# A Qualitative Study of the Parenting Support Needs of Mothers Raised in Out-of-Home Care

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by Jamie Ussher

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## Abstract

This thesis explored the experiences and perspectives of parenting support for mothers who spent time in out-of-home care. First, it investigated how their experiences and relationships while growing up influenced later support. Second, it identified what mothers believe to be the most valuable forms of support and how they accessed them. Using a qualitative methodology, Interpretative Phenomenological Analysis, semi-structured interviews were conducted with eight participants. Study findings consisted of four superordinate themes: the influence of upbringing on a mother's supports, obtaining support, accessibility of support, and pathways to support outcomes. The women in the current study had complex upbringings which influenced their early days of mothering and support networks. Although they experienced a range of difficulties, they also experienced and valued compassionate support and people who were available for them and their children. Findings suggest that mothers are open to parenting support but face various barriers to accessing it. Practice and policy implications are discussed in view of meeting the needs of these young mothers at a time when they may be more open to support, in hopes of creating positive pathways for them and their children.

# Chapter 1: Introduction

The purpose of this study was to explore how mothers who spent time in out-of-home care perceive support and how their experiences while growing up influence support and their access to it. This thesis reports on the findings of a qualitative study which carried out that purpose. Chapter one describes the literature relating to children in out-of-home care, their development and later outcomes. Chapter two presents the literature on young mothers who have been in or currently reside in care, offering rationale for the current study. Chapter three explains the research methodology and method of the study. Chapter four gives the study results, and chapter five provides a discussion of the study findings and their implications.

## What Is Known About Mothers Who Resided in Out-of-Home Care When They Were Children?

Out-of-home care (OOHC) refers to alternative living arrangements or accommodation for children and young people who are no longer able to live with their parents. The term encompasses multiple types of care including short term (i.e. emergency or respite care), transitional, or permanent care. Out-of-home placements could be in foster homes, relative or kinship homes, family group homes, or in a residence. Based on global data from 2006 to 2017, it is estimated that approximately 2.7 million children are in formal alternative care (i.e. OOHC) throughout the world (Petrowski, Cappa, & Gross, 2017). In New Zealand, approximately 20% of children come to the attention of Oranga Tamariki, the government's care and protection agency (Oranga Tamariki Evidence Centre, 2020). Though each situation is different and often complex, children may go into OOHC due to safety issues within their current home including caregiver risks (e.g. substance abuse, domestic violence), child behaviour problems, mental health difficulties of the child or parent, and maltreatment (i.e. the experience of neglect or physical, sexual, or emotional abuse) (Barth, Wildfire, & Green, 2006). When a child is removed from their home there may different

short- and long-term goals for that child, such as returning home or reunification with their parent, adoption, living with a relative, long-term foster care, or emancipation (Child Welfare Information Gateway, 2020). For example, for the estimated 250,103 children who exited foster care in the USA in 2018, 49% were reunited with their parent or primary caregiver, 25% were adopted, 11% went to live with a guardian, 7% were emancipated, 7% went on to live with a relative, and 1% had other outcomes (Child Welfare Information Gateway, 2020). However, each country varies, as New Zealand, for example, has very limited options for adoption from OOHC (Oranga Tamariki, 2020).

### *The Psychosocial Development of Children in Care*

A child develops according to many factors, including the child's biological make-up, their environment, the various systems in which they are connected both in proximal and distal ways, and how the child interacts with each of these factors (Bronfenbrenner & Morris, 2006). These dynamics can serve as either risk or protective factors within the wider systems, influencing the trajectory of the child's development over time and creating pathways to multiple outcomes (Cicchetti, Toth, & Maughan, 2000). A child who has come into OOHC is not the product of a single experience, but a result of many interactions that have happened in their life to this point (Cicchetti et al., 2000).

Experiences of abuse or neglect influence the normal developmental processes, causing ongoing emotional, social, neurocognitive, and physical problems (Palacios et al., 2019). These adverse experiences put children at higher risk for developmental difficulties and mental health disorders as well as relationship difficulties (Rebbe, Nurius, Ahrens, & Courtney, 2017; Tarren-Sweeney, 2008b). Children who have experienced maltreatment and emotional trauma come into foster care with higher rates of externalising and internalising problems than children who have not been maltreated. Pecora et al. (2009) report studies showing that almost half of children in care between the ages of 2 and 14 years old have both

emotional and behavioural problems. Children who have experienced maltreatment are at higher risk for aggressive and antisocial behaviours (Kendall-Tackett, 2003). McMillen et al. (2005) found that adolescents in OOHC had high rates of psychiatric disorders, with more than half of the adolescents having at least one disorder before entering foster care, likely due to a number of factors related to their families of origin.

Though children who have been maltreated have increased likelihood of developing a psychiatric disorder at some point in their life, symptoms may not develop till later (McCrory & Viding, 2015). McCrory and Viding (2015) describe a theory of latent vulnerability to symptoms of clinical disorders. The theory describes how as a child's specific biological make-up responds to their adverse environment, it creates a pathway which effects their neurocognitive systems. Their heightened vigilance to threat is an adaptive response to their adverse surroundings, however their interactions (including reward, threat, and memory processing) in subsequent environments become maladaptive once out of the adverse environment (McCrory & Viding, 2015). Typically, when cases of maltreatment are investigated and confirmed, child protection concerns are addressed and therapeutic interventions are utilised only if the child meets psychiatric diagnostic criteria (McCrory & Viding, 2015). If symptoms have not developed when a child goes into care, they may not receive therapeutic intervention which may lead to further mental health and relationship difficulties.

### *The Acquisition of Relational Permanence, Belonging, and Connectedness*

When a child has a caregiver who is accessible and able to meet their needs it increases the chances that they may go on to have healthy relationships, giving children a sense that relationships are safe and can be relied on. As children get older, relationships and the resources they provide are an important part of their development, helping them adjust to independence (Duke, Farruggia, & Germo, 2017). Often for children their early learning of

relationships, their resources, and the social structures come from the parent-child relationship. A sense of belonging is nurtured when these relationships offer relational connectedness and are permanent (Barry, 2011). It is important that children experience enduring relationships that offer unconditional acceptance, support, security, and nurturance for their growth and development (Cicchetti et al., 2000).

When children have experienced a lack of protection or abuse from the very person who is meant to be providing care, it can make it difficult to trust other people who are meant to care for and protect them. A lack of trust in adults may have become the child's default mode of engagement as in their past experiences this was a protective mechanism (McCrory & Viding, 2015). Then, once in care they may be placed in a new home where they are expected to form new connections, learn new sets of rules, and enter a different family system. All of this adds to the complexity of relational connection for children who are removed from their family and home (Pecora, White, Jackson, & Wiggins, 2009). Children need not only legal and residential permanence but relational permanence, a sense of belonging and a joint commitment of one person to another (Brodzinsky & Smith, 2019; Palacios et al., 2019). The need every child has for stability and connection has already been damaged for a child who enters care as, at the very least, they have already suffered one relational loss.

The trauma of maltreatment and feelings of rejection from those who should have protected them may lead to interpersonal difficulties in future relationships (Chase, Maxwell, Knight, & Aggleton, 2006; Connolly, Heifetz, & Bohr, 2012; Tarren-Sweeney, 2008b). OOHC may be an impermanent solution for children who have come into care for a variety of reasons, including hopes of reunification with biological parents and placement breakdowns. Though it is a worthy goal for children to grow up within their biological families and can be of great benefit to the child and their family, it must be done safely. If the

child's safety becomes an issue after reunification has occurred it can lead to further disruption and change for children who are then put back into OOHC (Biehal, Sinclair, & Wade, 2015). One study showed that four years after children were reunified with their biological families, 63% were back in OOHC after unstable reunification due to further maltreatment, inadequate parenting, or the parent's inability to cope with their child's behaviour (Biehal et al., 2015).

Attachment difficulties and trauma contribute to the development of relationship difficulties and conduct and attention problems (Tarren-Sweeney, 2018). Children who have been placed into foster care come with difficulties that require empathy and understanding from their caregivers (Palacios et al., 2019). The road to recovery from past trauma is often long and difficult, which necessitates emotional and physical endurance on the part of the caregivers (Tarren-Sweeney, 2018). Many foster carers are ill-equipped to offer a therapeutic environment for a recovering child (James, Landsverk, Slymen, & Leslie, 2004). Difficult externalising behaviours are a major factor contributing to placement breakdowns (Newton, Litrownik, & Landsverk, 2000). Many adolescents leave the care system at 16-18 years old without a permanent and stable relationship (Tarren-Sweeney, 2016). Young people transitioning out of OOHC who have not experienced permanency and endearing relationships have been found to lack supports, life skills, and emotionally healthy relationships (Oranga Tamariki Evidence Centre, 2018).

***Outcomes for Young People Who Exit Care Upon Reaching Legal Adulthood***

The terms "care leavers" or foster youth who "age out" refer to youth who have been in OOHC and are transitioning to independence. Different countries, and even locations or states within those countries, vary the age at which young people leave OOHC. For example, in the USA some young people leave care at 17 while others can stay in care till 21 years old, depending on the state legislation (McCoy, McMillen, & Spitznagel, 2008). Currently in New

Zealand, young people can stay in OOHC up to 21 and, whether they stay in care or not, care and protection services are to maintain contact up to age 21. In some cases young people can stay under the state's guardianship till they are 25 years old (Oranga Tamariki Evidence Centre, 2019). However, this legislation is new and young people may leave OOHC for a variety of reasons beyond meeting age criteria, including placement breakdowns, running away, becoming incarcerated, or moving in with biological families (McCoy et al., 2008).

There are many factors that contribute to outcomes for youth leaving the care system - their experience of being parented, maltreatment, being in OOHC, the opportunities or lack thereof in education and practical skills, social skills, and the amount of current and ongoing support. Some youth in care have stable placements and will continue on with permanency, moving into further education or employment. However, many young people leaving care lack skills and support. For them, the transition to adulthood can be overwhelming (Pecora et al., 2009). Results of research on the outcomes for those who have aged out of OOHC are disheartening. One study found that young people who have exited OOHC are doing worse than other young people in a number of areas including employment, education, substance abuse, mental illness, and basic living (i.e. homelessness) (Courtney & Dworsky, 2006). Many end up living back with their biological families. Others are homeless or have criminal involvement (Courtney & Dworsky, 2006). Some of these outcomes are discussed further below.

**Lack of Support.** At a time when support is desperately needed, transitioning from OOHC can be daunting. It is all the more difficult for youth transitioning out of care who lack permanent support from family or a place to return to as needed (Pryce & Samuels, 2010). A brief on young people transitioning from OOHC from the Oranga Tamariki Evidence Centre (2018) identified that half of young people transitioning out of care in New Zealand lack life skills, social skills, and struggle to have healthy relationships. Sixty percent

of young people transitioning out of care reported having on-going difficult family dynamics (Oranga Tamariki Evidence Centre, 2018). Young people transitioning out of care are often in relationship deficit, without a sense of identity or belonging (Courtney & Dworsky, 2006; Svoboda, Shaw, Barth, & Bright, 2012).

At a time when older youth would receive financial and emotional support from adults in their lives, there are a number of young people who leave the care system without this. Many young people leaving care have weakened support due to their adverse childhood experiences prior to entry into OOHC and subsequent negative experiences within the care system (Melkman & Benbenishty, 2018). A study of 445 care leavers in Israel focused on the relationship between childhood adversity and adult functioning, with support as a mediating factor (Melkman & Benbenishty, 2018). Adult functioning was gauged by adjustment, economic stability, and housing. Support was delineated to three categories: practical, emotional, and informational or guidance. Support had a significant mediating role between childhood adversity and adult functionality (Melkman & Benbenishty, 2018). The size and adequacy of the young person's support network played a role in how supports affected their functioning. Support for young people exiting care is important for positive outcomes in psychological wellbeing (Perry, 2006).

**Education, Employment, and Housing Difficulties.** Lack of housing, lower education levels, and ability to gain employment are all linked for youth trying to live independently after leaving OOHC. Young people leaving care may live in a variety of housing situations – government housing, independent or private rentals, moving back in with their biological family, continuing on with their foster carer, moving around between places, or homelessness**.** The challenge of getting to school and negotiating social norms may become too difficult for an adolescent in OOHC to navigate. Young adults who have been in care tend to move around more frequently (Wade & Dixon, 2006). Current realities include

greater difficulty obtaining labouring jobs, lack of affordable housing, and a need for higher education in attaining work (Gypen, Vanderfaeillie, De Maeyer, Belenger, & Van Holen, 2017)**.** Young people who have aged out of OOHC may have had poorer education and therefore fewer job opportunities with lower earning potential (Courtney & Dworsky, 2006; Gypen et al., 2017).

**Mental Health Difficulties.** A study of 373 seventeen year old young people in OOHC found 61% of participants had at least one psychiatric disorder in their lifetime, with 62% reporting onset prior to entering OOHC and 37% meeting criteria in the last year (McMillen et al., 2005). The youth in care had higher rates of disorders according to diagnostic criteria when compared to non-fostered youth, including three times greater rates of depression and two times greater rates for post-traumatic stress disorder (PTSD). They also had higher rates of disruptive behaviours such as defiance and hostility (McMillen et al., 2005).

Another study found, when compared to youth of the same age still in OOHC, those who had exited care had higher rates of mental health disorders including depression, social phobia, post-traumatic stress disorder, and alcohol and substance abuse or dependence (Courtney and Dworsky, 2006). This may be due to unresolved issues that arise once youth are independent, at which point they may not have the support to engage in therapeutic work (Pecora et al., 2009).

**Pregnancy.** A study of youth who were connected with child welfare services reported 80% had engaged in sex by 17 years of age (James, Montgomery, Leslie, & Zhang, 2009). Similarly, 87.8% of care leavers in Courtney and Dworsky (2006) study reported having sexual intercourse. Compared with females in a general population sample, female care leavers reported a greater likelihood of having had sexual intercourse (89.8% verses 77.9%) (Courtney & Dworsky, 2006). While not necessarily a harmful outcome, earlier

sexual activity increases the risk for pregnancy. This same study found that by age of 19 almost half of the female participants in their study who had left care had been pregnant, a higher rate when compared to the 20% who had never been pregnant in a comparison sample of 19-year-old females. Youth who were still in care reported fewer pregnancies, however 22% reported having an abortion whereas only 3% of care leavers reported ending a pregnancy in an abortion (Courtney & Dworsky, 2006).

Adverse childhood experiences and placement instability may contribute to higher rates of unprotected sexual activity and early pregnancy (Svoboda et al., 2012). Childhood sexual abuse has been shown to be a predictor for higher subsequent sexual behaviour among children and adolescents (Tarren-Sweeney, 2008a). Youth who stay in care longer may have greater protective factors regarding early pregnancy, including caregiver supervision which gave less opportunities for early sexual activity and therefore lower rates of pregnancy (Courtney & Dworsky, 2006). Caregiver connectedness and monitoring led to decreased sexual activity and more frequent use of protection among foster youth (James et al., 2009). Fewer pregnancies could be a result of access to birth control and access to abortion services because of caregiver connectedness as foster youth report that the absence of a caring adult is a barrier to accessing reproductive health information (Love, McIntosh, Rosst, & Tertzakian, 2005).

### *Longer-Term Outcomes for People Who Have Spent Time in Care*

Though not every young person who leaves care struggles, the longer-term outcomes for adults past the transitioning period are not far removed from the earlier outcomes described (e.g. lack of support, education and employment, mental health difficulties). Long-term outcomes are impacted by previous experiences and the current context of a person's life. The young person's experience in OOHC up to the point of leaving influences what will happen post foster care (Wade & Dixon, 2006). Equally, each interaction afterward will have

positive or negative effects. Young people who have difficulties with their emotional, behavioural, and mental health tend to struggle after leaving care. If there is substance abuse or ongoing criminal activity, the young person will struggle to a greater extent (Kääriälä & Hiilamo, 2017; Wade & Dixon, 2006). The culmination of experiences affect current choices and opportunities, with each new experience or interaction adding to future implications (Kääriälä & Hiilamo, 2017; Wade & Dixon, 2006). Therefore, without protective factors that sufficiently mitigate the risks, care leavers may continue to experience difficulties.

An evaluation of outcomes for young people who aged out of the foster care system in the Midwest of the USA showed that outcomes stayed consistently poor for young people when assessed at 19 through to 26 years old (Gypen et al., 2017). At 26 years old foster care leavers generally had fewer high school and university qualifications, lower employment rates, and lower annual earnings. Homelessness, mental health difficulties, and substance abuse continued as longer-term outcomes (Gypen et al., 2017). Hook and Courtney (2011) found similar results, showing that only half of 24-year-old participants who transitioned from foster care to adulthood were employed compared to the unemployment rates for similar age young adults living in the same area (approximately 13%). Low educational levels, incarceration, motherhood, ethnicity, and lack of experience all created barriers to employment and better wages (Hook & Courtney, 2011).

Cameron et al. (2018) compared outcomes of adults (aged 28-31 years) who had been in care with those who had not, using data from studies conducted in Britain, Germany and Finland. The authors found that those who had been in care continued to struggle in gaining educational qualifications and had higher unemployment rates (Cameron et al., 2018). Care leavers were more likely to have children, though by this stage of adulthood the gap of having a family was narrower. However, care leavers were more likely to have become parents at younger ages. Many of the those who had been in care were still receiving support

from the government through welfare. Those who had been in care had lower levels of health satisfaction and greater levels of psychiatric disorders when compared to those who had not been in care (Cameron et al., 2018).

While the data is clear on the risk of harmful outcomes for young people exiting care, there are also positive outcomes for this same population. Study findings highlight the need for social and personal capital for youth coming from the foster care system (Collins, Jimenez, & Thomas, 2018; Hook & Courtney, 2011). Having support that is both formal and informal is key to the success of young people transitioning to independence, especially in areas of employment, developing life skills, housing, and positive mental wellbeing (Wade & Dixon, 2006). Good support, positive experiences with foster families, affirmative school experiences, placement stability, healthy attachments, and future planning positively impact the long term outcomes for young people who leave care (Wade & Dixon, 2006).

**The Developmental and Attachment Mechanisms That Account for Parenting Difficulties Among Young Adults With a History of Severe Maltreatment**

Transitioning to independent living can be an overwhelming challenge. For some young people leaving care this learning curve is hastened when they start a family. Not only are they trying to learn how to live independently, finding housing and work, but they are also preparing to become a parent (Wade & Dixon, 2006). Like most parents, mothers who grew up in OOHC want to do well for their children and many view parenting positively. However, these mothers also face high rates of individual and systemic challenges that make achieving their parenting goals more difficult than for other parents (Chase et al., 2006). The maltreatment these mothers experienced before coming into OOHC as well as the stress and challenges following care placement put them and their children at greater risk for negative outcomes. Interrupted relationships with both their biological and carer families, poorer

educational outcomes, lack of formal and informal support, and barriers to accessing services all make it more difficult for mothers who have been in OOHC (Chase et al., 2006).

It is important to note that many mothers go on to break the intergenerational cycle of maltreatment, especially with protective factors such as social support and financial stability (Dixon, Browne, & Hamilton-Giachritsis, 2009). However, the stress of becoming a parent while young in addition to their experience of maltreatment and unhealthy relationships may create a heightened risk for maltreating their children (Bert, Guner, & Lanzi, 2009). It is important to briefly consider child development and attachment before discussing the mechanisms within these which add to parenting risks and the intergenerational transmission of attachment difficulties and trauma, which will follow.

***Development***

A developmental psychopathology framework gives insight into the life of a child who has been maltreated. Child development includes the child's biological make up as well as how the child interacts with the surrounding systems. The ontogenic level includes the child's temperament, physiological regulation, attachments, how they engage in peer interactions, and adaptability (Cicchetti et al., 2000). There are systems surrounding the child going out from the ontogenic level. Cicchetti et al. (2000) describe these as the microsystem, exosystem and macrosystem. Moving out from the child, the microsystem encompasses the child's immediate relationships and surroundings. This includes socioeconomics, family environment, parental mental health, parenting style, parental employment, and housing. The next layer is the exosystem, interactions and relationships that impact the child but do not have a direct affect. This includes how safe the wider community is, support systems available or lack thereof, and community resources. Lastly is the macrosystem that is made up of the wider culture surrounding the child, including customs, beliefs, national security and finances, employment rates, and racism. Typically there are many factors at each level

that contribute to a child experiencing maltreatment including the child's current environment and family context, the supports or stressors around the child and their context, the influences of intergenerational patterns, and the impact of government policy and societal constructs (Cicchetti et al., 2000). The child's development is impacted by how these factors interact and the outcomes of those interactions. It is important to view the individual parts within the whole system and vice versa to better understand how each factor and interaction impacts a maltreated child and how these interactions contribute to the difficulties maltreated parents have in parenting.

