monetary payment as a form of support was reported in five included studies (Brown & Calder, 2000; Hudson & Levasseur, 2002; Kirton, 2001; MacGregor, et al., 2006; Samrai, et al., 2011). Foster carers’ experiences of this form of support differed both across and within studies, with some satisfied and others desiring more (Hudson & Levasseur, 2002; Kirton, 2001; MacGregor, et al., 2006). These perceptual differences likely reflect the differing economies and financial supports within individual countries. Four included studies identified respite services as a necessary, but difficult to obtain, form of practical support (Hudson & Levasseur, 2002; MacGregor, et al., 2006; Murray, et al., 2011; Samrai, et al., 2011). For some foster carers respite services provide a reprieve from the daily demands of providing foster care and enable them to have time with their own biological families, particularly their biological children (Hudson & Levasseur, 2002; MacGregor, et al., 2006). One barrier identified to respite was foster carers concern for the foster children’s well-being (Hudson & Levasseur, 2002; Murray, et al., 2011). These foster carers worried that respite may create a sense of instability or cause the children to feel abandoned or rejected (Hudson & Levasseur, 2002; Murray, et al., 2011). Reliance upon payments as income was also found to prevent foster carers use of respite services as payments often ceased for the duration of respite (Kirton, 2001).

Although not a focus of this review, practical support in the form of training was discussed in four studies (Hudson & Levasseur, 2002; MacGregor, et al., 2006; Murray, et al., 2011; Samrai, et al., 2011). Training to deal with children’s complex behavioural issues was a clear priority (Hudson & Levasseur, 2002; MacGregor, et al., 2006; Murray, et al., 2011). MacGregor et al. (2006) suggest this training should be individualised according to respective children’s needs. Foster carers have also identified their need to develop self-care strategies (Murray, et al., 2011). In addition to actual skill acquisition and development, training is valued as it affords opportunities for emotional support between foster carers (Hudson & Levasseur, 2002; MacGregor, et al., 2006).
The foster carer’s well-being

The provision of foster care can be seen to have both positive and negative effects on the personal well-being of foster carers. In turn, the wellbeing of foster carers has concomitant effects on foster placement stability, child outcomes and foster carer retention (Wilson, et al., 2000).

Positive effects

Generally, the experience of providing foster care is described as intrinsically rewarding (Buehler, et al., 2003; MacGregor, et al., 2006; Rosenwald & Bronstein, 2008). Personal satisfaction is gained by providing children with a safe, stable nurturing home environment which enables children to grow and mature (Buehler, et al., 2003). In so doing, foster carers contribute to a greater good and feel personally useful (Buehler, et al., 2003; MacGregor, et al., 2006; Rosenwald & Bronstein, 2008). The reciprocal loving relationships which develop between foster carers and children are rewarding for the carer (Broady, et al., 2010; Pickin, et al., 2011). Moreover, for some, providing foster care meets their own personal desires to parent and have a family when unable to do so by other means (Riggs, Delfabbro, et al., 2009). Several studies indicate the provision of foster care to have a positive effect on the entire family, enabling the development of respect and acceptance of differing cultures and value systems (Brown & Campbell, 2007; MacGregor, et al., 2006; Samrai, et al., 2011).

Negative effects

Foster carers manage an increased incidence and severity of behavioural difficulties with children in care compared to the general population (Broady, et al., 2010; Farmer, et al., 2005; Morgan & Baron, 2011; Murray, et al., 2011). This has been found to negatively impact on carers’ individual well-being (Broady, et al., 2010; Buehler, et al., 2003; Farmer, et al., 2005; Morgan & Baron, 2011; Murray, et al., 2011; Rosenwald & Bronstein, 2008; Wilson, et al., 2000), as well as create tension within the foster family (Broady, et al., 2010; Wilson, et al., 2000).

Management of difficult behaviours is described as stressful, tiring, time-consuming and unrelentening (Pickin, et al., 2011; Rosenwald & Bronstein, 2008; Wilson, et al.,
2000). Morgan et al. (2011) identified a significant positive correlation between children’s behavioural difficulties and foster carers’ (n=58) levels of stress ($r=-0.69$, $p<0.01$), anxiety ($r=0.49$, $p<0.01$) and depression ($r_s=0.25$, $p<0.05$). Parental efficacy (Morgan & Baron, 2011) and supportive personal networks (Farmer, et al., 2005) have both been found to partially mediate these negative effects on foster carer well-being. Conversely, Murray et al. (2011) reported foster carers’ well-being equivalent to parents at large, despite children’s increased behavioural difficulties. The small sample size (n=17), however, means that this conclusion must be interpreted with caution (Murray, et al., 2011).

Foster carers experience fear and grief due to the potential transitory nature of foster care (Broady, et al., 2010; Buehler, et al., 2003; Pickin, et al., 2011; Riggs, Delfabbro, et al., 2009; Thomson & McArthur, 2009). Foster carers fear becoming too attached to the children, and once attached, fear losing the children (Broady, et al., 2010; Riggs, Delfabbro, et al., 2009). The later appears heightened when foster carers perceive themselves fulfilling a parental, rather than professional, role (Broady, et al., 2010; Riggs, Delfabbro, et al., 2009). Coupled with foster carers’ fear of losing a child is their articulated sense of powerlessness in relation to the child welfare system (Broady, et al., 2010; Pickin, et al., 2011; Thomson & McArthur, 2009; Wilson, et al., 2000).

When a child is removed from a foster family, carers reportedly experience bereavement (Pickin, et al., 2011; Samrai, et al., 2011; Thomson & McArthur, 2009). This grief has been reported regardless of the reasons for the child’s removal and whether or not the decision is supported by the foster carer (Pickin, et al., 2011; Samrai, et al., 2011; Thomson & McArthur, 2009). Feelings of grief are exacerbated when not recognised or validated by others (Riggs, Delfabbro, et al., 2009; Thomson & McArthur, 2009).

**Discussion**

Extant foster care research literature generally focuses on the children in care (Ciarrochi, et al., 2011). Such research often considers the foster carer as a resource and a determining factor on the overall outcomes for the children in care (Cashmore, et al., 2007; Cole, 2005; Leathers, 2006). Despite their demonstrated influence on the
children in care, comparatively little research has focussed on the foster carers themselves. This review highlights persistent issues, provides new insights and enables a fuller awareness of the experiences and effects of providing foster care.

This review provides evidence that despite considerable discussion, the role of the foster carer remains poorly defined. The need for role clarification is paramount, given it is seen to have a profound impact on foster carers’ well-being (Broady, et al., 2010) and the potential for concomitant effects on the children in care (Riggs, Augoustinos, & Delfabbro, 2009; Schofield & Beek, 2005). Regardless how individual foster carers characterise their role (parentally or professionally) the dyadic nature of caring relationships means their experiences will directly impact the children in their care in a similar fashion (Chou, 2000; Early, Gregoire, & McDonald, 2002).

Caring for children with complex physical, mental and developmental health difficulties is arduous (Duchovic, Gerkensmeyer, & Wu, 2009; Early, et al., 2002), and requires skills and support beyond that of traditional parenting (Ellermann, 2007; Hollin & Larkin, 2011). Foster carers need both personal and professional support to provide optimal care given the well documented complexity and magnitude of foster children’s health difficulties (Schneiderman, 2004; Webster & Temple-Smith, 2010). Support in the form of group training programs serves to equip foster carers with skills and knowledge of various childhood related difficulties (Rork & McNeil, 2011; Turner, Macdonald, & Dennis, 2007). This review affirms the use of such programs given their potential to increase parental efficacy and provide networking opportunities for foster carers, subsequently improving foster carer well-being.

It is evident from the findings that foster carers experience heightened levels of anxiety, depression and stress in relation to their care giving role. These experiences vary according to how they characterise their role and relate to the child welfare system and its personnel. In light of the challenges recruiting and retaining foster carers, the anecdotal and empirical evidence suggesting the provision of foster care has negative implications for care providers well-being is concerning. The factors addressed within this review need to be considered in the context of existing child welfare policy, particularly given the concomitant effects of foster carer well-being on the children in care.
Implications for nurses

Caregiving occurs in a variety of contexts and is known to have positive and negative implications for both the care provider and recipient (Van Manen, 2002). It is important for nurses to understand that within these contexts, caregivers value the services provided to the care recipient, but also desire to have their own needs recognised and addressed (Wynaden et al., 2006). By acknowledging foster carers caregiving experiences, nurses increase their awareness and understanding of the value and role foster carers have in the lives of children. In so doing, nurses will be well positioned to assist foster carers to identify and express their needs in relation to their important caregiving role (McMurray, 2004).

While the National Framework emphasises the health and well-being of children, it should not be to the detriment of those caring for them (Council of Australian Governments, 2009). Strategies to support foster carers as individuals, as well as care providers, are warranted and may serve to reduce attrition. To date, providing appropriate support to foster carers has proven challenging and may require a new approach to both policy and practice. In their capacity as health care professionals, nurses are well positioned to advocate for both social and health reform. As new frameworks are developed, there is a clear need for nurse education regarding their specific roles and responsibilities in regards to child welfare issues. This knowledge may assist nurses to effectively collaborate with and support foster carers in their caregiving role.

Limitations

The findings of this review should be considered within the limitations of the review process and the studies reviewed. Sample sizes of included studies vary markedly, ranging from 5 (Pickin, et al., 2011) to 932 (Wilson, et al., 2000) participants. There is a preponderance of female participants represented in these studies compared to male foster carers. Although no specific gender based issues were identified in this review, the gender imbalance may contribute to a female biased perspective. Further, several studies either report on aggregate samples or neglect to differentiate between foster carers involved in the provision of various types of care (eg. long-term, short-term, respite and/or crisis foster care). Since there is evidence of perceptual
differences between individuals providing different types of foster care (Blythe, Jackson, Halcomb, & Wilkes, 2012; Hudson & Levasseur, 2002; Riggs, Delfabbro, et al., 2009), such mixed samples potentially fail to provide the complete picture. The majority of studies relied on cross-sectional samples and included individuals with varying lengths of experience providing foster care. This is a point of concern, as such sampling may result in ambiguous findings as the needs, perspectives and experiences of providing foster care have been shown to evolve with time (Blythe, Halcomb, Wilkes, & Jackson, 2012; Hudson & Levasseur, 2002; Lauver, 2008; Marcellus, 2008). That is, the limited experiences and perspectives of a novice foster carer are likely to differ to those of a seasoned foster carer. Future research should acknowledge that foster carers are not a homogenous population and these differences should be taken into account particularly when considering application of results (Rork & McNeil, 2011).

**Conclusion**

This paper reviewed 18 studies investigating the experiences and effects of providing foster care. In spite of the intrinsic rewards of foster care this review has identified experiences which negatively impact on the well-being of foster caregivers. These adverse effects include; role ambiguity, poor relationships with child welfare personnel, a perceived lack of personal and practical support and difficulty managing challenging behaviours of children. Increased parental efficacy and reliance upon personal support networks were identified as mitigating factors.
References


CHAPTER THREE: METHODOLOGY

“The most basic of all human needs is the need to understand and be understood. The best way to understand people is to listen to them.”

~ Ralph G. Nichols

INTRODUCTION

This chapter outlines the methodology that this study employed to investigate the experiences of women who provide long-term foster care. It details the recruitment strategies, participant eligibility, data collection methods and relevant ethical issues for this study. A description of the data analysis procedures used for this study is provided as well as a discussion of the measures used to ensure rigour. This chapter is complemented by chapter four which presents Paper 2 and explores the challenges of being an insider researcher.

QUALITATIVE RESEARCH

Qualitative research values subjective knowledge and places importance on individuals and their experiences (Schneider, Elliot, Beanland, LoBionda-Wood, & Haber, 2005). Ultimately, qualitative research seeks not only to recount an event, but to construct and articulate an understanding of the entirety of the experience from the perspective of the individual who experienced it (Welch, 2011). A qualitative methodology was chosen for this study in order to gain insight into and

---

understanding of the women’s experiences of providing long-term foster care in Australia.

CHARACTERISTICS OF STORIES AND STORYTELLING

Stories are a fundamental form of communication which enable us to relay messages, share experiences and knowledge, express ourselves and entertain others (Atkinson, 1998; Bowles, 1995; Yoder-Wise & Kowalski, 2003). Stories are central to human life (Carson & Fairbairn, 2002). Constructed within unique, social, historical and cultural contexts, stories help us to understand our world and define our position within it (Bailey & Tilley, 2002; Smith & Sparkes, 2006). Randell (2001) writes “to be a person is to be a story” (p. 57).

The stories people tell are the sum of their individual experience and attributed meaning. It is meaning, not truth, that is found in stories (Bailey & Tilley, 2002; Gaydos, 2005; Polkinghorne, 1995). Meaning is subjective, it makes up a person’s view of reality and defines a person’s actions (Krauss, 2005). Stories enable us to express meaning and demonstrate how it came to be.

As a research methodology, storytelling is recognised as an effective meaning making strategy as it affords the opportunity for reflection (Bailey & Tilley, 2002; Frank, 1995; Roberts & Taylor, 2002; Smith & Sparkes, 2006). Reflection is essential to gain insight into the storytellers experiences (Smith & Sparkes, 2006). Both Atkinson (1998) and McAdams (1996) assert that the articulation of one’s story facilitates reflection enabling the unconscious to be made explicit. In this way, storytelling facilitates participants to make sense of their unique experiences (Holloway & Freshwater, 2007; Smith & Sparkes, 2006). Since foster care is rendered twenty-four hours a day, seven days a week, participation in this study offered a unique opportunity for participants to intentionally reflect on and make meaning of their experiences.

Unlike other research methodologies, where the onus to impart valuable information is on the participant (Jackson, 1997; Rice, 2009), storytelling is a collaboration between two equally important individuals; the storyteller and the listener (Atkinson, 1998). This collaboration results in a story that is co-created (Sakalys, 2000). As a co-creator, the listener serves as a catalyst and guide (Anderson & Jack, 1991;
Atkinson, 1998) ensuring the storyteller’s perspectives and experiences are the focus of the story (Holloway & Freshwater, 2007). Therefore the identity of the listener (Blythe, Wilkes, & Halcomb, In press-a) and the quality of the relationship between the listener and the storyteller directly influences the story being told (Bailey & Tilley, 2002). The identity of the researcher and factors influencing her relationship with the women in the context of this study are discussed in Paper 2 presented in Chapter four (pg. 47).

**STORYTELLING AS RESEARCH**

It has been suggested that all research is essentially a form of storytelling, either about ourselves or our world (Carson & Fairbairn, 2002). However, storytelling as a methodology in its own right has been of increasing interest to a range of researchers over recent decades (McCance, McKenna, & Boore, 2001). Storytelling enables individuals to translate their experiences into words. The resulting story is a complete account of their experiences beyond the biophysical, including their inner most thoughts and feelings (Bailey & Tilley, 2002). Stories provide access to these complex realities and thus enable understanding of individuals and their experiences.

Storytelling has been demonstrated to be particularly useful to gain insights into the experiences of vulnerable groups (Holloway, Freshwater, & McKenzie, 2007). Peters (2006) explored the experiences of infertile couples who, after accessing artificial reproductive technology, remain childless. Women’s experience of a sexually transmitted infection (East, Jackson, Peters, & O’Brien, 2009) and the concept of independence as defined by persons living with a spinal cord injury (Ortiz, 2008) have also been explored using a storytelling methodology. The storytelling methodology has also been used to develop understanding of different aspects of motherhood, including the experience of childbirth (Leamon, 2009), mothering a child in home hospice care (Lehna, 1999), and mothering an adolescent who uses illicit drugs (Jackson & Mannix, 2003). Further to this, researchers have used storytelling to illuminate the experience of child-to-mother violence (Jackson, 2003) and ‘mother blaming’ (mothers being held responsible for the actions, behaviour, health and well-being of their children) (Jackson & Mannix, 2004). By using storytelling, women were able to share their personal experiences as mothers which illuminated distinct healthcare needs for women in each context.
This literature demonstrates stories to be a source of meaningful evidence since the storytelling methodology enables researchers to construct and disseminate an understanding of individual experiences. This understanding is beneficial as it demonstrates how various life experiences affect people and how people make sense of those experiences (Welch, 2011). Inherent in stories is the potential to inform social and health care practice and thereby contribute to the knowledge development of these disciplines (Liehr, 2008; Riessman & Quinney, 2005; Yoder-Wise & Kowalski, 2003). The stories gathered for the purpose of this research have enabled insight and understanding of how providing long-term foster care impacts women’s lives.

**FEMINIST PERSPECTIVES INFORMING THIS STUDY**

Feminist theory is a broad theoretical and ideological perspective which seeks to empower and value women (Aranda, 2006; Jackson, 1997). To this end, feminist research attempts to minimise the inherent power discrepancy between the researcher and participants (Hesse-Biber & Leavy, 2007; Stanley & Wise, 1990). Using a storytelling methodology enabled collaboration between the researcher and participants thus diminishing the power inequities. Moreover, Frank (2002) asserts the invitation to share one’s personal story implies value. For the women participating in this study, telling their stories to a genuinely interested party can validate their lives and experiences making them feel valued (Holloway & Freshwater, 2007).

Feminist informed research seeks to provide insight into phenomena that affect women’s lives (Hall & Stevens, 1991) in an effort to improve women’s social and political contexts (Coppock, Haydon, & Richter, 1995). Foster care is heavily gendered; with women providing the majority of care to children and managing the specific responsibilities associated with the provision of foster care (Siminski, et al., 2005; Swartz, 2004). This research sought to provide insights into women’s experiences of providing long-term foster care to enable greater understanding of their unique circumstances. Such an understanding can be used to inform social and health care policy and practice.
DATA COLLECTION

PARTICIPANT ELIGIBILITY

This study sought to recruit female participants who were providing, or had provided, foster care to at least one child on a long-term basis. The focus of this study was women’s experiences of providing long-term foster care. Therefore, male foster carers and women who were only providing or had only provided kinship, crisis, short-term or respite foster care were not eligible to participate.

RECRUITMENT

Multiple convenience and snowballing strategies were used to access the target population and recruit a convenience sample. A media release was placed in several local newspapers of the Western Sydney area and recruitment posters were placed on community notice boards in multiple shopping and community centres in Western Sydney, in three relevant child focused clinics, and online (Appendix B, pg. 167). The Australian Foster Care Association (AFCA) also circulated a request for volunteers throughout their national network by word of mouth and via email. Following their interview, participants were also provided with fliers to distribute to other potential participants.

A pre-paid mobile phone was obtained exclusively for recruitment purposes. This mobile number and an email address were included in all recruitment strategies as the initial points of contact for interested parties. Once an individual made contact and expressed her interest, an information package was sent to her via Australia Post or electronic mail. This package included a hand written note of appreciation for interest in the study, an information sheet, a consent form, and a list of counselling services (Appendix C, pg. 169).

Approximately one week after sending the information package, interested women were contacted by phone to ensure they had received the documentation and to answer any questions. If the woman was willing to participate, a signed consent form was gained and a mutually convenient interview time was scheduled.
INTERVIEWS

This study used individual, in-depth, semi-structured conversational interviews to enable the women to share their stories. Although data collection methods such as this can be time consuming and resource intensive for the researcher they offer significant benefits (Appleton, 1995). In keeping with the storytelling methodology, the questions posed were broad, allowing each woman to articulate her experiences at her own discretion without a priori restrictions (Atkinson, 1998). Moreover, conversational interviews are characteristically dialogical and equitable and thus necessitate collaboration between the researcher and participant (Atkinson, 1998; Bailey & Tilley, 2002). This interview process allowed the researcher to encourage the women’s critical reflection, and afforded the opportunity to probe and clarify the women’s intended meaning (Schneider, et al., 2005). A list of questions used to initiate and guide the interview process can be found in Appendix D (pg. 173).

Since stories can be expressed both verbally and textually (Carter, 2008) and given the geographical distance between the researcher and some of the women, this study employed a combination of face-to-face (n=9; 45%), telephone (n=9; 45%) and computer mediated interviews (n=2, 10%). Face-to-face interviews were undertaken either in the home of the participant (n=7) or, if the participant preferred, at the UWS in a private office (n=2). Telephone and face-to-face interviews were audio recorded and field notes taken. Computer mediated interviews occurred through an exchange of emails. The value of computer mediated interviews, as a method of data collection, has increased with the advancement of technology (Mann & Stewart, 2000), and has been found beneficial to research as it offers an increased level of anonymity and comfort to participants (East, Jackson, O’Brien, & Peters, 2008). Data collection continued until it was agreed that no new themes were emerging and saturation had been achieved (Tuckett, 2004).

DATA ANALYSIS

Audio recorded interviews were transcribed verbatim by a professional transcription service. Recently, the use of verbatim transcription in research has been questioned as it is predisposed to human error, time consuming and expensive (Halcomb & Davidson, 2006). However, the storytelling methodology emphasises the importance
of individuals conveying the story they want heard, in their own words. This necessitated verbatim transcription.

The process of transcription is susceptible to error (DiCicco-Bloom & Crabtree, 2006; Halcomb & Davidson, 2006; Poland, 1995). Capturing the spoken word in text form can be difficult, even for experienced transcribers, as people often speak in run-on sentences (DiCicco-Bloom & Crabtree, 2006). Transcribers’ attempts to make the text grammatically correct may result in the insertion of punctuation that alters the meaning when read (Braun & Clarke, 2006; DiCicco-Bloom & Crabtree, 2006). Therefore, transcripts were audited against the original recordings by the doctoral candidate, to identify and amend any inconsistencies (DiCicco-Bloom & Crabtree, 2006; Halcomb & Davidson, 2006; Poland, 1995).

The transcripts of audio recorded interviews and digital files of emails were entered into the computer software package NVivo™. This software does not perform analysis, rather it is recognised for its ability to ease the complex organization and retrieval of information (Pope, Ziebland, & Mays, 2000). Analysis of the data was dependent on the emerging skills of the doctoral candidate and the guidance of her supervisory panel. As the initial stages of data analysis can be laborious (Li & Seale, 2007), using this computer program allowed the doctoral candidate multiple attempts at grouping the information without wasting paper. Using this software to manage the data, rather than a traditional paper based system (such as photocopies, note cards or spreadsheets) was also an environmentally friendly decision.

Analysis was an iterative process requiring familiarity with the data (Braun & Clarke, 2006; Dickson-Swift, James, Kippen, & Liamputtong, 2007; Tuckett, 2005a). This began with the auditing process which facilitated close contact with both recorded and transcribed data. Repeatedly listening to audio recordings and re-reading transcripts and emails enabled the identification of semantic themes. Largely descriptive, semantic themes are based on what the participant has actually said (Braun & Clarke, 2006). Progression beyond semantics required immersion in the data (Anderson & Jack, 1991). Accordingly, immersion in the women’s stories enhanced understanding of each woman’s experience from her vantage point.

Analysis of the women’s stories was influenced by Anderson and Jack (1991) who propose three ways of listening to facilitate understanding. The first is to listen to the
storytellers “moral language” (Anderson & Jack, 1991, p. 19). These are self-evaluative statements which allow the relationship between a person’s self-concept and cultural norms to be examined. For example, when reflecting on the possibility that the boys in her long-term care may repeat their biological parent’s patterns of behaviour which necessitated the boys’ placement into foster care, Uma stated: *I really believe mums carry the guilt, so I would probably blame myself.* This statement reflects society’s tendency to hold mothers accountable for their children’s behaviour. Judging herself against this norm reveals how Uma perceives herself in relation to the boys in her care.

The second way of listening proposed by Anderson and Jack (1991) is to attend to participants “meta-statements” (p. 21), which can reveal a discrepancy within the self or between what is expected and what is actually being said. Meta-statements demonstrate the storyteller’s personal reflection, which is often occurring as the story is told (Anderson & Jack, 1991; Atkinson, 1998). For example, when asked what the hardest part of being a long-term foster carer was, Gloria replied:

*The hardest thing? I think if I’m really honest and I go right down to the very core, all the investment that I could put in and it could be for nothing.* [pause] *No - yeah, gee I don’t know, that is a hard question. There’s a element of that, of that whole, you know like I feel like I’ve poured my heart and soul into these kids and they might just get to the other end and go well thanks but see you, I’m off and you know and just go and pursue the lifestyle of their birth parents, which really concerns me. But I mean again that’s [pause] I deal with that by saying at least I did the best I could and if that’s their choice, well that’s their choice.*

Gloria’s reply reveals an internal struggle. Her initial reply reveals her fear that her investment in the lives of her boys may be for naught, then she pauses and corrects herself, twice. In her story it is clear that Gloria positions herself as a mother to the boys in her long-term care. The depth of her emotional investment in the boys becomes obvious as she goes on to explain her fear, then she pauses again as if realising hers is not the fear of a mother, but that of a foster carer. This reality causes Gloria to momentarily distances herself from the boys by saying it’s their choice.
Finally, Anderson and Jack (1991) suggest listening to the logic of the story. By identifying consistencies and contradictions in a person’s story, and analysing the way they relate to each other, understanding of the experience is enhanced (Anderson & Jack, 1991). For example, several times throughout her story Felicia openly criticized the child protection system for its inability to protect the best interest of children and its poor treatment of foster carers. Yet when asked what the best part of being a long-term foster care was, Felicia stated;

> I mean, the kids are great kids. I go to places with all my kids and people say oh gee, your kids are lovely children, and they really are. I guess working in the system as well, as much as it's negative. But there's a positive to it as well. Because if there were no policies, if there were no procedures, these kids would still be where they were - back at home being abused. [pause] As much as I whinge about the system, I'm glad it's there.

Using the techniques suggested by Anderson and Jack (1991) the women’s stories were scrutinized and analysed for common themes. As themes emerged they were presented to and discussed with the doctoral supervision panel to confirm the analytic process. Although member validation is commonly used establish credibility in qualitative studies (Hall & Stevens, 1991), this approach was deemed unsuitable for this study as it discounts the collaborative nature of storytelling by reducing and/or negating the researchers co-contribution to the story (Atkinson, 1998; Sandelowski, 1993).

ETHICAL CONSIDERATIONS

Researchers have a responsibility to be conscious throughout the research process of numerous ethical considerations associated with the conduct of human research (National Health and Medical Research Council (NHMRC), 2007). The moral principles of respect for individuals, beneficence and justice are paramount to research with women providing foster care given their vulnerability (Blythe, Halcomb, Wilkes, & Jackson, 2012a). This project was approved by the UWS Human Research Ethics Committee (HREC) prior to the commencement of data collection (Approval No H7474) (Appendix E, pg. 175).
AUTONOMY

Autonomy refers to an individual’s ability make an informed decision independently, without coercion (Charter, 2011). Every woman who inquired about the study and met the eligibility criteria was invited to participate. To ensure their autonomy, each woman was sent a detailed information sheet which explained the intent of the study, detailed the interview process and listed the potential risks and benefits of participating (Appendix C, pg.169). The women were also given a mobile phone number and an email address to ask questions concerning the study or to communicate a desire for no further contact. Interested women were informed that participation was voluntary and that they were free to withdraw from the study at any time without penalty.

CONSENT

Participant information sheets and consent forms were sent via Australia Post or electronic mail prior to the data collection (Appendix C, pg. 169). This gave potential participants the opportunity to read and understand the intent of the study as well as the potential risks and benefits involved with participation. As can be seen from Appendix C (pg. 169) these sheets also detailed what was required of participants and informed them of their rights as participants. Prior to the interview, the information sheet was discussed and participants were given the opportunity to ask questions. These steps enhanced autonomy and empowered women to make an informed decision regarding their participation. Those who expressed a willingness to participate in the study were asked to sign a written consent form before data collection commenced.

CONFIDENTIALITY

It is assumed that individuals will be more inclined to participate in research if the researcher guarantees anonymity (Minichiello, Sullivan, Greewood, & Axford, 1999). The importance of participant anonymity became apparent very early during recruitment for this study. Several potential participants expressed concern that the statutory bodies who govern their status as foster carers would be aware of their participation. A thorough explanation of the procedures undertaken to ensure anonymity was necessary to allay participants’ concerns.
Anonymity was ensured on all transcripts, digital recordings, data collection forms and field notes by the assigning of coded participant numbers and pseudonyms. One master list of participant names and coded numbers was kept and accessed only by the doctoral candidate. Transcripts were closely scrutinised and identifying information removed. Generic terms such as “department”, “system”, and “agency” were used to replace the names of the specific statutory bodies to which participants were accountable. Brackets [ ] have been used to signify when this occurred within a participant’s direct quotation. Pseudonyms have been used to refer to participants, and their family members, in all publications and presentations resulting from this study.

Hard copies of study data was maintained in a secure filing cabinet and computer files were password protected as per NHMRC (2007) guidelines and UWS (2009) policy. These data will be securely stored for the mandatory five years following publication of findings and then permanently destroyed (NHMRC, 2007; UWS, 2009).

Computer mediated interviews posed a threat to anonymity as the internet is a public domain (Binik, Mah, & Kiesler, 1999) and there was potential for participants’ computers to be accessed by others (Kralik, Price, Warren, & Koch, 2006). Participants were made aware of these issues prior to the interview. In an effort to minimise the threat to anonymity, participants were encouraged to delete emails or to save them in a secure file protected with a password.

**Beneficence**

Issues of confidentiality, stigma and social isolation may prohibit foster carers from discussing their experiences. Due to the exploratory nature of this study, there was a possibility that some or all of the participants would discuss issues during the interviews that they might not have previously considered disclosing. Further, there was potential for strong emotions to surface as participants reflected on their experiences of providing long-term foster care. It was difficult to predict whether the opportunity to share their stories would be cathartic or emotionally distressing for participants (Pennebaker, 2000). This was a significant issue during computer mediated interviews as the visual and/or vocal cues of distress that can be observed during face-to-face and telephone interviews are not observable with this means of
communication (East, et al., 2008). Emotional support and information about professional counselling services and online support groups were provided to all participants prior to data collection in an effort to minimise any distress arising from the interviews.

**RIGOUR**

In the context of research, rigour refers to the quality of the research process. Rigour is achieved when the study processes and outcomes are reasonable, appropriate, congruent, and significant (Hall & Stevens, 1991; McBrien, 2008). Slevin & Sines (2000) assert that a qualitative study is deemed rigorous if the findings are found to be credible, transferable, dependable and confirmable. The specific strategies used to ensure rigour in this study are described below. Additional information regarding some of these strategies can be found in Paper 2 presented in chapter four (pg. 47).

**CREDIBILITY**

A study has credibility if it can establish the findings clearly reflect the perspective of the participant in the research (Hall & Stevens, 1991). Qualitative researchers are encouraged to engage in multiple strategies to enhance credibility (Creswell, 2007; Slevin & Sines, 2000). This study utilised three strategies to ensure credible findings; reflexivity, peer review and thick descriptions.

The collaborative nature of storytelling necessitates reflection from both participants. This occurs for the storyteller, both consciously and unconsciously, as she is telling her story (Blythe, et al., In press-a; Hayman, Wilkes, Jackson, & Halcomb, 2012). However, a more deliberate effort at reflection is necessary for the listener (researcher) to ensure the participant’s story remains the primary focus (Atkinson, 1998). This helps to minimise the influence of the researcher’s subjectivities, biases, ideas and assumptions on the story being told (Hewitt, 2007). This reflexivity was particularly important in this study given the researchers insider status (Blythe, et al., In press-a). The reflective methods used by the researcher are described in Paper 2 (pg. 47).

Member checking, whereby participants read their own transcripts and validate the text, is advocated by some scholars to establish credibility (Guba & Lincoln, 1981;
Hall & Stevens, 1991). This approach was deemed unsuitable for this study as it discounts the collaborative nature of storytelling thereby reducing and/or negating the researcher’s co-contribution to the story (Atkinson, 1998; Creswell, 2007; Sandelowski, 1993). Further, variations within stories can occur between the time of the interview and the time of members’ validation (Sandelowski, 1993). These variations do not invalidate the original story, but rather can be attributed to the dynamic nature of stories (Atkinson, 1998). Finally, the effects of reading or listening to one’s own story are, at best, uncertain and potentially a burden to the participant (Sandelowski, 1993).

The credibility of a study is partly contingent on the skills and ability of the researcher (Angen, 2000; Guba & Lincoln, 1981). Therefore, to augment credibility, this study was subjected to multiple peer reviews both by external reviewers and the doctoral supervision team (Blythe, et al., 2012a; Blythe, et al., In press-a, In press-b). The peer review process affords experienced researchers the opportunity to scrutinise a study and provide feedback (Slevin & Sines, 2000). Components of this research were presented to the doctoral supervision panel, at conferences, research forums and groups, as well as writing syndicates. This enabled the methods, meanings and interpretations to be challenged by a range of individuals and subsequently confirmed or amended by the doctoral candidate.

Finally, the credibility of qualitative research can be enhanced through the provision of rich, thick descriptions (Tuckett, 2005b; Welch, 2011). Storytellers tell their story better than anyone else (Frank, 1995). Consequently, careful use and presentation of the data was considered imperative to ensure the credibility of this study. In order to present an accurate account of what was said, verbatim quotes have been presented within the findings.

**TRANSFERABILITY**

Transferability is the degree to which the findings of a study can be applied to another context or setting (Guba & Lincoln, 1989). Generally, the transferability of research is determined by the reader, rather than the researcher (Guba & Lincoln, 1989). Transferability was enhanced in this study through the provision of clear descriptions of the research context and participants (Miles & Huberman, 1994). Similarity to existing literature can confirm and support the transferability of findings.
(Grbich, 2007). The findings of this study resonate with contemporary foster carer literature confirming their transferability (Broady, Stoyles, McMullan, Caputi, & Crittenden, 2010; Daniel, 2011; Riggs, Delfabbro, & Augoustinos, 2009b). Specific demonstrations of this transferability can be found in the peer-reviewed publications presented in chapters six (pg. 71), seven (pg. 89) and eight (pg. 117) of this thesis.

**DEPENDABILITY**

Dependability in qualitative research refers to consistency in the research process (Ryan-Nicholls & Will, 2009). A study must be transparent to in order to demonstrate dependability. Transparency can be achieved by leaving an audit trail by which outside researchers can review the methods used to conduct the study (Ryan-Nicholls & Will, 2009). Data was collected by one researcher using a semi-structured interview schedule to initiate and guide all the interviews (Appendix D, pg. 173). The researchers’ position in relation to the study was clearly described in the introduction of this thesis (pg. 2) and made known to participants prior to data collection. Discussions regarding the analytic decision making process used to interpret the data were undertaken with the supervisory panel and a record of these decisions was kept by the doctoral candidate. The researchers’ reflective journal and field notes have also been retained.

**CONFIRMABILITY**

Confirmability is the degree to which the findings of a study can be confirmed or corroborated by others (Tuckett, 2005b). A number of strategies, which are discussed in Paper 2 (pg. 47) of this thesis, were used to enhance the confirmability of this study’s findings. These strategies were paramount given the researcher’s position in relation to the study and included ongoing reflection, auditing transcripts and peer review.
CHAPTER FOUR: THE CHALLENGES OF INSIDER RESEARCH

PUBLICATION

Paper 2:


RELEVANCE TO THESIS

This chapter presents a peer-reviewed publication detailing the challenges faced and strategies employed by the doctoral candidate as an insider researcher. When conducting qualitative research, there is potential for the researcher’s position to impact upon the credibility of the data collected and the findings produced (Gunasekara, 2007). This is particularly applicable to the novice researcher (Darra, 2008). As outlined in Chapter 1, the researcher approached this study as an ‘insider’. This positioning, in concert with her status as a novice researcher, posed specific methodological challenges. Some of these challenges were identified prior to commencing the study, whilst others emerged during the conduct of the study. The purpose of a doctoral program is essentially two-fold; resulting in a significant and original contribution to knowledge, and the development of high level research skills. Identifying and managing methodological challenges within the study helped to ensure the rigour of the investigation and enhanced the intellectual and professional development of the doctoral candidate (Zeegars & Barron, 2006).
Title: The challenges of being an insider in story-telling research

Abstract

Aim: To describe the challenges related to being an ‘insider’ researcher in a study using a feminist informed story-telling research design and discuss strategies to manage these challenges.

Background: The positioning of the researcher within qualitative research has numerous methodological implications. Often qualitative researchers share similar experiences or characteristics with their participants. Such an ‘insider’ position provides challenges for the researcher in conducting the research. Understanding these challenges and planning how to manage them is beneficial for both the researcher and the conduct of the project.

Data sources: This paper is based on the research teams’ experience of undertaking a feminist informed story-telling study exploring the experiences of Australian women providing long-term foster care.

Review methods: This paper provides a discussion of the methodology used in the investigation.

Discussion: Four key challenges were identified as impacting on the research as a result of the ‘insider’ status of the primary researcher, namely; assumed understanding, ensuring analytic objectivity, dealing with emotions as an ‘insider’ and participants’ expectations. Strategies to address these challenges include; participant probing, researcher reflexivity, review by ‘outsider’ researcher, identifying the risk, debriefing, making the aims and use of study outcomes clear, and acknowledging participants’ expectations. Methods to implement these strategies are described.

Conclusion: The use of an ‘insider’ researcher was beneficial to our study design, and could be seen to facilitate recruitment and rapport, enabling collaboration and the generation of stories rich in content. By identifying the challenges associated with ‘insider’ research and employing strategies to mitigate them, researchers can effectively use an ‘insider’ position in conjunction with a storytelling research design.
Implications for future research: Further investigation of the ‘insider’ within different qualitative research designs would be useful in identifying challenges and benefits specific to those designs.

Key words: insider, qualitative research, method, storytelling

Introduction

In qualitative research, the researcher is considered to be the instrument of data collection. Therefore, his/her life experiences and identity have an impact upon the way that the data is collected and the analysis of the data (Couture, Zaidi, & Maticka-Tyndale, 2012; Griffith, 1998; Pezalla, Pettigrew, & Miller-Day, 2012). As such, it is imperative that qualitative researchers clearly identify their position within the research (Corbin Dwyer & Buckle, 2009; West, Stewart, Foster, & Usher, 2012). This positioning is particularly related to the researcher’s relationship to those being studied. For example, in this study of Australian long term female foster carers (Blythe, Halcomb, Wilkes, & Jackson, 2012a, 2012b; Blythe, Jackson, Halcomb, & Wilkes, 2012c), the PhD candidate was also long term foster carer. In this case the researcher is considered an ‘insider’ as she shares the experience of being a female foster carer with participants. Other ‘insider’ specific characteristic, role or experience under investigation with study participants (Burns, Fenwick, Schmied, & Sheehan, 2012; Corbin Dwyer & Buckle, 2009; Griffith, 1998; West, et al., 2012; Yakushko, Badiic, Mallory, & Wang, 2011). A researcher who does not possess this commonality or shared experience, such as the researcher supervisors who had never provided foster care, would be considered an ‘outsider’ (Corbin Dwyer & Buckle, 2009).

Much has been written on the positioning of the researcher in qualitative research, with ongoing debate regarding the advantages and disadvantages associated with the researcher’s position as either an ‘insider’ or an ‘outsider’ (Burns, et al., 2012; Griffith, 1998; West, et al., 2012; Yakushko, et al., 2011)., with ongoing debate regarding the impact of the researcher’s stance as either an ‘insider’ or an ‘outsider’ in relation to the research (Burns, et al., 2012; Griffith, 1998; West, et al., 2012; Yakushko, et al., 2011). Most recently discussions have focussed on the fluidity of
the researcher’s position and reflect the dynamic nature of people and context (Burns, et al., 2012; O'Connor, 2004; West, et al., 2012). This perspective negates the debate positioning one stance as superior to the other and asserts there to be an element of both ‘insider’ and ‘outsider’ in all qualitative research (Dowling, 2000; Griffith, 1998). Given this, the potential benefits and challenges associated with ‘insider’ research are applicable to numerous qualitative research contexts.

This paper explores the methodological challenges associated with ‘insider’ research in relation to our storytelling study which examined the experiences of women (n=20) providing long-term foster care. We use scholarly literature and the experiences of the first author (SB), as an “insider” researcher, to identify the challenges faced and describe strategies used to overcome them.

**Background**

**Advantages of “insider” research**

The literature identifies numerous advantages of ‘insider’ research. Given their close association and established community links, the ‘insider’ researcher may have easier access to the study population, particularly marginalised groups (Griffith, 1998; Hayman, Wilkes, Jackson, & Halcomb, 2012; Yakushko, et al., 2011). As a member of the community, the ‘insider’ researcher is often viewed on a more equal footing, thus minimising the power differential between the researcher and participants. This may enhance the development of rapport and enable reciprocity between the researcher and participant (O'Connor, 2004). It has also been suggested that, based on their mutuality, participants likely engage in more open dialogue with the ‘insider’ researcher resulting in the generation of a greater depth of data than would otherwise be gained (Corbin Dwyer & Buckle, 2009). As an ‘insider’, the researcher can be seen to have tacit knowledge based on his/her familiarity with the group being researched, which informs the research and enables greater understanding (Rooney, 2005).

**Disadvantages of “insider” research**

Various disadvantages associated with ‘insider’ research are also discussed in the literature. Although being ‘insider’ may aid in identifying and recruiting participants,
it does not guarantee the development of rapport with participants (Kusow, 2003). In some socio-cultural and experiential contexts participants may be uncomfortable talking with an ‘insider’ and prefer the anonymity of an ‘outsider’ (Couture, et al., 2012). Further, the ‘insider’ researcher’s similarity to the study participants has the potential to cause presumption (Couture, et al., 2012). In such cases, the ‘insider’ and/or the participants may respectively, and inadvertently, fail to seek or provide sufficient detail during data collection consequently precluding effective in-depth analysis. Finally, the ‘insider’ may lack the objectivity necessary to ensure accuracy of the findings unless strategies are implemented to ensure the credibility of the study (Rooney, 2005).

Our study

This study used a storytelling design to explore the experiences of twenty women providing long-term foster care for children and young people in Australia (Blythe, et al., 2012a, 2012b; Blythe, et al., 2012c). Participants shared their stories via semi-structured telephone, face-to-face or email interviews. Interviews were conducted by the first author who, as a female long term foster carer, identified herself to participants as being an “insider” researcher. Interviews were audio-recorded and thematically analysed using techniques suggested by Anderson and Jack (1991). Three major themes arose from the data, namely; (i) Mothering revealed; (ii) Seeking recognition; and (iii) Mothering in the system. These findings have been reported elsewhere (Blythe, et al., 2012a, 2012b; Blythe, et al., 2012c).

The storytelling design

Stories are a fundamental form of communication which enable us to interact and connect with others (Atkinson, 1998; Bowles, 1995; Yoder-Wise & Kowalski, 2003). Shaped within a personal, social, historical and cultural context, stories allow us to construct our identity (Smith & Sparkes, 2006) and make sense of our world (Bailey & Tilley, 2002). More than a chronology of life events (Polkinghorne, 1995); stories and are imbued with personal meaning (Gaydos, 2005). People draw meaning from and give meaning to their experiences (Krauss, 2005). The story is an expression of that meaning and how it came to be.
As a research methodology, storytelling is being increasingly used in nursing research, and is widely recognised as an effective meaning making strategy (Bailey & Tilley, 2002; Frank, 1995) as it provides the opportunity to critically reflect on experiences (Smith & Sparkes, 2006). Through the articulation of one’s story, the process of putting words to the experience, the unconscious is made explicit allowing new insights to be gained (Atkinson, 1998; McAdams, 1996). Stories elicited for research purposes are particularly valuable as they demonstrate how life events affect people and how people give meaning to these events (Minichiello, Sullivan, Greenwood, & Axford, 1999).

Unlike the traditional semi-structured qualitative interview, storytelling necessitates collaboration between two equally important individuals; the storyteller and the listener (Atkinson, 1998). People tell their stories selectively in order to convey the meaning which they intend the listener to hear (Bailey & Tilley, 2002). Consequently, the purpose for telling the story and the identity of the listener determines what elements of the story are told (Bailey & Tilley, 2002). Moreover the questions posed when using a storytelling methodology are necessarily broad, to facilitate participants in articulating their experiences without restrictions (Atkinson, 1998). This has significant implications within the research context as the information an individual chooses to reveal and/or conceal are largely dependent on the relationship between the participant and the researcher (DiCicco-Bloom & Crabtree, 2006). Thus the researcher’s position, as ‘insider’ or ‘outsider’, directly influences the stories told by the participant.

Given foster care is heavily gendered, with women providing the majority of care, our research was informed by feminist principles (Siminski, Chalmers, & McHugh, 2005; Swartz, 2004). As a research methodology, storytelling is particularly suited to the principles of feminist theory as both it can empower and facilitate change (Gabriel, 1995; Stanley & Wise, 1993), inform social policy (Coppock, Haydon, & Richter, 1995; Van der Staay, 1994), and give voice to marginalised groups (Hesse-Biber, 2007; Turton, 1997). Similar to storytelling, feminist informed research values the individual and emphasises collaboration between researchers and participants (Atkinson, 1998; Stanley & Wise, 1993).
The benefits of ‘insider’ research were particularly suited to our study design, and could be seen to facilitate both recruitment and rapport. However, to elicit these benefits SB had to first disclose her position as a woman who provides long-term foster care to participants. Self-disclosure can be defined as personal information about oneself communicated to another (Cozby, 1973). Self-disclosure, by the researcher, is advocated as an effective strategy for facilitating reciprocity between participants and the researcher and is viewed as good feminist practice (Hesse-Biber, 2007). Through her self-disclosure, SB positioned herself as an insider, and an ally to participants, and could be seen to facilitate both recruitment and rapport as potential participants moved from tentative to enthusiastic upon the disclosure of SB’s ‘insider’ position. In keeping with our methodology, the ‘insider’ researcher position enabled collaboration and resulted in the generation of stories rich in content (Blythe, et al., 2012a, 2012b; Blythe, et al., 2012c). Despite the benefits, the researcher’s ‘insider’ position also brought a number of challenges.

**Identification of challenges**

The four main challenges of ‘insider’ research revealed in the literature and through our experience were: assumed understanding; ensuring analytic objectivity; dealing with emotions as an ‘insider’; and managing participant expectations (Table 1).
Table 1. Overview of challenges, strategies and methods of implementation

<table>
<thead>
<tr>
<th>Challenge</th>
<th>Management Strategies</th>
<th>Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Assumed understanding</td>
<td>a) Participant probing</td>
<td>• Recognise cues</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Encourage participant reflection by asking probing questions</td>
</tr>
<tr>
<td>2. Ensuring analytic objectivity</td>
<td>a) Researcher reflexivity</td>
<td>• Written account of the ‘insider’ prior to the study</td>
</tr>
<tr>
<td></td>
<td>b) Review by ‘outsider’ researcher/s</td>
<td>• Ongoing reflection</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Reflective journaling</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Audit transcripts against recorded data</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Discuss data with ‘outsider’ researchers familiar with analytical method</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Seek peer review as themes emerge</td>
</tr>
<tr>
<td>3. Dealing with emotions as an ‘insider’</td>
<td>a) Identify the risk</td>
<td>• Ongoing reflection</td>
</tr>
<tr>
<td></td>
<td>b) Debriefing</td>
<td>• Acknowledge and understand the potential for emotional impact</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Discuss the emotional impact of the research with other researchers and non-researchers</td>
</tr>
<tr>
<td>4. Managing participant expectations</td>
<td>a) Make aims and use of study outcomes clear</td>
<td>• Information packages</td>
</tr>
<tr>
<td></td>
<td>b) Understand and acknowledge participants’ expectations</td>
<td>• Verbal discussion, encourage questions and offer clear answers</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Ongoing reflection</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Inform participants of study findings</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Focus on and fulfil the aims of the study</td>
</tr>
</tbody>
</table>

**Assumed understanding**

The assumed understanding, between participant and researcher, inherent in ‘insider’ research has been identified as a challenge for data collection (Sprague, 2005). In a storytelling interview, the questions posed by the researcher are necessarily broad to
enable participant to share their experiences (Atkinson, 1998). However, assumed understanding between the ‘insider’ researcher and participants may encourage participants to omit information when sharing their stories. For example, participant comments such as; “You should know that” or “You know what I mean” were clear signifiers that something had been left unsaid and that clarification from the participant was needed. To achieve clarification we used probing questions such as: “Can you explain what you mean by ....” or “Could you give me an example?” to encourage participants to expand on what they actually meant rather than relying on what the researcher might have assumed they were referring to (McEvoy, 2001). This encouraged participant reflection and generally led to more detailed description of the experience.

**Ensuring analytic objectivity**

In sharing their stories, participants open their lives to scrutiny and critique, thus researchers have a responsibility to ensure the findings contribute to the development of knowledge (Creswell, 2007). There is suggestion that ‘insider’ research improves credibility as it enables the recognition and interpretation of subtleties to which ‘outsider’ researchers are not privy (Rooney, 2005). However, it is more likely that the tacit knowledge of the ‘insider’ poses a challenge during data analysis (O'Connor, 2004). Researchers’ experiences impact the knowledge they produce (Griffith, 1998), therefore steps need to be taken to minimise bias and ensure credibility. Further, it was important to ensure that the findings reflected the stories and experiences of the participants, rather than the experience of the ‘insider’ (Atkinson, 1998; Frank, 1997; Stanley & Wise, 1990). This necessitated a level of analytic objectivity. Strategies implemented to ensure analytic objectivity of ‘insider’ research included: researcher reflexivity and review of analysis by the ‘outsider’ researchers in the group.