### *Attachment*

It is important to give a brief overview of attachment theory to give perspective on how attachment plays into the intergenerational patterns and possible parenting difficulties. Attachment theory describes the effects of the quality of the parent-child relationship – their interactions, its reciprocal nature, and the goodness-of-fit between child and caregiver. A child's attachment behaviour seeks closeness with a person whose behaviour is predictable and protective. Generally, infants are open to engagement with any and all caregivers in this way but become more set on a caregiver who is responsive and engaged as time goes on. When a child experiences a secure attachment relationship it provides security for them to explore from and safety in returning (Bretherton, 1992), though patterns of attachment can change over time. However, there are secure and insecure attachment styles which, over a period of time, the child learns as a pattern and way of perceiving relationships in the world. The learned attachment style is dependent upon the quality of the social interactions and the sensitivity of the caregiver (Bretherton, 1992).

Adolescents exiting OOHC have often experienced attachment-related difficulties from a young age, either in their biological family or once in care or both, leading to interpersonal and relationship difficulties (Tarren-Sweeney, 2013). Young women who

become mothers soon after leaving care may carry unhealthy attachment patterns into current relationships including the relationship with their child if they have ‘unresolved trauma’ (Iyengar, Kim, Martinez, Fonagy, & Strathearn, 2014). One description of ‘unresolved trauma’, which comes from psychotherapy, is when a person experiences trauma or loss and either dismisses the importance of the experience or holds too much information about the event and, therefore, their future processing of information becomes maladaptive (Ivengar et al., 2014). Ivengar et al. (2014) coded unresolved trauma when examining frightening or dangerous experiences that continued to have an effect on the mother and her behaviour, thoughts, and feelings. They found unresolved trauma is likely to influence the way a mother responds to her child and affects the attachment between them. The mothers in the study who were able to reorganise attachment patterns and work through unresolved trauma were able to change attachment patterns with their own children. Reorganisation meant mothers were actively pursuing making sense of earlier experiences and changing their perception of them. However, the number of mothers in the study who were reorganising was small and further, larger studies need to be conducted (Iyengar et al., 2014). Having attachment theory in mind is helpful when seeking to understand the intergenerational styles of parenting that become mechanisms of risk or protection to continuing or breaking the cycle of abuse (Chamberlain et al., 2019).

***Risk mechanisms***

Many factors contribute to difficulties in parenting after a history of maltreatment. These include poor mental health (specifically post-traumatic stress disorder (PTSD) and depression), low parental warmth, valuing corporal punishment, young parental age, lack of knowledge about child development, parenting stress, fewer social supports, low social functioning, negative coping strategies, insecure attachment, and living with a violent adult (Chamberlain et al., 2019; Dixon, Browne, & Hamilton-Giachritsis, 2005; Dixon et al.,

2009). These factors each influence the others creating mechanisms leading to multiple pathways formed through the combinations of factors. The concepts of equifinality and multifinality are useful here. Equifinality refers to the idea that diverse pathways may lead to the same outcome. Multifinality acknowledges that one factor can contribute to multiple outcomes. Though there are many factors and various pathways that can account for parenting difficulties, a few prominent ones will be discussed in this section.

**Young Parenting.** Having a young parental age is a risk factor for parenting difficulties and child abuse when there is a parental history of child maltreatment (Dixon et al., 2005). Mothers who become pregnant at a young age face a number of challenges when raising a child during their adolescent years (Borkowski et al., 2007; Conn, de Figueiredo, Sherer, Mankerian, & Iverson, 2018). Often challenges are due to lack of partner support, poor mental health, lack of financial support, difficult family relationships, and stigma (Dhaka & Musese, 2019; Easterbrooks, Kotake, Raskin, & Bumgarner, 2016; Sellers, Black, Boris, Oberlander, & Myers, 2011; SmithBattle & Freed, 2016). Beyond the young mother's personal context, societal norms and policy play a role in her experience of mothering at a young age (McDermott & Graham, 2005; Silver, 2008; SmithBattle, 2007).

**Social Isolation.** Parents who have experienced maltreatment in childhood often continue to experience social and emotional difficulties (Chamberlain et al., 2019). Often mothers who have been maltreated in childhood struggle with later relationships, have less social support, and are more isolated (Berlin, Appleyard, & Dodge, 2011). Mothers may not have learned adequate relationship skills and therefore struggle to retain healthy relationships with friends, partners, and formal support. The lack of social support and greater social isolation were predictors of child maltreatment for mothers who had experienced physical abuse in one study (Berlin et al., 2011). Reducing isolation and increasing social support is a key part to breaking the cycle of maltreatment (Aparicio, 2017).

**Negative Support.** While increasing social support is important, there are specific types of people and support that are more protective than others. For example, when young people exit the care system they may struggle to find a place to live and may move back in with the family from which they were removed. Courtney and Dworsky (2006) found that of the 321 young adults in their study who had left care, 35% were back with their biological parents and 17% were with other relatives. One qualitative study found that biological families were not only unsupportive but were a strain to mothers. The mothers instead became a resource for their biological family instead of the other way around (Radey, Schelbe, McWey, & Holtrop, 2017).

Another study involving 286 young mothers (14-21 years old) explored what factors served as protective for mothers who had a history of maltreatment in discontinuing the cycle of abuse (Easterbrooks, Chaudhuri, Bartlett, & Copeman, 2011). Data collected considered the mothers' childhood history of abuse, current poverty, financial stress, lack of current social support, depressive symptoms, current support from their mother (child's grandmother), education, and risky behaviours (Easterbrooks et al., 2011). The study found mothers had lower risk for maltreating their child if they had less support from their own mother. While grandmothers can be a great support to young mothers and the development of the child, this study found that young mothers who had been maltreated were less likely to victimise their child if their mother was not a support to them. If the mother's biological family was used as a support she was more likely to perpetuate the cycle of abuse. Therefore, even though social support is a known protective factor, the type of support may be a crucial component for positive outcomes (Easterbrooks et al., 2011).

However, when mothers have positive support they are more likely to break the cycle of maltreatment. Greater support may allow the parent to have more positive engagement with their child (Dixon et al., 2009; Jaffee et al., 2013). Mothers who had been neglected as

children but had greater social support had higher maternal empathy than those with less social support (Bartlett & Easterbrooks, 2015). Young mothers had lower rates of child maltreatment when they had access to social support. However, as noted previously, the type of support the mother received and who offered it are important variables (Bartlett & Easterbrooks, 2015). Bartlett and Easterbrooks (2015) encouraged strategies that provide young mothers greater social connections while also addressing the needs of the young mothers.

**Poor Mental Health.** Children who have been maltreated are at greater risk for mental health problems. If untreated, poor mental health can lead to further risk factors, increasing the risk of maltreatment, substance abuse, and family violence (De Bellis, 2001). Parents who maltreat their children have been shown to have higher rates of depression, substance abuse due to post traumatic stress disorder (PTSD), and behaviours that are antisocial (Ammerman, Peugh, Teeters, Putnam, & Van Ginkel, 2016).

**Substance Abuse.** Increased rates of substance use may be another mechanism through which exposure to childhood maltreatment can increase the odds for engaging in harmful parenting (Appleyard, Berlin, Rosanbalm, & Dodge, 2011). Mothers who have been maltreated may use substances as a way of self-medicating or coping with their painful past. Substance abuse makes it more difficult to parent as judgment becomes impaired and the parent is less emotionally regulated and less sensitive to their child's needs (Appleyard et al., 2011). Appleyard et al. (2011) tested the pathway between mothers' childhood experiences of abuse, substance use problems, and child victimization. They found when mothers had experience of sexual or physical abuse they had higher substance use problems that led to victimising their child (Appleyard et al., 2011). However, this is not always the case as Goldberg and Blaauw (2019) found no significant difference between parental substance use disorders and child abuse. The authors acknowledged the small clinical sample used may

have affected the results (Goldberg & Blaauw, 2019). Further, it may indicate other factors play a mediating role on child abuse in the midst of substance use.

A study of mothers recovering from drug and alcohol addictions showed that mothers who had higher rates of neglect, emotional abuse, parental alcoholism, and negative home lives in their childhood felt greater distress and experienced problems in their parenting (Harmer, Sanderson, & Mertin, 1999). As mothers tried to recover from addiction they often had less social support, usually due to negative family relationships and current relationships that were linked to their drug lifestyle. To leave both their adverse childhood experiences and their drug habit behind they had to cut a number of relationships, making recovery and parenting all the harder. Harmer et al. (1999) found mothers trying to recover from substance abuse exhibited behaviours that reinforced their child's defiant behaviour, in turn making it harder to parent.

**Domestic Violence.** It is more common to have a violent adult in the house when the mother has a history of childhood maltreatment (Dixon et al., 2005; Renner & Slack, 2006). Domestic violence affects both the mother and child on a number of levels and having a violent adult in the house may lead to poorer parenting. One study found that beyond the traumatic effect of domestic violence exposure on the child, the mother's response and the level of her own posttraumatic stress from the violence affected the child's response in both the child's posttraumatic stress symptoms and their internalising behaviours (Schechter et al., 2011). When the mother experiences domestic violence and has a posttraumatic response, she may be less available to help her child regulate his or her emotions. Domestic violence has psychological impacts on the mother which then may affect the attachment relationship she has with her child, even if she tries her best to provide warmth and protection for her child (Schechter et al., 2011). It is worth noting that while a mother who was maltreated or witnessed violence as a child is more likely to be victimised as an adult which will likely

affect her child, it does not necessarily demonstrate she will go on to maltreat her child (Renner & Slack, 2006).

## Intergenerational Transmission of Attachment Difficulties and Trauma

It is estimated that 25-33% of children who have been maltreated will go on to repeat the cycle of abuse and most parents who are involved with known instances of maltreatment have been maltreated themselves (De Bellis, 2001). However, studies of the intergenerational continuity of maltreatment vary, some say the experience of abuse as a child leads to heightened risk for subsequent maltreatment while others show a history of maltreatment is one risk among many but not necessarily the central factor (Berlin et al., 2011). As seen above, there are many factors that account for the intergenerational transmission of attachment difficulties and trauma which impact the following generation.

The intergenerational pathways are varied and complex. They begin with the biological development of a maltreated child and patterns of attachment. Within the pathways are multiple risk factors accounting for parents who were maltreated to have difficulties in their own parenting. These risks can be buffered by protective factors. The interactions of risk and protective factors contribute to whether an intergenerational transmission of attachment difficulties and trauma occur. When discussing the continuing cycle of attachment and trauma it is important to take a holistic approach, assessing the different contributing factors across the various systems of a person's life.

### *Developmental Trauma*

Various theories or frameworks are used to explain the cycle of maltreatment. Attachment theory has been discussed. Another framework is developmental traumatology. Developmental traumatology is a way of looking at how child maltreatment (and other intense experiences) affect the psychobiological systems, specifically exploring how

biological stress systems and brain maturation describe the cognitive and psychosocial outcomes as a result of effects of maltreatment on brain development.

Childhood maltreatment can have an effect on the health and behaviour of subsequent generations through toxic stress (Shonkoff et al., 2012). When a child is maltreated the child's neurobiological systems are deeply impacted (De Bellis, 2001). The systems in the brain influence the child's developmental and regulatory structures, impacting how the genes interact with life experiences. Maltreatment has ongoing influence on the brain systems and stress responses (Tarullo & Gunnar, 2006), and likely impacts the occurrence of psychiatric disorders (Teicher et al., 2003). An infant or child who is maltreated likely experiences symptoms of post-traumatic stress disorder (PTSD) as the impact of the traumatic stress shows in their biopsychosocial make up including brain development (De Bellis, 2001). These symptoms could lead to mental illness including attachment disorders, internalising and externalising disorders, and cognitive and learning disorders. If untreated, these disorders can lead to other difficulties with conduct, alcohol and drug abuse, and personality disorders, all of which can lead to an increased risk in maltreating one's own child through adverse parenting abilities (De Bellis, 2001). Developmental traumatology describes what a child (who then becomes an adult) is experiencing at an ontogenic level which then influences their interaction with all other environments and systems within their world. All that is happening at the ontogenic level then impacts how a person who has been maltreated interacts with those around them (Teicher, Samson, Anderson, & Ohashi, 2016).

### *Social Learning Theory*

Another explanation of intergenerational abuse comes from social learning theory, which maintains that generational transmission occurs since children are exposed to abuse and then go on to model that behaviour. As they learn from and model what they have seen and experienced they then continue the cycle. The results of Bert, Buner, and Lanzi (2009)

study based on Bandura's model of social learning theory examining parental childhood history of abuse, parenting knowledge, and parenting behaviour indicated that mothers with a history of maltreatment were at higher risk for abusing their children. Prior childhood maltreatment is linked with punitive parenting practices (Bert et al., 2009). Bert et al. (2009) found that mothers' responsivity to their children decreased and their inclinations toward abusive behaviour increased for those who had experienced greater abuse. This is one explanation of the continuation of maltreatment. Closely linked to this theory is social cognitive theory's explanation of the discontinuation cycle in which the parent observes new models and new behaviours are learned through cognitive processes (Chamberlain et al., 2019).

### *Ecological Systems Theory*

Beyond the effect of the mother's experience of childhood abuse it can be difficult for a young mother who is transitioning from OOHC to navigate independence as she learns to care for her young child as well as herself. The wider systems and government policy that affect the young mother's personal context are also factors within the intergenerational transmission of abuse. Government policy continuing to provide financially and offering further social work support for mothers who have been in OOHC can affect outcomes. Dixon et al. (2009) explored the differences in patterns of those who broke the intergenerational cycle of abuse from those who maintained it and those who initiated the cycle. While acknowledging the complexities of abuse, they found that an adequate financial situation and social supports were protective factors that differentiated those parents who broke the maltreating cycle from those who maintained or initiated it (Dixon et al., 2009). However, societal norms and public policy give differing ideas on what is best for the young mother and her child (SmithBattle, 2007). Often young mothers are held to and guided by policies they did not participate in creating (Ware, Breheny, & Forster, 2017). Ware et al. (2017)

argue that a one size fits all approach is discriminatory and does not allow for mothers to be encouraged in their new mothering role.

Further, though the intergenerational cycle of abuse is often viewed from a social standpoint, some say it should be considered a public health issue where parents and children involved in care and protection services should be screened for their mental health and given appropriate treatment from a multidisciplinary team of mental health professionals, specifically interviewing around PTSD symptoms (De Bellis, 2001). A holistic approach to stopping the cycle is needed.

**Summary**

Children who have been maltreated and spent subsequent time in OOHC have various disadvantages. The effects of maltreatment are vast and go on to play a role in each interaction and relationship (Cicchetti et al., 2000; De Bellis, 2001; Tarullo & Gunnar, 2006; Teicher et al., 2003). Mothers who have been maltreated and experienced impermanency in OOHC face parenting challenges, especially when they become pregnant soon after leaving OOHC as they may have little support and struggle to navigate independence as well as learning to care for a child. Their experiences of maltreatment, OOHC, social and interpersonal relationships, and mental health difficulties all impact their parenting journey.

# Chapter 2: Literature Review

A systematic review of the literature was carried out to identify studies on mothers who resided in OOHC at some time during their childhood. The review aimed to evaluate research on mothers who have been in OOHC by identifying studies with mothers currently or previously in care, gaining understanding of their lives as well as risk and protective factors for them and their children. Further, the review sought to identify gaps within the literature for the current study to address.

## Selection Criteria

Inclusion/exclusion criteria for the literature review were as follows:

- Studies focused on mothers and/or pregnant women who were currently or previously in OOHC for any duration during their childhood were included.
- Studies conducted directly with mothers were included in this review, even if other sources were utilised in data collection. Studies that gained perspectives exclusively from service providers, social workers, or fathers were excluded.
- Studies specifically around pregnancy rates or prevention, including those pertaining to sex education and reproductive health, for youth in OOHC or care leavers who had not become parents were excluded as the focus was on women who were pregnant or mothers at the time of the study.
- Studies of mothers with a history of child maltreatment, without specifying if participants had been in OOHC were also excluded.

## Search Strategy

In order to identify relevant and published research the following electronic database searches were utilised: PsycInfo, Psychology and Behavioral Sciences Collection, PsycArticles, SocINDEX with Full Text, PsycBooks, CINAHL with Full Text, EBSCOhost. Using Boolean search operators (* indicates truncation) combined in various ways the terms

pregnan*, parent*, young mother*, foster care*, out-of-home care, and residential care were used. The following search fields were also used: foster care, youth in care, former foster care, and aging out to see if additional studies met the criteria. Some searches came up with systematic reviews, in which their reference lists were examined to identify other studies that may have been missed during the search.

**Outline**

The most useful search terms for the defined criteria were "foster care or residential care or out-of-home care" and "young mother* or teen* mother* or adolescent mother*". This search resulted in 153 listings. Specifically looking at academic journals narrowed the findings to 110 results. From there the abstracts were read to determine whether the study met the above criteria. Additional sources were accessed by looking at relevant articles' reference lists and citations. Meta-syntheses and reviews were also referenced to see if additional studies should be added. 17 articles reporting on 12 studies met the review's inclusion criteria, of which nine were qualitative studies, two were quantitative, and one was mixed method.

The literature of young mothers who have transitioned from OOHC is varied. On one hand, it discusses the stress and abuse risk for these mothers and their children (Budd, Holdsworth, & HoganBruen, 2006). On the other hand, the literature shows that even with the personal and societal constraints, this time of great transition can create an opportunity for resilience and life definition (Aparicio, 2017; Bermea, Forenza, Rueda, & Toews, 2018). This review outlines the various findings from studies available on mothers who have been in OOHC based on their study aims, although many of the studies overlap in findings. Studies are categorised in six subheadings: the experience of motherhood, the meaning of motherhood, both the experience and meaning of motherhood, day-to-day life and needs, psychosocial factors related to parenting outcomes, and support.

**The Experience of Motherhood**

Three qualitative studies explored the experience of motherhood. Two studies were from the USA, one specific to mothers in residential foster care (Bermea et al., 2018) and another with three African American mothers transitioning out of foster care (Haight, Finet, Bamba, & Helton, 2009). The third study was with mothers in or previously in care in Canada (Dominelli, Strega, Callahan, & Rutman, 2005).

Bermea et al. (2018) conducted a study with 39 adolescent mothers (15-21 years old) who went into residence after becoming pregnant. Using qualitative data from four focus groups (an average of 10 mothers per group), study findings formed two clusters of themes – struggles and resilience. The resilience cluster consisted of social supports that helped mothers to cope, peer relationships, and lifestyle changes (Bermea et al., 2018). Mothers said they made decisions motivated by the desire to model healthy behaviour for their children and therefore had less freedom, new priorities, and less time with their friends. Mothers made sacrifices to grow in maturity and desired to be different as a parent than their own parents (Bermea et al., 2018).

Mothers discussed support and relationships with other mothers, which was facilitated by living in the residence (Bermea et al., 2018). Mothers felt they were able to push through stigma and see themselves as valuable within their new role and social group as a mother if they had supportive people around them, both peers and adults (Bermea et al., 2018). The study reflected residential care offered consistency and access to support mothers may not have been receiving from social workers outside the residence due to heavy caseloads and time unavailability (Bermea et al., 2018). Interestingly, possibly because of the easy access to support and lack of stigma within the residence, mothers felt they needed little to no other external support outside the residence (Bermea et al., 2018). It was outside the scope of this study to explore long-term outcomes for this group of mothers once they were living outside

the residence, so it is unknown as to whether the mothers continued to access support when it was not readily available due to their living situation.

Struggles identified were stigmatisation, judgement, and difficulties with the father of their baby (Bermea et al., 2018). Mothers described feeling judged on a daily basis by those outside their residence. Mothers said once they became pregnant, people they loved turned their backs on them and other mothers talked of being disowned or having family members who stopped speaking to them (Bermea et al., 2018). Some mothers felt their ability to parent was judged and therefore were not open to advice around parenting, particularly if it was unsolicited. Even though mothers did not want unsought parenting advice, they were open to the training they received through the residence where they lived as they viewed it as a supportive environment (Bermea et al., 2018). It is difficult to know whether this was more about the characteristics of valued support or if it was specific to the type of support and whether it was invited or not. Additionally, this study was specific to mothers in a residential care facility and therefore it is difficult to know whether these findings would be similar to mothers who are not in that same supportive environment.

Haight et al. (2009) interviewed three African American mothers who were transitioning out of foster care. The three mothers were observed, videoed, and interviewed over a seven-month period while they took part in a writing workshop for foster youth. Mothers had a follow up interview after the workshop which included their reflections on their writing (Haight et al., 2009). These women were characterised as resilient in comparison to other mothers in foster care as they had completed high school, one going on to further study, two of the mothers were working part-time, and all three mothers were parenting their children and taking part in a parenting programme as part of their transition out of foster care (Haight et al., 2009). Study findings were classified around the common beliefs of the three mothers regarding their views on children, challenges, and sources of

support. Study findings need to be seen in the context of the study which had only three participants of the same ethnicity. The strengths of this study are seen in triangulation of data collection methods, prolonged engagement, and multiple coders for the analysis (Haight et al., 2009).

Challenges mentioned by the mothers were financial difficulties, stigma, caseworkers who were negative, and meeting service obligations. Haight et al. (2009) noted, to combat some of these challenges, mothers had an "oppositional gaze", meaning a resistance to stigma, oppressive messages, and negative stereotypes. One mother in Haight et al.'s (2009) study likened stigma to having strikes against her – strikes for being a young black mother, another strike for being in foster care. Besides wider society, the three women in this study said their interactions with care and protection agency workers were also negative and stigmatising. However, the study found that if mothers purposely ignored stigma and societal opinions, they were able to move forward in productive ways (Haight et al., 2009).