*Researcher reflexivity*

Reflexivity involves an awareness and understanding of one’s own subjectivities in relation to the research (Hall & Stevens, 1991) and occurs throughout the research process (Olesen, 1994). This practice discourages presumption and encourages the researcher to seek clarification directly from participants (O'Connor, 2004). The
potential for critical reflexivity to minimise knowledge distortion and enhance credibility has made it a crucial component of qualitative enquiry (Burns, et al., 2012; Rice, 2009). In the writing of reports from this study, the researchers have used participants’ quotes to demonstrate how the data and findings are clearly linked.

The process of researcher reflexivity began early on as SB’s personal experiences, as a woman and provider of long-term foster care, provided the initial impetus for the study. This “pre-reflective process” enables the identification of personal biases and beliefs which may influence the analytic process (Dowling, 2006, p. 10). Prior to the study, SB reflected upon and wrote an account of her own story which was shared with the ‘outsider’ supervision panel. This strategy enabled the supervision team to understand SB’s position and encourage SB’s reflexivity throughout the study. This was particularly useful during data analysis as it enabled the research team to also identify areas of potential bias.

Journaling has been acknowledged as an effective means for personal reflection (Dowling, 2006; Hayman, Wilkes, & Jackson, 2012). Maintaining a journal throughout the study enabled SB to continually reflect on her own experiences and biases. This strategy was especially helpful during data collection as it was easily accessible and not time constrained. This meant SB could utilise the journal in preparation for and/or immediately after a participant interview. The following excerpt of SB’s journal, written shortly after an interview with a participant, demonstrates SB’s reflective processes; “When referring to herself in relation to the [foster] kids, she’s a mum/but when doing so in the context of the department, she’s a carer. How can she vacillate between the 2? Do I do that? And if so, why?” Further, because SB’s reflection was documented, she was able to revisit her experiences, thoughts and feelings as required.

Review by ‘outsider’ researchers

Review of the analytical process and findings by ‘outsider’ researchers also served to promote the credibility of the study. This necessitated ensuring accurate transcription, as the transcripts served as the basis for analysis and discussion with the entire research team. As qualitative data analysis is an iterative process, SB, who undertook initial data analysis, was able to present and discuss emerging themes with
the research team. The experienced ‘outsider’ researchers on the team regularly reviewed the analysis undertaken by the ‘insider’ doctoral candidate. This process ensured a critically analytic perspective was maintained (Miles & Huberman, 1994; Slevin & Sines, 2000)

**Dealing with emotions as an ‘insider’**

Characteristically dialogic, storytelling necessitates the development of an interdependent relationship between researcher and participant (Atkinson, 1998; Frank, 2000). Consequently, researchers using a storytelling design need to be able to assess the impact of the research on both the participants and themselves (Dickson-Swift, James, Kippen, & Liamputtong, 2007). The exploratory nature of our study made it difficult to predict the information participants would disclose. Given her ‘insider’ position, this research topic was particularly sensitive to SB, and as such, there was potential for significant emotional impact (Dickson-Swift, James, Kippen, & Liamputtong, 2008). Acknowledging this potential, prior to data collection, was the first step towards managing any emotional impact.

Debriefing is an effective strategy researchers can use to deal with the emotional impact experienced as a result of the research process (Beale, Cole, Hillege, McMaster, & Nagy, 2004; Dickson-Swift, et al., 2008). Debriefing occurs both formally and informally, facilitates reflection and helps to minimise detrimental effects to the researcher’s well-being (Dickson-Swift, et al., 2007). During our study, SB experienced a range of emotions in response to hearing participant’s stories. As a doctoral candidate, SB was able to formally debrief during regularly scheduled supervision meetings. As experienced qualitative nurse researchers these supervisors were well equipped to assist SB to process her emotions in relation to the study. Additionally, taking care to ensure participant confidentiality and anonymity, SB was able to debrief informally with fellow research students and peers. Debriefing in these ways assisted SB to articulate and process her journey as an ‘insider’ during the study.

**Participant expectations**

Researchers have a responsibility to clearly explain the aims of the study and how the findings will be used (Houghton, Casey, Shaw, & Murphy, 2010). The
researcher’s goal may be the dissemination of findings through presentation and publication, an often slow process to which participants are not privy. Conversely, participants may desire more immediate and tangible results such as changes in policy and practice which have a direct impact on their daily lives. While the challenge of differing expectations between researcher and participant may exist within all research methodologies, it has been suggested they are amplified in the context of ‘insider’ research (Yakushko, et al., 2011). This may be due to the ‘insiders’ own perception rather than over pressure exerted by participants. Strategies to manage participants’ expectations include: making the aims and use of study outcomes clear and understanding and acknowledging participants’ expectations.

**Make the aims and use of study outcomes clear**

In keeping with the storytelling design, our goal was to produce knowledge with the potential to improve marginalised women’s lives (Fine, Weis, Weseen, & Wong, 2003). The participants in our study were informed of this broad aim at the first point of contact, immediately prior to data collection and again post interview. However, as is common with qualitative research the exploratory nature of our study made it difficult to predict the specific findings or their implications (Houghton, et al., 2010). At times, participants were frustrated by this lack of specificity and some suggested issues on which the research team could focus. One participant highlighted her suggestions stating: “So there, that’s an issue, as well” (Darla). Generally, participant frustration was soothed when participants were reminded of the overall aim of the study and SB’s ‘insider’ position.

**Understanding and acknowledging participants’ expectations**

Significant efforts were made to deconstruct the traditional passive role of the research participant and establish a collaborative, non-exploitative, reciprocal relationship (Creswell, 2007). This was achieved, in part, through disclosure of SB’s ‘insider’ position. However, although she was acknowledged as ‘one of their own’, SB was not regarded as an equal by participants. Participants recognised SB as an ‘insider’ with means and influence beyond their own capacity. As such, participants expressed specific expectations of SB to facilitate change in a way that they themselves could not. For example, after talking about her frustration with the foster
care system Ana stated; “But I can't change it. Maybe you can change it; maybe you can sort the program out”.

As an ‘insider’ researcher and member of a marginalised group, it is easy to lose sight of one’s power and privilege relative to the study population (Yakushko, et al., 2011). The responsibility that accompanies participants’ expectation of the ‘insider’ researcher can be personally challenging and, at times overwhelming. Ongoing reflection can assist the ‘insider’ to acknowledge and understand participants’ expectations. This will assist the ‘insider’ to concentrate on the research, focus on the study aims and ultimately complete the project.

**Conclusion**

The ‘insider’ researcher position had significant benefits for our study and could be seen to facilitate recruitment, aid rapport and enable collaboration resulting in the generation of stories rich in content. Despite the benefits, the researcher’s ‘insider’ position brought a number of challenges which are identified in this paper as: assumed understanding, ensuring analytic objectivity, dealing with emotions as an ‘insider’ and participants’ expectations. Seven strategies were implemented to manage these challenges, namely: participant probing, researcher reflexivity, review by ‘outsider’ researcher, identifying the risk, debriefing, making the aims and use of study outcomes clear, and acknowledging participants’ expectations. These rigorous strategies proved helpful in ensuring the credibility, audibility and transferability of our findings.
References


West, C., Stewart, L., Foster, K., & Usher, K. (2012). Accidental insider: Living the PhD study. *Collegian (Royal College of Nursing, Australia)*.


CHAPTER FIVE: FINDINGS

Not flesh of my flesh, nor bone of my bone,
but still miraculously my own.

Never forget for a single minute,
you didn’t grow beneath my heart, but in it.”

~ Fleur Congley Heyliger

INTRODUCTION

The above poem above captures the essence of the study findings, which are presented over the following four chapters. This chapter provides a brief discussion of the study participants and their individual contexts and identifies the three main themes, and corresponding sub-themes, that emerged from the data (Table 1, pg. 70).

PARTICIPANTS

Twenty women volunteered to share their stories of providing long-term foster care. Three participants (15%) responded to the media releases placed in local newspapers. The majority of participants (n=13; 65%) were recruited via word of mouth, either by another participant or through the Australia Foster Care Association. A small number of participants became aware of the study through the fliers and online advertisements (n=4; 20%). Interviews were conducted face-to-face (n=9, 45%), over the telephone (n=9, 45%) and via the computer (n=2, 10%). Oral interviews lasted

4 Retrieved November 17 2012 http://angelsofloveadoption.org/poems/
between 47 and 112 minutes in duration (mean 71 minutes). Computer mediated interviews were collated into a single digital file for each participant and contained 1562 and 1930 words respectively. Participant recruitment and data collection continued until saturation was achieved. No participants withdrew their consent after initially agreeing to participate in the study.

A brief synopsis of each woman’s story is presented below to aid the readers understanding of their individual contexts. Pseudonyms have been used throughout this thesis and related publications and presentations to provide anonymity to participants, their families and the children in their care. These pseudonyms were randomly assigned and are not intended to resemble the individual women in any way.

Ana was a 73 year old widow at the time of her interview. She is the mother to seven biological children and had provided long-term foster care to three Indigenous Australian girls. Prior to retirement, Ana had worked for several years as a trained mothercraft nurse. Over the course of her adult life, Ana had provided short-term foster care for more than 20 children. During her interview, Ana explained the children of one of her long-term foster daughters had been identified as “at risk” and subsequently removed from their parents’ home. Ana referred to these children as her grandchildren and was trying to gain custody of them.

Beth was a 55 year old divorcee and mother of two grown biological children. At her interview Beth was in the process of trying to adopt the child for whom she had been providing care for the last five years. Although this child came to her on a short-term basis, his requirements for care changed to long-term. In her interview, Beth explained the child’s cultural heritage differed to her own and thus it was deemed inappropriate, by the system, for her to remain his foster carer on a long-term basis. This child remained in Beth’s care for a period of four years while efforts were made to identify a more suitable long-term foster carer. When a potential long-term carer was finally found, Beth fought to keep the child in her care and was successful. Prior to this, Beth indicated she had provided short-term foster care for more than 30 children.

At the time of her interview, Carol had been providing foster care for over 20 years. The biological mother to two grown children, this 55 year old divorcee had also
previously adopted two long-term foster children. At the time of the study, Carol was providing long-term foster care to three adolescents who she was trying to adopt. Carol had also, on occasion, provided short-term foster care.

In addition to their one biological child, 57 year old Darla and her husband had raised three long-term foster children. She affectionately referred the children of her long-term foster children as her grandchildren. Passionate about foster care, Darla indicated she had also provided short-term and respite care for “hundreds” of children.

Felicia was a married 43 year old woman with three biological children. At the time of her interview, Felicia explained that her first long-term foster placement was rescinded after two years when the children’s biological grandparents filed for custody. The loss of those children prompted Felicia and her husband to only provide short-term care for a number of years. However, at the time of the study they were providing long-term foster care to six children. In addition, they had applied for physical custody of the infant daughter of their eldest long-term foster son. At the time of the interview the infant was living with another foster carer.

Unable to have biological children of their own yet still desiring a family, Gloria and her husband became foster carers. At the time of the study, Gloria was providing long-term foster care for two boys. Both had come into her care as infants and were now adolescents. Prior to this, Gloria had provided short-term foster care to adolescents.

A small business owner, 46 year old Helen had initially begun providing long-term foster care to a sibling group of three children with the help of her partner. During her interview, Helen explained an allegation of abuse was made against her partner which led to the removal of the children from their care. In order for her to regain custody of the children while the allegation was investigated, Helen was told her partner had to leave the residence. Ultimately the allegation was unfounded, but asking her partner to leave for the duration of the investigation led to the termination of their relationship. Helen was left as the sole carer for the children and after two years she found herself unable to cope. At the time of the interview, Helen was still caring for the youngest sibling on a long-term basis and providing regular respite
care for the elder two siblings who had been placed with another foster carer. Helen had remained single and had no biological children of her own.

Irene was a 55 year old married woman with no biological children. Initially, Irene and her husband had provided short-term foster care. When Irene and her husband were asked to care for a sibling group of five children on a long-term basis, they ceased to provide short-term care. At the time of her interview, Irene was in the process of helping her eldest long-term foster daughter to plan her wedding.

Jodi was a 41 year old married long-day care provider. After multiple unsuccessful attempts to conceive her own child using invitro fertilization, Jodi and her husband became long-term foster carers. After becoming foster carers, Jodi decided to try conceiving one last time. At the time of the study, Jodi and her husband were caring for three long-term foster children as well as their own biological child.

Sixty-two year old Karen became a foster care following the encouragement of her adult biological daughter. At the time of her interview she was caring for two children; one on a long-term basis whom she was trying to adopt and the other on a short-term basis.

Laura was 65 years old, married and the mother of four biological children. She had 21 years experience providing both long- and short-term foster care. At the time of data collection Laura was providing long-term foster care for three children.

Mary was a 45 year old divorcee and the mother of two biological children. She had ten years experience providing foster care. At the time of her interview, Mary was caring for one child on a long-term basis who had been placed into foster care by his biological parents due to his significant physical and developmental disabilities. As such, his biological parents retained some legal parental authority. Mary also had one short-term foster child in her care.

At the time of her interview Natalie had been providing long-term foster care for nearly eight years. Fifty-three, married and the mother of three biological children, Natalie had originally intended to provide only short-term foster care. However, when the care requirements changed from short-term to long-term for the child in her care, Natalie became a long-term carer. This is the only child for whom Natalie has provided foster care.
Fifty-nine year old Olivia was married and the mother of one biological child. Initially, Olivia and her husband provided respite care, followed by short-term foster care. At the time of data collection they had been caring for two children on a long-term basis for a period of five years. They also had one short-term foster child living in their home.

Paula was a 59 year old woman with six biological children. She had provided both short- and long-term foster care for several years. However, following an unfounded allegation of abuse made against her, she made the decision to no longer provide short-term foster care. At the time of her interview, Paula was providing long-term foster care to four children.

At the time of her interview Rachel was a 63 year old widow and the mother of four biological children. She had spent over 15 years caring for four children in long-term care; three were still living with her, the eldest had grown and left her care but remained in very close contact with her and the family. During this time she also cared for 44 children on a short-term basis.

Tracy was 56 years old and had five biological children. Tracy and her husband have cared for six children needing long-term foster care, three of whom they have since legally adopted. She indicated that over the years that had also provided short-term and crisis care to more than 200 children.

Uma was 42 years old, married and the mother of two teenage biological children. At the time of data collection, Uma and her husband had been providing long-term foster care for two boys, who were full biological siblings, for a period of three years.

Seventy-two year old widow, Vicki, had 44 years experience providing foster care. Prior to his death, Vicki and her husband raised three biological children and one long-term foster child. Over the years Vicki had provided short-term foster care to “countless” children.

Yvonne was a 52 year old single woman and mother of two biological children. She had 12 years experience providing both short- and long-term foster care. At the time of her interview, Yvonne was caring for two children on a long-term basis.
Overview of the themes

Three major themes arose from the data: ‘mothering revealed’; ‘seeking recognition, stigma and misconceptions’; and ‘mothering in the system’. Each of these themes, the related sub-themes and the corresponding publication are presented in Table 1 (pg. 70). These peer-reviewed publications comprise chapters six (pg. 71), seven (pg. 89) and eight (pg. 117) of this thesis.
<table>
<thead>
<tr>
<th>Theme</th>
<th>Sub-theme</th>
<th>Publication</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mothering revealed</td>
<td>A mother’s commitment: <em>I’m in it for the long haul</em></td>
<td>Paper 3</td>
</tr>
<tr>
<td></td>
<td>A mother’s struggle: <em>It’s easy to take the blame</em></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Seeking recognition: Stigma and misconceptions</td>
<td>Labelling: <em>I don’t like calling myself a carer</em></td>
<td>Paper 4</td>
</tr>
<tr>
<td></td>
<td>Separation: <em>You know who your true friends are... the ones who stick with you</em></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Status loss and discrimination: <em>You’re second rate</em></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Power dynamics: <em>Powerless</em></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mothering in the system</td>
<td>Ongoing scrutiny: <em>Living in a glass bowl</em></td>
<td>Paper 5</td>
</tr>
<tr>
<td></td>
<td>Broken promises: <em>They tell you you’ll get lots of support, you get none</em></td>
<td></td>
</tr>
</tbody>
</table>
CHAPTER SIX: MOTHERING REVEALED

PUBLICATION

Paper 3:


RELEVANCE TO THESIS

This paper is based on the first major theme ‘mothering revealed’. This theme consists of three sub-themes (Table 2, below) which reveal participants maternal self-perceptions and illuminate how these women characterised and justified themselves as mothers. Specifically, this theme established that participants perceived themselves as mothers, rather than carers, to the long-term foster children in their care.

TABLE 2. Theme one: Mothering Revealed

<table>
<thead>
<tr>
<th>Sub-themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>A mother’s commitment: I’m in it for the long haul</td>
</tr>
<tr>
<td>A mother’s love: To be a mum you’ve got to have the heart</td>
</tr>
<tr>
<td>A mother’s struggle: It’s easy to take the blame</td>
</tr>
</tbody>
</table>
Perceptions of Long-Term Female Foster-Carers: I’m Not a Carer, I’m a Mother

Stacy L. Blythe*, Elizabeth J. Halcomb, Lesley Wilkes, and Debra Jackson


*Correspondence to Stacy L. Blythe, RN, BN(Hons), University of Western Sydney, School of Nursing and Midwifery, Family and Community Health Research Group, Locked Bag 1797, Penrith, NSW 2751, Australia. E-mail: s.blythe@uws.edu.au

Abstract

The need for foster-carers has significantly increased in recent decades as growing numbers of children are in need of out-of-home care. However, despite their importance to the foster-care system, the foster-carer role is imbued with ambiguity. The perceptions and expectations of the foster-carer role differ greatly between child protection workers, the children in foster-care, the wider community and foster-carers themselves. This paper seeks to provide insight and understanding of provision of long-term foster-care from the perspective of the female carer. The findings presented in this paper are drawn from a larger doctoral study that examined women’s experiences of providing long-term foster-care in Australia. Analysis revealed participants did not perceive themselves as foster-carers, but rather viewed themselves as mothers to the long-term foster-children in their care. This understanding has the potential to: inform both policy and practice in relation to long-term foster-care; provide useful recruitment information;
and possibly serve to augment relations between child protection workers and women who provide long-term foster-care.

**Keywords:** Long-term foster-care, foster-carer, mothering, families, fostering

**Accepted:** March 2012

**Introduction**

Foster-carers have a fundamental, but ambiguous, role within the community. Although not biologically related or legally empowered as parents, foster-carers provide a family environment within their own homes for children who are unable to remain with their birth families (Maluccio et al., 2006). In recent decades, the need for foster-carers has significantly increased, on an international scale, as growing numbers of children are entering care (Colton et al., 2008). This has resulted in a marked increase in research attention towards foster-carers (Sellig, 2006; Blythe et al., 2011).

The ambiguity surrounding foster-carers has long been apparent in the literature (Rhodes et al., 2003). Within the literature, the terms ‘foster-carer’ and ‘foster parent’ are often used interchangeably (Mietus and Fimmen, 1987). Indeed, some studies refer specifically to male and female providers of foster-care as ‘foster fathers’ or ‘foster mothers’ (Smith and Smith, 1990; Inch, 1999). The use of such terminology is not without controversy, as it is considered, by some, to be politically inappropriate and disparaging towards biological parents (Eitzen and McIntosh, 2004; Thomson, 2007). Other authors assert that recognition of the parental role foster-carers play in the lives of foster children does not negate or diminish the importance of the birth parents (Riggs et al., 2009b).

The child protection system in Australia is complex; administrated by both government departments and private organisations; and governed by legislations, policies and protocols that vary between each state and territory (Australian Institute of Health and Welfare, 2011). This system is responsible for protecting and maintaining the health and welfare of children in Australia. The positioning of foster-carers within this system is ambiguous (Riggs et al., 2007). Within the literature, foster-carers have been variously described as both clients of, and colleagues to, child protection workers; employees and volunteers; substitute parents and specialised care providers (Mietus and Fimmen, 1987; Rhodes et al., 2003; Thomson, 2007). This lack of consistency in language within the literature is reflective of the ambiguity surrounding the foster-carer role in the wider community. Moreover, there is significant disagreement amongst foster-carers themselves regarding their role. Some foster-carers are calling for the development of a professional identity that recognises them as members of the child protection team (Butcher, 2005; Smyth and McHugh, 2006; Kirton et al., 2007b). Conversely,
other foster-carers reportedly reject the idea of a professional identity (Butcher, 2004; Smyth and McHugh, 2006; Kirton et al., 2007a). Those who reject the professional identity identify themselves in terms of their place in the lives of the foster children, referring to themselves as parents within a family rather than professionals within the child protection system (Smyth and McHugh, 2006; Riggs et al., 2007; Broady et al., 2009). The role ambiguity within society creates a difficult milieu for foster-carers.

Foster-care is generally provided on an immediate, short-term or long-term basis. Emergency foster-care is used for children needing immediate care and generally lasts for a few weeks (Colton and Williams, 2006). Short-term foster-care may last up to a few years, during which time reunification with the biological family is the primary goal (Colton and Williams, 2006). When reunification with the biological family is deemed to be untenable or unachievable, children are placed into long-term foster-care until they reach the age of maturity (Schofield, 2002). Although terminology and duration vary between child protection systems, both within Australia and internationally (Australian Institute of Health and Welfare, 2011; Sellick, 2011), for the purpose of this paper, the terms ‘emergency’, ‘short-term’ and ‘long-term’ will be used to describe the different types of foster-care.

There is emergent evidence to suggest that foster-carers’ understanding of their role may differ according to the type of foster-care they provide (Smyth and McHugh, 2006; Riggs et al., 2007, 2009b). In their investigation of 450 foster-carers in Australia, Smyth and McHugh (2006) identified that those who provided long-term foster-care were less supportive of a professional identity compared to those who provided short-term foster-care. Additionally, providers of long-term foster-care have been found to identify themselves as parents (as opposed to paid carers) and prefer to communicate in terms that acknowledge this relationship (Riggs et al., 2007, 2009b; Blythe, et al., 2011).

Although the literature investigating the perceptions and experiences of foster-carers is increasing, little is known about women’s experiences of providing long-term foster-care or how they characterise their role (Broady et al., 2009; Daniel, 2011). Studies have demonstrated the provision of foster-care to be heavily gendered, with the majority of care being provided by women (McHugh et al., 2004; Grimm and Darwall, 2005; Siminski et al., 2005); thus, an understanding of the female perspective is imperative.

Method
Design

The findings presented in this paper are drawn from a larger doctoral study that examined women’s experiences of providing long-term foster-care in Australia. A qualitative storytelling approach, informed by feminist
principles, was used to inform the data collection. This methodology was selected as it values subjective knowledge, places importance on women’s individual experiences (Jackson et al., 2005) and recognises ‘meaning’ rather than ‘truth’ as a legitimate end product (Bailey and Tilley, 2002). Shaped within a personal, social, historical and cultural context, stories are more than a chronology of life events; they are imbued with personal meaning (Polkinghome, 1995; Gaydos, 2005). It is through stories that we shape our identity and make sense of our world (Smith and Sparkes, 2006).

Participants

Women who provided long-term foster-care were the focus of this study. Multiple strategies were used to access this population, including a media release, recruitment posters, web-based advertisements and snowballing. Interested parties were invited to contact the first author via telephone or e-mail. Subsequently to initial contact, participants received an information package, through the postal service or electronic mail, which gave an overview of the study, eligibility criteria and interview process. It also delineated the voluntary nature of research and the ability to withdraw from the study at any time without penalty.

Data collection

Data were collected in 2010, using semi-structured interviews that posed broad questions and enabled participants to convey the story they wanted heard, in their own words. To enable the inclusion of participants with significant child-care responsibilities, multiple interview techniques were employed. Interviews occurred either face to face (n = 9), over the telephone (n = 9) or electronically using e-mail (n = 2).

Ethical considerations

The study was approved by the relevant Institutional Ethics Committee. Informed consent was gained prior to collecting data. Recruitment ceased when data saturation was achieved (Grbich, 2007). Pseudonyms have been used to ensure confidentiality of both participants and the children in their care.

Data management and analysis

All audio-recorded data were transcribed and entered with text data into computer-assisted data analysis software (NVivo9™), which was used to
aid in the management and analysis of data. Data accuracy was achieved by auditing transcripts against recorded interviews (Halcomb and Davidson, 2006). Analysis was an iterative process, requiring familiarity with the data, which was achieved by reading and re-reading the data as well as listening to audio-recorded data several times. Once immersed in the data, analysis was influenced by techniques suggested by Anderson and Jack (1991), who emphasise the importance of women’s statements that are self-evaluative, self-reflective and contradictory of self. Data were then coded and grouped into broad themes and examined for relevant sub-themes.

Findings

Analysis of the complete data-set revealed three major themes. These have been termed as: (i) Mothering revealed; (ii) Seeking recognition; and (iii) Mothering in the system. Each of these major themes had a number of sub-themes. Given the extent of the data, this paper reports only the content of the first major theme, Mothering revealed, and its three sub-themes: (a) A mother’s commitment: I’m in it for the long haul; (b) A mother’s love: To be a mum you’ve got to have the heart; and (c) A mother’s struggle: It’s easy to take the blame. The findings revealed in the other two major themes are reported elsewhere (Blythe et al., 2011).

Participants

Twenty women volunteered to share their stories of providing long-term foster-care (see Table 1). The majority of participants were residing in New South Wales ($n = 14$) at the time of data collection. The remaining participants represented Victoria ($n = 4$), South Australia ($n = 1$) and the Australian Capital Territory ($n = 1$). The participants had between three and forty-four years’ experience providing foster-care. In total, participants provided long-term foster-care to fifty-four children. In addition to long-term foster-care, seventeen women had also provided short-term foster-care.

Mothering revealed

Participants’ stories revealed a clearly perceived distinction between the responsibilities of short-term and long-term foster-care. This distinction could be seen to influence the participant’s maternal self-perception. Three participants revealed this distinction influenced their decision to only provide long-term foster-care. The remaining participants ($n = 17$) contrasted their experiences of providing both long-term and short-term foster-care to demonstrate the perceived differences. Though participants
Table 1 Participant characteristics

<table>
<thead>
<tr>
<th>Participant pseudonym</th>
<th>State of residence</th>
<th>Age</th>
<th>Experience providing short-term foster-care</th>
<th>Number of long-term foster children</th>
<th>Number of biological/adopted children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anna</td>
<td>NSW</td>
<td>73</td>
<td>Yes</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td>Beth</td>
<td>NSW</td>
<td>55</td>
<td>Yes</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Carol</td>
<td>NSW</td>
<td>55</td>
<td>Yes</td>
<td>3*</td>
<td>4</td>
</tr>
<tr>
<td>Darla</td>
<td>ACT</td>
<td>57</td>
<td>Yes</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Felicia</td>
<td>NSW</td>
<td>43</td>
<td>Yes</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>Gloria</td>
<td>SA</td>
<td>48</td>
<td>Yes</td>
<td>2</td>
<td>None</td>
</tr>
<tr>
<td>Helen</td>
<td>NSW</td>
<td>46</td>
<td>Yes</td>
<td>1</td>
<td>None</td>
</tr>
<tr>
<td>Irene</td>
<td>NSW</td>
<td>55</td>
<td>Yes</td>
<td>4</td>
<td>None</td>
</tr>
<tr>
<td>Jodi</td>
<td>NSW</td>
<td>41</td>
<td>No</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Karen</td>
<td>NSW</td>
<td>62</td>
<td>Yes</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Laura</td>
<td>VIC</td>
<td>65</td>
<td>Yes</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Mary</td>
<td>NSW</td>
<td>45</td>
<td>Yes</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Natalie</td>
<td>NSW</td>
<td>53</td>
<td>No</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Olivia</td>
<td>VIC</td>
<td>59</td>
<td>Yes</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Paula</td>
<td>NSW</td>
<td>59</td>
<td>Yes</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>Rachel</td>
<td>NSW</td>
<td>63</td>
<td>Yes</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Tracy</td>
<td>NSW</td>
<td>56</td>
<td>Yes</td>
<td>2*</td>
<td>7</td>
</tr>
<tr>
<td>Uma</td>
<td>NSW</td>
<td>42</td>
<td>No</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Viki</td>
<td>VIC</td>
<td>72</td>
<td>Yes</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Yvonne</td>
<td>VIC</td>
<td>52</td>
<td>Yes</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>

* Indicates participant also adopted previous long-term foster children.

were not biologically or legally mothers to the children for whom they provided long-term foster-care, all identified themselves as mothers. Carol explained: ‘… to me I’m not a [foster-] carer, I’m a mother.’

Participants did not extend this perception of the maternal role to other foster children in their care. For those children in short-term, crisis and/or respite foster-care, participants described themselves as foster-carers. This relational difference was partially due to the responsibilities participants associated with providing short-term foster-care. Yvonne clarified:

... the court makes these decision about when the children go home and where the children are going and I see that as part of your role as a [short-term] foster carer to be facilitating that as best as you can.

Participants identified the responsibility of a short-term foster-carer to include preparing the children for either reunification with their birth families or transition to a long-term placement. Given the notion of future reunification or transition, participants described that to assume a mothering role was inappropriate. Conversely, participants specified their responsibility as a long-term foster-carer to involve embracing the children into their own families. Felicia explained: ‘In short-term you’re preparing the child for their long term placement. Where long-term—you’re it. So you’re mum… … Your family becomes their family.’
The nature of the foster-care system is such that a child’s care requirements can change and, sometimes, foster-carers are asked to keep short-term foster children on a long-term basis. When Yvonne reflected on her own experience of this, she stated: ‘There was a shift.’ She went on to explain how she transitioned emotionally and psychologically from foster-carer to mother:

You might say, well, I am too attached to her [foster child] but that’s because the idea’s been put in my head. [The department] have actually asked me would I do permanent care for her you see. I guess because I’ve said ‘Yes, I would like to,’ and I’ve made that decision that I’m responding to her... and so I think I feel extra, extra protective of her and maternal towards her (Yvonne).

Participants’ stories did not describe what they do as long-term foster-carers; rather, their stories defined who they are as mothers. This maternal self-perception dominated participant’s stories and it is from this perspective that they discussed their lives. Rachel stated: ‘It is my life... it is who I am.’ Based on this understanding, the following three sub-themes reveal how participants characterised and understood themselves as mothers.

**A mother’s commitment: I’m in it for the long haul**

Generally, foster-care is time-limited in that, when care orders end or children in foster-care reach the age of maturity, the children become legally responsible for themselves. Although programmes and services are available during this time of transition (Hill *et al.*, 2010; Collinsa and Ward, 2011), effectively, the foster-carer’s mandate to provide care for the children is rescinded. Despite this, participants articulated their commitment to long-term foster children as life-long and clearly anticipated their maternal caring role to evolve and continue as the children matured into adults:

People often say what happens when they turn 18 and I say: The same thing that happens when your biological children turn 18, they get to do what they want but they’re still your child. It makes no difference to me when they turn 18 as to what they do or where they go, as far as I’m concerned this is still their family and they have the rights of every other child in the family (Tracy).

Within Western society, it is expected that children will grow up and eventually leave the family home, but it is not customary for children to grow up and leave the family. Rather, as adult children form committed relationships and become parents themselves, the family expands. Given this expectation, and participants’ maternal self-perception, it was not surprising to find some participants not only anticipated continuing their maternal role in the lives of their adult foster children, but also spoke of fulfilling the role of grandmother to their foster children’s children. Irene remarked: ‘One day I might have a grandchild from one of these four, if I’m lucky.’
Foremost in participants’ stories was their commitment to the children. Most participants described a willingness to accept the good with the bad, celebrating and lamenting with and for the children. Although some participants revealed caring for the children was often arduous due to the children’s complex behavioural, developmental and psychological needs, their commitment to the children was unwavering. When reflecting on her own commitment, Gloria commented:

… it’s been bloody hard work but I guess we went into these two boys [thinking] okay, we’re going to see them through and no matter what is required, we’re going to do the best we can to make sure that happens.

A mother’s love: to be a mum you’ve got to have the heart

Although the participants acknowledged that caring for children, even on a temporary basis, carried with it a natural emotive element, they described the foster-carer–child relationship as constrained. This level of constraint enabled participants to relinquish the children in short-term foster-care; Natalie explained: ‘… when he was in short-term care I felt like I had a little box around my feelings.’ However, in assuming a mothering role, participants emotionally connected with the children in a way they could not in providing short-term foster-care:

… the likelihood that they’re going to stay [long-term], it does change the way that you feel about them. Well for me it does; it definitely changes the way that … you allow yourself to be a lot more connected with them and love them more. I think in a more intimate way (Yvonne).

Many participants described making deliberate, consistent efforts to emotionally engage the children. Rebuff and rejection from the children were common experiences as participants endeavoured to establish maternal–child bonds. Despite their position of emotional vulnerability and frustration, participants were patient, prioritising the children’s emotional well-being before their own, allowing the bond to form gradually at a pace set by the children:

But I used to think, am I ever going to break through with this child? You know, what can I do? But I knew that I could not force myself. … Eventually, after staying back and just doing it at a distance she finally let me through (Carol).

The reciprocal nature of the mother–child dyad carries with it desires and needs of both the child and the mother. Similarly to biological and adoptive mothers, most participants described their desire to bond with the children, in a way they could not when providing short-term foster-care, and found fulfilment and satisfaction when that bond occurred. However, the time and effort it took to form intimate maternal relationships with the children surprised a few participants:
It didn’t happen as we kind of just thought it would, you really have to work at it. You seem to be forever looking for it and hoping it is reciprocated and it takes a long time for that to happen (Uma).

Once established, the mother–child dyad allowed participants to understand the children’s individual needs, desires and struggles. Consequently, several participants described their understanding of the children to be superior to others, including those agencies legally responsible for the children:

I feel, you know, as their mother, I can see where their heart’s cry is, and that’s what I would like to do—not to have a department who really doesn’t know these kids, doesn’t put time into these kids, doesn’t know how they tick, how they feel, the stresses they’re under… If they [the department] really knew what made them [the foster children] tick, it would be a totally different issue (Carol).

A mother’s struggle: it’s easy to take the blame

Generally, participants set high maternal expectations of themselves. Further, some participants expressed a desire to make up for any parental deficits the children may have experienced prior to entering care. This meant more than just providing a safe, nurturing environment moving forward and incorporated creating an environment that could facilitate healing. However, despite participants’ good intentions and best efforts, at times, the children continued to struggle. When this happened, many participants experienced anxiety, self-doubt and guilt:

It makes you feel perhaps inadequate, like I haven’t put in enough effort sometimes maybe. I think to keep it in perspective, I know they [the foster children] know they’re loved and I know that they have a stable life [now]. That the consistency is there, although you do feel like they’ve missed something. It’s easy to take the blame (Uma).

Children in foster-care often experience negative social, emotional, psychological, behavioural, educational and physical difficulties (Teicher et al., 2003). Mothering children with such complex needs presented numerous challenges for many participants; however, this did not assuage participants’ self-critique. Rather, participants questioned their maternal ability when their efforts appeared ineffective:

So you think you’re going to get this child and it may not bond to you, but eventually it will and it’s not hard work and as long as you stick it out basically it will happen… in the meantime the child tells you it hates you, wants to hurt you, is a screaming mess in the corner foaming at the mouth, just having a tantrum and you’re standing there going well, I don’t know what to do (Uma).
High self-imposed maternal expectations and harsh self-critique negatively impacted on many participants’ health, causing anxiety, loss of sleep and fatigue:

I get to a certain point then, like I was not sleeping well either and I’m waking up in the middle of the night, I’m awake for two hours just worrying about stuff. So then it has this cumulative effect that can be quite eroding (Gloria).

The experience of self-doubt, anxiety and guilt in relation to their mothering role was not described by participants as unusual or out of the ordinary. Rather, such experiences were explained to be a natural part of being a mother. Uma stated: ‘I think mums always carry the guilt.’

Discussion

This doctoral project set out to explore women’s experiences of providing long-term foster-care. The sample size and selection process were in line with qualitative methodological standards and appropriate for the aim of this study (Grbich, 2007). However, this sample does not reflect the experiences or perspectives of cultural minority groups, as the majority of participants (n = 19) had an Anglo-Australian heritage. Given these limitations, these findings are not generalisable; however, their similarity to extant literature confirms and supports their transferability (Grbich, 2007). The findings presented in this paper resonate with the work of Riggs et al. (2007, 2009b, 2010), which found that providers of long-term foster-carers identify themselves as having parental (rather than paid carer) relationships with the children and expressed a desire to have those relationships recognised and acknowledged.

The women in this study identified themselves as mothers to the long-term foster children in their care. Broadly stated, the goal of foster-care is to provide children with a stable family-like environment conducive to their healthy development (Ponciano, 2010). Optimally, foster-care has the potential to enable attachment (Laybourne et al., 2008), facilitate healing (Riggs et al., 2009a) and provide a secure base from which children can draw strength and develop resilience (Schofield, 2002; Schofield and Beek, 2005). Further, research has demonstrated that foster-carers who are sensitive and committed are a key determinant in achieving optimal outcomes for foster children (Sinclair and Wilson, 2003). By positioning themselves as mothers, participants were able to commit to and love the children in a way they deemed those who took on a paid caring role could not.

Deeply entwined with notions of femininity and gender, motherhood is presumed to be the primary identity for women (Letherby, 1994; Arendell, 2000; Kruger, 2003) and is generally regarded as a state of being (Garey, 1999). However, despite the extensive body of literature about motherhood and mothering, there is still no agreed definition of what constitutes a
mother beyond the biological conception or legal adoption of a child. Irrespective of this, participants in this study identify themselves as mothers to children with whom they have no biological or legal link.

It is widely accepted that ‘the family’ is a social construct that evolves with time and, until recently, was generally formed through biological or legal means (Poole, 2005; Lynch, 2010). Traditionally, white, middle-class, married, heterosexual couples with biological children have been endorsed as the ideal Western family (Gilding, 1997; Padavic and Butterfield, 2011). However, numerous alternative forms of families that are not necessarily biologically or legally constructed, such as same-sex couples with children, are being acknowledged within Western culture (Jackson and Darbyshire, 2004/05; Weber, 2010). Conversely, although ‘the family’ itself is increasingly diverse, the traditional roles within the family (mother, father, children) have largely remained unchanged (Wilde, 2007; Padavic and Butterfield, 2011). The social salience of these roles make them the benchmark against which all new family identities are negotiated, measured and defined.

The influence of dominant mothering ideology, often referred to as ‘the good mother’ or ‘intensive mothering’, is apparent in participants’ stories (Arendell, 2000; Goodwin and Huppaz, 2010). Located within the context of the ideal Western family, this paradigm purports that mothering is child-centred, emotionally involving and time-consuming (Hays, 1996), necessitating self-sacrifice and resulting in self-blame and guilt when not wholly achieved (Gross, 1998). Despite criticisms, this ideal remains the normative standard by which all mothers in Western society are evaluated and evaluated themselves (Arendell, 2000; Goodwin and Huppaz, 2010). Although participants constructed their stories in line with this ideology, they did not illustrate themselves as ‘good mothers’ per se, but as mothers who struggled to attain this ideal.

Feminist theorists are largely responsible for ‘mother’ being viewed as a socially constructed and separate from that of ‘woman’ (Arendell, 2000; Goodwin and Huppaz, 2010). The notion that ‘mother’ is socially, rather than biologically or legally defined is increasingly prevalent in the literature (Bernstein, 2001; Ridgeway and Correll, 2004; Bemiller, 2010). Collett (2005) argues that a biographical event does not a mother make, but that a woman truly becomes a mother ‘by playing a socially defined, publicly visible role’ (Collett, 2005, p. 328). However, the idea of ‘mother’ as a social construct is not new. Rubin’s (1967) Theory of Maternal Role Attainment (MRA) posits motherhood does not coincide with the expectation or arrival of a child, but evolves as the woman achieves a sense of being and comfort in her role. Over the past several decades, the theory of MRA has been further refined and expanded to reflect a woman’s maternal self-perception as a dynamic, fundamental and inextricable part of the woman who chooses motherhood (Rubin, 1984; McBride and Shore, 2001; Nelson, 2003; Mercer, 2004). In essence, becoming a mother permanently changes a woman’s self-perception. Four participants
did not have biological or legal children of their own; their decision to provide long-term foster-care enabled them to choose motherhood and develop a maternal self-perception. Based solely on the relationships they constructed with their long-term foster children, these four women identified themselves as mothers. Conversely, sixteen participants had biological children of their own. Thus, at best, providing long-term foster-care afforded these participants the opportunity to maintain their maternal self-perceptions. However, theorists contend transference does not occur, but rather a new dimension of the woman’s maternal self-perception is created with each additional child (Rubin, 1967; Mercer, 2004).

Social policy and practice tend to favour biological and legal family links, disregarding socially constructed familial ties (Shdaimah, 2010; Padavic and Butterfield, 2011). Such a preference presumes emotional attachment coincides with biology or legality and is superior to any alternative. However, research demonstrating the importance of socially constructed family relationships to individuals’ health and well-being challenges this assumption (Eitzen and McIntosh, 2004; Schofield and Beek, 2005; Riggs et al., 2009b). Existing social policy and practice should be reviewed and amended to reflect the increasing diversity of society’s families and constituents.

Understanding the provision of foster-care from the carer’s perspective has important implications for the recruitment and retention of foster-carers. Feelings of exclusion and powerlessness have been articulated by foster-carers when describing their relationships with child protection workers and are identified as factors contributing to foster-carer attrition (Wilson et al., 2000; Sheldon, 2002; Gilbertson and Barber, 2003; Rosenwald and Bronstein, 2008). Child protection workers who have an understanding of the maternal self-perceptions of women providing long-term foster-care may be more sensitive to the women’s desire for inclusion in decision making for the children. Such inclusion has been cited in the literature as contributing to foster-carer satisfaction (Sanchirico et al., 1998).

It is clear that the participants perceived themselves as mothers to the long-term foster children in their care. However, questions remain regarding how these women maintain their maternal self-perception within a governing system that retains legal authority over the children, thus limiting their maternal autonomy. Moreover, how the children’s biological mother may impact upon these women’s maternal self-perceptions is unclear. It is also difficult to determine, from this small sample, whether the age of child at placement or the number of previous placements influenced participants’ maternal self-perceptions. Further investigations are needed to determine whether these maternal self-perceptions are widely held by women providing long-term foster-care within different countries and cultures. Studies should also seek to determine whether the children living in foster-care, other members of the foster family, professionals within the child
protection system and persons in the wider community perceive women who provide long-term foster-care as mothers.

As society increasingly accepts diversity in families, the roles within the family should also evolve beyond their traditional constraints and definitions. Perhaps the definition of 'mother' could be expanded within Western society to acknowledge socially constructed maternal–child relationships. Such a change in societal perception is necessary, as the body of evidence that suggests denying women who provide long-term foster-care the position of mother has a negative effect on their health and well-being is increasing (Broady et al., 2009; Blythe et al., 2011). Moreover, given the concomitant effects maternal well-being has on child well-being (Streisand et al., 2010), this societal change also has the potential to significantly impact the children in foster-care.

In conclusion, this paper has added to the literature on foster-carers and provided some insight into women's experiences and perspectives regarding the provision of long-term foster-care in Australia. Further research, in Australia and internationally, is needed to develop the body of knowledge relating to foster-caring and foster-carers from a range of perspectives. Such an understanding is essential to recruitment, retention and foster-carer satisfaction by facilitating the development of appropriate evidence-based strategies to support foster-carers.

Acknowledgements

The authors would like to thank the women who participated in this study. Stacy Blythe, the lead author, is a full-time Ph.D. Candidate and recipient of an Australian Postgraduate Award. This scholarship is funded by the University of Western Sydney.

References


CHAPTER SEVEN: SEEKING RECOGNITION:
STIGMA AND MISCONCEPTIONS

PUBLICATION

Paper 4:


RELEVANCE TO THESIS

This publication stems from the second theme ‘seeking recognition: stigma and misconceptions’ (Table 3). Using a framework provided by Link and Phelan (2001), this paper argues that women who provide foster care experience stigma and are consequently at risk for the numerous negative health implications.

TABLE 3. Theme two: Seeking Recognition: Stigma and Misconceptions

<table>
<thead>
<tr>
<th>Sub-themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Labelling: <em>I don’t like calling myself a carer</em></td>
</tr>
<tr>
<td>Stereotyping: <em>It’s because of all the bad publicity</em></td>
</tr>
<tr>
<td>Separation: <em>You know who your true friends are... the ones who stick with you</em></td>
</tr>
<tr>
<td>Status loss and discrimination: <em>You’re second rate</em></td>
</tr>
<tr>
<td>Power dynamics: <em>Powerless</em></td>
</tr>
</tbody>
</table>
The Stigma of Being a Long-Term Foster Carer

Stacy L. Blythe, RN, BN (Hons)¹, Debra Jackson, RN, PhD², Elizabeth J. Halcomb, RN, PhD¹, and Lesley Wilkes, RN, PhD¹

Abstract
Stigma is a powerful social phenomenon with insidious health implications. Understanding stigma as it applies to various populations is imperative for nurses as it enables nurses to enhance individual patient care and nurses are well positioned to influence both social and health care policies which may exacerbate the experience of stigma. This article is a report of a study to explore the experiences of women who provide long-term foster care. Interviews were conducted with 20 women who provided long-term foster care in Australia. Data were coded according to the components of stigma described by Link and Phelan (2001). Findings reveal participants rejected the label of foster carer to avoid the negative stereotype. When unable to conceal their foster carer label, participants experienced social isolation and status loss. Moreover, participants felt marginalized and disempowered within the governing systems.

Keywords
stigma, nursing, family nursing, foster care, foster carer

¹Family & Community Health Research Group, School of Nursing and Midwifery, University of Western Sydney, Sydney, Australia
²Faculty of Nursing, Midwifery & Health, University of Technology, Sydney, Australia

Corresponding Author:
Stacy L. Blythe, RN, BN (Hons), Family & Community Health Research Group, School of Nursing and Midwifery, College of Health & Science, University of Western Sydney, Locked Bag, 1797, Penrith NSW 2751, Australia
Email: s.blythe@uws.edu.au
Introduction

Stigma can be defined as an aspect or attribute which is deemed socially unacceptable, and deeply discrediting, and reduces those who are stigmatized “in our minds from a whole and usual person to a tainted, discounted one” (Goffman, 1963, p. 3). Numerous groups of people have been identified as stigmatized by society. These include, but are not limited to, persons with mental (Corrigan & Watson, 2007; Hasson-Ohayon, Levy, Kravetz, Vollanski-Narkis, & Roe, 2011), physical (Barg, Armstrong, Hetz, & Latimer, 2010; Esmail, Darry, Walter, & Knupp, 2010; Green, 2003), behavioral (Kauffman, Mock, & Simpson, 2007) and intellectual disabilities (Bernier, Mao, & Yen, 2010; Jahoda, Wilson, Stalker, & Cairney, 2010); obese persons (Lawrence, 2010; Teixeira & Budd, 2010); homosexuals (Baiocco, D’Alessio, & Laghi, 2010; Goldstein & Davis, 2010); and women with sexually transmitted infections (East, Jackson, Peters, & O’Brien, 2009; Merin & Pachankis, 2011). Stigmatized groups are known to have an increased risk of developing physical and mental health problems, such as hypertension and anxiety, when compared with nonstigmatized groups (Link & Phelan, 2006; Major & O’Brien, 2005).

Studies have found that foster carers feel powerless, undervalued, and without a voice (Gilbertson & Barber, 2003; Rosenwald & Bronstein, 2008; Wilson, Sinclair, & Gibbs, 2000). Furthermore, foster carers report feeling stigmatized by the media (Rosenwald & Bronstein, 2008; Sheldon, 2002), disrespected by agency personnel (Maclay, Bunce, & Purves, 2006; Whiting & Huber, 2007), ostracized by their peers (Kelley, 1993), and misunderstood by their own family and friends (Farmer, Lipscombe, & Moyers, 2005). Extant literature suggests that these poor relational experiences often leave foster carers feeling socially isolated (Farmer et al., 2005). Although existing literature reports elements of the stigma experience, a comprehensive analysis of the concept of stigma as it applies to women who provide long-term foster care is not evident in the literature. Using the theoretical framework proposed by Link and Phelan (2001), this article examines stigma as experienced and described by women providing long-term foster care and the implications for nurses and health professionals.