The study found the cultural beliefs and practices of these mothers likely supported their resilience – specifically their view of children, spirituality, and sources of support. All three mothers described children using positive attributes and saw children as a blessing and a gift for which to be grateful (Haight et al., 2009). The authors note the love and pride these mothers experienced for their child created the space to redefine themselves and create a permanent family. Redefining themselves included motivation to accomplish goals, create a good life for their child, and reaching out to supports, giving opportunity to a new life trajectory (Haight et al., 2009).

Mothers described parenting from a communal approach and explained the idea of "othermothers", women who served as mother figures and provided guidance and mentoring but were not a biological parent (Haight et al., 2009). Foster mothers who provided emotional and practical support for them as they became parents were specifically mentioned (Haight et

al., 2009). Though the mothers shared negative experiences of prior foster mothers, they had all gone on to experience a positive relationship with their current foster mother and were grateful for her involvement. All three women in the study had foster mothers who offered love and support to both them and their children (Haight et al., 2009).

Alongside the relationship with their foster mother, they were open to being mentored by other mothers and had a desire to reach out to other young mothers they might be able to help (Haight et al., 2009). Likewise, peer support was found important as mothers wanted to connect with other women who had similar experiences and were in a similar situation (Haight et al., 2009). Taken from this study, the concept of "othermothers" was referenced in other study findings when discussing people who came alongside the mothers: co-parents, extended family members, and foster parents who modelled supportive parenting practices (Aparicio, Pecukonis, & O'Neale, 2015; Bermea et al., 2018).

Last was a small-scale study in Canada used grounded theory to explore the experiences of mothers who were or had previously been in foster care (Dominelli et al., 2005). Eleven women, who had become mothers while in state care, were individually interviewed and three focus groups were conducted with 20 care and protection workers (Dominelli et al., 2005). At the time of the study mothers were 16 to 24 years old (first pregnancies at 13 to 18 years old) and had 17 children between them with eight of the children still in the care of their mother (Dominelli et al., 2005). There were three main research questions exploring how the young women experienced mothering, how practitioners perceived their work with these mothers, and what policies and practices affected this population (Dominelli et al., 2005). Conversation topics during the interviews with mothers were around participants' perceptions and understanding of their experiences, including how and why their experiences occurred and the practitioners and policies that influenced their lives (Dominelli et al., 2005). This paper focused on why and how the care

system has failed and the societal and structural inequalities affecting mothers' parenting capacities, which the authors argued can be overlooked while the system focuses completely on the mother's abilities (Dominelli et al., 2005).

Study findings reported mothers felt unsupported and were left with inadequate resources while trying to parent in state care (Dominelli et al., 2005). Identified needs from the study findings were social support, someone to care for them as they cared for their baby, and someone to talk with about their own wellbeing. However, mothers reported when they reach out to social workers for help regarding their own needs, needs that would impact their parenting ability, they were ignored (Dominelli et al., 2005). The study depicted state care as a failing parent and grandparent, reporting that in state care "familialism's call for parenting with consistent care-givers in close relationships becomes inconsistent serial or group parenting" (Dominelli et al., 2005, p. 1136). Mothers discussed relationships which kept changing, placements that were unstable, and inconsistent group homes. Mothers said they desired caring carers who provided boundaries and accountability. They wanted social services, their 'parent', to offer them attention, time, and nurturance, but recognised social workers were overloaded (Dominelli et al., 2005). Some mothers shared about valued, positive experiences which were characterised by cultural sensitivity and human dignity, which included being listen to and having alternative options offered (Dominelli et al., 2005).

In each of the studies findings were characterised by difficulties and strengths. Difficulties were depicted through the terms 'struggles', 'challenges', or 'needs' and each showed strengths using the terms 'resilience' or 'valued experiences'. The need for support was a strong finding in all three of the studies and two of them discussed the difficulty of experiencing stigma and judgment. However, two of the studies were with specific populations (residential foster care and three African American mothers in a writing course) which led to distinct intention when discussing findings within their research aims. Dominelli

et al. (2005) explored the experience of mothers, however the article was specifically examining the role state care plays into that experience, while the other two articles were specific to their study population based on ethnicity or residence.

**The Meaning of Motherhood**

Two qualitative studies explored the meaning of motherhood. The first was an interpretative qualitative study Pryce and Samuels (2010) conducted using interviews with participants from a mixed-method longitudinal study. The larger study was an evaluation of adult outcomes of former foster youth in the Midwest of the USA (Courtney et al., 2005), which was previously mentioned in the first chapter of this paper.

Pryce and Samuels' (2010) qualitative study was added to the larger study to examine how the meaning of motherhood is impacted by childhood history and the experience of being mothered (Pryce & Samuels, 2010). Participants were selected using a latent class analysis method with study participants from the first wave of the larger study to make sure the qualitative portion showed the same diversity of the larger sample (n=732) (Pryce & Samuels, 2010). 15 mothers who had been in foster care participated. Two were pregnant, the others had between one and four children, and all but one of the mothers had their children in their care (Pryce & Samuels, 2010). Findings were put into three categories: 'finding purpose in motherhood', 'influence of mother-child relationship history on young adult motherhood', and 'conviction amid constraint' (Pryce & Samuels, 2010).

'Finding purpose in motherhood' included mothers explaining the deep sense of responsibility they felt when they became a mother, needing to grow up and become an adult (Pryce & Samuels, 2010). The relational bond they felt with their baby increased their sense of purpose. Similar to mothers in Bermea et al. (2018) and Haight et al. (2009) studies, mothers took up new goals because they were motivated to make changes for them and their child, not just them alone (Pryce & Samuels, 2010).

Interviews explored the relationships these mothers had with their biological and foster families, romantic relationships, and how their views of parenting were shaped by their experiences of being parented, which fed into the second theme (Pryce & Samuels, 2010). Due to abuse histories and inconsistent relationships in foster care, many mothers did not have examples of positive parenting. Few of these women could say their own parents were models for them to look to, as those parents had either abused them or had, at least, not been able to protect them from perpetrators (Pryce & Samuels, 2010). Mothers reported finding it difficult to move forward as a mother while dealing with the trauma of the past, struggling to make sense of their history in order to prevent repeating the abuse cycle (Pryce & Samuels, 2010).

These previous findings culminated in 'conviction amid constraint' where Pryce and Samuels (2010) reported the purpose some women feel in becoming a mother is shaky. Within the new identity of motherhood, findings also described pain and loss due to past experiences for some of the mothers in the study. Though becoming a parent was a time of opportunity it also brought up past experiences of being mothered, which added to the stress mothers experienced in parenting (Pryce & Samuels, 2010). Rooted in their own experience, mothers were fearful their children would be removed. They wanted to do things differently than their childhood experience, but this conviction was one factor in a mix of factors (i.e. low income, employment difficulties) contributing to outcomes for these mothers (Pryce & Samuels, 2010).

In the second study, Rolfe (2008) explored the meaning of motherhood with 33 marginalised (i.e. socially excluded) women who had become mothers before 21 years of age (mean age 17 at time of first birth), 22 of whom had been in foster care or residential placements. Participants were recruited through an organisation in England which worked with families and young people leaving foster or residential care and participated in

individual or group interviews (28 individual and five group interviews with 27 participants) (Rolfe, 2008). Findings were discussed in two sections. The first revolved around how women described their day-to-day experiences which were – 'hardship and reward', 'growing up and being responsible', and 'doing things differently'. The second section was how the women discussed mothering and themselves as a mother (Rolfe, 2008).

Mothers discussed how motherhood was both difficult and worthwhile in 'hardship and reward' (Rolfe, 2008). Constantly being tired, having financial difficulties, and limitations on their freedom made motherhood more difficult. However, mothers said that although mothering was difficult the rewards, such as excitement over a child's development, outweighed the difficulties (Rolfe, 2008). Mothers described 'growing up and being responsible' not as positive or negative, but as part of what it meant to become a mother. Mothers gave up hobbies and freedom, sacrificing for their children. Mothers who had spent time in foster or residential care discussed this and highlighted the fact that they needed to prove themselves as adequate parents (Rolfe, 2008). The last theme within this section was 'doing things differently' in which mothers talked about how life events had unfolded differently than others, and sometimes themselves, had expected. Mothers described wishing they had greater resources or careers before having children and how having children young meant they experienced poverty and unemployment. Mothers said the order of events and experiences in their lives were different than the 'normal' pathways (Rolfe, 2008). Another part to 'doing things differently' was how the mothers discussed wanting to do things in a different way than what they had experienced as children. They wanted their family to look different to the one they had experienced growing up, which often included a different lifestyle, one that did not have drugs or crime (Rolfe, 2008).

Mothers' self-descriptions, encompassing motherhood, employment, and the role of carer, were presented in the second section of findings. Motherhood was core to how they

described themselves and in where they found their identity (Rolfe, 2008). Mothers desired to be employed and able to provide for their children, but struggled to be independent (Rolfe, 2008). The last identity was that of 'caring' and the role of carer. Mothers described bringing up younger siblings or feeling like they cared for their own parents and so, in some ways for some of the mothers, they felt prepared for their role as mother (Rolfe, 2008).

These studies both had some notable strengths. Pryce and Samuels (2010) use of a latent class analysis method selecting participants from a larger study may be able to represent mothers from the larger study. Rolfe (2008) conducted interviews over multiple sites, allowing for greater diversity within results. Group interviews may have helped participants shield against social desirability as the authors felt participants were able to discuss and challenge one another during the group sessions, though, it may have had the opposite effect. However, many of the mothers participated in both the group interview as well as an individual interview which may have given them opportunity to share on various levels.

Similar to Dominelli et al. (2005), Rolfe (2008) had an aim of examining what mothers constructed in their minds in response to social constructs of young motherhood. The study identified participants who were marginalised economically, socially, and through the dominant discourse of what it is to be a young mother or a good mother, specifically for mothers who had been in foster care. The authors said their approach took into account the ways society constructs ideas about young mothers (Rolfe, 2008). While they were able to gain the perspectives of the mothers firsthand, it is hard to know if the women in the study felt those social constructs on their own accord and could speak to them or if they were guided toward them throughout the interview.

**The Meaning and Experience of Motherhood**

One study focused on both the meaning and experience of motherhood. Three articles discussed findings from a study conducted by Aparicio (2015) entailing 18 in-depth interviews with six participants using Interpretative Phenomological Analysis (IPA). Participants had between 1 and 3 children, were between 14 and 20 years old at the time of having their first baby, and were between 19 and 22 years old at the time of the study (Aparicio, 2015). Ages for first entering foster care were 3-18 years old and participants had between 2 and 17 placements. The primary aim of the study was to explore how teen mothers from foster care experience motherhood (Aparicio, 2015). Flowing from that aim was three subsequent questions: how mothers made sense of themselves as mothers, who were the people and systems that affected them in their parenting, and how their concept of motherhood related to the relationship they had with their children (Aparicio, 2015). The use of IPA as a method was useful in allowing a deep exploration to interpret motherhood which sought to seek the understanding of the mothers. While Aparicio (2015) discussed the dominant discourse of teen motherhood in foster care, the aim was not to contest that discourse, but instead to offer the experience and meaning of the mothers in her study.

The first article presented findings from the interviews focusing on being mothered and mothering. Themes emerged and were put into three categories – ‘darkness and despair’, ‘glimpses of light in the darkness’, and ‘new beginnings’. ‘Darkness and despair’ discussed past experiences of being mothered. For the six participants becoming a parent triggered past trauma from childhood when it linked with current situations (Aparicio et al., 2015). For example, mothers discussed experiencing homelessness and poverty as children due to their mothers’ substance abuse. They lacked a sense of belonging and connectedness, starting first with homelessness in childhood and then through moving into foster care (Aparicio et al., 2015). Once in care, many of the mothers longed for their own mother, no matter how much

their mother had hurt them. After becoming mothers themselves, some went on to experience homelessness and poverty while trying to support their own children (Aparicio et al., 2015). One mother in the study had to give two of her children to a family member as she could not economically provide for them.

'Glimpses of light' included gaining new support, especially from the father of their baby and his family, foster care support, education, and learning to be a mother (Aparicio et al., 2015). The six participants discussed how their pregnancy brought their biological family together and connected them in a different way to family members who had previously not been part of their lives (Aparicio et al., 2015). Mothers described gaining a new status when they became a mother and said they felt the father of their baby saw them differently, in a more positive light, once they became a mother (Aparicio et al., 2015).

Mothers discussed learning to parent as knowing what not to do and wanting to do things differently, therefore needing to look to "othermothers" to model positive parenting practices (Aparicio et al., 2015). Some mothers described their foster parents as parenting examples and mentioned them as a source of support, although the relationships varied with some foster parents taking over the parenting, others being present beside the young mother, and others not involved at all. Aparicio et al. (2015) found mothers' perceptions of foster parents changed over time, and especially as they became mothers. If foster parents shared the joy the mother felt in having a baby, it was easier for that mother to go to her foster parent with questions about her baby or parenting (Aparicio et al., 2018).

Education was another 'glimpse of light in the darkness' discussed by the mothers (Aparicio et al., 2015). Mothers who had dropped out of school had gone back and five of the participants were currently in school and viewed it as a source of empowerment. Participants described educators who pushed them to continue with study and graduate. Some participants were further encouraged to study knowing that it was not simply for them, but would help

their child as well (Aparicio et al., 2015). Overall, mothers felt life changed for the better when they got pregnant, giving them purpose and a reason to live. Even though there were challenges to becoming a mother, they felt it was worth it (Aparicio et al., 2015). This concept fed into the theme of 'new beginnings' including mothers describing the love they experienced for their children and the hopes and dreams they had for the future (Aparicio et al., 2015). However, it is unclear whether a new sense of purpose and a positive identity as a mother equated to positive outcomes for the mother and her child. As participants may not feel comfortable disclosing negative experiences or incidents of maltreatment for their own child, it is hard to know how the women's experiences of becoming a mother influenced her parenting practices (Aparicio et al., 2015).

The second article presenting findings around how teen mothers in foster care experienced motherhood while trying to discontinue the cycle of child maltreatment with their own child (Aparicio, 2017). Findings came through two themes – the first, mothering differently, meant treating their children well and avoiding their child going into the foster care system, and the second was reducing isolation and developing support. While some mothers had positive experiences with other mothers which gave them the ability to identify characteristics of good parenting, others needed support in knowing how to parent differently (Aparicio, 2017). Mothers described a lack of experience with healthy parenting practices from their biological parents and said they wished they had women who could mentor them (Aparicio, 2017).

Along with learning new ways to parent, mothers described their need for relationships and support (Aparicio, 2017). Mothers reported they found parenting classes and other groups helpful. Participants discussed how classes provided them with parenting skills while also reducing isolation. Classes and groups gave mothers opportunities to get out of the house and meet other mothers in their same stage of motherhood (Aparicio, 2017).

These groups also normalised parenting struggles and feelings of being overwhelmed. Mothers said they appreciated groups where former participants were incorporated and facilitators shared from their own experiences (Aparicio, 2017). Mothers also had a desire to reach out to trusted people such as foster parents, friends, family members, and therapists. Instead of having supports that withdrew or took over, mothers wanted someone who would nurture them while they nurtured their new baby. Mothers wanted to be able to talk through their own childhood trauma, current parenting stressors, and new ways of coping with stress. However, mothers struggled to seek support for fear of their child getting uplifted if they disclosed struggles (Aparicio, 2017). Though mothers identified their need for support, the study did not go on to address how mothers navigated the tension of desiring support while fearing what would happen if they did reach out for help. The process of reducing isolation and gaining support is still unclear.

The last article conveys the study's third major theme which is how the women in the study made sense of themselves as mothers and how their concept of motherhood related to the relationship with their child and experiences of parenting (Aparicio, Gioia, & Pecukonis, 2018). Mothers described the beginning of their parenting journey in both positive (e.g. happy, proud) and uncertain (e.g. nervous, frustrated) terms. Factors that played into their experience were whether they had the support of foster parents, the pain of their own childhood, fear of children being removed, inability to meet basic needs, and difficult living situations including homelessness (Aparicio et al., 2018).

Aparicio et al.'s (2018) study found mothers felt 'time' was a primary factor in settling into motherhood. Several years after becoming mothers, participants said they were better able to cope and meet the needs of their child, knew more about child development, and were more confident as a parent with time as the primary factor. However, other mothers in the study, specifically if they had gone on to have more children in a close timespan,

continued to struggle, with some children going to live with relatives and another mother becoming homeless with her 2 children (Aparicio et al., 2018). At times the study's findings contradicted as the mothers reported parenting could not be taught or learned from others, instead it was more about relaxing into the role, while other participants recognised social supports, including informal mentoring and learning from other parents, as a crucial part of parenting differently than their biological families (Aparicio et al., 2018). These mothers acknowledged that because they had not received guidance from their families they had to look elsewhere for support. One mother said that she had no one and depended on movies for information on parenting (Aparicio et al., 2018).

**Day-to-Day Life and Needs**

Two articles discussed the day-to-day life and needs of mothers from care. The first was a study with 55 young mothers who were participants in a larger study looking at post-care outcomes (e.g. education, housing, employment) for 261 young people leaving foster care in the UK (Barn, Andrew, & Mantovani, 2005). Barn and Mantovani (2007) focused on all 55 mothers for quantitative data and conducted qualitative interviews with nine of the mothers looking at what factors may lead to early motherhood and the attitudes and behaviours women have to becoming mothers. Using questionnaires, interviews and focus groups they explored outcomes as well as perceived needs, concerns, and support levels (Barn & Mantovani, 2007).

Qualitative data showed the contextual risks within their families of origin included neglect, turbulent relationships with stepfathers, and sexual abuse (Barn & Mantovani, 2007). Once in care, mothers continued to have relational difficulties and lack of permanency with more than 50% of the mothers having between five and ten placements once in care and having a variety of placement types – foster homes, children's homes, and secure units (Barn & Mantovani, 2007). Through interviews the study found family disruption, mental health

difficulties, risky behaviour, and lack of education factored into early motherhood for the study participants (Barn & Mantovani, 2007). Family disruption and abuse experienced by the mothers continued to affect them throughout their lives and had potential to create risk for both the mother and her child, though this was not verified as the study was not longitudinal. Mothers discussed not knowing how to deal with all they had been through (Barn & Mantovani, 2007). The study found depression, feelings of low self-worth, and self-harm as common among the mothers interviewed. One mother attributed getting involved in an unhealthy relationship with her baby's father to her experiences growing up. Another mother described the violence and rejection she experienced from the father of her child which led her to low points where she wanted to attempt suicide (Barn & Mantovani, 2007).

Quantitative data showed that over half the mothers in the study (n=28) had been in trouble with the police and interviews revealed drug and alcohol use and prostitution occurring while the women were in care (Barn & Mantovani, 2007). Early pregnancy was affected by these risky behaviours along with lack of knowledge around sex and pregnancy prevention. Over two-fifths of the mothers stopped attending school between the ages of 14 and 15 and another two-fifths finished at 16 years old (Barn & Mantovani, 2007). Qualitative interviews showed that mothers missed sex education in school and it was not discussed elsewhere. All but one woman, who had planned her pregnancy, had accidental pregnancies (Barn & Mantovani, 2007). Mothers from foster care in this study had not set out to get pregnant but instead risky behaviour, mental health difficulties, education and employment disadvantages, and family disruption may have influenced her becoming pregnant (Barn & Mantovani, 2007). Though the study found these hardships often continue after the baby is born, many of the mothers came to view the experience of motherhood as positive and one that brought enjoyment and love (Barn & Mantovani, 2007).

A second study looking at the day to day life and needs of mothers from care followed on from a larger study which was an ethnography of youth leaving foster care (Schelbe, 2013). Schelbe and Geiger (2017) observed and interviewed 33 youth who were parents, 21 of which were mothers. Parents were between 17 and 23 years of age at the time of the study, had been in foster care till at least 16 years of age, but were not currently in care (Schelbe & Geiger, 2017). Data were made up of field notes from two years of observations and interviews with parents. Findings consisted of the following categories: 'balancing the joys and challenges of parenthood', 'limited parenting skills', 'wanting a better life for their child', 'limited resources and support', 'threat of system involvement', and 'children as a source of motivation' (Schelbe & Geiger, 2017).

Among the findings was the balance of the joy that the young parents felt alongside the challenges due to lack of support and insufficient resources (Schelbe & Geiger, 2017). Some of the participants did not have correct child development information and became frustrated when their child did not meet their expectations. The study found that mothers knew what not to do, but not what to do in its place (Schelbe & Geiger, 2017). Mothers identified they needed help as they had not learned good parenting from their own parents. Though young mothers in care found parenting difficult, they also discussed children as a source of happiness and with pride (Schelbe & Geiger, 2017). Parenting brought joy, and parents were excited to show their children to peers and service providers. During study observations parents told service providers how their child was developing and growing using positive language. One mother described that even after a long day when she would like to rest, she was happy to spend time playing with her child because she loved being a mother (Schelbe & Geiger, 2017).