Conceptualizing Stigma

To date, the discourse regarding stigma has been largely guided by Erving Goffman’s (1963) seminal work Stigma: Notes on the Management of Spoiled
Identity. Multiple scholars across various disciplines have continued to refine the concept of stigma (see, for example, Crocker, Major, & Steele, 1998; Link & Phelan, 2001; Major & O’Brien, 2005; Yang et al., 2007). Despite continued refinement, there is variability within extant literature regarding the defining elements of stigma (Barreto & Ellemers, 2010). However, scholars do agree that stigma is a socially constructed phenomenon that is relationally and contextually specific and negatively affects those who are stigmatized (Crocker et al., 1998; Link & Phelan, 2001; Major & O’Brien, 2005; Yang et al., 2007).

Link and Phelan (2001) identify stigma to exist when five interrelated components converge within the context of power differential; these are labeling, stereotyping, separation, loss of status, and discrimination. The first component, known as labeling, is a process of social differentiation and identification. Human diversity results in a plethora of differences between individuals, the majority of which are deemed socially inconsequential. However, when deemed socially salient, that difference is assigned a label. The second component occurs when negative connotations are attributed to the label to form a stereotype. Generally stereotypical differences are socially significant and deemed undesirable. When the social distinction is made between labeled persons and the wider community, a separation occurs. This disconnection of the labeled individual from society is the third component. When people are labeled, stereotyped, and socially distanced from society, they experience a loss of social status and discrimination that leads to unequal treatment and opportunities.

Foster Care

Internationally, the need for out-of-home care has increased exponentially over the past decade as growing numbers of children and young people are entering care (Colton, Roberts, & Williams, 2008; Cox, Buehler, & Orme, 2002; Grimm & Darwall, 2005; McHugh, 2005). Foster care is where children and young people below 18 years who are no longer able to live with their family are placed with alternate caregivers on a short- or long-term basis (Victorian Department of Human Services, 2003). In Australia, a nation with a population just more than 22 million, there are more than 26,000 children and young people living in kinship or foster care (Australian Institute of Health and Welfare, 2011). Despite efforts to expedite decision making and minimize exposure to maltreatment, these children often experience negative social, emotional, behavioral, educational, and physical sequel (Teicher et al., 2003; Woods, 2008).
While the numbers of children entering foster care is increasing, there is a growing rate of foster carer attrition (Colton et al., 2008). Foster carers provide a family-like environment within their homes for children who are unable to live with their biological families. They assume the responsibility of providing a safe, stable, and nurturing home for children and young people entrusted to their care but are not considered the legal guardians (Marcellus, 2008). Despite being an essential component of the foster care system, relatively little is known about foster carers or their experiences (Grimm & Darwall, 2005; Triseliotis, 2002). This may be due, in part, to the foster care systems emphasis on the recipients (children and young people) rather than the providers of care and evidenced by the preponderance of foster care research focusing on children and young people in care. However, research is now available that has contributed to some beginning understandings of those who provide foster care (Grimm & Darwall, 2005; Rodger, Cummings, & Leschied, 2006; Siminski, Chalmers, & McHugh, 2005). These studies suggest that most frequently it is the female foster carer, married or single, who serves as the primary care giver (Grimm & Darwall, 2005; Rodger et al., 2006; Siminski et al., 2005).

Within the Australian context, each state and territory has its own child protection system guided by numerous legislative acts, policies, and protocols. Although variability exists between systems, each employs foster care as the primary form of out-of-home care (Bromfield & Higgins, 2005). Unlike residential care, where children are placed in a residential building with paid, rostered, or live-in staff, foster care is provided within the private homes of foster carers. Foster care also differs to kinship care as foster carers are initially strangers to the children, whereas kinship carers have either a preexisting friendship with, or are biologically or legally related to, the children. Foster care can be further differentiated according to the care orders determined by the judicial system. Crisis or emergency foster care generally refers to the need for immediate care for the children under a provisional order. Short-term or temporary foster care generally applies when the children require care for a longer amount of time while their biological families attend to the issues which resulted in the need for foster care. Long-term or permanent foster care refers to judicial orders placing children into foster care until they reach the age of maturity, which is generally 18 years of age. All of the participants in this study were caring for children with long-term foster care orders.

The data for this study were drawn from a larger doctoral study that used a qualitative, storytelling methodology to examine women’s experiences of being long-term foster carers in Australia. The aim of this article is to examine stigma as experienced by women providing long-term foster care.
Method

Participants

Women who were or had provided foster care to at least one child on a long-term basis were recruited using a process of snowball sampling. An information package was sent to eligible participants through the postal service or email. This package included a note of appreciation for interest in the study, a consent form, and an information sheet which gave an overview of the study aims, eligibility criteria, and interview process. Approximately 1 week after posting the information package, potential participants were contacted by telephone to answer any queries and to ensure they wished to proceed in participating in the study. As is common with qualitative data, recruitment ceased when data saturation was achieved (Polit & Beck, 2008).

Data Collection

Data were collected during 2010 from 20 participants using semistructured, in-depth conversational interviews. The interview process allowed the researcher to encourage participants’ critical reflection and afforded opportunities to probe and clarify participants intended meaning (Jackson, Daly, & Chang, 2005). The questions posed were broad and designed to elicit stories, allowing participants to articulate experiences at their discretion without a priori restrictions (Atkinson, 1998). As stories can be expressed both verbally and textually (Carter, 2008), interviews were conducted either face to face, via telephone, or through an exchange of emails. The multiple interview techniques employed enabled the inclusion of geographically distant participants (Mann & Stewart, 2000). It also allowed flexibility regarding when interviews were to occur between participant and researcher (Reddy et al., 2006). This flexibility was particularly advantageous for this study given participants’ care-giving responsibilities. Oral interviews were digitally audio-recorded and transcribed verbatim. Email interviews were collated for analyses.

Ethical Approval

Ethical approval was granted by the Institutional Ethics Committee. Participants were provided an information sheet, which stated the aims of the study, detailed the inclusion criteria, and explained the interview process should they choose to participate in the study. This information sheet also
explained the voluntary nature of research, including the participant’s ability to withdraw from the study at any time without penalty. Informed consent was obtained prior to each interview. Participant confidentiality was insured by use of pseudonyms in the research report.

**Data Analysis**

Computer-assisted data analysis software (NVivo) was used to aid in the management and analysis of data. Using the feminist narrative techniques suggested by Anderson and Jack (1991), data were subject to thematic analysis. One dominant theme identified was Stigma and Misconceptions. Data were subsequently coded according to the components of stigma described by Link and Phelan (2001): labeling, stereotyping, separation, status loss, and discrimination. Rigor was ensured through meticulous management and presentation of the data. Accuracy of the data was achieved by comparing transcripts with recorded interviews.

**Findings**

Twenty women participated in the study (see Table 1). Their ages ranged from 41 to 73 years with the average age of 55. Most participants were not currently engaged in paid employment outside the home ($n = 15$), including two retired participants and one on maternity leave. All but three participants also parented biological children. Most participants ($n = 11$) were married, with five participants being divorced, two widowed, and two single. Participants had between 3 and 44 years of experience as foster carers. In addition to providing long-term foster care, 18 participants had also provided short-term, respite, and/or crisis foster care.

**The Stigma Experience**

One important finding of this study was the participants’ perceived distinction between short-term and long-term foster carers. Participants articulated this distinction: short-term foster carers cared for children on a temporary basis and assisted those children to transition to another family, whereas long-term foster carers had an ongoing commitment to and relationship with the children enabling them to nurture the children into adulthood. More specifically, as long-term foster carers, participants perceived and described themselves as mothers. This maternal self-perception dominated participant’s stories, and it is from this perspective they discussed their lives.
Table 1. Participant Characteristics

<table>
<thead>
<tr>
<th>Participant pseudonym</th>
<th>Age</th>
<th>Marital status</th>
<th>Employment status</th>
<th>Number of long-term foster children</th>
<th>Number of biological/adopted children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anna</td>
<td>73</td>
<td>Widowed</td>
<td>Retired</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td>Beth</td>
<td>55</td>
<td>Divorced</td>
<td>Unemployed</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Carol</td>
<td>55</td>
<td>Divorced</td>
<td>Unemployed</td>
<td>3&lt;sup&gt;a&lt;/sup&gt;</td>
<td>4</td>
</tr>
<tr>
<td>Darla</td>
<td>57</td>
<td>Married</td>
<td>Employed</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Felicia</td>
<td>43</td>
<td>Married</td>
<td>Unemployed</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>Gloria</td>
<td>48</td>
<td>Married</td>
<td>Unemployed</td>
<td>2</td>
<td>None</td>
</tr>
<tr>
<td>Helen</td>
<td>46</td>
<td>Single</td>
<td>Employed</td>
<td>1</td>
<td>None</td>
</tr>
<tr>
<td>Irene</td>
<td>55</td>
<td>Married</td>
<td>Unemployed</td>
<td>4</td>
<td>None</td>
</tr>
<tr>
<td>Jodi</td>
<td>41</td>
<td>Married</td>
<td>Maternity leave</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Karen</td>
<td>62</td>
<td>Divorced</td>
<td>Unemployed</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Laura</td>
<td>65</td>
<td>Married</td>
<td>Unemployed</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Mary</td>
<td>45</td>
<td>Divorced</td>
<td>Unemployed</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Natalie</td>
<td>53</td>
<td>Married</td>
<td>Employed</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Olivia</td>
<td>59</td>
<td>Married</td>
<td>Employed</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Paula</td>
<td>59</td>
<td>Married</td>
<td>Unemployed</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>Rachel</td>
<td>63</td>
<td>Single</td>
<td>Unemployed</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Tracy</td>
<td>56</td>
<td>Married</td>
<td>Unemployed</td>
<td>2&lt;sup&gt;a&lt;/sup&gt;</td>
<td>7</td>
</tr>
<tr>
<td>Uma</td>
<td>42</td>
<td>Married</td>
<td>Employed</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Vicki</td>
<td>72</td>
<td>Widowed</td>
<td>Retired</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Yvonne</td>
<td>52</td>
<td>Single</td>
<td>Unemployed</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>

<sup>a</sup> Participant also adopted previous long-term foster children.

Participants perceived their experience of stigma to be due, in part, to widely held misconceptions of foster care which they believed were primarily based on the temporary nature of short-term foster care.

*Labeling.* Labeling occurs when one is perceived as having a socially significant difference to others. However, not all differences are obvious or visible. Goffman (1963) theorized a distinction between individuals whose stigmatizing characteristics were visible (termed the *discredited*) and those whose stigmatizing characteristics were concealable (termed the *discrementible*). The participants in this study fall into the latter group. That is, they were not easily recognized as different to other mothers until placed into a situation which required them to disclose their position as foster carers.
Although each participant had independently chosen to provide foster care, they rejected the label of foster carer. Rather, participants identified themselves as mothers and sought to be recognized as such. Carol explained, “I see myself as—a mother. I really don’t like calling myself a [foster] carer, because it puts it in a totally different attitude.” The label of foster carer was perceived by participants to be impersonal, to denote detachment, and to require a certain amount of professional distance from the children. Instead, the participants perceived themselves as a mother, which implies a level of relational intimacy, affection, and devotion which are not generally associated with the role of a paid carer (Hays, 1996). Moreover, participants felt the label mother accurately portrayed their maternal investment in the children. This investment was characterized as deeply emotional, highly personal, and not subject to the professional boundaries generally applied to hired care providers. Gloria described her investment: “I feel like I’ve poured my heart and soul into these kids.”

Participants believed society’s narrow perception of family allowed for only one woman to carry the label of mother in reference to a child. This perception is reinforced by a bureaucracy that disregards the performance of maternity and only recognizes biological or legal claims to motherhood. Although the participants perceived themselves as mothers, the foster care system insisted on labeling and recognizing them solely as foster carers. Felicia’s narrative illustrated how this was at times confusing for the children:

... it was a Mother’s Day visit and I took my [foster] kids down [to see their biological mother] and the [social] worker had bought a present. She gave it to one of my girls and said “Here, give this to mum for Mother’s Day.” The little girl walked straight over [to me] and said “Here mum, this is for you.” The worker came over and said “oh that’s not for you [Felicia]. That’s for the real mother” [biological mother]. The kids just looked at her [social worker] like she’s [biological mother] not my real mother. That’s my real mum [Felicia].

The conflict in labeling caused participants to conceal their label whenever possible. This often involved concealing the children’s positions within the foster care system from outsiders because revealing such would indirectly result in participants being recognized and labeled as foster carers. Moreover, participants’ stories revealed they felt any label associated with the foster care system carried with it an element of stigma. In the following excerpt, Karen details her experience of seeking medical treatment for Sally, a child in long-term foster care:
The nurse said to me: “oh, this is your foster child?” Sally said, “I am not a foster child; I am mummy’s child.” She [the nurse] went away and the doctor came back and he said, “Hello, Sally, is this your mum?” Sally said, “Yes.” He said, “Can I just have a look? I just want to check your tonsils.” She said, “If mummy says it’s all right you can have a look.”

When Sally went out [of the exam room] he came back and he said to me: “I am sorry, that was not presentable; it was not nice; it will not happen again, because she is a child.” I said, “That’s right, she is a child, not a foster child, so why did she [the nurse] do that to her?”

I thought about it [that situation], I think it’s not right. You bring them up as your own and everyone puts a stigma on them; they’re a foster child.

When Karen told this story, she pronounced the final two words of the above narrative with disdain emphasizing her perception of the stigma associated with foster care. Such interactions contribute to participants’ concealment their foster carer label. However, concealment of this label is ethically impossible within the context of the children’s medical treatment. Participants are therefore obliged to reveal their label when accessing health care services for the long-term foster children in their care. This obligation leaves foster carers vulnerable to the stigma and negative stereotyping associated with their label.

**Stereotyping.** Stereotyping occurs when negative characteristics are attributed to a label and subsequently projected onto individuals assigned that label. Such attributes are generally deemed socially undesirable and are negatively regarded by the wider community (Link & Phelan, 2001). It was the participants’ perception that the wider community regarded foster carers with suspicion, queried their motives, questioned their affection for, and doubted their commitment to the foster children. Quite simply, participants believed foster carers were regarded as self-centered and money grubbing by the wider community, as well as uncaring, indifferent, and lacking in commitment to the children. However, characteristics contrary to their attributed stereotype were apparent throughout participants’ stories.

A general lack of understanding regarding the allowance paid to foster carers was perceived by participants as predominantly responsible for the negative stereotypes attributed to foster carers. Irene stated, “I think the other thing that was a real big issue was that people saw that you got money for these children.” The perception that foster carers earned a wage for services rendered meant they could not be recognized as anything other than
paid carers who were self-centered and financially motivated. Karen found it particularly hurtful when she discovered her friend shared this perception; she recalled her friend’s admonition, “What you do is bloody ridiculous. For a lousy $400 a fortnight, she said . . . you don’t make nothing out of it.” The perception that providing foster care was a means of generating income was openly rejected by participants, as was demonstrated by Karen’s response to her friend: “I said: but I’m not here to make money out of it!”

Participants suggested the financial issues surrounding foster care were, at best, misconstrued. Rather than wages for services rendered, participants likened the allowance to the child support paid by a noncustodial parent to the custodial parent. Within the context of foster care, the government becomes the legal guardian and thus financially responsible for the children in foster care. However, the government delegates physical custody of the children to the foster carer who is subsequently held accountable for the day-to-day care of the children. As the legal guardian, the government becomes financially responsible for the children, while the foster carer is responsible for the judicious dispersal of monies intended to support the children. Participants disputed the stereotype of being money grubbing, asserting that the monies they received belonged to the foster children. Jodi explained,

... what do I get—$300—$400 and something a fortnight. I mean when you’re buying clothes, paying for food, all sporting activities—the money is nothing. If you’re spending it on the kids—how it should be spent on the kids, that’s nothing. You don’t even look at that money. You don’t even count that money.

The perception that foster carers are self-centered and financially motivated generates a persona devoid of altruism or affection, causing the wider community to view foster carers with skepticism. Foster carers emotional authenticity toward the children is subsequently questioned and doubted resulting in foster carers being stereotyped as uncaring and indifferent toward the children. Karen explained, “People look at [foster] carers as, ‘Oh, they’re getting paid to look after those kids.’” How can they love them? Participants disputed this stereotype by articulating their heartfelt love for the foster children; “I love her [foster child] as much as I love my own [biological] child [Karen].”

The general lack of understanding regarding the nature of long-term foster care meant the wider community did not understand participants’ commitment to the children in their care. Suggestions participants resign their position as foster carers or relinquish the children when caring for them
became challenging were not uncommon and reflected the widely held perspective that foster carers are detached, impersonal, paid carers. Uma stated,

... I’ve had many people say, can’t you send them back? If I would ring someone and say we are having a bad day or this [a behavioral issue] is what happened yesterday, quite a number of people have said to me, well can’t you send them back?

Participants openly rejected the perception that they were poorly committed to the children. Rather participants stories demonstrated their deep commitment to the long-term foster children in their care. Comments such as “I’m in it for the long haul” (Jodi) and “... long term to me is forever” (Mary) permeated the stories. Moreover, rather than relinquishment participants opted to self-sacrifice when circumstances with the children became challenging. Gloria explained,

I’ve resigned from a few things in the last couple of weeks just recognizing that okay, to see this kid through this stage of his life, I’m going to have to drop a lot of the other things that I would normally do.

Gloria indicated she mourned losing the time to do things that she enjoyed; however, her commitment meant the child’s needs were prioritized over her own. Gloria justified her sacrifice, stating, “I’m committed to doing the best I can for him.”

By and large, participants rejected both the label and the associated stereotype of foster carer. They did not perceive themselves as detached, impersonal, paid carers who could easily resign and relocate to another position. Rather, participants believed their actions aptly reflected their self-assigned label of mother. Moreover, they indicated their frustration at the persistence of the widely held general misconceptions regarding foster care and asserted such beliefs were fuelled by the poor image of foster carers portrayed in the media. Mary explained,

It’s all because of the bad publicity [foster carers] get. But there are a lot of good [foster] carers out there and that’s what’s sad because you don’t hear the good stories in the news and on programs, you only hear all the bad ones like they were put into foster care and this happened and that happened while they were in care. But what about the thousands that are out there that are with good [foster] carers?
The negative stereotype attributed to foster carers in general was also rejected by participants on the basis of their status as long-term foster carers. That is, participants differentiated themselves from other sorts of foster carers (particularly short-term carers) by labeling themselves mothers, refuting any question of motivation, affection, or commitment. Furthermore, rather than eradicate the misconceptions and stereotypes, some participants deflected them onto a different subset of foster carers, highlighting the distinction participants made between short-term and long-term foster carers. Prior to receiving his long-term foster care orders and living with Jodi, Damian was in short-term foster care. In the following narrative, Jodi, who temporarily cared for Damian, describes the short-term foster carer:

His [previous] foster carer should rot in hell. She is in it for the money. Her and her husband go to Hawaii every two years with the money that they make. She makes me sick. She makes me so angry but they keep giving her the babies. So she actually had him [Damian] from 17 months and I got him at [age] three and he had nothing. So where are his birthday presents; where are his Christmas presents; where’s his clothes; where’s his shoes? Nothing—how can he have nothing? Whereas every cent I get is spent on my kids. Other people that have had kids from her have said the same thing. Where’s their stuff?

Although unintended, Jodi’s deflection propagates the negative stereotype of foster carers in general as they are usually viewed, discussed, and researched collectively. This aggregation is reflective of Link and Phelan’s (2001, p. 367) assertion that although there is tremendous variability between individuals, oversimplification is necessary to create social groups. By applying the negative stereotype to another member of her group (foster carers), Jodi perpetuates the stereotype ascribed to all foster carers.

*Separation.* Separation occurs when the reactions of others produce a profound sense of being devalued, disrespected, or viewed as less than fully human (Goffman, 1963). Participants perceived lack of maternal recognition and the negative stereotype associated with being a foster carer left participants feeling marginalized by society. Although parenting is held in considerable esteem by society, participants were regarded solely as foster carers, not parents. As such, participants were unable to discuss their parental concerns or struggles with other mothers, for fear of suggestions of relinquishment. Moreover, participants revealed they could not enjoy maternal solidarity with other mothers because they were not recognized as mothers themselves. Rachel’s narrative revealed this meant she could only confide in
those in similar situations: “Only my [foster] carer friends—they understand but the general public doesn’t understand at all.”

Generally, children in foster care experience numerous emotional and behavioral difficulties due to issues of neglect or abuse experienced prior to entering foster care (A. Taylor, Swann, & Warren, 2008; C. Taylor & Broadhurst, 2008). As such, it is not uncommon for children to exhibit socially inappropriate behaviors such as tantrums, swearing, screaming, or physical violence. Observing such behaviors can be an uncomfortable experience, particularly when the cause for such behaviors is unknown or misunderstood. This creates a milieu of social awkwardness and often leads to diminished social interaction for the foster carer. Carol’s experience of this left her feeling abandoned by some whom she had regarded as close friends prior to becoming a foster carer. Carol explained,

A lot of people move away, because the kids can be so troubled, you know, with their behaviors and everything, a lot of people can’t cope with that. . . . the friends I have got, that have stuck with me, are really true friends, but a lot have sort of—turned away—because the kids are troubled in their own way.

Carol found it difficult to maintain lasting friendships because she was a foster carer. Carol perceived the foster children’s difficult behaviors to be partially responsible for her loss of friends. Unlike paid carers who are rostered a set number of hours per week and afforded regular days off, sick leave, and annual leave, foster carers have the children with them constantly. The unrelenting nature of foster care coupled with the children’s emotional and behavioral issues exacerbated participants social isolation. Upon reflection, Carol lamented the friendships lost but not as much as she valued those that remained and became her closest friends: “So yeah that part of it I suppose was hard, but then as I said, you know who your true friends are—the ones who stick with you [Carol].”

In an effort to resist the social isolation experienced as foster carers, some participants forged new friendships with other long-term foster carers. The camaraderie experienced within these groups of commonality mitigated the feelings of social isolation and separation. Olivia explained,

One of the good things about being a [foster] carer is the new friends I have made with a regional support group. I don’t believe we would still be [foster] carers without this group of friends. Our friends know
what the stress of being foster carers is, they know when we just need someone to talk too, and they also know how to listen.

Participants valued friendships with women who shared similar experiences and relied on them for emotional support. Building such connections helped to soothe their sense of isolation. Others, like Gloria, were not as fortunate: “...I never had opportunities to really connect with [other foster] carers.” Gloria went on to explain she had difficulty finding people in whom she could confide: “Talking wise I find that—finding people that really get a handle on the whole foster care thing is quite tricky ... there’s like no understanding of what it [foster care] really entails.”

Participants revealed they experienced a sense of separation from the rest of society. This separation was largely due to their maternal self-perception. That is, participants perceived themselves as mothers but were not generally regarded as mothers by the rest of society and, in particular, other mothers. As a result, participants not only felt excluded but also withdrew themselves from society based on their position as foster carers. This separation caused the participants to seek out other foster carers in search of camaraderie, support, and understanding. When they were unable to develop such friendships, participants experienced social isolation.

*Status loss and discrimination.* Link and Phelan (2001) theorized an inherent loss of status to occur when people are labeled, excluded, and stereotyped. Connecting a person to undesirable characteristics consequentially reduces his or her status in the eyes of the stigmatizer. Participants were clearly aware of their assigned label and attributed stereotype which resulted in their separation from the wider community. Awareness of their status loss was most evident in participants’ attempts to reject and/or conceal the label of foster carer.

In addition to their perceived loss of status as foster carers, participants also experienced what they deemed to be overt discrimination. However, although participants perceived these discriminatory acts to be due to their lesser status as foster carers, their narratives revealed participants also felt discriminated against when they were denied access to the rights and responsibilities associated with the label of mother. Despite having physical custody and responsibility for daily care of their children, foster carers have limited authority over the children. Participants’ stories revealed they became frustrated when confronted with the limitation of their authority as these limitations reinforced their label of foster carer. Moreover, such limitations conflicted with participants’ maternal self-perceptions resulting in their perception of discrimination. Describing her status as a foster carer, Vicki stated,
You’re second rate, you’re not in charge of that child. You’re given all the dirty jobs to do, feed them, wash their clothes, sit up at night nursing them when they’re having nightmares, taking them places, bandaging their knee and putting a bandaid on, but you’re not allowed to make any major decisions for them.

**Power dynamics.** Link and Phelan (2001) contend that stigma is dependent on power. Generally those who stigmatize not only possess the power to label, stereotype, and exclude individuals or groups, but they influence the wider community in such a way that their perception becomes the acceptable norm. Moreover, stigmatizers generally control access to important life domains such as education, employment, accommodation, and health care. This control can be either overt or subtle, but without it, stigma cannot be enacted (Link & Phelan, 2001). Thus when stigmatized, one becomes disempowered.

As foster carers, participants found themselves accountable to a large, impersonal, and highly regulated system. In the Australian context, the minister responsible for children in out-of-home care defers authority to the government department which works in tandem with the family courts. It is the case workers and case managers who are employed within these departments who personify authority over the foster children on behalf of the minister. Foster carers are thus directly accountable to the case workers and case managers for the care of the long-term foster children. This accountability leaves foster carers, their lives, and their homes open to constant scrutiny. Tracy put it this way: “When you become a foster carer, your life’s an open book.”

The process to become a foster carer was described by participants as “very invasive” (Uma). Generally the most invasive component was the written life story. This was a document which the participants were asked to write detailing all significant events of their lives up to their application including details of their family network, romantic relationships, experiences with illness, places of residence, and any trauma or tragedy they had experienced. This document was retained within their file following their approval to become foster carers. Unlike other members of the foster care team, foster carers do not have access to departmental files. This meant other members of the foster care team potentially had access to highly intimate details of participants’ lives, whereas participants had little to no knowledge of theirs. This intimate knowledge inequity left participants feeling an unequal member of the foster care team. Uma explained, “I could say it makes me feel uncomfortable . . . But yeah I guess it is in a file and they can read it whenever they like. A bit scary.”
As members of the foster care team, participants indicated they were generally excluded from decision-making processes regarding the long-term foster children in their care. Their lack of authority meant participants were often forced to comply with what they deemed to be ill-informed decisions made by detached representatives of the foster care system. Participants revealed they felt coerced into compliance with decisions out of fear of the children being removed from their care. This was deemed particularly true for new foster carers who were described as being afraid: “To jump up and down because if they do they’re scared that the children will be removed” (Felicia). However, for some participants, this fear remained:

Powerless. Because they [the department] have the power and the authority and I was scared for my children. If I don’t do what they want, they walk in and say—we’re taking them. I’ve always got that fear because you live in a glass bowl. They always seem to be there in the shadows, that’s how I feel. . . . (Paula)

To fully understand the power dynamics at play, one must comprehend the relationship the participants had to the children in long-term foster care. Participants considered themselves mothers to these children, as such; these children were participants’ first priority and central to their lives. Removal of the children from their lives was an unacceptable option. However, it is important to note that participants’ fears of losing their children were not motivated solely by their own potential loss but the potential consequences for their children. Reflecting on her experience of having her children removed, temporarily, following an allegation that was later deemed to be false, Paula stated,

It just destroyed me. They [the department] just destroyed these three children that I love, these children that I’ve got now. I’d had them all since birth. It really destroyed the children, they were sobbing, crying. . . . I was distraught for them because they were (pause) and I just felt so helpless. I was really distraught.

By and large, the power dynamic reinforcing the experience of stigma for participants resided within the foster care system itself. Within this system, many participants felt marginalized, scrutinized, and powerless. However, as some participants became more knowledgeable about the system and the shortage of foster carers, they began to realize their own importance to the system. This empowered participants to assert themselves and challenge
the department and the agencies who had the authority. Felicia explained, “I don’t need them. That’s my thing—as foster carers we don’t need our agencies. They need us.”

Participants revealed that at times enacting departmental decisions caused tension between themselves and the children. Vicki described it as putting: “A wedge in between them [foster carer and foster child], a huge wedge.” However, some participants found making the department responsible for explaining decisions to the children to be empowering. Although participants still had to bear some of the consequences of those decisions, they were in a better position to assist the children to deal with those decisions than if the children deemed them to be solely responsible.

We make the department tell the children. We say we’re not going to tell them that this is the decision. You made it, you come and talk to the kids and then we’ll carry out your wishes, but until you come and speak to those children and tell them that you’ve made this decision, along with their biological parents and if the kids aren’t going to like it, you can tell them, because we’re not. That’s what we do. We say: You’ve made the decision; then you wear the consequences. You explain it that to the child. (Tracy)

**Discussion**

Link and Phelan’s (2001) framework was useful for guiding the analysis and synthesis of participants’ data. Though the scope and depth of this analysis is limited by the relatively small sample size, the findings reveal participants in this study have experienced stigma as a consequence of providing long-term foster care. Although the findings of qualitative studies cannot be generalized, extant literature can support and confirm their transferability. Participants’ descriptions of fear, powerlessness, isolation, and stereotyping within the foster care system resonate with existing foster carer literature (Briggs & Broadhurst, 2005; Ellice, 2011; Thomson, 2007) suggesting the incidence of stigma may affect all foster carers.

The findings of this study are similar to several recent Australian studies which found long-term foster carers to identify themselves as parental figures to the foster children, rather than paid carers (Riggs, Augustinos, & Delfabbro, 2007, 2009; Riggs, Delfabbro, & Augustinos, 2009). Recognition of this perspective is imperative to understanding participants’ experience of stigma as essential components of the stigma experience were largely reliant on participants own perception. That is, participants perceived themselves as
mothers and perceived themselves to experience discrimination when denied the rights and responsibilities associated with that label. Research has demonstrated that regardless of the antecedent, the perception of being stigmatized has the potential to affect individuals in the same way as overtly discriminatory acts (Blasovich, Spencer, Quinn, & Steele, 2001; Finch, Kolody, & Vega, 2000). Given this understanding, it is clear that based on Link and Phelan’s (2001) theoretical model, the participants did in fact experience stigma and as such are potentially subject to its effects on their lives.

Fear of being inaccurately stereotyped was largely responsible for participants’ concealment of their foster carer label. The active concealment of a concealable stigma has been found to be psychologically stressful (Smart & Wegner, 1999). Such findings imply that disclosure may alleviate this stress but only to the extent that individuals feel affirmed and supported by those in whom they choose to confide (Chaudoir & Quinn, 2010; Corrigan & Matthews, 2003). However, social rejection as a result of disclosure has been shown to reinforce concealment of stigma (Ahrens, 2006), thus further compromising psychological well-being. Furthermore, fear of disclosure has been identified as a source of chronic stress in persons with concealable stigmas (Ragins, Singh, & Cornwell, 2007). Although participants bore a concealable stigma, at times they were legally, ethically, or morally obliged to reveal their foster carer label, such as when seeking health care services for the foster children. These studies suggest that as long as the perceived stigma associated with being a foster carer persists, participants will continue to experience psychological stress.

Participants experienced varying degrees of social isolation, due in part to the foster children’s difficult behaviors. This issue of maternal isolation due to children’s behavioral difficulties has also been identified with biological mothers of children diagnosed with attention deficit hyperactivity disorder (ADHD; Peters & Jackson, 2009). While some participants in this study indicated they had developed friendships with other foster cares, others indicated they did not have that opportunity and remained socially isolated. Extant research suggests when individuals positively identify with a stigmatized group (in-group) and are highly regarded within this group, those individuals are more likely to demonstrate resilience when experiencing stigma (Crocker & Garcia, 2006). The association between resilience and a strong in-group identity is one possible avenue for future research with this population. However, such research may prove to be problematic given the lack of cohesion among foster carers demonstrated within this study.

Participants varied reactions to stigma within the power dynamic of the system is consistent with contemporary stigma literature (Crocker &
Lawrence, 1999; Crocker & Major, 1989; Shelton, Alegre, & Son, 2010). Whereas some participants remained compliant with the sanctions and labels allocated them by the system, others became empowered and challenged the system. Analysis of stigma associated with hepatitis C and human immunodeficiency virus have demonstrated reactions to stigma to evolve over time suggesting individuals develop skills and strategies which enable them to manage the effects of stigma (Butt, 2008; Ingram & Hutchinson, 1999). Similarly, participants within this study described novice foster carers as apprehensive and characterized the experienced as more assertive and resistant to the power differential. Whether this variance over time applies to all foster carers is unknown but warrants further investigation.

Recent research has found that stigma experienced from a powerful source is likely to lead to more negative effects such as stress, burnout, loss of motivation, and poor productivity and are exacerbated when the stigmatized individual is reliant on that source (Barreto, Ellemers, & Fiske, 2010). Participants’ reliance on impersonal, highly regulated, powerful systems has implications for participants’ experience of and reactions to stigma and may explain participants’ perception of being stigmatized by the wider community. That is, participants may project their perceptions of stigma onto the wider community as a consequence of experiencing stigma from such a powerful source. Furthermore, Shelton et al. (2010) emphasized the importance of studying both stigmatized and nonstigmatized individuals, suggesting research should investigate the extent to which individuals may display behaviors which appear biased toward a particular group, when in fact they are not. This is particularly relevant for foster carers as they describe components of their stigma experience coming from the wider community but experience the power differential within the confines of government regulated systems such as the foster care system, as well as health and education systems. The degree to which the wider community negatively regards foster carers is not known and may be attributed to a general lack of knowledge rather than an intentional bias.

**Conclusion**

Research on stigma has flourished over the past few decades (Shelton et al., 2010), and several nurse researchers have participated in this discourse (e.g., Butt, 2008; Pinto-Foltz & Logsdon, 2008; Weber, 2008, 2010). Health professionals have a responsibility to be nonjudgmental and to critically reflect on the values and beliefs which shape their decision making. Despite this, stigma remains a poorly understood concept which often goes unrecognized
by health professionals within themselves and others (Gouthro, 2009; Ross & Goldner, 2009; Uys et al., 2009). Unrecognized stigma can impede therapeutic nurse–patient interaction, and thus it is imperative that nurses clarify their understanding of stigma. In so doing, nursing practice can be enhanced, enabling the provision of individualized empathetic care (Pinto-Foltz & Logsdon, 2008). Moreover, nurses care for their allocated patients within the context of their patient’s families, therefore developing and understanding of stigma as it applies within the contexts of families is paramount.

Participants’ experience of social isolation was twofold. For some, their isolation was due to their inability to find camaraderie with other mothers. Although participants perceived themselves as mothers, they were not recognized as such by other mothers. Consequently, participants were either excluded or chose to withdraw themselves from opportunities to network with other mothers. Although some participants were able to develop social networks with other foster carers, many were not. Women such as these could benefit from participation in support groups and opportunities to meet other long-term foster carers. By inviting and including long-term female foster carers in mothering support groups, rather than foster carer support groups, nurses can demonstrate their understanding and acceptance of long-term foster carers mothering role. In so doing, nurses can minimize the negative health effects of stigma and social isolation experienced by long-term female foster carers.

Given the complex social, emotional, behavioral, and physical difficulties experienced by the children in foster care, these women can have disproportionate interaction with the health care system and, consequently, nurses. It is therefore imperative that nurses recognize and understand the experience and consequences of stigma within this previously unidentified cohort of stigmatized women. This understanding will serve to increase nurses’ awareness to the ways we mitigate or contribute to the stigma of our patients and their families within both our practice and research. For example, this study has demonstrated that some people find the “foster” label offensive. Bearing this in mind, when caring for a foster family, nurses may choose to adopt the designations used within that family to address family members. In so doing, nurses acknowledge and affirm the relationships within the family, from the family’s perspective. This will assist in establishing effective therapeutic relationships with the family.

Understanding the concept of stigma and recognizing those affected provides an opportunity for nurses to advocate for those who have been marginalized and depreciated. At the bedside, nurses have the opportunity to mitigate stigma firsthand, and on a larger scale nurses are well positioned to
influence both social and health care policy. Raising the awareness of nurses about women’s experiences of providing foster care has the potential to inform practice and enable appropriate support for this cohort of women, thus minimizing possible negative impacts on their health and well-being.

**Acknowledgment**

The authors would like to thank the women who participated in this study.

**Authors’ Note**

The first author, Stacy Blythe, is a full-time PhD candidate and recipient of an Australian Postgraduate Award funded by the University of Western Sydney.

**Declaration of Conflicting Interests**

The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

**Funding**

The authors received no financial support for the research, authorship, and/or publication of this article.

**References**


Bios

Stacy L. Blythe, RN, BN (Hons), is an associate lecturer in the School of Nursing & Midwifery at the University of Western Sydney, Australia. Family health is her main research interest. She is currently undertaking doctoral studies investigating the experiences of women who provide long-term foster care. Prior to this, she undertook a systematic review in the area of dementia which resulted in her first publication: “The Efficacy of Nurse Implemented Non-Pharmacological Strategies for the Symptom Management of Agitation in Persons With Advanced Dementia Living in Residential Aged Care Facilities” appearing in JBI Library of Systematic Reviews (2009, with E. Chang, A. Johnson, & R. Griffiths).

Debra Jackson, RN, PhD, is a professor in the Faculty of Nursing, Midwifery and Health at the University of Technology, Sydney, Australia. She has an interest in family health and leads a research program into mothering. Recent publications include “Mothers’ Experiences of Parenting a Child With Attention Deficit Hyperactivity Disorder” appearing in the Journal of Advanced Nursing (2009, with K. Peters), “Development and Validation of the Child-to-Mother-Violence Scale” appearing in Nurse Researcher (2011, with M. Edenborough, L. Wilkes, & J. Manix), and “Mothering Disrupted by Illness: A Narrative Synthesis of Qualitative Research” appearing in the Journal of Advanced Nursing (2010, with T. Vallido, L. Wilkes, & B. Carter).

Elizabeth J. Halcomb, RN, PhD, is an associate professor in the School of Nursing & Midwifery at the University of Western Sydney, Australia. Her research activities focus on primary care nursing, nursing workforce, evidence-based practice, and mixed-methods research. Recent publications include “Reciprocity During Data Collection: Negotiating Cooperative Research Relationships Through Story-Sharing With Lesbian Mothers” appearing in Nurse Researcher (in press, with B. Hayman, L. Wilkes, & D. Jackson), “Beyond the Ceiling Effect: Using a Mixed-Methods Approach to Measure Patient Satisfaction” appearing in International Journal of Multiple Research Approaches (with S. Andrew, Y. Salamonson, B. Everett, & P. M. Davidson, 2011).

Lesley Wilkes, RN, PhD, is a professor in the School of Nursing and Midwifery at University of Western Sydney, Australia. Her main research interests are family health and workplace issues for nurses. Recent publications include “Development and Validation of the Child-to-Mother-Violence Scale” appearing in Nurse Researcher (2011, with M. Edenborough & D. Jackson) and “Mothering Disrupted by Illness: A Narrative Synthesis of Qualitative Research” appearing in the Journal of Advanced Nursing (2010, with T. Vallido, D. Jackson, & B. Carter).
CHAPTER EIGHT: MOTHERING IN THE SYSTEM

PUBLICATION

Paper 5:


RELEVANCE TO THESIS

This publication is based on the third theme ‘mothering in the system’. This theme consists of three sub-themes (Table 4) which describe the difficulties participants experience when mothering within a highly regulated and controlled system. These difficulties were found to challenge participants’ maternal self-perceptions and are identified as negatively affecting participants’ health and well-being.

TABLE 4. Theme three: Mothering in the System

<table>
<thead>
<tr>
<th>Sub-themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ongoing scrutiny: Living in a glass bowl</td>
</tr>
<tr>
<td>Maternal Autonomy: There are battles all the time</td>
</tr>
<tr>
<td>Broken promises: They tell you you’ll get lots of support, you get none</td>
</tr>
</tbody>
</table>
Title: Caring for vulnerable children: Challenges of mothering in the Australian foster care system

Abstract:

Foster carers have a significant responsibility in caring for vulnerable children. In order to support and facilitate foster carers it is important to understand how they perceive and fulfil this responsibility. A qualitative story-telling study, informed by feminist perspectives, was used to conduct in-depth, semi-structured interviews with twenty women providing long-term foster care in Australia. Thematic analysis revealed these women characterised themselves as mothers, rather than paid carers, to the long-term foster children in their care. Using this maternal self-perception as the starting point, this paper reveals some of the challenges and difficulties participants encountered when mothering within the confines of the child protection system. Implications for nursing practice are discussed. These implications focus on ways that nurses can effectively support foster carers, thus optimising the health and well-being of the vulnerable children in their care.

Keywords:

Foster care, child protection, mothering, nurses, vulnerable

Introduction:

Nurses have long been concerned with the health and well-being of vulnerable populations. Vulnerability can be conceptualised as the propensity of certain social groups to experience higher levels of morbidity and mortality when compared to the general population (Flaskerud & Winslow, 1998). Children (and young people) who reside in out-of-home care are a vulnerable population (Bruskas, 2008; Galehouse, Herrick, & Raphel, 2010; Webster & Temple-Smith, 2010). Compared to the general population, these children experience a higher incidence of physical, cognitive, developmental, emotional and behavioural issues (Carbone, Sawyer, Searle, & Robinson, 2007; Nathanson & Tzioumi, 2007). Such health issues are largely attributed to the children’s experiences prior to entering care but have also been demonstrated to be exacerbated while in care (Kools & Kennedy, 2003; Nathanson, Lee, & Tzioumi, 2009; Nathanson & Tzioumi, 2007; Zhou & Chilvers, 2010). Given
their health issues, these children, and their carers, likely have increased interaction with the health care system and, subsequently, nurses. Such interaction presents an opportunity for nurses to positively impact on this vulnerable group. In order to optimise this interaction nurses need to understand the complex issues faced by foster carers. This paper seeks to provide insight into the experiences of foster carers providing long term care to children within the foster care system.

**Background:**

The child protection system in Australia is comprehensive, aiming to promote the health and well-being of children rather than merely respond to issues of abuse or neglect (Council of Australian Governments, 2009). This necessitates collaboration between various government departments and private organisations in the health, welfare, justice and education sectors to provide adequate support to vulnerable families and children. When early intervention is ineffectual or untenable, physical removal of children from an unsafe living situation to an alternate environment is sometimes necessary (AIHW Australian Institute of Health and Welfare, 2012). In 2011 there were some 37,648 Australian children in out-of-home care. The majority (73%) of these children were on long-term guardianship orders and nearly half of these children (45%) live with foster carers (AIHW Australian Institute of Health and Welfare, 2012). These data demonstrate the significant role that foster carers play in supporting Australian children in out-of-home care.

Foster carers play a fundamental part in maintaining child health and well-being, as they are responsible for the day to day parental tasks of care-giving, as well as providing a safe environment and negotiating access to resources (Bonfield, Collins, Guishard-Pine, & Langdon, 2010; D. Riggs, Augoustinos, & Delfabbro, 2009a). One of the key factors associated with optimal outcomes for children in foster care is the careful and deliberate selection of appropriate foster carers (Henderson & Scannapieco, 2006; Holland & Gorey, 2004; Sinclair & Wilson, 2003). Evidence suggests that foster carers have the capacity to improve the health and well-being of the children in their care (Schofield & Beek, 2005a, 2005b; Tarren-Sweeney & Hazell, 2006). Specifically, healthy attachment to a foster ‘parent’ has been found to facilitate healing, provide a sense of belonging and promote resilience for this vulnerable group of children (D. Riggs, et al., 2009a; Schofield, 2002; Schofield &
Therefore the need to attract and retain high quality and committed foster carers remains a high priority in Australia (Council of Australian Governments, 2009).

Recent literature suggests that foster carers may themselves be a vulnerable group (Blythe, Wilkes, & Halcomb, Under review). Foster carers have been found to experience heightened levels of anxiety (Farmer, Lipscombe, & Moyers, 2005), depression (Cole & Eamon, 2007) and stress (Wilson, Sinclair, & Gibbs, 2000) when compared to the general community. Additionally, adverse health consequences in relation to their care-giving role have been reported, including; anger and guilt when placements breakdown (Gilbertson & Barber, 2003), personal frustration due to role restriction (Blythe, Halcomb, Wilkes, & Jackson, 2012a; Lauver, 2008), threats to personal safety (Briggs & Broadhurst, 2005), loss of sleep (Marcellus, 2004), social stigma (Blythe, Jackson, Halcomb, & Wilkes, 2012b), discrimination and marginalisation (D. Riggs, Delfabbro, & Augoustinos, 2009b; D. W. Riggs & Augoustinos, 2009). Moreover, most frequently it is the female foster carer, married or single, who serves as the primary care giver to the children (Grimm & Darwall, 2005; Rodger, Cummings, & Leschied, 2006; Siminski, Chalmers, & McHugh, 2005). Given foster carers’ significant contribution to out-of-home care for vulnerable children, there is a clear need to identify and understand the factors which contribute to their vulnerability in order to develop strategies with which to support and thus retain carers.

Method

Design

This paper stems from a doctoral study which explored the experiences of women who provide long-term foster care in Australia. The study used a qualitative storytelling design, guided by feminist perspectives, to gain insight into the foster care experience from the female carer’s perspective in Australia. This narrative-based feminist approach was selected as it minimises the inherent power discrepancy between participant and researcher (Stanley & Wise, 1990), emphasises reciprocity and collaboration (Atkinson, 1998), values women’s subjective experiences
(Jackson, Daly, & Chang, 2005) and acknowledges ‘meaning’ as a legitimate end product (Bailey & Tilley, 2002).

**Participants**

A purposive sample of 20 Australian women who have provided long-term foster care were recruited via recruitment posters, media releases, web-based advertisements and word of mouth. Following initial contact, eligible participants were sent an information package containing a written note of appreciation for interest in the study, an information sheet detailing the study aims and voluntary nature of participation, a consent form and a list of counselling services. Data collection continued until saturation was achieved.

**Data collection**

In-depth, semi-structured interviews were conducted by the lead author in 2010. Taking into account the care-giving responsibilities of participants, multiple methods were used to enable flexibility regarding when and where the interviews were to occur. These included: face-to-face, telephone or an exchange of emails. The interview questions were designed to encourage participants’ critical reflection (Jackson, et al., 2005). Oral interviews were audio recorded and transcribed by a professional transcription company. Transcripts and emails were de-identified and entered into computer-assisted qualitative data analysis software (NVivo9™).

**Ethical considerations**

Ethics approval was obtained from the relevant Institutional Ethics Committee. Participants were informed of the voluntary nature of research. Informed consent was gained prior to each interview. Confidentiality of participants, and the children in their care, is maintained by the use of pseudonyms.

**Data analysis**

Transcripts and emails were read repeatedly to gain understanding of participants’ experiences. Text was coded and grouped into themes and then re-examined for relevant sub-themes using techniques suggested by Anderson and Jack (1991), these include; scrutinising the logic of the story, paying particular attention to self-
evaluative and self-reflective statements. These techniques enhance understanding by enabling examination between the individual’s sense of self and cultural norms and revealing discrepancies within the self (Anderson & Jack, 1991).

Rigour

Rigour was enhanced through the authors’ on-going self-reflection regarding this research (Hall & Stevens, 1991; Hewitt, 2007; Rice, 2009). This reflexivity was particularly important for the lead author who, as a woman providing long-term foster care to children, found herself positioned as an ‘insider’ to the participants (Blythe, Wilkes, & Halcomb, Under review-a). This critical reflection enabled the identification of personal biases that had potential to influence data analysis (Dowling, 2006). The strategies used to facilitate this reflection have been detailed elsewhere (Blythe, et al., Under review-a). Accuracy of transcription was achieved by simultaneously listening to recordings and reading transcripts of interview conversations. Initial data analysis was undertaken by the first author. The iterative nature of qualitative data analysis enabled the subsequent authors, who were positioned as ‘outsiders’ and experienced in the method, to regularly scrutinise and verify the accuracy of the findings as they emerged (Blythe, et al., Under review-a; Slevin & Sines, 2000; Tobin & Begley, 2004). Direct quotes from participants’ interviews and emails are presented throughout the findings to demonstrate how conclusions were drawn from the data (Blythe, et al., Under review-a; Koch, 2006).

Findings:

Twenty women elected to share their experiences of providing long-term foster care (See Table 1). These women were authorised foster carers within the New South Wales (n=14), Victoria (n=4), South Australia (n=1), and the Australian Capital Territory (n=1) child protection systems. In total, these women provided long-term foster care to 54 children.
Table 1. Participant characteristics

<table>
<thead>
<tr>
<th>Participant Pseudonym</th>
<th>Age</th>
<th>Marital Status</th>
<th>Number of long-term foster children</th>
<th>Number of biological/adopted children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anna</td>
<td>73</td>
<td>Widowed</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td>Beth</td>
<td>55</td>
<td>Divorced</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Carol</td>
<td>55</td>
<td>Divorced</td>
<td>3*</td>
<td>4</td>
</tr>
<tr>
<td>Darla</td>
<td>57</td>
<td>Married</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Felicia</td>
<td>43</td>
<td>Married</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>Gloria</td>
<td>48</td>
<td>Married</td>
<td>2</td>
<td>None</td>
</tr>
<tr>
<td>Helen</td>
<td>46</td>
<td>Single</td>
<td>1</td>
<td>None</td>
</tr>
<tr>
<td>Irene</td>
<td>55</td>
<td>Married</td>
<td>4</td>
<td>None</td>
</tr>
<tr>
<td>Jodi</td>
<td>41</td>
<td>Married</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Karen</td>
<td>62</td>
<td>Divorced</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Laura</td>
<td>65</td>
<td>Married</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Mary</td>
<td>45</td>
<td>Divorced</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Natalie</td>
<td>53</td>
<td>Married</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Olivia</td>
<td>59</td>
<td>Married</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Paula</td>
<td>59</td>
<td>Married</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>Rachel</td>
<td>63</td>
<td>Single</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Tracy</td>
<td>56</td>
<td>Married</td>
<td>2*</td>
<td>7</td>
</tr>
<tr>
<td>Uma</td>
<td>42</td>
<td>Married</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Vicki</td>
<td>72</td>
<td>Widowed</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Yvonne</td>
<td>52</td>
<td>Single</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>

*Indicates participant also adopted previous long-term foster children.