Schelbe and Geiger (2017) explored types of support the mothers wanted and barriers to obtaining those supports (Schelbe & Geiger, 2017). All of the parents had financial

struggles and most of them lived in poverty. Many found it difficult to find adequate housing and it was difficult to obtain and hold down a job as they did not have the support of consistent childcare (Schelbe & Geiger, 2017). Parents discussed that they did not have support through friends, family, or professionals. The study found mothers often know they need help but do not know how to access it (Schelbe & Geiger, 2017). Mothers said they struggled to ask for help when it came to the needs of their child and needs connected to aging out of care. Some participants were forced to make difficult choices around childcare and living situations when trying to provide for their child while having little to no support. They wanted financial support as well as emotional support and guidance in their parenting, but felt alone (Schelbe & Geiger, 2017). Mothers did not know how to navigate the systems to obtain resources, access support or ask for help (Schelbe & Geiger, 2017). Mothers explained they feared their children would be removed and some in the study had had their child uplifted and placed into foster care. Mothers said that their care and protection social workers or foster parents had told them they would call child protective services on them (Schelbe & Geiger, 2017).

These studies both engaged with the everyday life of mothers from care, including the joy, happiness, and pride they felt for their child, but also the challenges they faced. Both studies found mothers from care lack support and resources. Lack of permanency in childhood and beyond often left mothers with little support, and they were prone to mental health difficulties and engagement with risky behaviours. Mothers from these studies encountered poverty due to lack of education and limited employment opportunities. The studies took different methodological approaches, one a mixed method and one an ethnography. As is the nature with ethnography, Schelbe and Geiger's (2017) study was bound by time and space. Long-term outcomes for the parents are unknown as the study was done shortly after they left foster care and focused on the immediate transition from care.

Similarly, Barn and Mantovani (2007) also focused on the immediate needs of mothers. The findings show mothers from foster care have risks and vulnerabilities and may be open to support due to the new purpose they feel in parenting. However, findings did not address how these women can access and gain support in this time of vulnerability.

**Psychosocial Factors Related to Parenting Outcomes**

Two studies looked at whether psychosocial factors correlated with specific outcomes, the first was the relationship to child maltreatment risk and the second was with parenting stress. The studies overlapped participants who were in foster care in the USA. The first study had 75 participants, mothers who were between 14 and 18 years old and had a child between 2 and 20 months of age in their care at the time of the first study (Budd, Heilman, & Kane, 2000). Home visits were conducted for the initial assessment including an interview and the following measurements: Child Abuse Potential (CAP) Inventory, Wide Range Achievement Test-Revised (WRAT-R), Parent Opinion Questionnaire (POQ), Home Observation for the Measurement of the Environment (HOME) Inventory, Symptom Checklist 90-Revised (SCL-90-R), and Arizona Social Support Interview Schedule (ASSIS) (Budd et al., 2000).

Findings reflected that over half (56%) of the mothers recorded scores on the CAP inventory putting them in the elevated range for abuse potential, 25% had scores in the normal range, and 19% were invalid scores (Budd et al., 2000). In assessing social support, mothers reported a mean of 6.28 persons offering social support. While the authors noted this number is smaller than reported in other studies, the mothers in this study reported that they were fairly satisfied with their levels of support. Mean scores relating to unrealistic parenting expectations put mothers between mean levels reported with control samples and maltreating parents. Scores also indicated low quality of infant stimulation. However, neither unrealistic parenting beliefs nor quality of infant stimulation findings were significant (Budd et al.,

2000). The CAP Inventory abuse scales scores showed moderate correlations between educational achievement, emotional distress, and social support satisfaction (i.e. +/- .41-.44). The variables together accounting for 47% of the variance in CAP scores (Budd et al., 2000). Using a multiple regression equation due to the overlap in emotional distress items on two of the measurements (CAP and SCL-90-R), high emotional distress was no longer significantly correlated in predicting abuse scores and Budd et al. (2000) encourage interpretating these correlations with caution. However, low academic achievement and dissatisfaction with social support were still significant. Support satisfaction was shown to be a more significant factor than network size in social support the authors point out may show that perception of the sufficiency of social support is a bigger factor in child abuse risk (Budd et al., 2000).

The second study examined variables associated with parenting stress in young mothers who had been in foster care (Budd et al., 2006). Using a longitudinal correlation design, Budd et al. (2006) recruited 49 mothers from the earlier study of 75 young mothers in foster care (Budd et al., 2000). The second study tested two hypotheses. The first was whether parenting variables (specifically childrearing beliefs, quality of parent-child interactions, and child abuse risk) and personal adjustment variables (emotional distress and social support) seen in time one (from the study above) predicted later parenting stress (Budd et al., 2006). The second was if the mother's current adaptive functioning would affect current parenting stress. Adaptive functioning was measured by education, childbirth, and social support status domains and the parenting variable measurements used in the first study were listed above (Budd et al., 2006). The follow up consisted of a telephone interview. Measures used consisted of: Structured Client Interview, Parenting Stress Index-Short Form, and Arizona Social Support Interview Schedule. Time between the two studies ranged from 18 to 28 months (averaged 22.5 months) (Budd et al., 2006).

Overall, mothers had high levels of parenting stress as seen through 35% of reported scores exceeding cut-off levels for clinically significant distress. However, there was no normative comparison group to see what percentages of other mothers have high levels of parenting stress. Parenting and psychosocial variables at time 1 were tested with parenting stress at time 2 to identify the relationships between them (Budd et al., 2006). Regression analyses showed parenting variables – child abuse risk, beliefs around childrearing, and the quality of parent-child interactions – were significantly related to parenting stress later on and explained 28% of the variance in total stress. Emotional distress and social support (personal adjustment variables) were not significant predictors of later parenting stress (Budd et al., 2006). The concurrent relationship between adaptive functioning and parenting stress was also examined. Current functioning was examined by looking at educational achievement, satisfaction with social support, and number of children. Current educational status and support satisfaction were factors related to parenting stress (Budd et al., 2006).

Both studies showed the significance of social support, potentially lowering the risk of child abuse in the first study and reducing current parenting stress in the second. Findings from this study aligned with qualitative studies reviewed in which mothers discussed the empowerment of education and the need for social support (Aparicio et al., 2018; Chase et al., 2006; Radey et al., 2017). Another interesting comparison between these studies and previous ones is that in this study neither unrealistic parenting beliefs nor quality of infant stimulation findings were significantly correlated with abuse risk. As many of the qualitative studies have highlighted mothers' parenting beliefs as a possible protective factor, Budd et al. (2000, 2006) offer insight to this. However, it is still unclear how parenting beliefs may contribute to parenting outcomes.

Budd et al. (2006) note though parenting stress decreases with educational achievement and stronger social supports, these could be proxy variables for other factors

like stable placements and access to interventions. Limitations of these studies were the relatively small sample sizes, which may have reduced the power in finding significant differences when doing regression analyses, and the fact that except for the HOME inventory, which entails observations, measurements used were self-report. Additionally, the validity of instruments used had not been established with adolescent mothers and therefore may have skewed results, though the CAP inventory uses validity scales to index ward against response distortion: faking good, faking bad, and random responses (Budd et al., 2000). However, it is important to note that CAP scores are not actual maltreatment risk, but instead a proxy indictor.

**Support**

Lastly, two qualitative studies exploring support for young mothers from foster care, among other aims, are discussed through five articles. First, Chase et al. (2006) conducted a qualitative study to explore factors which contributed to early parenthood for young people in or leaving foster care, to establish what support is available to young parents, and to distinguish what allows or prevents them from gaining that support. 47 young mothers between the ages of 15 and 22 years old were interviewed as were 16 young fathers and 78 professionals and carers across four care and protection service sites. Two other articles were written from this study, one which examined how the experience of being in foster care may have contributed to teenage pregnancy (Knight, Chase, & Aggleton, 2006a), and a second focusing on the experiences of foster care and the possible connection with the emotional influences around pregnancy as well as learning around sex and relationships and support throughout pregnancy and the early days of parenting (Knight, Chase, & Aggleton, 2006b).

Chase et al. (2006) found that mothers' prior experiences of abandonment and rejection shaped their decisions around pregnancy. Young mothers had a strong need for attachments and to be loved, which fed into their response to being pregnant. Within the

context of their difficult upbringings and loneliness, early pregnancy was seen to be more positive than negative for the many of the young mothers interviewed because it brought new focus and provided a foundation to their lives (Chase et al., 2006). Not having a permanent family was a prompt for them to keep the baby. One mother said that her baby was the only friend she had. The love and connection mothers felt for their babies brought other positive changes like getting off drugs, finding employment, and making plans for the future (Chase et al., 2006).

Knight et al. (2006a) similarly reported mothers continued with their pregnancy because of the instability they experienced in the care system. Feelings of rejection and insecurity created emotional vulnerability which strengthened the desire for mothers to keep their baby in hopes their child could meet their emotional needs (Knight et al., 2006a). However, even in this, their feelings of rejection and loneliness did not necessarily fade. Mothers said they continued to isolate themselves, feeling there was no one they could trust (Knight et al., 2006a). Some mothers reported that though becoming a parent was seen as positive, in retrospect they would have waited to become pregnant. They said they felt overwhelmed with the responsibility and some shared experiences of post-natal depression (Knight et al., 2006a). Housing difficulties, such as accommodation being temporary or close to drug use and violence, created more pressure in parenting (Chase et al., 2006).

Personal supports for the mothers consisted of partners, birth families, and social services (Chase et al., 2006). 51% of the mothers reported having a partner who may or may not been the father of one of their children, 43% did not have a partner, and 6% had intermittent partner relationships (Chase et al., 2006). The study reported both partner and biological family relationships could be a source of support, but other times were detrimental to the mother's ability to cope if the relationships were violent or tense (Chase et al., 2006).

During semi-structured interviews some of the women also discussed their foster placements as a support (Knight et al., 2006b). Though some of the women felt alone during pregnancy, many reported feeling very supported by their caregiver. Some of the young mothers experienced mother and baby foster placements which showed to be valuable in provided support to the mothers (Knight et al., 2006b). Young mothers who reported supportive, trusting relationships with their foster carer also identified the mother/child placement helped them ask for help and access support. One mother said a longer placement would have been valuable to her if government resources would have allowed it to continue (Knight et al., 2006b). Though the study found these placements to be supportive, there was often a lack of clarity within the responsibilities of the mother, foster carers, and social workers (Knight et al., 2006b).

Mother's experiences of social service support were mixed and often prior experience influenced how mothers engaged with services (Chase et al., 2006). Knight et al. (2006a) reported participants described a sense of loneliness due to being uplifted from their biological families and then instability of placements. This often led to a lack of trust in professionals as mothers did not know who would listen to them and who would keep it confidential (Knight et al., 2006a; Radey et al., 2017). More than half the participants reported, just as no one had educated them about sex or relationships, they did not have anyone to help them make decisions about their pregnancy. This lack of instruction was often due to disrupted education, but also uncertainty reported by professionals of who ought to carry this responsibility (Knight et al., 2006a). This aligns with Barn and Mantovani's (2007) finding that access to information about education and sexual health may be jeopardised when young women have not had stability within the care system. Both that study and Chase et al. (2006) showed many adolescent mothers in care left school early and mothers felt disempowered to access services as foster parents and social workers do not always have the

skills or impartiality to discuss sexual health and relationships with adolescents in care (Barn & Mantovani, 2007; Chase et al., 2006).

Instead of being viewed as supportive, mothers often found social services stressful, anxiety producing, and confusing (Knight et al., 2006b). Young people said they were hesitant to trust the system, adults, and carers because of their early experiences that put them into care as well as unpredictability of social workers, home and residential group placements, and carers who had failed to support them in the past (Knight et al., 2006b). Young parents felt communication from protective services about processes and assessments were unclear (Chase et al., 2006). Mothers were less likely to ask for help for fear that they may be seen as incompetent and worry their child will be removed from their care (Chase et al., 2006; Schelbe & Geiger, 2017). They believed they were at a disadvantage because of their foster care history and had to show they were able to parent well enough even when asking for help. Mothers who had been in foster care did not trust social services, felt they had already been labelled and would not be given a chance if there was an investigation about their child (Chase et al., 2006). At times mothers felt their well-being went unnoticed by professionals due to the practical needs and complexity of their lives (Chase et al., 2006).

The study found that with the complexity of past trauma, current realities can be difficult for a mother to navigate and challenging for professionals to support (Chase et al., 2006). However, when there was a specific service for care leavers this kind of support was seen as more consistent, holistic, and accessible as the services were based on the clients' needs and their individual circumstances (Chase et al., 2006). What was valuable to mothers was having a person who they could trust, who was available and could adapt to their needs. Instability within those key relationships, especially with services, was a barrier to mothers being open to this kind of support (Knight et al., 2006b). Mothers said they could identify

which relationships were authentic and those who viewed them as paperwork (Knight et al., 2006a).

This study explored the experiences and influencing factors of motherhood however did not address how to meet the needs and the mechanisms involved. The authors note study findings leave some questions unanswered such as what is good practice in supporting young parents, how much support should young parents receive, what are the longer term outcomes for young parents, and how child protection services assessments could be done in a more positive way with greater understanding for the parent involved. Chase et al. (2006) noted there is a need for independent and neutral support. While this may be the case, it could otherwise mean that there are specific characteristics that are vital to mothers accessing support, even if it is from care and protection employees.

In the second study, Radey et al. (2016) explored the everyday lives, strengths, and needs of parents aging out of foster care. Data was collected through three small group interviews with 15 parents aging out of foster care and three small group interviews and one individual with 14 service providers that worked with these parents from a particular county in Florida, USA. Parents ages ranged from 18 to 26 (average was 22 years). Five participants were still in care and the others had left care. Of the 15 parents, 13 were women. Study findings were presented in three categories: ‘adversity and stress’, ‘motivation and resilience’, and ‘need for mentorship and parenting skills’.

Radey et al. (2016) found daily stress for these parents came from the struggle to meet basic needs such as housing, childcare, and transportation without supportive relationships. Parents aging out of foster care were particularly vulnerable as some had little support from their biological or foster family while they raised their child (Radey, Schelbe, McWey, Holtrop, & Canto, 2016). Other parents had relationships from their biological families or peers. Radey et al. (2016) found if a mother does turn to someone for help it is most often the

father of her baby, however, some mothers felt conflicted about the support coming from the baby's father. Service providers found support from the father and other romantic relationships to be detrimental to the young mother and believed mothers made poor decisions based on the relationship and believing she had no other options of support (Radey et al., 2016). Both service providers and mothers in this study recognised mothers lacked support which created difficulties, though the mothers did not believe the lack would impede positive outcomes (Radey et al., 2016). While service providers felt overwhelmed by the needs, parents felt that with a bit more support they would succeed. Parents believed they had opportunity to break the cycle of abuse with their own children. However, service providers felt parents did not have opportunities to succeed (Radey et al., 2016).

Motivation and resilience were seen in the motivations of the parents and overcoming adversity (Radey et al., 2016). Parents said they were motivated to change when they became parents. Even in the day-to-day struggles parents faced, they felt they were able to manage. However, service providers felt parents needed to think more long-term (Radey et al., 2016). There was also discrepancy between the parents and service providers on the view of resources. While parents felt they were able to access resources once they were pregnant and parenting, service providers believed youth became pregnant to access those resources (Radey et al., 2016). Some parents said they do not know how to access support and resources (Radey et al., 2016). It was unclear whether this is due to a lack of relational skills stemming from unstable relationships prior to and while in care or unawareness of available supports. This study encouraged further research exploring the informal and formal support mechanisms known to influence to positive outcomes (Radey et al., 2016).

Parents shared they wanted guidance, mentoring, and emotional support that is encouraging and acts as a role model for them in parenting (Radey et al., 2016). While service providers believed parents had a greater need for knowledge around child

development, parents wanted to know how to discipline and care for their child as well as information around bonding (Radey et al., 2016). The study found parents are open to guidance from professionals and believed mentors could also provide informational support (i.e. ideas, knowledge), however often service providers felt limited in the amount of time they could help, especially after the parent had exited foster care (Radey et al., 2016). The study found peer support in the forms of groups or peer mentors was important, even when the information shared was not completely accurate. While providers validated the importance of mentoring and peer support, they believed mentors are hard to identify and keep (Radey et al., 2016). The need for support is evident in the literature, but once again the gap is in knowing how mothers access support.

A subsequent article described the findings in light of perceptions of social capital, specifically exploring how relationships function for mothers leaving foster care and what are the relationship implications for mothers' supports (Radey et al., 2017). Radey et al. (2017) found that mothers from foster care often lack helpful social relationships and have blocks to accessing positive support. Service providers said mothers lacked knowing what healthy relationships looked like or how to be safe within relationships (Radey et al., 2017). Looking at the perspectives of 13 mothers, themes included a lack of beneficial relationships and useful support. Often social service providers believed positive community support was available, but mothers did not experience it this way and instead felt it was inaccessible (Radey et al., 2017). Interestingly, mothers were recruited from a service agency and so may have been more connected than other mothers who are aging out and may have more support, but still felt that support was inaccessible.

The study divided lacked support into specific outcomes – expressive and instrumental (Radey et al., 2017). Expressive outcomes were from affirmational and emotional support, meaning having someone to give the mother encouragement, be a role

model, and be emotionally available. Instrumental outcomes came from informational and practical support. Informational support was having someone to provide instruction and mentorship. Practical support was financial help, childcare, and transportation assistance (Radey et al., 2017). The study discussed that social capital may be available yet still not convert to a used resource. The study found that mothers felt they were unable to access resources and support due to a lack of trust and norms within their childhood (Radey et al., 2017). Lack of trust often came from negative experiences where mothers had informal childcare arrangements that went poorly or new friends who brought drugs into the house. The authors noted the lack of trust may be a systemic issue as mothers had not experienced continuity of care throughout their foster care experience and now did not trust professionals (Radey et al., 2017). The norms described in this study had to do with mothers wanting to break the intergenerational cycle. They wanted to be there for their child as their parent was not there for them. Therefore, they felt they needed to do it on their own. In their desire to break the abuse cycle, they did not utilise support (Radey et al., 2017).

**Limitations and Gaps Within the Literature**

While many studies focused on identity formation, strengths, and needs of young mothers from OOHC, the studies reviewed did not appear to specifically explore how mothers address their needs and how they have or have not been able to access valuable relationships and support. Pryce and Samuel (2010) encourage further research to emphasize how young women from care make meaning of other relationships, asking specifically who these young women reference if they do not have their own mothers as models for motherhood.

Chase et al. (2006) found mothers felt they needed to attempt parenting alone as they had experienced little support while in foster care. While the study showed the need for consistent and holistic support, it was unclear how to engage parents after their negative prior

experience of support. The study also pointed out the uncertainty about what 'good practice' entails when supporting young parents leaving care, confirming the complexity and intensity of supporting this population (Chase et al., 2006). While parents in this study were asked about types of supports available and how accessible services were perceived, there was no indication of the pathways to that support or how young mothers accessed those services.

Aparicio (2017) emphasised that supporting young mothers from care can require a great deal of investment in the relationship for those trying to support (e.g. foster parents, social workers) which can be difficult while possibly dealing with the mothers difficult behaviour (Aparicio, 2017). However, the mothers from Haight et al. (2009) study said that, after a number of difficult foster parent relationships, they all came to have foster mothers they appreciated. Some studies emphasised long-term, consistent relationships while others seemed to indicate the characteristics and the timing of the support were more influential to a positive outcome. Though studies have shown the need for support and have given understanding of barriers, the mechanisms for accessing and gaining support seem unclear.

Mothers say they have insufficient support and experience unmet needs, however, service providers believe resources are present and available (Radey et al., 2017). If mothers are adolescents they may be in a time of resisting authority figures, testing boundaries, and making risky decisions (Aparicio et al., 2018). Other mothers want to prove that they can do it on their own but may therefore not seek help when needed (Pryce & Samuels, 2010). There is need to study what factors contribute to mothers accessing supports and how the known barriers (e.g. lack of trust, trying to do it alone) can be overcome. Aparicio (2017) encourages further research to learn how these processes of reducing isolation and gathering supports happen so that organisations can help mothers create connections. Similarly, Radey et al. (2016) encourage research on the mechanisms of informal and formal supports so parents

who have been in care can access support and create a new trajectory, breaking the cycle of abuse.

**The Rationale for the Current Qualitative Study**

The transition to becoming a mother is life changing. The role itself and the increased responsibility are scaffolded when there is increased support for the mother, therefore influencing the support and care of the child. Adolescents and young adults who spent time in OOHC and experienced little security themselves or a model of a dedicated permanent parent, committed unconditionally to their child, are on their own to figure out how to parent. Often these mothers want to give their child what they have not had, but need help as they did not have positive parenting in their own lives (Schelbe & Geiger, 2017). Getting that help can feel risky as parents say they fear asking for help because of their own history with the care system. They are afraid to ask for help but also struggle to know how to provide and care for their child (Connolly et al., 2012). Datta et al. (2017) stated that while engaging mothers from care in research may be difficult, further research focusing on the needs of young mothers who experienced OOHC was needed, specifically asking what mothers perceive their needs to be and therefore with what support would they be willing to engage.