Data analysis identified three dominant themes, each of which comprised of numerous sub-themes. The first two themes (1) Mothering revealed and (2) Seeking recognition, found women who provide long-term foster care identify themselves as mothers, rather than paid carers, to the children in their care (Blythe, et al., 2012a) and feel stigmatised when denied that maternal identity (Blythe, et al., 2012b). Moreover, these women characterise themselves in line with dominant mothering ideology (Blythe, et al., 2012a). This ideology, commonly referred to as ‘the good mother’ or ‘intensive mothering’, asserts mothering necessitates self-sacrifice, is wholly child-centred, emotionally intensive and time-consuming (Goodwin & Huppatz, 2010; Hays, 1996). Further, ‘good mothers’ are uniquely equipped to intuit and respond to their children’s needs (Macdonald, 1998) and are ultimately responsible for the healthy growth and development of their children (Ganong & Coleman, 1995). When any part of this hegemonic ideal is not achieved, mothers
experience significant self-blame and guilt (Gross, 1998) which in turn have significant implications for the women's health and wellbeing (Jackson & Mannix, 2003). These findings have been reported previously (Blythe, et al., 2012a; Blythe, et al., 2012b).

This paper presents content from the third dominant theme; (3) Mothering in the system. It explores participants’ struggle to achieve ‘the good mother’ ideal in the context of the child protection system and the subsequent threats to health and wellbeing which are relevant to nurses, and other health professionals, who frequently come into contact with them. This theme consists of three sub-themes, these are: a) Ongoing Scrutiny: Living in a glass bowl, b) Maternal Autonomy: There are battles all the time, and c) Broken Promises: They tell you you’ll get lots of support, you get none. Each of these sub-themes is presented individually.

a) Ongoing scrutiny: Living in a glass bowl

Participants described their lives as subject to ongoing scrutiny by the system as a result of providing long-term foster care. Unlike birth mothers, participants were required to continually demonstrate their maternal capacity to care for long-term foster children. Although described as “invasive” (Laura), participants explained that they willingly complied with the initial accreditation process as they deemed accreditation signified acknowledgement and approval of their ability to appropriately care for children. However, participants’ stories demonstrated that initial accreditation did not ratify their maternal practices or empower them to mother the foster children. Rather, participants were under continued surveillance: “They [the system] always seem to be there in the shadows...” (Paula).

Regular home inspections and financial expenditure inquiries, as well as assessment and critique of participants’ parenting practices and behaviour management strategies were reported. This ongoing scrutiny was seen as burdensome for participants. Irene’s narrative demonstrates the physical and emotional impact of

---

5 Throughout this paper the term system refers to the government departments and private organisations, in health, welfare, justice and education sectors, which share responsibility for child protection.
being subject to regular home inspections while caring for a sibling group of five children:

Sometimes I did not [clean the house] because I was just too exhausted - and I mean the mess of having five kids in a three bedroom home – it was really difficult. It was very hard to keep clean. We used to have to clean it when they went to bed. Sometimes I was just too tired to.

Some participants came to perceive the ongoing scrutiny as a lack of trust in their maternal ability. This perception was particularly true for participants who felt they had successfully raised biological children of their own. Tracy stated: “We bring these [foster children] up, as we did with our biological children, none of them who have turned into mass murderers or drug addicts, so something must have been done right.”

Ongoing scrutiny, at times, led to system personnel becoming involved in matters that were considered, by participants, as “things that you normally, as a family, handle” (Paula). This was a considerable source of frustration for participants when involving disciplinary issues with the children. In these cases, the system’s involvement was viewed, by participants, as maternally disempowering and potentially harmful for the children. Such intrusion was seen to segregate members of the household from one another, thus undermining the family as a unit. Vicki explained: “They [the system] want the child to be brought up and accepted in the family, normally, as one of your children, but then they don’t allow you to do it.”

So insidious were the effects of ongoing scrutiny that when legal adoption or aged related emancipation from the system removed the need for involvement of the system, the entire family celebrated: “.... We were just happy to be out of [the systems’] control. So we just sort of had a little bit of a family celebration” (Rachel).

b) Maternal Autonomy: There are battles all the time

The word “powerless” (Karen) was used to describe foster carers’ positioning within the confines of a highly controlling and regulated system. Unlike other custodial mothers, participants’ parental authority was restricted as legal authority, over and for the children, remained with the system. However, the extent of this restriction
was surprising and difficult for participants. They struggled to reconcile their significant maternal responsibilities with their limited authority. As Rachel described: “Step up and be a parent” she [case worker] said. We can’t be a parent because you [the system] won’t let us. You keep taking the authority out of our hands”.

Exclusion from the decision-making processes regarding the children in their care was a source of great frustration for participants, particularly when those decisions were regarded as normal day-to-day parental responsibility which did not necessitate external interference. For example, deciding when a child should commence school is a parental decision that is generally made without outside input. However, decisions regarding foster children’s schooling are the system’s responsibility. Carol demonstrates her frustration with this restriction:

She [foster child] was due to start school. She was already a premmie baby that was behind the eight-ball anyway, and I fought with [the government department] to give her another 12 months at pre-school, and they absolutely knocked it back. And now she’s 18 months behind in school, and she’s really battling.

Like Carol, many other participants described how they “fought” the system to have their opinions heard and considered. Exclusion from decision making conflicted with participants’ maternal self-perception. It limited their ability to mother the children and their involvement in the children’s lives. Felicia stated: “I want to be part of the decision making... I want to be part of my kids’ lives”.

Within participants’ stories, the system seemed to emphasise the legal, rather than the emotive, aspects of caring for children. However, at times the legal limitations impinged on the participants’ ability and desire to nurture and emotionally support the children. This was most clearly demonstrated in Mary’s story. When her foster son was hospitalised, Mary was asked to liaise between the health care and social service sectors. This required her to spend significant time away from her foster son at a time when he needed her. The frustration and urgency she experienced can be seen when she explained:
At the beginning of the year he did get really sick and he ended up in hospital for eight weeks. He had pancreatitis and he stopped breathing and they resuscitated him. The paediatrician said there are no medical papers anywhere, no forms signed, legal papers or anything ... There was just all this stuff that the hospital needed to know ... So I was emailing and calling [the government department] to try and find out. ...Finally, [a case worker] got on the phone... “I need to know some information,” I said. “Anyway I can’t talk to you at the moment. Call this person.”(which was the hospital) I said, “You need to speak to a nurse, a doctor or the counsellor because you need to answer questions and I can’t answer them and you can [Mary].

Although all participants described feeling powerless at times within the system, some found ways to rediscover their maternal autonomy. Initially compliant with the system, over time, many resented being limited in their ability to mother the children. As participants’ maternal self-confidence grew they became more assertive and less fearful. Darla explained: “If you strongly believe that something is in the best interest of the child, and [the system] is not hearing it, sometimes it’s better to do it, and say sorry after the event”.

c) Broken Promises: They tell you you’ll get lots of support, you get none

Participants told of how they began providing foster care with the understanding that the system would cover the financial costs of caring for the children, facilitate access to specialist services as required, and provide any necessary training for them as foster carers. This expectation was largely based on advertising campaigns and the recruitment information sessions. Mary’s narrative demonstrates that the reality of providing foster care differed greatly to these promises: [At training] “they tell you that there is help and support and everything out there. But once you’re thrown in, it’s not out there at all.”

The unmet expectation of support for the children created an environment of distrust and cynicism and left the women feeling suspicious of the department. The women questioned the legitimacy of department who asserted that their focus was the children’s best interests, yet was unable or unwilling to provide resources to the children in a timely manner. As participants identified themselves as mothers to the
children, they found themselves personally obligated to meet the children’s needs. Uma demonstrates this obligation:

They [foster children] were important enough for us to want and initiate the process to care for, so they’re really important enough for me, as important as my own children. I would do it for them [own children], so you do what your kids need, you just do it.

Specialised knowledge and skill is often required to manage physical, mental and developmental health complexities of children in care (Ellermann, 2007). Nearly half of the participants had experienced personal blame, reprimand and critique, rather than support, when they were struggling to manage the children’s complex emotional and behavioural issues. This can be seen in the following excerpt of Gloria’s transcript:

[He] got placed with us and I think we saw a social worker once in 12 months. There was no support, there was nothing. It wasn’t until we had some problems and then we were seen as the big bad ogres and what have you done wrong and blah, blah, blah.

As participants realised they were not going to get the support for themselves or the children they felt had been promised to them, they eventually stopped asking for it. This left participants feeling isolated, unsupported and lost within the system. Natalie stated: “But we weren't quite prepared for the lack of support that there was when he first came and how lost we might become in the system.”

Discussion:

Research into the provision, maintenance and outcomes of child protection as a system, is generally conducted from the perspective of the policy makers (Farrell, 2004), those enacting policy (Thomson, 2007); or the recipients of care (Ciarrochi, Randle, Miller, & Dolnicar, 2011). Increasingly, researchers are investigating the foster care experience from the carer’s perspective and have found long-term foster carers identify themselves as parental figures to the children rather than paid carers within the system (Blythe, et al., 2012b; Broady, Stoyles, McMullan, Caputi, & Crittenden, 2009; D. Riggs, Augustinos, & Delfabbro, 2007; D. Riggs, et al.,
Using the foster carers’ perspective as the starting point, this paper explored the difficulties of mothering within the child protection system.

Within the traditional family context, the care of children is the responsibility of the parent(s). The daily demands of care-giving, nurturing and managing behaviour in children are stressful (Crnic, Gaze, & Hoffman, 2005; Crnic & Greenberg, 1990). When children have complex physical, cognitive, psychological or emotional needs the demands on parents are increased (Ross, Blanc, McNeil, Eyberg, & Hembree-Kigin, 1998). When the parent(s) perceive a discrepancy between the demands of parenthood and their ability to meet those demands they experience elevated levels of stress. Mitigation of this perception is necessary for the optimal functioning and development of both the parent(s) and the children (Crnic & Greenberg, 1990; Deater-Deckard, 2005). Like conventional parents, long-term foster carers are responsible for the same day-to-day parental tasks associated with caring for children and thus are subject to similar stresses. However, unlike conventional parents, foster carers often lack the authority and resources to meet the demands of parenting foster children unaided. Given participants’ maternal self-perception, it is not surprising their stories demonstrated significant frustration.

Participants’ experience of ongoing scrutiny from the system resonate with existing foster carer research (Briggs & Broadhurst, 2005). However, the experience of having one’s mothering scrutinised, judged and critiqued is not unique to foster mothers. The phenomenon of ‘mother blaming’ as it is described in the literature (Jackson & Mannix, 2004) is evidence that all mothers experience a degree of external scrutiny. This experience has been shown to negatively affect women’s health and well-being; causing feelings of guilt and self-blame and anxiety (Jackson & Mannix, 2004). The findings from this study suggest women who provide foster care are subject to increased levels of scrutiny, and thus concomitant negative effects on their health and well-being.

Current dominant mothering ideology stipulates a woman’s ability to recognise, understand and respond to her children’s individual needs is an important maternal trait (Arendell, 2000). Further, good mothers should be resourceful and seek expert advice and support in their nurturing role (Goodwin & Huppatz, 2010). In keeping with this ideology, and their own maternal self-perceptions, participants sought
support from the system. Their unsuccessful attempts to gain support for themselves and/or the children made participants feel powerless and isolated. Moreover, the experience of having their requests for support repeatedly denied or resulting in criticism precluded participants from seeking assistance in the future.

**Implications for nurses**

Nurses, along with other health and social service professionals, have a duty to provide optimal care to vulnerable populations. Implicit in this is the responsibility to support and assist those providing the day-to-day care to vulnerable populations (Golding, 2010; Henry, Pollack, & Lazare, 2006). To do this, nurses need an awareness of the health risks specific to both the vulnerable populations and their carers. The findings that have been reported in this article provide an account of some of the challenges and difficulties of mothering within the system. These findings have specific implications for nurses as they are likely to encounter children in foster care and their carers within a variety of contexts, including hospital settings, school clinics, community health programs, specialist paediatric services and general practice.

Evidence from the literature suggests nurses have some understanding of their professional responsibilities regarding child protection, largely emphasising their role in the prevention or reporting of child maltreatment (Crisp & Lister, 2004; Land & Barclay, 2008). Comparatively less attention has focused on the nurse-foster carer relationship (Barton, 1999; Lauver, 2008). Within this context, it is important for nurses to recognise whether a foster carer characterises herself personally or professionally, in relation to the children, as it may have a significant and direct effect on her self-esteem and emotional well-being (Blythe, et al., 2012a; Broady, et al., 2009). Participants in this and other recent Australian studies (D. Riggs, et al., 2009b; Smyth & McHugh, 2006), characterised themselves as parents, rather than paid carers. Given this perception, nurses are well-situated to provide ongoing support to foster mothers. Research has found nurses can influence and esteem women’s maternal self-confidence and sense of autonomy by providing them with the opportunity to talk about their mothering experiences (Fenwick, Barclay, & Schmied, 2001; Jackson & Mannix, 2003). To do so effectively, nurses require some understanding of challenges and difficulties of mothering within the system.
The new national framework for child protection in Australia has demonstrated a shift in emphasis from protecting children from abuse and neglect to promoting their health and well-being (Council of Australian Governments, 2009). However, despite national consensus regarding the purpose and focus of child protection, there remain significant bureaucratic differences between jurisdictions. Nurses, as well as other health care professionals, need a clear understanding of the child protection system if they are to effectively fulfil their professional responsibilities in this regard (Henry, et al., 2006; Land & Barclay, 2008). Continuing education programs are warranted to keep health care professionals appropriately informed of their own responsibilities as well as the policies and legislations governing foster carers (Rowse, 2009). This knowledge may assist nurses to minimise, rather than exacerbate, the inherent tensions of mothering within the foster care system.

Research has demonstrated a loss, perceived or actual, of maternal autonomy negatively affects the health and well-being of mothers (Lapierre, 2010; Lloyd & Hastings, 2009; Lupton & Fenwick, 2001). Given the findings of this study, it may beneficial to use a strengths-based approach when working with foster children and their families. Such an approach has been found to improve both individual and family functioning (Feeley & Gottlieb, 2000; Goldfarb et al., 2010). Using a strengths-based approach, nurses can help foster mothers identify, develop and utilise their own strengths effectively and appropriately within the limitations of the system. Such an intervention has the potential to mitigate the negative health effects associated with the loss of maternal autonomy.

Findings from this study add to the evidence that foster carers experience stress, anxiety and frustration as a result of working with the system and suggest this experience negatively impacts their health and well-being. Given the significant influence foster carers have on foster children (D. Riggs, et al., 2009a; Schofield & Beek, 2005b) and the impact maternal well-being has on child well-being (Streisand, Mackey, & Herge, 2010) there is a clear need to support and assist foster mothers. In so doing, the health and well-being of the vulnerable children living in foster care, as well as their carers, can be optimised (Marcellus, 2010).
Limitations of the study

The findings of this study reflect the experiences and perspectives of women providing long-term foster care for foster children with finalised guardianship orders in Australia. Women caring for foster children with temporary or interim custody orders, or within the context of respite care may not share these perspectives. Although the size and composition of the sample are limitations which prevent generalisability of the findings, participants’ reported maternal self-perceptions and their descriptions of fear and powerlessness are similar to existing foster care literature thus confirming and supporting their transferability (Briggs & Broadhurst, 2005; Broady, et al., 2009; Daniel, 2011; D. Riggs, et al., 2009b).

Conclusion

Foster carers have a significant responsibility in caring for vulnerable children. This study has shown that the female foster carers themselves are also vulnerable. In particular, interactions with the foster care system cause stress and frustration which ultimately have a negative effect on their health and well-being. As more long term foster carers question their mothering position, the system and health professionals, including nurses, need to understand their position and work in ways to protect all parties in the relationship, not only the children but also the foster carers.

Acknowledgments The authors would like to thank the women who participated in this study.

Authors’ Note Stacy Blythe, the first author, is a full-time PhD candidate and recipient of an Australian Postgraduate Award funded by the University of Western Sydney.

Declaration of Conflicting Interests The authors declare there are no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding No financial support was given to the authors for the research, authorship, and/or publication of this article.
References:


CHAPTER NINE: DISCUSSION AND CONCLUSION

INTRODUCTION

The most significant finding of this study was the women’s role distinction between being a foster carer and becoming a mother to the children in their long-term care. Although all of the women who participated in this study provided long-term foster care, most had also provided crisis, short-term and/or respite care. As providers of multiple kinds of foster care, they articulated a clear distinction between their roles as providers of long-term foster care versus other types of temporary foster care. Unlike temporary foster carers, once the decision was made to raise a child in a long-term capacity as an integral member of their family, the women ceased identifying themselves as a "carer" to another’s child(ren) and became a mother, in the fullest sense of the word, to the child(ren). This maternal self-perception dominated the women’s stories and it is from this perspective that they discussed their lives.

BECOMING A MOTHER

Becoming a mother profoundly influences a woman’s psychosocial development (Mercer, 2004). More than the performance of the relational and practical work of child rearing, being a mother is an inextricable part of a woman’s identity (Arendell, 2000). Although there are varied perspectives regarding how becoming a mother affects a woman’s identity it is generally agreed that being a mother is fundamental to a woman’s sense of self and can be seen to influence all aspects of her life (Medina & Magnuson, 2009; Weaver & Ussher, 1997). Mothers’ responsibility for the socialisation and development of future generations leave them open to critique according to socially and politically constructed ideals (Goodwin & Huppatz, 2010). Although these ideals are acknowledged as being unrealistic and unattainable, they are the normative standard against which mothers in Western society continue to be
measured (Arendell, 2000; Medina & Magnuson, 2009). As discussed in Paper 3 (pg. 71), the women in this study characterise themselves in line with dominant mothering ideology and set high maternal expectations of themselves which necessitated their life-long commitment, emotional vulnerability and self sacrifice (Blythe, Halcomb, Wilkes, & Jackson, 2012b). These ideals and expectations supersede those of a foster carer caring for children on a temporary basis. In the context of this study, when a child required long-term foster care the women’s perceived role evolved such that the identity of “mother” was revealed in every case.

The revelation of becoming a “mother” demonstrated the women’s shift in mindset from temporary foster carer to life-long mother, which they deemed as necessary to achieve long-term optimal outcomes for the children. This understanding, whether learned or intuited, is supported by contemporary research in mental health which indicates the development of primary, selective attachment between a child and parent (usually the mother) is essential for healthy biopsychosocial development (Zeanah, Berlin, & Boris, 2011). Attachment can be defined as the child’s propensity to seek comfort, support, nurture and protection from a small number of caregivers (Zeanah & Smyke, 2009). Children who experience primary attachment to a consistent, committed, loving caregiver achieve positive long-term outcomes (Schofield, 2002), develop resilience (Riggs, et al., 2009a) and are less likely to develop psychopathology (Dozier, Stovall-McClough, & Albus, 2008). Conversely, children who have limited, poor or disrupted attachments are known to experience stress, trauma, loss and increased psychopathology (Dozier, et al., 2008; Smyke, Dumitrescu, & Zeanah, 2002). Children’s attachment to a primary caregiver is activated progressively over time and involves brain-based changes that bond the caregiver-child dyad together (Schore & McIntosh, 2011; Sheridan & Nelson, 2009). Significantly for the women in this study, the quality of a child’s attachment is dependent on three things; firstly, the amount of time the caregiver-child dyad have together; secondly, the consistency of care provided in terms of comfort, nurturance and protection; and finally, the depth of the caregivers’ emotional investment in the child (Cassidy & Shaver, 2008; Colin, 1996). The women in this study were well positioned to facilitate attachment given their close physical proximity to and daily interaction with the children in their long-term care. Moreover, as foster carers, the women were accountable for providing the first two components of attachment; time
and consistent comfort, nurturance and protection. The third component, the depth of their emotional investment in the children, was a deliberate choice.

In this study, the women articulated their emotional investment in a child to be dependent on how they perceived their role in the child’s life. That is, if they perceived themselves as a short-term caregiver, they limited their emotional investment and avoided perceiving themselves as anything more than a temporary caregiver, committed to providing for the child’s needs for a limited time. However, if their role was to provide long-term care, they typically described making the same kind of emotional investment in the child as would a biological mother, and so, came to perceive themselves as the child’s mother. This is consistent with the literature that the most important variable in the quality of attachment for children in long-term foster care is the ability of the foster parent to make an unconditional emotional investment in the child (Dozier & Lindhiem, 2006; Smyke, Zeanah, Fox, Nelson, & Guthrie, 2010; Smyke, Zeanah, Fox, & Nelson, 2009).

Although there is a presumption that children’s attachment coincides with biology, research has demonstrated that healthy attachment is not dependant on biological ties and can develop as completely with non-biologically related caregivers as with biological relatives (Merrit & Franke, 2010; Smyke, et al., 2010; Zeanah & Smyke, 2008). Children who are placed with sensitive, committed foster carers have demonstrated the ability to develop healthy attachment and achieve optimal long-term outcomes (Laybourne, Andersen, & Sands, 2008; Schofield, 2002; Wilson, Petrie, & Sinclair, 2003). These outcomes, however, are largely contingent on foster carers own state of mind with respect to attachment (Dozier & Lindhiem, 2006; Dozier & Sepulveda, 2004; Dozier, Stovall, Albus, & Bates, 2001). Simply put, children in long-term foster care benefit most when foster carers understand and value attachment and are willing and able to develop and maintain such relationships with the children in their care. Therefore the finding that the women who participated in this study perceived themselves as mothers can be considered to be a highly desirable situation in terms of the attachment that this will facilitate with the foster children in their care.
MOTHERHOOD DENIED

Despite the benefits to the foster children in terms of improved attachment, the women in this study encountered significant opposition to their mothering role from the child protection system and society which privileges biological links over any other filial ties. This opposition could be attributed, in part, to society’s difficulty recognising more than one “real” mother in children’s lives. Adoption scholars argue society’s “hyper-valuing of biological ties” precludes any woman, other than the woman who gives birth, from being recognised as a “real” mother (Lynch, 2010, p. 222). Regardless of their legal parental status, adoptive mothers are generally viewed as being subordinate to biological mothers (Fisher, 2003; Kline, Karel, & Chatterjee, 2006; Waggenspack, 1998) and consequently have been found to experience stigma (Leon, 2002; Wegar, 1997, 2000). Similar to adoptive mothers, the foster mothers who participated in this study experienced stigma due to the absence of biological ties to the foster children in their care (Blythe, et al., 2012c). However, unlike adoptive mothers, the women in this study experienced the stigma related to their lack of legal authority for the children. This necessitated the women in this study to defer parental decisions to the statutory bodies which held legal parental responsibility for the foster children. These legal limitations are largely pragmatic and thus were not found to inhibit the women’s emotional investment in or maternal commitment to the children. Nevertheless, because the women identified themselves as mothers to the children in their care, these pragmatic restrictions were perceived as obstacles to them fulfilling their mothering role and thus exacerbated their perceived stigma.

The women’s stories clearly describe their experience of stigma. Their efforts to reject or conceal the foster carer label for fear of being negatively stereotyped clearly demonstrate their perceived subordination, as foster carers, within society (Blythe, et al., 2012c). However, it is the general lack of recognition for them as mothers to the children in their care that can be seen to cause the most angst. This is largely due to the women’s perception that this lack of recognition negatively impacts upon the children. The development of secure attachment and a sense of belonging with their foster family are essential for healthy psychosocial development of long-term foster children and have also been shown to aid in the recovery from maltreatment (Riggs, et al., 2009a; Schofield, 2002). Given the innate need for attachment, it is not
surprising that many children in foster care define the intimacy between themselves and their primary caregiver using in a metaphor which society can recognise, thus they identify their foster carer as “mother” (Eitzen & McIntosh, 2004; Surbeck, 2003). However, the idea that biological maternity is superior to any other maternal role is deeply entrenched in western societies and has been identified in young children (Lynch, 2010; Watkins & Fisher, 1993). The extent to which biological mother is constructed as the “real” mother may directly undermine the authority and challenge the attachment of the functional mother (Leon, 2002), potentially causing the child to question his/her belonging in the family (Fernandez, 2007). Denying the female foster carer the role of “mother” in the children’s lives has the potential to disrupt attachment, which is known to have deleterious long-term psychosocial consequences for the children.

The experience of being unrecognised and, at times, denied the role of “mother” can be seen to threaten the women’s sense of self. Essentially, one’s self, is created contextually and is based on interactions with others (Goffman, 1963). Interactions which challenge, rather than affirm, an individual’s sense of self have been shown to have a range of negative health implications including; increased anxiety, hypertension, and decreased working memory (Major & O’Brien, 2005). Individuals who experience threats to their sense of self take measures to actively avoid future challenging interactions, thus minimising potential health risks (Green, Davis, Karshmer, Marsh, & Straight, 2005). This study revealed there is little safe haven within the context of foster care. The participating women found acknowledgement and affirmation of their maternal self perception from the children in their long-term care, their husbands/partners, their own biological children and some of their extended family. Generally, outside these relationships, the women’s maternal sense of self was at risk, leaving them subject to the associated negative health consequences. This finding is similar to those of Broady et al. (2010) who found any challenge to the foster carers’ parental identity created significant inner turmoil.
In the context of this study, the greatest threat to personal wellbeing described by the women was the discontinuity between their self-identification as mothers to the children in their long-term care, and the child protection systems requirement to identity itself as the parent. This necessarily relegated the women to the status of a foster carer, with no parental authority and limited autonomy. In addition, the system reserved the status of mother for the women who gave birth to the children. Therefore women in this study were denied both the status of a mother and the authority of a parent.

Throughout the interviews, the women described experiences where the system reminded them of the legal limitations of their role in the child’s life. In these situations the caseworker, statutory body, or political designate was reinforced as being the one with legal parental responsibility. However, as Scott (2010) succinctly states, although legally empowered, the system cannot parent:

While the State may make financial provisions and uphold the legal rights of the children for whom it is responsible, it cannot perform the functions of the family – to provide the enduring bonds of attachment which nurture the ability to love and to be loved. The State is a cold breast and a dry nipple (p. 5).

The system’s assertion of its legal authority for the children in foster care has been documented previously in the literature as has been shown to cause feelings powerlessness and subordination in foster carers (Gilbertson & Barber, 2003; Maclay, Bunce, & Purves, 2006; Marcellus, 2010; Rosenwald & Bronstein, 2008). The findings of this study contribute to literature as it is the first time this experience has been described from the perspective of a carer identifying herself as “mother”. For the women in this study, the system’s assertion of its parental authority undermined and devalued their journey of making an unreserved emotional commitment to the child in their care and at times created pragmatic barriers to maintaining their parental role. It has been argued that when a person is strongly committed to a goal but lacks the authority to achieve it, a situation arises that precipitates hopelessness and depression (Astbury & Cabral, 2000; Brandtstadter & Rothermund, 2002).
The women’s resilience and long-term success was contingent on learning to “mother” in a system which systematically discounted their role yet held them accountable. Within the women’s stories, the system’s role was largely described as one of supervision rather than support. This left the women subject to critique and minimally resourced as they cared for children who were known to have complex physical, developmental and psychosocial difficulties (Nathanson & Tzioumi, 2007; Tarren-Sweeney & Hazell, 2006). When requests from foster carers for assistance from the system were met with reprimand or rejection, the women in this study reacted in one of two ways. Some of the women became ardent advocates for the children within their care demanding the statutory bodies provide the resources necessary to support the children. Other women withdrew from the system, developing networks and accessing services outside the system. Both strategies enabled the women to provide for the children, but were seen to create an environment of conflict and distrust with the system personnel who were legally responsible for the children. This is congruent with Maclay, Bunce and Purves (2006) who found foster carers heavy reliance upon or independence from the system caused tension with system personnel.

**IMPLICATIONS OF FINDINGS**

The findings of this study suggest that in current practice, there is greater emphasis placed on maintaining the children’s biological identity and the parental authority of the statutory bodies charged with their ongoing care and protection compared to the children’s development of healthy attachment. However, the day-to-day care essential to the children’s healthy development cannot be rendered by the biological mother (due to the children’s long-term physical removal from her care) or the statutory body charged with their care and protection (due to its insensibility). When it has been deemed necessary that such care be provided primarily by another woman for the rest of the child’s dependent life (and often well beyond), denying her the status of mother and the authority of parent is a significant risk to her own long-term wellbeing and potentially the wellbeing of the child. Given this finding, existing policy and practice should be reviewed to recognise and support the foster mother in her role.
The need for good quality foster care cannot be underemphasised. However, it is evident from this study that society has a poor understanding of foster care and as such, foster carers experience stigma. This misunderstanding contributes to difficulties recruiting and retaining foster carers (Colton, et al., 2008). The findings of this study challenge societal misconceptions by providing insight into the realities of providing long-term foster care from the woman’s perspective. Dissemination of these insights to the community can raise awareness of this issues faced by this group.

Health and social service providers regularly work with and support vulnerable families in an effort to prevent family breakdown or to achieve family restoration. When these efforts prove ineffective and the decision is made to place a child into long-term foster care, a new family is formed which warrants the same level of support and intervention. Providing appropriate support for these families can be challenging. Findings from this and other studies indicate understanding and acknowledging how long-term foster carers perceive their role is a good first step (Riggs, Augoustinos, & Delfabbro, 2007; Riggs, et al., 2009b). Such an understanding can enable health and social service providers to adopt a family centred approach when working with foster children and their foster carers.

This study provides valuable information which can be used to improve foster carers’ relationships with the child protection system and its staff. This information is beneficial to the recruitment and retention of foster carers as poor relationships with system personnel has been identified as a key factor contributing to foster carer attrition (Sinclair, Gibbs, & Wilson, 2004; Wilson, Sinclair, & Gibbs, 2000). Although collaboration with foster carers is advocated in policy documents, many health and social professionals do not fully comprehend what families experience when they make the long-term commitment to a foster child. This indicates a need for education to ensure that health and social service providers have a clear understanding of the value and role foster carers play in children’s lives. Such an understanding can minimise conflict and facilitate collaboration between system personnel and foster carers.

Based on the findings of this study, education regarding the concept of attachment is warranted for health and social service providers as well as for foster carers. This
shared understanding can enhance children’s attachments and optimise their long- 
term outcomes. Health and social service providers who understand attachment may 
be more inclined to recognise and work with long-term foster carers as parents. 
Further, as providers of care working with foster families, these professionals are 
well placed to assist the development of healthy attachment between foster children 
and their long-term carers.

STRENGTHS AND LIMITATIONS OF THIS STUDY

STRENGTHS OF THIS STUDY

Using a feminist informed, story-telling methodology for this research was 
considered to be a strength as it enabled participants to take control and subsequently 
feel empowered. Women were able to reflect upon and make meaning of their 
experiences as they conveyed their stories. This method generated new insights and 
facilitated greater understanding of the women’s experiences of providing long-term 
foster care.

Although research in the area of foster care is increasing, comparatively little 
research reports foster carers’ experiences (Ciarrochi, Randle, Miller, & Dolnicar, 
2011). The majority of this research tends to homogenise providers of various types 
of foster care (eg. long-term, short-term, respite foster care) into a sample potentially 
missing important nuances relative to specific types of foster carers (Blythe, et al., In 
press-b). This study has contributed to extant literature by exploring a specific 
population; namely women providing long-term foster care.

The use of multiple interview methods facilitated the inclusion of geographically 
distant women. It also enabled greater flexibility regarding the time and place 
interviews were to occur. Women were able to choose the method they deemed least 
intrusive and fit best with their significant care-giving responsibilities.

Finally, the candidate’s position as an ‘insider’ in relation to the research was 
beneficial to the study (Blythe, et al., In press-a). In keeping with the methodology, 
the ‘insider’ position helped minimise the inherent researcher-participant power 
differential and enabled collaboration. This resulted in the generation of content rich 
stories.


LIMITATIONS OF THIS STUDY

The sampling procedures employed in this study aligned with qualitative methodological standards and suited the aim of the study. Despite this, there is potential for bias as the sample was self selected and thus the findings may represent women who are more proactive compared to other providers of long-term foster care. This study focused on women’s experiences of providing long-term foster care in the Australian context, thus women’s experiences from other countries were not investigated. The majority of participants (n=19) were of an Anglo-Australian heritage, thus the experiences of Indigenous and various cultural groups are not reflected in the findings. Further studies with women from culturally diverse backgrounds may reveal different experiences. The findings of this study are limited as they reflect current issues and trends within a specific historical, cultural and political context.

While there were benefits to using multiple data collection methods there were also disadvantages. Telephone and email interviews did not allow for the observation of subtleties, such as body language and other non-verbal cues (Schneider et al., 2005). Further, email interviews were limited as they did not afford the same opportunities for probing as did verbal interviews (Mann & Stewart, 2000).

The story-telling methodology presented a number of challenges for the candidate (discussed in Chapter 4). Despite the numerous strategies employed to overcome these challenges, the findings are limited due to her position as an ‘insider’ researcher. A heuristically designed approach, which valued and included (rather than excluded) the candidate’s personal experiences, may have resulted in different findings.

Finally, as a research methodology, story-telling may be inherently limited. Stories gathered for the purpose of research have the potential to influence policy and practice (Yoder-Wise & Kowalski, 2003). Given the reason for telling one’s story influences what parts of the story are told (Bailey & Tilley, 2002) it is possible that the women participating in this study conveyed their stories selectively in order to achieve their own, unstated agendas. In so doing, important elements of participants’ experiences may have been omitted thus limiting the generalisability of the findings.
RECOMMENDATIONS FOR FUTURE RESEARCH

The women who participated in this study clearly articulate becoming a mother to the children in their long-term care. Future research investigating the biological mother’s response to this finding is warranted. Such research may contribute to the development of collaborations between foster and biological mothers which ultimately benefit the children.

The participants equate their relationship with the children in their long-term care with biologically formed mother-child dyads. Future research using quantitative methods to measure and compare attachment within these dyads could extend these findings and generate new understanding. This has the potential to influence current policy and practice as it applies to children and their long-term foster carers.

Further research into the experiences of both women and men providing long-term kinships care is needed to gain insight into how these long-term carers characterise their role in relation to children with whom they have a prior (often biological) relationship. For example, when the biological aunt becomes the long-term kinship carer of her niece/nephew, does her sense of self evolve in a similar fashion to the women in this study? This understanding is essential to development of appropriate support services for long-term kinship carers.

Finally, this study explored women’s experiences of providing long-term foster care. Future research examining both men’s and women’s experiences of providing other types of foster care would be beneficial to further extend our understanding. Gaining such insights has the potential to facilitate appropriate (ongoing) support and interventions to assist foster carers to provide optimum care to children.
CONCLUSION

This study has provided a unique insight into women’s experiences of providing long-term foster care in Australia. The findings reveal a dual vulnerability affecting both the women and the children in their long-term care. The vulnerability of both groups has its aetiology in the fact the child protection system, legal system, health care system and society at large assume the best interest of the children is served by perceiving the woman who gave them birth as their only "true" mother. This assumption is made even when the children’s well-being has been judged to necessitate their placement in the long-term care of another woman. This assumption is evidenced by terms such as “carer”, and “foster carer” continuing to be applied to women who raise these children for the rest of their lives, whilst "mother" is reserved solely for the biological parent. This bias means children in long-term care often experience limitations in developing typical levels of attachment to their foster parent, and these parents experience an extensive stigma when they offer an uninhibited level of emotional bonding and commitment to the children by identifying themselves as the "mother."
REFERENCES


University of Western Sydney. (2012). Doctor of philosophy policy.


Ms. Ref. No.: COLL-D-12-00032R2
Title: The foster carer's experience: an integrative review
Collegian: The Australian Journal of Nursing Practice, Scholarship and Research

Dear Stacy,

I am pleased to inform you that your paper "The foster carer's experience: an integrative review" has been accepted for publication in Collegian: The Australian Journal of Nursing Practice, Scholarship and Research.

Below are comments from the editor and reviewers.

Thank you for submitting your work to Collegian: The Australian Journal of Nursing Practice, Scholarship and Research.

Yours sincerely,

Professor John Daly RN PhD FRCNA FCN
Collegian: The Australian Journal of Nursing Practice, Scholarship and Research

Comments from the editors and reviewers:

Thank you for your revisions- please ensure that you ensure endnote has formatted correctly

--------------------------------------------------------------------------------------------------------------------------

For further assistance, please visit our customer support site at http://help.elsevier.com/app/answers/list/p/7923. Here you can search for solutions on a range of topics, find answers to frequently asked questions and learn more about EES via interactive tutorials. You will also find our 24/7 support contact details should you need any further assistance from one of our customer support representatives.

162
Dear Stacy

Re: The challenges of being an insider in story-telling research – Article ref: NR333

Thank you for your article which I am pleased to accept for a future issue of Nurse Researcher.

Please note that in common with all professional publications your article will undergo editorial changes before going to print, which may include changes to headlines and summaries.

A complimentary copy of the issue will be sent to each author following publication.

It is now assumed that this article will be solely published in Nurse Researcher and not submitted elsewhere, if this is not the case, please inform the editor immediately.

Please find attached a publisher’s agreement and author’s details form for your signature and return. The author’s details form must be completed with the full details for all authors where appropriate.

Dr. Leslie Gelling
Editor, Nurse Researcher

Helen Hyland
Administration Manager Specialist Journals
PA to Gary Bell, Senior Editor, Specialist Journals

RCN Publishing Company
The Heights
59-65 Lowlands Road, Harrow on the Hill
Middlesex HA1 3AW
Direct: 020 8872 3138
Email: helen.hyland@rcnpublishing.co.uk
08-Mar-2012

Dear Stacy

"Perceptions of long-term female foster carers: I'm not a carer, I'm a mother"

I am pleased to inform you that we are in a position to accept your resubmitted paper for publication in The British Journal of Social Work. The comments of the reviewers who reviewed your manuscript are included at the foot of this letter. As you can see one of the reviewers is suggesting some minor changes in terms of sentence structure and meaning. You should deal with these at the proof reading stage.

Thank you for considering the journal and congratulations! On behalf of the Editors of The British Journal of Social Work, we look forward to your continued contributions to the Journal.

In order to publish your article, Oxford University Press requires that you complete a licence agreement online. A link to the online licensing system, and instructions on how to select and complete a licence, will be provided to you by the Production Editor at Oxford University Press in due course.

You should expect to receive a PDF proof of your article for correcting in approximately 4 weeks. This will come via email directly from 'Oxford Journals'.

Yours sincerely

Dr. Jim Campbell
Co-Editor
The British Journal of Social Work
bjsw.editorialoffice@oup.com
24-Aug-2011

Dear Mrs. Blythe:

Thank you for submitting your revised manuscript entitled "The stigma of being a long-term foster carer" to the Journal of Family Nursing. I have reviewed your final revisions and am pleased to accept your manuscript for publication. I will begin to prepare your manuscript for publication immediately and will let you know if I have further queries.

A JFN permissions agreement will be sent to you by separate email.

Thank you for choosing Journal of Family Nursing as a place to publish your research.

Sincerely,
Janice M. Bell, RN, PhD
Editor, Journal of Family Nursing
jmbell@ucalgary.ca
From: CNJ Editor [mailto:editorial@contemporarynurse.com]
Sent: Tuesday, 25 September 2012 3:26 PM
To: Stacy Blythe
Subject: Decision on Manuscript ID:CNJ2449 - Accepted

Dear Stacy Lee Blythe,

Thank you for submitting your manuscript entitled 'Caring for vulnerable children: Challenges of mothering in the Australian foster care system' for consideration for publication in the Contemporary Nurse Journal.

The reviewers reports were somewhat conflicting, though it has been decided that your paper is provisionally accepted for publication. Your paper is scheduled for inclusion in Vol. 44/1, Special Issue on Advances in Health Care with Vulnerable and Marginalised populations.

From this point on you may receive some communication from our copy-editor M. Krishna Kumar (Krish) from Quick Sort (India) econtent@quicksortindia.com.

Once again, thank you for submitting your manuscript to Contemporary Nurse.

Sincerely,

Amelia Ross
CNJ Editorial team
editorial@contemporarynurse.com

Contemporary Nurse
editorial@contemporarynurse.com
Attention: Foster Carers
Invitation to participate in research

Are you a woman who is currently providing long-term foster care to a child or young person?

If so, you are invited to participate in a research project that seeks to explore your experience as a provider of long-term foster care.

The majority of primary foster carers are women and the research team is interested in hearing your story of being a long-term foster carer. Your stories have the potential to inform future policy development which could better support foster carers and enhance the living situations for the children and young people in foster care.

To find out more about this research project, please contact Mrs. Stacy Blythe Ph: 0433 347 344 Email: s.blythe@uws.edu.au

This research Project is endorsed by the University of Western Sydney.
APPENDIX C – PARTICIPANT INFORMATION PACKAGE
The stories of women who provide long-term foster care

Participant Information Sheet

As a female provider of long-term foster care, you are invited to participate in the research project "The stories of women who provide long-term foster care." This research is being conducted by Ms Stacy Blythe as a PhD project and is being supervised by Professor Debra Jackson, Professor Lesley Wilkes and Dr. Elizabeth Halcomb of the University of Western Sydney's School of Nursing and Midwifery. This project aims to explore the first hand experiences of women who provide long-term foster care to children and young people in Australia.

What does the project involve?
Participants in this project will be asked to share their experiences as providers of long-term foster care during an interview. Interviews will be audio-recorded to allow the researchers to transcribe what is said for later analysis.

How much time will the project take?
The interview will last 1-2 hours & will be conducted at a mutually convenient place & time.

What are the risks and benefits for me?
Telling ones' story is a powerful experience. While some of the experiences you share may be joyous, others may be distressing. Interviews will be conducted within an empathetic and supportive environment. Your identity will be known only to the primary researcher and will not be revealed in any reports stemming from the study. Should you become distressed, you are able to stop the interview at any time. Information regarding professional counselling services will be made available to all participants prior to the interview.

Whilst it is unlikely that any participant will directly benefit from this project, the information gained has the potential to develop a new understanding of foster carers. This understanding has the potential to influence future policy changes which could better support foster carers and enhance the living situations for the children and young people in foster care.

Do I have to participate?
Participation in this project is purely voluntary. If you choose to participate, you can withdraw at any time without giving a reason and without any consequences.

Can I tell other people about the project?
Yes, you are welcome to tell other people about the project and provide them with the principal investigators contact details. They can contact the principal investigator to discuss the potential for them to participate in the study.

Will anyone else know the results?
Findings of the project will be published in journal papers and presented at professional conferences. However, any information obtained in connection with this project that can be identified with you will remain confidential and will only be disclosed with your permission, except as required by law.

What if I have questions about the project?
Questions about the project can be directed to Mrs. Stacy Blythe (email s.blythe@uws.edu.au or phone 02 4570 1930).

NOTE: This study has been approved by the University of Western Sydney Human Ethics Research Committee. If you have any complaints or reservations about the ethical conduct of this research, you may contact the Ethics Committee through the Human Ethics Officer, Building K – Kingswood Campus, University of Western Sydney, Locked Bag 1797, Penrith South DC, NSW, 1797 (email humanethics@uws.edu.au, phone 02 4736 0883, fax 02 4736 0013). Any issues you raise will be treated in confidence and investigated fully, and you will be informed of the outcome.
The stories of women who provide long-term foster care

Participant Consent Form

1. I, __________________________ [name] agree to participate in the research described in the attached Information Sheet.

2. I acknowledge that I have read and understood the attached Information Sheet.

3. I understand that participation involves a face-to-face interview with the principal investigator of this research project at a mutually convenient time and place. I understand the content of the interview will focus on my experiences as a provider of long-term foster care to children in Australia. I understand that this conversation will be digitally audio-recorded.

4. I understand that my decision whether or not to participate in, or subsequently withdraw from this research project will not affect my current or future association with the University of Western Sydney or my relationship with the researcher.

5. I understand that my participation in this research project is purely voluntary and that I may withdraw from the project at any time without consequence.

6. I understand that my involvement is confidential and that the findings of this project may be published but no information about me will be used in a way that reveals my identity.

7. Before signing this consent form, I have been given the opportunity to discuss my participation in this project. I understand that if I have any further questions related to this project I can contact the principal investigator, Stacy Blythe on telephone 02 4560 1930 or email s.blythe@uws.edu.au.

8. Any concerns or complaints may be directed to the Human Ethics Officer, Building K Kingswood Campus, University of Western Sydney, Locked Bag 1797, Penrith South DC, NSW, 1797 (phone (02) 4736 0883, fax (02) 4736 0013, email humanethics@uws.edu.au).

Participant: ______________________________________

Signature: ______________________________________

Date: __________________________

Contact for further information:

Stacy Blythe RN BN(Hons)
PhD Candidate, School of Nursing and Midwifery, University of Western Sydney
Telephone: 02 4570 1930 Email: s.blythe@uws.edu.au
Thank you for participating in this research project. Should you have any concerns please contact Stacy Blythe (Ph: 02 4570 1930 or Email s.blythe@uws.edu.au).

If you would like to further discuss any of the issues raised during your interview, please make use of the numbers provided below.

DoCS Helpline: 132 111
To report child abuse and neglect 24 hrs

General support and counselling

- Lifeline: 13 11 14

- Relationships Australia: 02 9418 8800 or 1300 364 277

- Salvo Care Line: 02 9331 6000

Parenting issues

- Karitane: 02 9794 1852 or 1800 677 96
  24 hour parenting information and counselling

- Parent Line: 1300 1300 52
  Toll free, 24 hour telephone information, counselling and referral service for all NSW parents of children aged 0 – 18 years. Operates 7 days (including public holidays).

- Tresillian: 02 9787 0855 or 1800 637 357
  24 hour information and counselling for parents or carers of children under five years

Additionally, the New South Wales Department of Community services website has a comprehensive list of counselling services available to foster carers. They can be found on http://www.community.nsw.gov.au/about_us/contact_us/support_and_counselling_numbers.html
Interview questions:

Initially, the participants will be asked to tell their stories of becoming the carers of and caring for children in long-term foster care. The following questions may be used to prompt the story and guide the interview process:

1. Can you describe what it means to you to be the carer of children in long-term foster care?
2. Can you tell me about how you became a carer?
3. Can you tell me some good things about being a carer?
4. Can you tell me what has been difficult about being a carer?
5. What impact has fostering had on you? (personally, socially, emotionally, etc.)

Initial demographic data on the foster carer will be requested...

- Age
- Length of time as a carer
- Types of care rendered (only long-term? Or short-term as well, etc.)
- Number of children cared for to date
- Employment status
- Marital status
- Biological or adopted children?

Demographic data on the children in long-term care (bearing in mind the confidentiality issues surrounding foster care)

- Gender
- Ages
- Reasons for removal
- Number of previous foster homes
- Length of time in care
- Continued contact with birth family?
- Physical, psychological or emotional disabilities/diagnoses?
APPENDIX E – ETHICS APPROVAL
Notification of Approval

Email on behalf of the UWS Human Research Ethics Committee

Dear Debra and Stacy

I'm writing to advise you that the Human Research Ethics Committee has agreed to approve the project.

TITLE: *The stories of women who provide long-term foster care*

**H7474  Student: Stacy Blythe (Supervisor: Debra Jackson)**

The Protocol Number for this project is H7474. Please ensure that this number is quoted in all relevant correspondence and on all information sheets, consent forms and other project documentation.

Please note the following:
1) The approval will expire on 1 October 2010. If you require an extension of approval beyond this period, please ensure that you notify the Human Ethics Officer (humanethics@uws.edu.au) prior to this date.

2) Please ensure that you notify the Human Ethics Officer of any future change to the research methodology, recruitment procedure, set of participants or research team.

3) If anything unexpected should occur while carrying out the research, please submit an Adverse Event Form to the Human Ethics Officer. This can be found at http://www.uws.edu.au/research/ors/ethics/human_ethics

4) Once the project has been completed, a report on its ethical aspects must be submitted to the Human Ethics Officer. This can also be found at http://www.uws.edu.au/research/ors/ethics/human_ethics

Finally, please contact the Human Ethics Officer, Kay Buckley on (02) 4736 0883 or at k.buckley@uws.edu.au if you require any further information.

The Committee wishes you well with your research.

Yours sincerely,

Dr Janette Perz,
Chair, Human Research Ethics Committee

Kay Buckley
Human Ethics Officer
University of Western Sydney
Locked Bag 1797, Penrith Shire DC. NSW 1797
Tel: 02 4736 0883