Women who spent time in OOHC need support as they transition to becoming a mother, while the effects of maltreatment, trauma, and loss of identity still permeate their lives (Aparicio, 2015). There is greater need to study and understand the protective factors that are malleable in mothers getting support around themselves and their parenting (Stacks et al., 2014). Further research is needed to understand what types of social support are most likely to support a mother in her parenting as it is unclear as to which forms and from whom is most beneficial to a mother (Bartlett & Easterbrooks, 2015). Relationships, including social support do not come in a one-size-fits-all strategy, but instead need to meet the unique needs of a particular family (Bartlett & Easterbrooks, 2015). And it is important that the

information on support comes from working with the families who actually need the support (Chamberlain et al., 2019).

So, what does a young woman do when she does not have the family or community supports in place when she becomes pregnant? How does she learn to nurture when she may not have experienced being nurtured herself? How does she take care of herself while she takes care of her baby? Who will she rely on when things get difficult or unmanageable? Further, how will she access it all? Studies have shown that mothers who are young and have spent time in OOHC need support, but how they find and access that support is lacking in the research (Haight et al., 2009; Pryce & Samuels, 2010; Radey et al., 2016).

**Objective of the Current Study**

The objective of the current study was to explore the experiences and perspectives of support for mothers who were in OOHC. A qualitative methodology was used to interview women and obtain their personal accounts. The first aim of the study was to explore how the upbringing of women who spent time in OOHC influenced perceptions of and access to support. The second study aim was to identify the most valuable forms of support mothers who spent time in OOHC experienced as parents and what it was like to access that support. The hope of this study is that it will contribute to an improved understanding of the pathways for mothers to gain support which may be useful for practice and policy. From a practice perspective, this study seeks to give insight to the approach of engaging mothers who have been in care. At the policy level, it hopes to inform policy makers around services needed for youth aging out of OOHC, specifically mothers.

# Chapter 3: Methodology and Method

This chapter outlines research questions and study aims. Three qualitative methodologies are described and given consideration for this study. The rationale for the chosen methodology, Interpretive Phenomenological Analysis (IPA), is given. Then the study method is then outlined, including description of participants, procedure, data analysis, rigour and trustworthiness, and ethical considerations.

## Research Questions

How do experiences of relationships and support while growing up influence parenting support for mothers who spent time in OOHC?

What supports and relationships are most helpful to mothers who grew up in care as they raise their children?

How do mothers who grew up in OOHC identify and access support?

## Aims

There were two aims to this study. The first aim was to explore how the upbringing of women who spent time in OOHC influenced perceptions of and access to later support. Mothers were asked about their experience of growing up and if they had role models or people that they would want to imitate in parenting. The second aim was to identify the most valuable forms of support these mothers have experienced and how those supports were accessed. Mothers were asked to identify what relationships were or are perceived to be the most valuable to her and what her experience has been of accessing those relationships. The hope was to gain a deeper understanding of the experience of growing up in care and assessing support through qualitative research with a small group of women. Both aims pointed to understanding these mothers in new ways, in hopes of informing the way organisations choose to engage with and support them. One hope of the first aim was that it may speak to policy decisions about whether the care system meets the short- and long-term

needs of children in care. The second aim hopes to contribute to practice by giving greater understanding of the needs of mothers who spent time in care and give information on how to engage with and support them better.

## Selecting the Qualitative Methodology

Qualitative research studies the thoughts, feelings, and lived experiences of people, with a rich and deep analyses of data. The data comes from the use of language instead of the use of numbers which is often the data of quantitative research (Barker, Pistrang, & Elliott, 2015). The use of language offers greater description and complexity to the data and analyses. A qualitative methodology was chosen for this study as it has a number of advantages that fit within the research aims. A qualitative methodology allows for some flexibility within the data collection (Barker et al., 2015). One advantage of a qualitative methodology is that it allows for complex experiences to be shared and studied. Another advantage is the freedom to explore the participant's experience from different angles as their story unfolds throughout the interview. Data collection in a qualitative study is usually inductive and allows a hypotheses to emerge whereas a quantitative methodology is generally deductive and has a hypotheses to test out (Willig & Rogers, 2017). This study fits with a qualitative methodology as it requires obtaining detail within the stories of the mothers to gain understanding into their experience and perceptions and is inductive in its data collection. There are a variety of approaches to qualitative data. The following section describes three approaches that seemed to fit best with this study – Grounded Theory, Narrative Analysis, and Interpretative Phenomenological Analysis (IPA) – and then explains the rationale for the final choice for this study.

### *Grounded Theory*

Grounded Theory is a systematic approach for theorizing a process or interaction (Creswell, 2007). Grounded theory originated with studying social processes (i.e. connections

between actions and consequences) and generating theories from the collected data (Willig & Rogers, 2017). The desired outcome for a study using Grounded theory is theory generation. Grounded theory is a helpful approach to use when there is no available theory to explain a process or a current theory is incomplete (Creswell, 2007).

Generating theory comes from being grounded in data. It typically requires a large number of participant views taken into account. Typically 20-30 interviews from several visits are conducted so there is saturation of data (Creswell, 2007). The researcher goes back to the participant as many times as needed to understand the phenomenon. Data collection can come from various sources but there needs to be enough information for a theory to be developed. Data collection and analysis is not conducted in a linear way, but is more fluid in nature (Willig & Rogers, 2017). The collection of data keeps going until it becomes exhausted with the researcher going back and forth between analysis and gathering further data, then comparing new data with the categories that have emerged through analysis. As the data becomes saturated, categories surround a core phenomenon, coding takes place, and hypotheses are developed. A theory is then generated based on the process or interaction that shaped the participants. One challenge of using grounded theory is that it requires sufficient time for the cyclical process of gathering and analysing data. It can also be difficult to know when a category has been saturated. The schedule constraints of a master's thesis did not allow for grounded theory. Further, another challenge is that grounded theory involves theory generation with theoretical ideas set aside so that a possible theory can develop (Creswell, 2007). Generating a theory was not an aim of this study. Grounded theory was not the preferred choice for this study.

***Narrative Analysis***

A narrative approach explores and values stories at an individual level to obtain qualitative data, emphasising meaning and identity. Different approaches to sharing

someone's story and experiences include chronological order, plot line, and exploring interactions within a particular construct (Creswell, 2007). Possible structures to narrative research are to explore the setting, people, situation, and problem or difficulty and then end with the person's perspective on what they have shared (Barker et al., 2015). Interviews or documents may be used as the researcher tells the story of the person's experience (Creswell, 2007; Willig & Rogers, 2017). Narrative analysis seeks to offer new insight into particular circumstances and people through collecting data from the participants' stories and the meaning they carry in the stories (Creswell, 2007). Themes emerge from the data and are analysed.

A role of researcher is to interview in a way that encourages the participant to tell their story (Barker et al., 2015). The researcher's interest and questions may vary, but the hope is for new insights to be gained throughout the process (Willig & Rogers, 2017). As an individual recounts their story they may start to see connections, bringing interpretation, understanding, and meaning (Willig & Rogers, 2017). The experiences shared may reveal the influence of the systems surrounding the individual (Murray, 2000). The interviewer will interpret the perspectives shared in the narrative by asking questions of the data. Generally, there is structure to the analysis. It is important that classifications and themes come from the stories, and not the other way around (Willig & Rogers, 2017).

Narrative Analysis is often used in topics needing understanding and compassion, which is relevant to the current study. Studies done with Narrative Analysis often recognise the potential for distress from those sharing their stories, with sensitivity being extremely important (Brand, Morrison, & Down, 2015; Gibson, Morgan, Woolley, & Powis, 2011; McManus, Abel, McCreanor, & Tipene-Leach, 2010). A narrative methodology allows participants to share their story and adds to knowledge that may be difficult to obtain through other approaches due to the sensitivity needed in working with the participants. The

participants often find they understand themselves and their experiences in a deeper way as they share in the interview process, which can sometimes offer therapeutic meaning to the participant as identity is created and observed as the story is told (Barker et al., 2015; Willig & Rogers, 2017). Narrative analysis also acknowledges contextual factors surrounding the stories including stigma, stereotypes, colonisation, and marginalisation. It believes personal and cultural narratives should not be overlooked (Barker et al., 2015). The wider social and political context shapes the participants' story and that narrative shapes their identity.

***Interpretative Phenomenological Analysis (IPA)***

IPA is an in-depth approach concerned with someone's lived experience of a phenomenon, as well as how it is perceived, made sense of, and given meaning to by the person within their specific context (Willig & Rogers, 2017). Phenomenology, idiography, and hermeneutics are core features of IPA. Phenomenology is philosophical study of experience. The studied phenomenon is something that is important to humans or a specific group. The criteria of idiography focuses on the direct lived experience of a person, in their own words and in their own terms. IPA is interested in the individual experience, so studies typically have a small number of cases, each considered individually first and then as a whole. IPA can be used for reflection, but is best used as a method in exploring what is happening in the present or recent past, "wrestling in real time with something important that is happening to them" (Smith & Shinebourne, 2012). It often works at its best with new research topics or ambiguous complex areas.

IPA explores an experience as well as the meaning and impact of that event or experience from the perspective of the participant. IPA acknowledges that one's experience of the world is filtered through each person's personal lens so cannot be completely objective (Smith & Shinebourne, 2012). The researcher is actively involved and engaged in the obtaining and interpretation, looking at the experience within itself instead of predetermined

categories (Smith & Shinebourne, 2012). Hermeneutics involves the interpretation of what the participant is expressing. The researcher becomes an interpreter and meaning maker of the participant's experience, while at the same time trying to set aside one's own presumptions so that the phenomenon can speak for itself. While the participant is seeking to make sense of their experience, the researcher is trying to understand the participant making sense of the experience. IPA refers to this as a double hermeneutic where there is sharing of common humanity while also differing from one other. IPA draws on holistic thinking, gathering importance of the context and relationships around the experience as well as the person's acceptance of it, as they all add to the account of the experience.

The study design includes purposively selecting participants and commonly using a small sample size, though a single case study could be used. Depending on interpretative concerns, inclusion criteria is typically used to create a homogeneous group of participants. Participants are recruited through groups, agencies, personal contacts, and may involve snowballing to recruit more participants. Data collection is done through inviting accounts of experiences of the phenomenon from participants. The research is guided by exploratory questions that are broad and open ended, exploring the participant's experience and how they have made sense of it (Smith & Shinebourne, 2012).

Most IPA studies use semi-structured, one-on-one, interviews. This allows for flexibility within the interview while also gaining depth. IPA interviews are generally an hour or longer, allowing the dialogue to evolve and encouraging participants to talk. The researcher prepares prompts to guide the conversation. It is important for the researcher to establish rapport with the participant and be mindful of how they ask their questions. They actively listen, aiming to hold a reflective space and create a calm environment. Interviews often start with a descriptive question before going onto sensitive topics or reflection. While collecting data during the interview the researcher may monitor how the interview itself

affects the participant (i.e. may need to avoid certain questions or go about things gently). Interviews are then transcribed verbatim and data analysis ensues. IPA studies can use other methods to obtain data such as diaries and focus groups.

### *The Chosen Methodology*

Interpretative Phenomenological Analysis (IPA) was chosen for this study. Grounded Theory was ruled out as it requires a larger sample size than what can be achieved in a master's study and aims to generate theory, which was not an aim of the present study. This left Narrative and IPA. Though the current study is focused on meaning and experience, is not focused on personal identity or its construction. Narrative analysis focuses on the role of language and how a person tells their story. This does not align with the focus of this study. Additionally, the focus on the narrative from start to finish is not necessary as the aims of the study focus on specific times and a specific experience. Therefore, narrative analysis did was not the best fit for the specific study aims. IPA aligns with the aim of understanding the experience of support for mothers who have been in OOHC. It also offers a step-by-step process for data collection and analysis which is helpful for novice researchers like me. IPA informed the procedure and data analysis to explore the experience of support for mothers who spent time in OOHC.

## The Study Method

### *Study Participants and Recruitment*

Study recruitment was intentional to align with the research aims. As the study was focused on mothers who had grown up in the care system and the influence of that experience on both their parenting and supports, it was essential to recruit mothers whose biological family had Oranga Tamariki (formerly Child, Youth and Family Service - CYFS) involvement and, at some point, the mother had been removed from home for an unspecified amount of time. It was also ideal if the mother was 30 years or younger so that the relevant

information was not all that removed from her current experience. This aligns with an IPA methodology that is less reflective and more concerned with current phenomenon or recent past. Another criterion was for the mother to have been 25 years old or younger at the time of her first pregnancy. This was to create a somewhat homogenous group of participants. A mother who had her first child ten or more years after leaving the care system may have a very different experience and have avenues of support than women who become pregnant during their time in OOHC or soon after. Lastly, the mother was to have her child in her care currently. As the mothers in this study are a vulnerable group, recruitment sought to interview mothers who may be less distressed while discussing a sensitive topic. It should be noted, though, that one participant had one child in her care while her other child had been uplifted and placed with a family member. As the child in her care had been with her since birth (over a year now) and she has a positive relationship with her older child who was not in her care, she took part in the current study.

Study participants were recruited from a number of places. The initial aim was to recruit between 8-12 participants, first through a community organisation, then through an advertisement on a Facebook forum, and last through other organisations who could put the word out to their clients. In the end, seven participants were recruited through contacting professionals from a number of places (e.g. teen parent units, hospital social workers) as well as the initial community organisation, all within the Canterbury region. Each of these sources offer social services within their wider context and all work with young mothers, some of who have been in OOHC. I had hoped that my prior experience working in a community setting might facilitate participant recruitment as the referring staff would be aware of my relevant background. The organisations and agencies contacted were supportive of the research taking place and were willing to connect me with prospective participants. An

additional means of recruitment was an advertisement that went out to a forum of local mothers through Facebook. Each of these avenues connected participants to the study.

### *The Interview*

Typical to IPA interviews (Smith & Shinebourne, 2012), interviews ran between an hour and an hour and 45 minutes, the average being approximately one hour and 20 minutes. The interviews were semi-structured in nature and gave space for variance. Aligning with an IPA approach, semi-structured interviews allowed for interaction between myself and the participant while she explored her lived experience. This offered flexibility within the facilitation of her explored experience (Eatough & Smith, 2008). I used questions and prompts as a guide for the interview, which allowed the participant to tell her story and reflect on the meaning of it while being nudged in certain directions based on the prompts and questions (Smith & Shinebourne, 2012).

The interview schedule was discussed with my supervisors and revisions made based on their feedback. One major revision was to begin with the participants' pregnancy instead of beginning with their experience of growing up. This way the participant began the process reflecting on their pregnancy and early days with their baby and then moved into what life was like for them growing up. Though there was no guarantee that pregnancy and the surrounding circumstances were less traumatic than their upbringing, it allowed the mothers to share what they wanted about their pregnancy before delving into topics that would likely be more difficult to discuss.

The initial interview guide included the option of doing an eco-mapping exercise if needed, particularly if the participants were struggling to give a depth of information or found it difficult to bring to mind who had been in their life at the time of the pregnancy. However, this was not utilised during the interviews as participants did not find it difficult to give full in-depth information and examples from their lives.

After making revisions to the topics, prompts, and questions, I conducted a trial interview with a mother who had not grown up in care but was a new mother and willing to pilot the interview with me. This pilot interview was not used to gather research data but instead to assess any changes needed to the research questions. The interview schedule and its revisions are noted (see Appendices C and D).

Three main topics were explored during the interview – valuable supports, the influence of growing up in care on parenting, and identifying and accessing support. The following prompts and questions were used to guide the interview:

Topic 1: Valuable supports/relationships to a mother who grew up in care

- What was happening in your life when you became pregnant? Who was around?
- What have been the best parts of becoming a mum? Hardest parts? (or what stage?)
- What kind of relationships or support did you want when you became pregnant or had your baby? (Could be any kind of support… from friends/family/groups or agencies; could be emotional, around parenting, financial, educational, housing, etc.)
    - Who did you hope would step up/be involved? Did they? If not, did others?
    - What relationships were most valuable to you? Who did you feel close to?
    - When you think of support as: give strength, cheer on, advocate, stand up for, encourage, be there for… Who did you feel supported by and why?
    - If you could have anyone as a support (whether they are on it or not), who would that be?

Topic 2: The influence of growing up in care on parenting

- Tell me about growing up…what was it like? Who was around?
    - Age of entry into care
    - Lots of placements or just 1 or 2? Did you return to mum or dad?
    - Was it a whānau placement or other?

- Tell me about the adults in your life growing up, was there anyone special to you? What were they like?
    - Who "had your back"? Tell me about them…
- Who were your role models? Was there someone you would have liked to be like?
- When you became a mum who did you hope to be like – maybe someone you knew or someone you'd heard about or seen somewhere?)
- What are you like, as a mum? Describe yourself as a mum…
    - What do you wish you were like? Why?

Topic 3: Identifying and accessing support as a mother who grew up in care

- What support was the most helpful/least helpful when you had your baby? Why?
- Did you go about looking for help/support?
    - What was that like? Was there anyone who helped you figure it out?
- How did you know what kind of support you needed when you became pregnant?
    - Was that available? How did you find out about that support?
- Looking back now, thinking of yourself then, what do you wish you had?
    - If you could wave a magic wand, what would you have really appreciated when baby was born? OR if you had this wand for a friend, what would you give them?
    - Is there anything you look back on and just couldn't have done it without "_" OR the new-born period would have been way easier if you'd just had…
- What kind of support do you want as (insert child's name) grows up? How will you get it, do you think?

Before the interview began, there was a time of introduction and rapport building. I asked the participants if they had any questions before we began. I informed them on how the interview would go and the three topics we would discuss. I let them know that I would ask

questions along the way. It was important to give the time needed to build rapport so that each participant felt comfortable and at ease when the interview began. I also reminded them that the interview would be audio recorded. Audio recording the interview allowed me to be present with the participant as they shared. It provided me with the ability to be open to topics or points of discussion that I had not foreseen yet were important to the participant as they shared their story (Eatough & Smith, 2008). It also allowed for me to be sensitive to the participant, using active listening and empathising with them as they reflected on their life and upbringing, so that I could enter in to their story and seek to understand it (Eatough & Smith, 2008).

The interview finished with me asking the participant if there was anything they thought I would ask or anything that they had specifically wanted me to know. I thanked them for participating and gave them a small gift voucher for their time and participation. I checked in with them to see how they were feeling. I reminded them that if they felt distressed by our discussion they could reach out, reminding them of the information provided on the information sheet. Then I reoriented them back to their day.

Each interview was transcribed verbatim. A speech-to-text service was used to create an initial transcription. Following this, I reviewed and edited each transcript, making sure it was complete and accurate. Participants had the option of having their transcript sent to them.

***Study Procedure***

Initially I met with group facilitators and social workers from a community organisation in Canterbury to share the research proposal, gather relevant information for the study, and have them read over the information sheet and consent form that would be given to participants. I did this to note any feedback and sensitivity issues from professionals working with the mothers and to gain feedback on the research itself. After the study information was finalised and ethics approved the research, recruitment began.

In the first instance, participants were recruited from a community organisation in Canterbury. Possible participants were contacted by a social worker, group facilitator, or the team supervisor over the phone or face to face to give the mother the information about the study. If the mother was interested in participating, the employee from the organisation gained verbal consent from the mother for her phone number to be passed on to me so that she could be contacted with further information and have an opportunity to ask questions. If mothers gave verbal consent, I called them and introduced myself. I explained the study, its purpose, and the extent of the mother's involvement. If she chose to take part, we set up an interview. Participants were given the option to have the interview conducted in their home, in the organisation/hospital setting if they were comfortable and familiar with that space, or in a private room at the university. Participants were told that wherever the interview was held needed to be a quiet, private space, where children would not be present and we would be without interruptions. The participants and I then made a date and time and confirmed the meeting place. They received a text reminder before the set date and time.

Recruitment from the community organization did not recruit a sufficient number of participants. Therefore, in the second instance, participants were recruited from a post on a Facebook forum. The advertisement was posted and interested mothers were asked to contact me through email or Facebook. From there, I sent the mother an information sheet, with encouragement to read it and let me know if she is interested in the study. If she was, an appointment time was made for the interview.

While the first two methods were effective, additional recruitment was needed. In the third instance, other community organisations that work with mothers who may have resided in OOHC were contacted and sent the information sheet to share with current or prior clients who may be interested in participating. The same process as the first instance was followed. Originally this was a backup option if the first two instances did not recruit enough

participants, however it became an essential part of the recruitment process and allowed for greater diversity within keeping a homogenous sampling.

***Data Analysis***

IPA analysis involved thorough engagement in the data and the meaning gathered from it. The guidelines for IPA analysis are flexible and can be adapted to the research aims (Smith & Shinebourne, 2012). Though IPA analysis is multifaceted, it can be broken down into stages. These stages are not meant to be prescriptive but do offer steps. They are meant to be a helpful tool to researchers new to IPA, offering a way forward in analysing the data. The first three stages are used for each individual transcript. Stage four brings them together. Each of these stages are highlighted below.

The first stage involved absorbing the data by listening to and reading the transcripts individually multiple times, gaining greater insights with each reading. By going back and forth over the transcripts the researcher seeks to understand the participant's meanings and views the data in an interpretive sense (Smith & Shinebourne, 2012). As I read the transcript and listened to the interview I marked what stood out or interesting phrases. On the right margin of the page I wrote comments, notes, and reflections from the interview. These included observations around emotions, use of language, and connections to the wider content that seemed significant (Smith & Shinebourne, 2012). I highlighted or underlined specific phrases that stood out. I considered and noted initial interpretations in this stage as well. After initial comments and notes were made, I went back to the beginning of the transcript and moved into the second stage.

Continuing on with the same interview transcript, the second stage consisted of looking for connections between my initial notes and comments allowing themes to emerge. Since the whole transcript had been read and re-read, the parts (individual comments and markings) were seen within the whole and vice versa. I then aimed to apply psychological

concepts to the notes and formulate a phrase in the form of a theme. Pulling themes out from the initial notes continued throughout the whole of the transcript and themes began to repeat. Smith and Shinebourne (2012) discuss that the difficulty at this stage is for the theme to stay grounded in the individual context, while also being used to create broader themes that will work across multiple transcripts. To help me with this, I first went through the transcript, looking through the passages I had noted and sections highlighted and made notes in the left-hand margin that related to emerging themes. Then I went through it again, creating a Word document where I listed themes within a table and documented further thoughts, patterns, and comments that might help find connections when eventually viewing the transcripts as a whole. I also included any interpretations that came to mind as I considered my comments and the themes that had begun to emerge, making note of whether it was a participant's meaning or my own. In the notes on the Word document I also included time stamps for each item so that I could easily find them within the transcript as I continued analysis.

The third stage included finding connections between themes, grouping them by shared concepts, and then labelling the grouping or cluster. I listed the emerging themes, looked for links between them, and created clusters as it made sense. Smith and Shinebourne (2012) give imagery to clustering themes by describing a magnet pulling themes together. To help visualise this I drew cluster maps from the tables and notes I had created for each individual transcript. I then viewed each cluster in light of the transcript to confirm that it still made sense within the original context. I also pulled out specific phrases related to the particular cluster so they could be used as support for themes and written up with the results. From these clusters and themes, the table that had been created in step two was revised, identifying the strongest themes across the topic and breaking down the themes into subthemes including excerpts from the transcript, key words, and timestamps so that the transcript could be returned to as needed.

As stated previously, the steps discussed above were used for each individual transcript. Each stage is essential as it allowed me to go over the data multiple times, ensuring that the themes made sense from the data and gave integrity to the specific participant interview (Eatough & Smith, 2008). As each transcript was explored it influenced further analysis as similar themes were echoed or new themes emerged. As I went back to the earlier transcripts, it allowed the later analysis to influence the beginning transcripts. It was a process of repetition.

The final stage entailed using the clusters to make a final table of superordinate themes and subthemes from the collection of data. I went back to the transcripts, evaluated the individual tables, and then combined them to create a wider set of themes. To do this, themes had to be prioritized and reduced to the more relevant ones based on the depth and richness they provided as well as the convergence of the theme across the interviews. These themes were then introduced and written up in the results section with illustrations from the data given to provide further insight to the theme, allowing the voice of the participant to come through and giving integrity to the interpretation.

***Rigour and Trustworthiness***

The quality of a qualitative study cannot be based on the same validity measures a quantitative study would justify. The alignment of research questions and methods are important for internal validity (Punch, 2006). IPA was chosen as an effective method when the aim of the study and the research questions were considered. Further to this, the reliability and quality of the research was guided by the principles Yardley (2000) gives for assessing qualitative research – sensitivity to context, commitment and rigour, transparency and coherence, and impact and importance.

The first principle, sensitivity to context, includes sensitivity to existing theory and research on the topic (Yardley, 2000). This was pursued by exploring and reviewing the

relevant literature on the topic and specifically being open to research and theories that were different to my own leanings and perspectives. The supervision process also aided to sensitivity to context as my supervisors regularly pushed me to think in different ways or gave insight that revealed my own biases within the research topic.

Being aware of culture, marginalisation, socioeconomics, social interactions, power dynamics, and language are a part of sensitivity to context as well. I aimed to build trust with participants and made the interview a space one of compassion. In my desire to be sensitive and open I had to acknowledge that I do not understand what it is like to be a child in care or a young mother with little support. For most of my life I have had agency and opportunities the mothers in this study have not experienced. On the other hand, I have fostered children who are in care and have listened to their experiences and empathised with them. I have also worked for over ten years with young mothers who have little support, working with them to discover internal strength and external supports, empowering them to move forward in positive parenting and self-identity. Because of this, I needed to acknowledge that I had preconceived ideas about life in foster care and mothering while also bringing those experiences into the research as I genuinely wanted to explore the experiences of these young women and see what emerged as they shared their stories.

Sensitivity to context includes being culturally responsive and building connection and trust. The qualitative approach of this study aligned with these responsive research efforts and offered an open and gentle way of inviting participants to share their experience. Sharing stories has been used as a way to decolonize and give equal voice to those who are marginalised by power imbalances (Berryman, SooHoo, & Nevin, 2013). An important part of this is discerning how the research will be represented and whose interest and needs are being met. This was something I considered and discussed with a kaiārahi from the university. We also discussed and incorporated whakawhanaungatanga, a way of linking,

making connections, and getting to know one another. This is respectful way of connecting with people and understanding the world and a value at the heart of culturally responsive research (Berryman et al., 2013).

The second principle, commitment and rigour, is seen through the depth of engagement with the topic and study aims through the literature, chosen methodology, and interview process. The interview questions allowed participants to settle into the interview and build trust with me, while also giving depth to their story and experience. The process of transcribing and analysis offered examples and phrases to explore the data, allowing themes to offer both breadth and depth on the topic as they were explored. Participants were given the opportunity to look through the transcript of their interview to verify and make changes as needed, adding to the rigor of the study.

The third principle of transparency and coherence is shown through detailing the study method. There is a link between the research questions and the methodology and analysis used. This study explored the experiences of the mothers to give their specific perspective. Although other knowledge may have been gained by viewing other perspectives on the mothers' experience (e.g. practitioners, social workers, other family members) it would not have aligned with the aims of this study. A phenomenological analysis of the interviews with the mothers themselves offered a greater perspective to their lives and experiences. IPA was the most appropriate method. The validity of the study is further evidenced as IPA strives to be sensitive to the data and participant exerts required to support each theme. Transparency of the study come by clearly outlining what was done and the process of analysis (Smith & Shinebourne, 2012).

Lastly, impact and importance come from the gap in the literature addressed and the new knowledge obtained which can guide public policy and practice. The mothers in this study shared their experience of support, including barriers to gaining support or the ways

support was encouraged. This adds knowledge to aid policy and intervention strategies designed to help young women adjusting to motherhood and life as an adult, especially those who may be more vulnerable due to their upbringing. I also hope there was personal impact for the mothers in sharing their stories and exploring meaning within their experience. Many of the mothers noted they hope, through sharing their experience, other mothers will be helped.

### *Ethical Considerations*

The following were ethical considerations for this study.

**Informed Consent.** An information sheet outlining the nature of the research and what it meant to consent to the study was given to prospective participants. Participants were made aware that their participation was voluntary and they were able to discontinue the research within a specified timeframe. Participants were told they were able to decline research participation and it was fully their decision to participate, decline, or withdraw from the study. If they wished to participate, written informed consent was obtained.

**Privacy and Confidentiality.** Participants were assured of confidentiality of data gathered from interviews. To ensure anonymity and confidentiality, only I had access to the real identities of participants. No identifying details of the participants or their families were included in the written-up material. Pseudonyms were not used as readers may be able to identify the participant by piecing together information or quotes from the various participants. Instead of using pseudonyms, mothers are referred to generally as “participants” or “one mother” in the results section.

To create a safe space for interviews, the mother had the choice of meeting at the community organisation she was connected with, at the university, or in her home. A potential risk was if the participant could not guarantee her space at home would be private and confidential. If the interview took place within the mother’s home, she was asked to

ensure there was a suitable private place for the interview to be conducted. If she could not ensure this, the participant and I considered alternatives.

**Risk of Harm to the Participant or Their Children.** Another potential risk with this study was if there were subsequent child protection concerns from the information shared by the mother. It was explained to the participants that confidentiality would be kept with the exception of potential harm to the participant, their child/ren, or someone else. In this case, the researcher would have needed to break confidentiality to put help in place. Participants were informed they should only share what they were comfortable sharing and they did not need to answer any question they did not want to discuss. All of this was included on the information sheet given before participants consented to participation.

A final ethical consideration in this study was the potential for the participant to experience emotional distress while thinking about and sharing their life experiences. Though a qualitative methodology is well-suited for stories that are sensitive and call for compassionate research, the difficulty and potential for stress in sharing their story was acknowledged. The participant was welcome to have a support person with them during the interview, though no one chose to do so. As I had experience working with this population in previous work settings and am also in training as a child and family psychologist, I remained available for participants during and immediately after the interview in case strong emotions arose. If further support was needed, the participant was offered a referral to receive counselling services or other support. Both of my supervisors are registered psychologists who have considerable experience working with this population. If participants had needed further support, I could have referred participants to my primary supervisor who could have debriefed and assisted the participant or made an appropriate referral. As participants were mostly recruited through professionals, many had access to other supports prior, during, and after the research interviews. This was confirmed with participants.

This study was approved by the Human Ethics Committee at the University of Canterbury, approval number HEC 2020/70 (see Appendix E).

# Chapter 4: Results

To protect anonymity the participants as a whole will be detailed as a summary instead of specific individual details. Eight mothers were recruited to participate in the study. Māori were represented in similar proportion to statistics on children in OOHC in New Zealand. The current age of the mothers ranged from 17-30 years old (median age 24). They were between 16 and 23 years old at the time of their first pregnancy (median age 18). One mother was currently pregnant, three mothers had one child each, one mother had two children, and three mothers had four children each. Besides the mother who was pregnant, the current age of their children ranged from three weeks to 13 years old. The time that participants said they had been in care ranged from a few months to most of their lives. One participant spent only a few months in OOHC, four spent three to six years in care, and three spent over 11 years in OOHC. Two of the participants had a mix of family and non-family placements, two had family placements, and the other four participants had non-family placements. The number of placements ranged from one to 47. Five of the participants went back and forth to their biological homes a number of times. All but one of the participants lacked permanent placements and all of the participants were living on their own by 17, except for the participant who was pregnant and living with a caregiver in a foster home at the time of the interview.

Data from the semi-structured interviews were analysed and four superordinate themes were identified with subthemes emerging in each of the superordinate themes. This chapter details these themes which are summarised in the results table below.

*Superordinate Themes and Subthemes*

1. The influence of upbringing on a mother's supports
    a. Trauma as the norm
    b. Feeling different

    c. Learned helplessness
    d. Survival mode
    e. Loneliness
    f. Fear of the system
    g. Parenting
        i. Parenting guilt
        ii. Role models
2. Obtaining support
    a. Support perceived as valuable
    b. Support that was not perceived as valuable or wanted
    c. Support that was wanted but not available
3. Accessibility of support
    a. Support accessed
    b. Inaccessible support
4. Pathways to support outcomes
    a. Pathways to positive outcomes
    b. Pathways to negative outcomes

Each of the superordinate themes and subthemes are described in the sections below. Quotes from the interviews with the eight mothers are used to demonstrate the theme directly from the mothers' voices. Themes have been outlined into categories; however, the themes intersect and are connected in a variety of ways. Therefore, findings should be read as a whole and not in isolation.

**Theme 1: The Influence of Upbringing on a Mother's Supports**

This first theme captures the influence of the mothers' upbringing on her recent supports. During the interview mothers were asked what it was like growing, including what

adults were around and the influence of them on the mother. Mothers were asked about role models and asked to describe themselves now as a mother. Each subtheme will be explored and connected into how the mothers perceived and accessed support.

***Normalisation of Trauma***

All eight of the mothers discussed trauma from their childhood experiences and upbringing. Each mother mentioned blocking out many of these experiences as a coping strategy. Two mothers specifically said they would take time to reflect their experiences for the interview, but then would push them away again and not consider them afterward. Mothers' histories impacted their view of supports. First, perceptions of support depended on how they came to understand the care and protection system, its involvement with their parents and subsequently with them, and whether it was helpful or harmful. Secondly, trauma became the norm for them. Instead of seeking out beneficial relationships, mothers discussed seeking out violent relationships as it was known.

Mothers described resenting both the care and protection system and their mothers. Now as a mother they were trying to work through their childhood understanding of what happened to them. One mother described hating the system but also knowing that her mother was in the wrong. Two mothers talked about how their mothers had abandoned or rejected them prior to entering in to care. Reflecting back, they could now understand how taxing motherhood can be, but they also struggled to understand how a mother could abandon their child. These relationships with their biological families and the care system affected how they related in subsequent relationships with caregivers, friends, and partners.

Though it was not specifically asked, two mothers mentioned that their mothers grew up in OOHC. One of those mothers went on to describe the abuse she experienced by her mother, how after being removed from home she was put back with her parents, and how she

has felt the consequences of that abuse and the lack of mental health support ever since. As a new mother she shared her worries,

> *"I didn't want to have kids cause I'm so much like her (her mother) and I have to unlearn all these behaviours and unlearn all the ways my brain thinks…"*

One mother, whose mother had also grown up in OOHC, discussed how she went into her first placement before she was one year old. Since then she moved in and out of care throughout her entire life. She went back and forth to her parents until she was 14 years old, her parents went to jail, and she stayed consistently in OOHC through many different placements, many of which she ran away from. She explained she did not like being comfortable as she was not used to it. She said she found it difficult to settle places so would leave. She talked about purposefully going to find people that were like the abusive environment she had left in her biological home.

One mother described living in 40 different homes over a three-year period. She said there were homes where the girls in care were prostituted out. Many times she ran away from placements and ended up living with gangs. She said OOHC was not a good experience, but it was still better than living with her abusive mother. Other mothers described unsafe placements where drugs and abuse were present.

Another mother described carers that were *"really lovely",* but by the time she went in to care she had endured most types of abuse, had her own mental health difficulties, and explained the rules Oranga Tamariki put in place created *"bad dynamics"* in foster homes. When asked about the rules that created those dynamics, she said she was not allowed to go to the shops alone or even to the letter box, she described having a tracker (someone who followed her around) and not being able to go to *"normal"* classes at high school. She said this led her to want to run away from her trackers and run away from home, to go see her biological family with whom she was not allowed to be in contact. Although she did mention

a handful of caregivers she appreciated, she also described horrific experiences in many of the 47 placements, both in homes and residential placements. She described being escorted through the Christchurch airport in handcuffs at 14 years old when she was transferred to a new residential facility. This same mother said she looked through her care file which was difficult to read. She discussed mentally paying the consequences for all that had happened, but not fully remembering all that contributed to the way she felt now. Even though it was painful to read she stated,

> *"But I wanted to know. I wanted to know how messed up I was because I can't remember a lot of it."*

All but one of the mothers went on to experience abusive partners. When asked if there was anything anyone could have done to help during a season of living with an abusive partner, one mother described how trauma had so become the norm for her, at the time she was not able to imagine it could be different for her. She stated,

> *"I don't think there's anything anyone could have done because my entire life was just like, I think of building blocks, you know, like sort of making me what's the word, um, become like accustomed to the, the trauma, you know? And it got to a point, I think, where the trauma was like, I didn't know anything else and so it kind of felt safe to be in that trauma, you know, like, because it's what I knew. And um, there was times where like my youth group worker was like, you can leave him. Like, you know, you deserve better and stuff like that but I didn't believe her. Because like my parents had instilled in me at such a young age that I wasn't worthy, you know? And then so when (her child) was born, it wasn't a matter of like, I'm worthy. It's a matter of if I don't leave, I'm going to get my child taken off of me."*

However, many of the mothers went on to realise trauma did not have to be their norm and sought support. This will be discussed later in the chapter. However, even with the

personal shifts they made to change trajectories, mothers regularly felt on the outside of "normal". One mother went on to university and said that friends in her university classes did *"normal"* things, like play sports and go visit their parents. She said that she could not imagine what that would be like, since from early in life she was looking after her sisters and dealing with difficult experiences.

***Feeling Different***

Mothers talked about feeling different than everyone else because of the maltreatment they experienced and being in OOHC. For some, this was in life in general, for others, they specifically felt different as a mother. Their early lives were different and now as mothers they felt different than the typical mother. Sometimes these pictures of normal came from social media and other times they came from what is perceived to be the norm when children start at school. Their perception of feeling different sometimes led to shutting themselves off relationally. One mother described feeling anxious to meet her son's friends' parents because she felt different and was much younger than the rest of them. At sporting events she described herself standing alone, away from the other parents.

As will be described further, as mothers grew up they realised their home and experience of trauma was not the same as everyone else. One mother said growing up she always felt jealous of her friends who lived with their parents and had freedom as teenagers. She wanted the same type of family home, one she could call hers. A couple mothers described children who have experienced stability, safety, and love throughout their lives do not realise how good they have it. In their current season, mothers described other people who have *"normal"* lives where they can go back to their mother's house with their children and they are welcomed and can stay for dinner.

***Reaching Out for Help***

Mothers said they reached out for help as children and had negative experiences. One mother described getting on a bus with her two younger sisters at 13 years old to speak with their lawyer about the drugs, alcohol, and mistreatment they were experiencing at their foster care whānau placement. She said she also reached out to a school counsellor during that time but felt no one listened. At times mothers stopped reaching out for help as they learned it would not do any good. One mother described it as,

*"I assume like that you tell adults the truth, they're not going to help you."*

Mothers could remember the one or few people that believed them. One mother described a police officer as *"the only person that believed me"* when she ran away from her abusive home. One mother said she wanted help all growing up, but no one ever did anything. She had taken the opportunity read through her care and protection file which she said only confirmed that fact. Besides one *"office lady"* at her school who she spoke highly of, she said everyone saw her as a *"problem kid"*. Instead of getting help she was moved between her parents' homes, in both of which she suffered abuse, and eventually was put into OOHC at 12 years old. She wished she had been removed earlier, saying,

*"I wanted a family that loved me. I wanted a family that would protect me and care for me. And I never got that."*

***Survival Mode***

Mothers described being in survival mode throughout their growing up because of their early adverse experiences. For them, survival mode meant not being able to consider medium or long-term planning and a few of them used the concept of *'fight, flight, freeze'* to describe their reactions when in survival mode. This pattern continued while pregnant and in the early days with their child. One mother was interviewed in the first couple weeks of her daughter's life. She described her mental health struggles and how it often put her in survival mode. This was consistent with her life during pregnancy which she described as constantly

stressful due to house raids, police involvement, borderline personality disorder, pregnancy hormones, and a *"grumpy partner"*.

Another mother described losing her job due to her partner's drug addiction while she was pregnant,

> *"I ended up losing my job, I think when I was about 25 weeks (pregnant) and then we were, so when I got pregnant, we were already homeless."*

She went on to describe how she lacked support during that time as her friends and family had been pushed away because of her controlling partner. It was difficult for mothers to step out of survival mode and think about accessing supports. When asked about support she wished she had had during that time, that same mother said,

> *"It's hard to recall cause I feel like a lot of the time I was just in fight or flight mode. Like I was just literally trying to survive."*

When mothers experienced support and knew they were not on their own, they were able to come out of survival mode. Mothers discussed being able to consider their future, look for support, enrol in further study, and create safer environments for their children when they were able to come out of survival mode. One mother described it,

> *"I don't really need or want a lot of things anymore. So once I pretty much settled (in her caregivers' home), my needs and wants kind of just went out the window cause I didn't need anything. The things that I wanted was already getting met."*

***Loneliness***

Mothers described a deep sense of loneliness throughout growing up due to instability prior to and during their time in OOHC. One mother described how the back and forth nature of OOHC made her feel unloved,

> *"I wanted to go back to mum, but the way I see it is if you're going to sit there remove a child, that's going to screw with their head a lot more. Like it should either keep*

*them in the one place and keep them there forever instead of moving them. Because I think that it just made me feel like I wasn't loved or anything like that. Like it was, I couldn't stay in one spot, like every time I'd get used to something they'd move me and then they'd move me and move me and move me. If my mum was that bad, I think they should have just kept me away from her house instead of putting me back there all the time."*

Mothers continued to feel they had no one. Even mothers who seemed to have positive relationships around them now often felt alone. They felt there was no one who has known them their whole life and said they did not know if anyone would fully have their back if needed. One mother put it this way,

*"Sometimes I'm just like, if there was ever an emergency, uh, like what would I do if it was my kids that were hurt, where would my other kids go, who do I call and who would help me? Cause there's no one. No one would."*

Some mothers described having a person that they could go to sometimes, but they still would not know who to call if they needed someone in the middle of the night. Sometimes mothers had people, but because they feel different (as described above) and had experienced rejection they did not believe people wanted to be with them. One mother described getting invited to Christmas day at someone's house, but quickly dismissed it saying that it was just a pity invite. This may show the pervasive feeling and ingrained perception of loneliness could inhibit mothers from reaching out for support even when the support is available.

***Fear of the System***

Five mothers described times of being on high alert and fearful that Oranga Tamariki (OT) would uplift their child. One mother said she had a daily fear of losing her child. Mothers perception of this government support is described further in the next theme. However, the experience mothers had growing up in OOHC impacted their perception now

of Oranga Tamariki and how they understand OT involvement with their own children. One mother described saying she did not need help because for fear it would lead to her children being uplifted,

> *"So I said I didn't need that (respite) because I felt like if I said that I needed it, they'd come back and be like well, you can't handle your kids kind of thing. So I'd be like no, no, no, no, and they're trying to convince me, and I'm like I'm not taking respite."*

She went on to describe her experience as a child which explained why she was so adamant,

> *"It could've been because first thing, I went to respite care. And then I was like I don't want my kids to go into CYFs care. I've done everything you've wanted me to do so why is that not enough, why yous still trying to make me put my kids into respite care."*

Only one mother said she did not worry about her baby being uplifted. At the time of the interview she was pregnant and living with a foster carer. She described the advocacy of her caregiver and said there was no reason for uplift. She was certain she and the baby would be alright because she had the support of her caregiver. She felt she was not alone and would have help when her baby was born. She had full confidence that her caregiver was there for her, would encourage and stand up for her as needed.

***Parenting***

Mothers spoke of the joy and challenges of parenting. Interview questions asked about what adults mothers had around them while growing up, whether they had role models, how they viewed themselves as mothers, who they had hoped to be like as a mother, and if they had received support in their parenting. Some mothers discussed parenting with words describing the bond between them and their child, including emotions and relationship. Other mothers discussed parenting based on behaviours they want to exhibit as a mother (e.g. being

drug free, providing for their child). One mother who had good formal and informal support said that she just takes motherhood as it comes: if she does it right, she does it right; if she gets something wrong, someone will let her know. Two main findings came out from parenting – parenting guilt and role models associations.

**Parenting Guilt.** Feeling guilty and inadequate as a mother emerged as a subtheme. Four mothers stated feeling inadequate as parents, and two others said they wished they were different. One mother said,

> *"I just feel like he could have a bit of a better life than with me".*

She discussed wanting something ideal, a *"picket fence type".* She said she struggles to handle his emotions and sometimes felt the intensity of them was her fault and she must be doing something wrong.

Another mother described feeling like the *"worst parent in the world"* and having *"no idea what she was doing"* when she first became a mother. She said she felt like a different mother to others, not as *"maternal"*. When he was born she said she loved him and felt a bond, but the bond seemed different from that experienced by other mothers. From when her son was two to five years old she dropped him off at in-home childcare so that she could study. She described the woman who ran the childcare,

> *"She was like the mother he never had. Oh, he did have, but you know, the mother I wish he had've had."*

She went on to say that it was a place he could have fun and do activities. She described how she could not provide those things for him as she felt so depressed and alone at the time. She described herself as being exhausted during that time and that parenting felt like a *"chore"* and something that she could not enjoy at the time. At times, feeling like a not good enough parent led mothers to shut away from relationships and support. This mother said she missed

events, like going with her son to his friends' birthday parties, because she did not have the confidence as a mother and felt different than the other parents.

**Role Models.** The view of who could be seen as a role model for parenting was quite specific for the mothers in the study, with many of them equating it to someone they saw parenting in their same life season. When asked about parenting role models, six mothers pointed out a person they admired, but then quickly established they had not seen that person parent so could not call them a role model, even if that person had or was currently filling that role for them. Many mothers did not seem to see parenting as lifetime quality, but more in terms of the early years of a child's life.

For others, even if their parents did not fill the parenting role model space for them, it could not be attributed to anyone else. This made future carer relationships difficult to navigate. For example, one mother described getting a bracelet which said *"Happy Birthday, love from Mum and Dad"* on her 16th birthday from caregivers she had lived with for approximately four months. Looking back now, she said she wonders *"what were they up to?"*. Another mother had foster carers who introduced her as their *"adopted daughter"*. As she processed why this made her so upset she relayed,

> *"They were really lovely people, but they weren't, they weren't my mum and they weren't my dad… and my mum and my dad are supposed to be my role models and I could never connect with people like that… I was just a shell of a child."*

Later she went on to explain she felt they were trying to replace her parents. At that time, she said, she had a lot of love for her parents, her mother especially, even with all the maltreatment she had experienced. Of the carers, she said,

> *"These aren't my parents. Like, you need to know these are not my parents."*

She said for a long time no one else could fill that gap for her. However, she said after giving her mother so many chances, all of which led to disappointment, and she now hates her

mother. She has a good relationship with her birth father, who made significant changes by getting off drugs and alcohol.

One mother described not having role models as she did not know many people with children. Later, though, she described her grandmothers' parenting of her, making sure she was disciplined the right way and looked after, which she appreciated. Another mother, who had been raised from a few months of age by her grandmother, said since she was her granddaughter she could not say what her nan was like as a mother because she had not seen her raise her own children. However later, when describing the kind of mother she is herself, expressed the similarities between the way she parents and how both her father and grandmother parented her.

One mother said she looked to herself and learned what not to do from others. She said she looks up to her caregiver but would not follow her as a parenting role model as she had not seen her parent. Interestingly, though, this same mother described her caregiver with parental characteristics (e.g. taking care of her practically, advocating for her, offering her unconditional acceptance, being emotionally available, caring) for much of the interview.

One mother described her friends' family and mother in particular from when she started high school and realised life could be different than what she had experienced so far.

> *"I kind of witnessed how her family works and like their dynamics, like her mum didn't drink, her mum didn't smoke drugs. Her mum didn't like make her kids feel like crap. Like they had clothes… to see my friend's mum as a single parent with five kids, you know, being able to support them with everything….this is actually what's supposed to be."*

However, when this mother was asked if her friend's mother was someone she would like to be like as a mother, she said that she does not necessarily look up to her, but instead wishes she had that kind of life and mother.

Similarly, many of the mothers described snippets of a person they encountered who they thought was a mother they would want to be like, however, the mothers did not have enough time with the person to really glean from them usually due to short-lived foster placements or social relationships that did not last. Most mothers simply saw what they wished they had had for themselves. Some of them had not only not experienced parenting role models but felt as children they were parenting themselves or their younger siblings. Instead of thinking about role models for parenting, one mother discussed how she had to learn how to be a child when she was eventually put into a safe, caring environment at 13 years old. She describes it:

> *"I was (shocked). Because I went from being in a house where I was able to pretty much just look after myself and into an actual stable home where I was being fed proper meals every night, having clean clothes on my back, and you know, just the simple things."*

She recounted that it took her almost a year to get used to being cared for.

One mother said she loves parenting and would not choose anything else to spend her life on, however in the early days said she did not know anything about how to parent. She concluded it probably sounded silly, but no one told her about how to be a parent, so she googled what she needed to know and watched YouTube videos. When describing the basics of a role model she said it was someone who did not do drugs or abuse alcohol when the kids are around, someone that cared for their children, and provided for their basic needs. This subtheme points out the lack, or perceived lack, of support these mothers felt they had to know and experience how to parent differently.

**Theme 2: Obtaining Support**

Though each of the mothers had complex upbringings, they found support along the way. Some of the support was perceived to be vital and valuable, while other supports were

imposed on them. Mothers also discussed the support and relationships they wished had been available to them throughout their parenting journey.

***Support Perceived as Valuable***

Valued supports were described as: always there when needed, gave freedom, had realistic expectations, treated with respect, treated like the mother belonged, had good intentions, were passionate, kind, listened, tried to help, and consistent. Mothers were able to recall people who were kind, even if it was a one-time thing and they did not remember the person's name. Just one nice person along the way made an impact. Often it was not extraordinary help, but simply nice people in the everydayness of work and study.

For example, one mother described how her colleagues at work ended up being a great support. At first she described work colleagues as *"super doper nice"* and then went on to realise they are just *"normal"* people. However, she stated how shaping and significant it was to have normal people around her and to realise life could exist *"without all the drama"*. Other mothers described school as a place of safety and enjoyment. Three mothers discussed positive relationships with teachers and peers within the school context. These mothers went from traditional school to teen parent colleges once pregnant, finding them to be supportive for both education and peer relationships.

Compassionate social workers made a difference for mothers. One mother said she thought she *"hated"* social workers. While admitting this is mostly still the case, she said the hospital social worker surprised her. Through their relationship she learned to be open to other support. She described working through a lot of trauma in her conversations with the social worker while at the hospital in the neonatal intensive care unit (NICU) with her baby.

During a particularly difficult time, another mother discussed knowing she could speak with the hospital social worker and her midwife, both of whom she described as kind. She said she purposefully and intentionally reached out during her time at NICU. She

described thinking up issues she could talk to the social worker about as she was so lonely. She eventually got up the courage to talk with that same social worker about the violent relationship she was in and moved into supportive accommodation. This mother was one who had reached out for help her whole life. She admitted she does not understand herself how she was able to continue to reach out, looking for help, but she did, and this time she finally felt heard and understood. Prior to her time at NICU she also relied on her midwife. She described her as someone who stuck with her and was *"my person"*, even when in a relationship with a violent partner. Similarly to her experience with the social worker, the mother reported she would exaggerate worries about pregnancy just so the midwife would come see her and talk with her. She said the midwife carried her through that time and, thankfully, was still around when the violence and abuse become worse and she decided to leave.

Three participants mentioned foster care caregivers who were a support to them. Two mothers had gone through multiple placements and finally settled in a home the last two years they were in foster care, which was where they met. Individually, they spoke highly of the caregiver and, when pressed as to what it was they appreciated, they described how she would help them when needed, there was always food available, they had freedom, and no matter what she never kicked them out or gave up on them. They acknowledged the placement was not ideal for everyone who went there, and the caregiver has now stopped caregiving as she got in trouble for allowing adolescents in her care to become intoxicated. However, for them, they felt it was a supportive environment.

One participant was still in Oranga Tamariki care at the time of the interview. She made a number of significant changes when she became pregnant as she did not want her son to repeat what she had been through growing up. When asked how she knew what needed to be different she said,

*"Well, from living with nothing and then coming to live with full support and people around you, you kind of just clue on to them. You clue onto the changes…"*

She talked about the unconditional acceptance she received from her caregiver when she became pregnant. This mother had moved around her whole life and would not stay in placements. She said Oranga Tamariki had found it difficult to find a carer who would take her as she would run away and had had multiple suicide attempts. The placement she was in had started as respite, but she had now been there for over a year with no intention of leaving. She said she settled there and found a new purpose. When asked what was different she described feeling respected as a person and her examples were having her own space, gaining independence, and able to be a teenager. She felt her caregiver had realistic expectations, they discussed rules together, and her caregiver would advocate on her behalf, telling Oranga Tamariki when their rules did not make sense for her situation. For example, her caregiver helped to get her an extended curfew (had previously been 8:30 pm) and she was now able to have things like sugar and a television in her room. These things made her feel valued and like a *"normal teenager"*. She also felt she had a choice about the placement as it was only meant to be respite. The sense of autonomy in this decision was important to her. The mother said that though this caregiver did respite regularly, when she decided to stay she became the priority entirely and it has only been her there now. This mother described how her caregiver's family became her family.

Although most mothers did not see care and protection services as a support, one mother did appreciate their involvement. She said that her Oranga Tamariki (OT) social worker was *"lovely"* and that she *"understood"* the difficulties of being a young mother. She felt OT believed she was doing her best. She understood OT was involved since she had been in OOHC herself. From their support she was linked in with long-term community supports

for which she is grateful. Due to her own experience growing up and having OT involvement she felt they were there to help. She describes,

> *"Obviously when I was younger to just seeing that they were trying to help me get out of a bad environment living with my mum, and into a better environment. Just doing the things that they asked of us to do. You could just see that that's what they were trying to do with it. They weren't purposely trying to take me away from my mum. They were just wanting me to be in a safe environment."*

Which aligned with current beliefs around her involvement with them as a mother,

> *"If you work with them and do the things that they want you to do and they need you to do, they'll leave you alone… it all worked in well with having OT involvement and things like that because it got them off my back. So having support group networks, because that was the main concern was the fact that I didn't have support and they were worried. And then once, you know, I showed that then, they were happy as."*

Although another mother did not appreciate OT involvement, she described a time after her third baby when she felt so overwhelmed and alone. The only place she thought to call was Oranga Tamariki, which was Child, Youth, and Family at the time. She asked for a social worker to come and see her. She said someone came out, encouraged her that she could do it, and stated she felt quite supported in that moment.

While most mothers did not appreciate the manner in which OT social workers communicated with them, all of the mothers in the study were linked in with support due to OT involvement. One mother reflected that she had not wanted to engage with supports OT connected her to, as she felt she already had too much on her plate with multiple kids. However, she did engage and is still linked in with one of the community supports and has had the same worker four years later. Now she says she would not work with anyone else. OT also linked her with an organisation that ran courses and groups. She said,

> *"But then once I started doing that, I actually liked it. And I kind of wish I could do more courses… It's really good, just even meeting up with other mums just once a week, and just like knowing there's people to talk to than little humans, like adult conversation, I think is what I miss the most."*

All of the mothers were linked with further supports due to OT involvement and most of those supports were long term (up to five years). Every mother interviewed had positive things to relay about the community supports they received or continue to receive. One mother described this community longer-term support,

> *"They are one fantastic agency. I'd honestly, I'd be lost without them. Like they've been such a great help with everything right down from helping with breastfeeding to nappy changes and to learning the cues on when baby's hungry, and babies just need comfort and things like that. They're honestly fantastic to work with… they're always there if you need to call them. They're just a phone call away."*

Two mothers initially said they actually prefer professional help, but as they talked they could see the value and need for both formal and informal supports. Four mothers talked about friends who were their main support. One of the mothers said her one friend is the person who has been constant and often the only one available for her. Another mother described the importance of second chances which she received from her sister and friends and not knowing where she would be without them. She followed it up by saying she likely had not been the easiest or kindest person to be around during the time she was with an abusive partner, but people still helped her. She said,

> *"I feel quite lucky because people could have been like, oh, you know, um, that's your fault, you know, that you're in this situation, so I'm not going to help you, you know?"*

Only two mothers described having a supportive partner, either their current partner or a previous one. Wider whānau (biological and non-biological) support was mentioned a

number of times throughout the interviews. One mother was taken in by two of her half-sisters' grandmothers after going into OOHC. This same mother described a non-biological step uncle who later became a father to her. Throughout her life he was a source of consistent support. When she called and told him she was pregnant he said he would support her, and she said he has been her biggest support network over the years. She described always having someone when she needs them. Between these two *"nans",* two of her half-sisters, and her unofficially adopted father, this mother has a strong sense of wider family.

Four mothers described their partner's mother as someone who was or had been a source of support, either emotionally, financially, or practically. Other whānau supports mentioned were a partner's foster mother, grandmothers (biological and non-biological), unofficial adopted mothers who served as grandmothers to their children, fathers, and a doctor. One mother described her father, who although had been violent and an addict while she was growing up, became clean over the last few years. He has custody of her oldest child. She said they now talk daily and he is an emotional support to her as she raises her second son. She described how her dad and his wife have inspired her to make changes in her life as well.

***Support Not Perceived as Valuable or Wanted***

Mothers did not want support when they felt it came with judgment. One mother said she felt like everyone was against her instead of trying to help. She described the interaction with a Plunket nurse,

> *"Anything she'd had to say was so negative…criticising… Just there's nice ways to say things without feeling like everyone's attacking you."*

Instead of wanting to engage in support she said it made her want to shut off from everyone as she felt paranoid about her parenting.

Most mothers said they did not see Oranga Tamariki (OT), currently Child, Youth, and Family (CYFs), as a support. One mother said they did not empathise with children in care. Another mother said they were *'horrible'*. When asked what she meant, she described them as invasive and not passionate. When she was really struggling, she felt they just told her what to do. Alternatively, during that same difficult time when OT was involved this mother actually wanted to reach out for help and did, but to a social worker and midwife she felt cared about her. It was not that she did not want help or support, but the characteristics of the support made a difference. The outcome may have been the same, in this case going into a residential facility, but the positive way the midwife and hospital social worker went about it opened this mother up to future support.

One mother reflected,

> *"I think OT needs to be shut down or remodelled seriously, not just a name change… there needs to be thorough investigation into the caregivers. There needs to be thorough investigation into the social workers. A lot of these new social workers go in thinking they're going to change the world and then they're bullied by other social workers. And they end up being lost in the system too or they leave. They whole system needs to be remodelled urgently before it's too late."*

She went on to say how a child in care has no voice. She hopes for change, that the system can care about the child while helping and supporting, not judging, the family. Some mothers also described specific care givers within foster care as doing it for the wrong reasons.

Words mothers used to describe support that was not valued were: controlling, invasive, uncaring, in it for the wrong reasons, and grumpy. Mothers felt unbelieved, betrayed, misunderstood, rejected, judged, and uncared for by these supports. Sometimes mothers stayed in less than ideal situations or stopped reaching out for support when the perception was that support came with judgment and lack of care.

***Wanted but Inaccessible Support***

Mothers described times when they wanted more from professional support. One mother wanted a care and protection social worker for the parents, someone who was friendly and consistent. One mother described times she felt the only people she could rely on were paid professionals who had work boundaries. She said that she wanted to push those boundaries but eventually realised she needed to get the relationships she wanted elsewhere.

One mother said it would have been helpful to have support that was forced, as she had become so untrusting due to her life experiences and was at such a low point when her son was born.

> *"Someone sort of forced upon you every week... forced on you initially because when you're a new mum, you know, especially if you've had postnatal depression, you sort of shut yourself away."*

She said if the same person came around each week with a bag of food or nappies, maybe it would turn into a relationship. She said at the time her son was born the circumstances were so horrible and she had not necessarily wanted support. However, she was tight on money and would have let someone in if there was a *"perk"* with it. She said there were a couple times a lady from an organisation showed up with a bag of food. This mother never turned her away because they needed the food and *"she was so nice to speak to".*

Four mothers mentioned trying to obtain housing was a looming threat while they were pregnant. One mother described not knowing if she had somewhere to live and a roof over her head as a terrifying worry when she was pregnant. This was especially true for the six mothers who had nowhere to return to if needed. Three of the mothers had to move a number of times before settling into a rental that was their own.

While two mothers eventually experienced stable, caring foster placements that became family for them, six mothers said they currently wished they had somewhere to

return to or visit, like a parent's home. None of the mothers saw their own mother as a source of support, but those who lacked that type of relationship (all but two) wished they had someone in that role. One mother said she wished she could ring up her father or mother and have a coffee or ask them to take her child for an hour so she could run errands. Three mothers said they wished their own mother would *"step up"*, support them, and *"be a mum and nana".* One mother said her mother was only involved when it suited her, however she had cut it off as her mother's behaviour was not something she wants around her children. She went on to describe,

> *"I didn't really need her when I was a child and I don't need her now, so I'm just not fazed by it, the games she plays. So, whatever, I'm at the age now where I know she's not gonna change and there's no point in holding out hope."*

Similarly, another mother said she gave her mother so many chances, but now she hates her because of the choices she has made. She said she is *"nothing to her".* When asked when that shift happened, it had only been in the last year. Mothers wanted someone to fill the role of parent for them and grandparent to their children but did not want that from their own mother due to her destructive lifestyle. When two mothers described going to their mother at one point, they felt that they were caring for her instead of the other way around.

Four mothers wanted someone who would be present in the parenting journey with them, initially going to scans and to midwife appointments and later helping parent alongside them. Five mothers described the need they had to be instructed on how to parent. One mother said when her first child was born she lived with the mother of her partner who, for the most part, just let her parent on her own but would cook her dinner. She was grateful for the support she did receive from her. However, she said that she could have used some parenting advice and some practical help around parenting (e.g. the opportunity to have an

uninterrupted shower at times). While the support she received was appreciated, the mother described other support would have been helpful:

> *"I guess she just didn't really want to interfere and tell me what to do, but maybe sometimes it would have been great if she could help me with the sleeping thing because (child's name) would sleep for 40 minutes at a time and then he would just want to be breastfed for ages. And I mean, I couldn't even have a shower. Like I'd get in and I was out, so it was hard."*

Mothers had made difficult decisions due to wanting help. Most mothers described staying in abusive relationships too long because at times the partner was helpful, and they felt they had no one else. Two mothers described relying on neighbours to help as they had no one else available. One mother, who said she was very protective of her own children because of her abuse history, described allowing her children to stay overnight at the neighbours to get a break. She said the neighbours' children were uplifted by Oranga Tamariki, but she does not know why. Two mothers said they wished the father of their child/children was or had been more supportive.

One mother said she no longer had care of her first child due to her mental health difficulties and drug and alcohol addiction which surrounded her first pregnancy and early parenting days. At the time of the interview, she reported she was off drugs, had mental health support, and was parenting her second child. When asked if support made a difference the first time around she gave a differing perspective,

> *"I think it enabled me to drink, enabled me to not really care as much because someone was caring."*

**Theme 3: Accessibility of Support**

***Support Accessed***

One interesting finding that emerged was support accessed due to it being *"forced"*. Six mothers described how at times this was an important part of progressing through pathways to positive outcomes. Sometimes forced support happened because of Oranga Tamariki involvement. As seen above, though mothers did not always want the support, the outcomes were often positive and opened them to greater support networks. Though not always the case, mothers wanted support that, even if forced upon them at first, was kind, non-judgmental, and a relationship where the mother felt cared for and the person was trying to help. This type of person or support often led the mother to identify and access further support.

Other times forced support was from a loving caregiver. One mother described how her grandmother got her into counselling and made sure she went for a couple years because of the prior abuse she had experienced. Another mother described wishing support had been forced on her when disclosing abuse to her father. She said though she appreciated he believed her and was generally supportive, he simply asked if she wanted to go see the doctor or talk to the police and she said no. She said the abuse was never talked about again. When asked if, as a mother, she would have a different response and she replied yes. She described her dad as good and doing the best he could, while still wishing she had been forced to get support:

> *"I would want to know everything… I think I handle things different. Even though I said no to seeing a doctor or to the police, I'd be ringing the police on my way to the doctor. Like that's the sort of mum I am, I wouldn't care if my child's said no, we'd be going to the doctor and we would be calling the police."*

Proximity, ease, and timing were other factors in accessing support. For example, one mother described how she reached out to Work and Income New Zealand (WINZ) when she moved to a house that was in walking distance to their office. That same mother described

being to access study when she had a flatmate who had a car. Sometimes support was accessed simply because it was close or easy to obtain. One mother accessed support because she found out about it from her partner's sister who had the same support, appreciated it, and connected her to the organisation. She was also motivated because she felt by getting connected with the organisation they would help with other things as well. Three mothers discussed the timing of obtaining support. They said that, even though they are grateful to access it now, if the same support had been available years before, they do not think they would have accessed it as they were not ready for it.

Wanting different for their children was a motivator for each of the mothers in accessing support. One mother simply said she found a way to identify and reach out to support because she was determined not to be like her own mother. Five mothers described the effects of drugs, alcohol, abuse or gang violence in their families of origin and then later in their partners. They knew they did not want that for their own children, and it took time for them to realise their situation could be different, this became a factor in reaching out and accessing support. One mother said,

> *"I just needed to stop the cycle and just get rid of everyone and try and give something for (child's name) to be proud of."*

One mother who was doing drugs and living in an unsafe environment when she fell pregnant described the similarities to the home she grew up in, one with violence, yelling, and drugs. She did not want that for her baby. Because of the supportive relationship she had with her caregiver, she was able to get off drugs and move out of her partner's family's violent house. One mother who was in the early stages of openness to support said,

> *"I feel the only thing stopping me being a good mum, it's not my want to, or my ability. It's what was deeply ingrained in me without me knowing. It's my reactions."*

When discussing changing patterns she said,

*"I see it and I can't stop it and I can't and I can't, and I know I can't, not by myself."*

***Inaccessible Support***

Mothers described experiences of support as inaccessible. Sometimes it was simply that mothers did not know about supports were available to them. One mother described her experience 14 years ago of getting *"kicked out"* of OOHC on her 16th birthday, getting a $200 grant to buy suitcases, packing up and never hearing from the care system again until she had her own child and there were calls of concern. From exiting care she went into a relationship that became abusive. She described not knowing about support after having her son,

> *"I didn't even know that the benefit existed, and I didn't know that I could go and get money. And if I had've known, I probably would've left earlier than I did."*

She went on to describe the violence she experienced, but at the time not knowing what to do or where to go and being too afraid to leave.

Similarly another mother described not knowing what was available:

> *"Sometimes I wish there was support or you'd know where to go to get help if you needed it. But I don't actually think I knew what to do or where to go if I did even need help. I'd say… I kind of just did it by myself. And if there was trouble, I just dealt with it alone, I guess."*

She describes her experience of leaving care ten years ago at 17 years old,

> *"When you turned 17, that was it. They said, go get on a benefit. And they didn't take me to WINZ. I didn't know how I was supposed to get on a benefit, what I needed to go, what I was supposed to bring."*

Another factor that contributed to inaccessibility was intake criteria. One mother described feeling so alone, having no friends, and being isolated from everyone by her partner. She remembered hearing about a group home for mothers and babies, but she did not

fit the criteria as she said she looked *"too stable".* This same mother shared she had been just outside the criteria for supports a number of times. She said she felt she was failing at looking after her child but time after time she missed the criteria to receive help. She went on to say that either she would try miss out or someone would come around, Plunket for example, but she felt so judged she no longer wanted the support. This may indicate there were times that support was available, but mothers felt attacked and the support felt negative and therefore not accessible in the sense they were no longer open to it.

Similar to not meeting criteria was when mothers were perceived to be doing *"too well".* One mother who was in care at the time of the interview described not feeling supported by Oranga Tamariki now that she is doing well. Since living with her current caregiver she has gone off drugs, moved out of a violent home, and is settled. She said that Oranga Tamariki want her to move out once she has her baby. She said,

> *"Now that I've calmed down and settled down, they think that I don't need the support anymore, but to be fair, if the support got taken away, I may go back to that point."*

This mother knows that legally Oranga Tamariki have to keep her in care till she is 21 and she knows her caregiver will advocate for that. She stated,

> *"To be fair, the placement issues my caregiver deals with. I don't really deal with it because she knows that it just stresses me out. She knows I don't need it. She knows as long as she knows what I want she has always advocated for it."*

However, for mothers who do not know what is available or do not have an advocate through themselves or someone else, services or support may not be accessible.

Mental health difficulties were another reason mothers did not access supports. One mother described her anxiety which held her back from accessing support in her early years of parenting. She said she would not have picked up the phone to make the initial

appointment. If she did have the courage to call and make an appointment she would not attend because of how anxious she felt. When she did access support it was because she was forced due to care and protection concerns. On reflection, she felt the support had to be forced for her to overcome her anxiety and engage.

Alongside this may be the timing factor, as seen before. One mother described how low her own mental health was after maltreatment within her biological family and within OOHC. When her first child was born she was with a violent partner and dealing with drug and alcohol addiction. Her mental health and addiction made it difficult to be open to support and knowing how to utilise it. She said with her first child, having people support her by taking care of her child only made turning to drugs and alcohol easier. Another mother who had been isolated due to her partner, had lost her key relationships and her job, said she wished someone had reached out and helped her. However, while processing further, she acknowledged people had tried, but she was so consumed by him at the time she did not listen.

Sometimes it was simply the ebb and flow of information relationships that made support seem inaccessible. One mother, for example, felt informal support through friends and family was lacking due to the business of people's lives. Two mothers felt they had less support from their family because they had gone on to have subsequent children and were told if they wanted help they should *"stop popping out kids"*.

**Theme 4: Pathways to Support Outcomes**

Pathways emerged as mothers talked about their experiences. Some factors creating pathways which led to positive outcomes and others leading to negative outcomes. It could be as straightforward as one person – a teacher, a social worker, or the police – believing them which led to the mother reaching out again. Other times pathways began with the complexity of maltreatment.

***Pathways Leading to Negative Outcomes***

Mothers described experiences which created pathways leading to negative outcomes for them and their child. Most mothers described living with violent partners or in violent homes after leaving OOHC. Sometimes the pathway was due to their many adverse experiences as a child, which led to going into OOHC, which led to mothers feeling like no one cared or loved them, which led to unhealthy relationship decisions. One mother described the reason she believed she got into abusive relationships,

> *"I think that's just when nobody loves you… Well, you feel that no one loves you and you've been in CYFs care, you kind of like listen to what people say, like a male will say, rather than the actions that they show. What they're saying is what you want to hear, but deep down, you know, that it's probably not really a good idea."*

Once mothers were in an unhealthy relationship, they described being afraid and lacking options. One mother described having no one except her abusive partner and other people who had been in OOHC with her. She felt alone, lacked confidence in herself and lacked trust in people. When she felt judged by professionals who were meant to be supportive, it caused her to close off even more. She said the loneliness and desperation she felt led her to make poor choices, rely on her abusive partner, and do things she would rather not have done to provide for herself and her son. However, when this mother began to experience help that was caring and non-judgmental she was open, reached out for help, and progressed in positive ways.

***Pathways Leading to Positive Outcomes***

Three mothers described a collection of experiences as their *"rock bottom",* a place where they were both open to support and the support came along at the right time. One mother said soon after having her baby by caesarean section, she broke her leg. She could not lift her baby and could not walk. Beyond that she was homeless and was being physically and

emotionally abused by her partner (her baby's father). During this time, her baby was in Neonatal Intensive Care Unit (NICU) and she disclosed the abuse to her midwife. She found kindness from both her midwife and the hospital social worker. From NICU they sent her on to a mental health service which provides inpatient treatment for mothers, and babies are able to stay with their mothers as needed. This mother described feeling embarrassed and guilty that she had not said anything to her midwife sooner, but also was so relieved to be able to talk about the recent years of abuse to people who were empathetic and strategic in their support.

Another mother shared the exact date she hit rock bottom and decided *"enough's enough".* She reached out to an addiction programme, which she had already known about but had not been open to previously, and got clean. That programme connected her with other community supports, one of which was an organisation she had been connected with previously but had not fully engaged. That organisation connected her with housing support, and she was able to get access to her son when housing concerns had been addressed.

Six of the mothers interviewed found professional support often led to greater social support from friends and whānau. Although one mother mentioned sometimes desiring more from professional supports, those positive professional relationships often directed mothers to other supports and relationships. For one mother, experiencing kindness and help from professionals led to engagement with a teen parent college, a community organisation for young mothers, and reconnecting with friends. Moving from the hospital support to these other supports opened her world up. She said,

> *"I think at that point it helped me realize that there's more to life, you know? Like I was able to see things a bit, not, not clearer but like, Oh my gosh, like there's actually a world out here. Like, cause you know, I felt so small and so helpless, and stuck in every situation that I was in. And to like go from, you know, that to in a situation*

*where I could think about my future, like, I dunno, it just seemed like it looked a different, different world sort of. Like opening myself up to experiences that I hadn't had before, was just in itself…"*

Similarly, another mother described how support let to further support. When she had her son she was not aware of any support but saw a sign for Citizen's Advice Bureau on the back of a bus. She called them and they connected her with Work and Income New Zealand (WINZ). Through WINZ she found out about government financial assistance she could receive and on a subsequent visit she heard about the, new at that time, training incentive allowance which included money to help pay for childcare while studying. As she had to attend budgeting advice to receive financial assistance, WINZ connected her an organisation that later connected her with a woman who helped her create a resume. Once she had her resume she said it gave her a bit of confidence to actually send it out. She interviewed and secured a job she loves and is still at eight years later.

Other mothers described experiences that led to pathways for positive outcomes. For one mother it was non-judgemental professional help that led to further community support, then on to more study, leading to healthy friendships and relationships, and finally being about to think about life beyond survival. Another mother found a stable placement, which led to a feeling of belonging and being cared for, which led to healthy choices, which led to dreams for the future. And for another mother, being in OOHC as a child led to involvement with Oranga Tamariki when she became pregnant, which led her to get connected with further community support, which was a positive experience and led to feeling empowered to reach out at future times to gain support as needed.

Four mothers discussed how they were not open to support, but because it was forced they engaged and found they enjoyed it. Another mother who was forced to get support from Children's Team felt her worker did not listen to her, but even so, the support was effective,

helpful, and pushed her to organise paperwork that led to obtaining a government assisted house, getting her children registered at a doctor's office, and enrolling her children in preschool. One mother who did not have to engage with support through Oranga Tamariki wished she would have had that forced upon her. She said she felt the outcomes of a violent partner relationship would have been different.

# Chapter 5: Discussion

There were two aims of this study. First, to explore how the upbringing of women who spent time in OOHC influenced perceptions of and access to later supports. Second, was to identify the most valuable forms of parenting support these mothers encountered and their experience of accessing those supports. Through an IPA methodology, exploring the phenomenon of support, study aims were achieved using interviews with mothers who had spent time in OOHC. Four themes emerged from the data: 'the influence of upbringing on a mother's supports', 'obtaining support', 'accessibility of support', and 'pathways to support outcomes'.

## Summary of the Results

Mothers in the study shared experiences of adversity throughout their growing up years. They became accustom to trauma and chaotic lifestyles which impacted their view of supports, especially as many of them felt they had reached out for help without results. Once pregnant, mothers experienced various support, some of which was seen to be valuable, some seen as a burden, and others which they had hoped to have but instead were perceived as inaccessible. Mothers spoke of a complex relationship with child protection services, both because of their childhood experience and their experience as a parent. There was a dual experience for mothers in gaining support, in one way they sought it and in another way they accepted what was imposed. Though mothers mostly went on to experience supportive people and environments, they continued to long for a permanent family and place of unconditional belonging, which continued even now as mothers.

This chapter provides a discussion to the study findings and relates them to the context of other literature. Following this are sections on the strengths and limitations to the current study, practical and policy implications, and suggestions for further research. The chapter finishes with a brief conclusion.

## Theme 1: The Influence of Upbringing on a Mother's Supports

### *Normalisation of Trauma*

Trauma was described as a normal experience for mothers in the current study, first in their biological homes and then within OOHC. This impacted their future relationships with systems, caregivers, friends, and partners. One mother described her negative experiences as building blocks which normalised trauma and made her feel safe in the midst of drugs and violence. Another mother described running away from foster placements in search of environments which seemed familiar, even if they were violent. Findings of mental health for children in care have shown a high prevalence of interpersonal and social relationship difficulties (Tarren-Sweeney, 2013). This finding is also similar to Barn and Mantovani's (2007) study finding which described how the negative relationships mothers experienced in their biological families continued as they experienced relational difficulties and impermanency once in OOHC, with over half the mothers in the study having between five and ten placements. Likewise, most mothers in the current study experienced multiple placements in both foster homes and residences while in state care, with one stating she had 47 different placements.

Support and perceptions of support appear to be influenced by the mothers' upbringing and their experience of maltreatment and OOHC. Mothers described traumatic experiences which they said continued to affect them. Mothers' perceptions of care and protection services and social workers often began when they were children, when the agency was first introduced into their lives. Depending on the view they had of their parents at the time, they described mixed feelings about social workers and their involvement. Since becoming mothers they reported their understanding and perspectives of their own parents and of care and protection services had shifted, although most said they still struggled to make sense of these relationships which continued to feel dysfunctional. Mothers said they

understood different aspects of what their parents went through but were still unable to resolve the feelings of rejection. One mother explained feeling abandoned by her mother, but also confused by care and protection services who kept putting her back in her mother's care just to remove her again. She went on to say she felt unloved by both throughout her upbringing. As the mental health of children in care is affected by the amount of time and exposure to adversity prior to entry into care (Tarren-Sweeney, 2016), this mother would have had greater exposure to that adversity by going back and forth between state care and her birth home (Biehal et al., 2015). Further, the indecision of care and protection services and the lack of permanency offered may have impacted her sense of self and the feeling of being unloved.

Over time mothers said they became aware of the negative influence of early traumatic experiences as well as the poor modelling they received from their parents. Mothers said they realised they needed to unlearn behaviours and beliefs, though this was a difficult task as it meant engaging with painful past experiences. Most of the women said they purposely did not think about their difficult upbringing as it was too much for them to process. Others said they simply could not remember much of their childhood. One mother said she did not know if she had blocked it out or simply could not remember the first eight years of her life. This points to a dissociative mechanism, an inability to integrate information or a disconnection from events, which helps protect children from too many bad or unhappy experiences and is common for children in care (Putnam, 1997; Tarren-Sweeney, 2018). Whether they could not remember or purposefully pushed experiences aside, mothers had a difficult time making sense of their own childhoods while trying to learn how to parent. This aligns with mothers in other studies who described the struggle of moving forward as mothers while also dealing with their trauma history (Aparicio et al., 2015; Pryce & Samuels, 2010).

### *Feeling Different*

The experience of maltreatment and OOHC led mothers to feel different compared to the 'norm'. One mother said she realised what she was experiencing was different to other children when she started spending time at her friend's house as an adolescent. At times this feeling of being 'different' and their beliefs of how others might perceive or judge them led to socially distancing themselves. One mother described not going to certain events or asking for help because she felt different than others. Overall, mothers described wanting to experience 'home', a 'normal' childhood and adolescence, and a family that loved them unconditionally. Instead, they described multiple OOHC placements and lack of permanency or sense of normalcy.

This finding is congruent with other studies that found young mothers who spent time in care feel stigmatised. Haight et al. (2009) found mothers in their study felt judged and stigmatised by wider society. Likewise Bermea et al. (2018), in their study of young mothers living in a residence, said mothers felt judged by those outside the residence. However, Bermea et al.'s (2018) study also found mothers began to find value in their new role as well as the social group of mothers. As the mothers in the current study were not connected with other mothers similar to them and lacked permanent support, this finding differed. The mothers in the current study reported often feeling lonely and inadequate in their new role as a mother. This seems to suggest the power in supports, specifically social relationships where there is camaraderie, that can offer a buffer to stigmatisation.

### *Reaching Out for Help*

Many of the mothers said as children they had reached out for help only to feel that no one listened or acted on their behalf. Mothers discussed how they quickly learned there was often no point in reaching out or, a more detrimental outcome, asking for help could make things more difficult. One mother said she told someone she felt was a caring adult about the

abuse she was experiencing by her mother. Instead of receiving help the woman distanced herself and she never saw their family again. This is similar to Knight et al.'s (2006a) finding that mothers felt they could not trust anyone and continued to experience feelings of rejection and loneliness from their childhood.

***Survival Mode***

With seemingly no one to love and protect them, mothers said they went into 'survival mode', which was described using the language of 'fight, flight, or freeze'. Mothers shared that this mode often began when they were children and continued on during pregnancy and early stages of motherhood, if not beyond. Negative relationships, losing a job, violent partners, and not having a home were all examples mothers gave which often kept them in a state of survival. Mothers acknowledged that even if they felt more stable at the time of the interview, they knew they could enter into survival mode again, as they felt they did not have anyone to call or anyone to depend on in an emergency. Similar to this is findings from other studies where mothers did not have anyone they could call on when in need or had reached out for help with their own needs, which would impact their child, but felt ignored or judged (Dominelli et al., 2005; Radey et al., 2017).

***Loneliness***

Mothers described feeling lonely and reported they had no one and felt unloved, beginning with the rejection they perceived from their biological family and continuing on through the instability of OOHC. This aligns with the importance of stability, especially for children in care, and how placement disruptions confirm a child's view that they are unwanted and unloved (Tarren-Sweeney, 2016). Some mothers said they would have preferred to stay with their birth mother or father, others described wishing they would have been removed sooner, and others grew weary moving back and forth between foster homes and birth parents. Ultimately, they all described a desire to have experienced permanency. All

but one mother described leaving OOHC between 16 and 18 years old without anyone who was thinking of them or who felt a sense of responsibility for them.

### *Fear of the System*

Due to their experience of care and protection services as children, mothers said they had anticipated they would be involved with them as parents. Even if they wanted support, they did everything they could to avoid receiving help from care and protection services fearing it would lead to their children being uplifted. One mother would not receive respite care, effectively temporary state care, as that was what began her experience of being in and out of care as a child. Though she said she probably would have appreciated the break, she did not want her children ending up with the same fate she had experienced. This is similar to findings in other studies that described the fear mothers experienced when care and protection systems became involved (Knight et al., 2006a; Pryce & Samuels, 2010; Radey et al., 2017).

### *Parenting Guilt*

Similar to other studies, mothers in the current study described the joys and challenges of motherhood (Aparicio, 2015; Bermea et al., 2018; Haight et al., 2009; Schelbe & Geiger, 2017). Though similar to other studies which found mothers saw their children as a source of motivation to reach out for help and create new pathways, some mothers in the current study felt inadequate as mothers. They described the love they had for their child but instead of motherhood giving them a sense of positive identity they lived with feelings of guilt and inadequacy. Rolfe's (2008) study findings describe mothers felt different as their life pathway was perceived to be different however it was linked with the timing of pregnancy and parenting. For mothers in the current study the finding of feeling different seemed less about early pregnancy and more related to their childhood experiences of maltreatment and OOHC, a feeling that stayed with them through pregnancy and parenthood.

Mothers said they questioned whether their children would be better off with someone else who had a more 'ideal' life.

Though some mothers in the current study felt a good fit with the role of 'mother', others described a disconnection to the term. For example, 13 years into motherhood, one mother said she is still "*far from maternal*" though she went on to describe her relationship with her son using language which could be used to described being maternal (i.e. protecting him, giving structure, the closeness between them). This finding is different than the emphasis in other studies on identity for the women in becoming a mother (Aparicio, 2017; Bermea et al., 2018; Haight et al., 2009). This difference may be due to the specific aims of the current study which did not emphasise the meaning of motherhood verses the aims of these other studies which related to the specific experience or meaning of motherhood.

***Role Models***

Similar to Pryce and Samuels (2010), mothers in the current study did not look to their own parents as role models, but also had a difficult time describing other role models. Few were able to describe parenting role models; however it became apparent that their definition of this shaped their answers. During the interviews mothers were asked about the adults in their lives while growing up, specifically if there was anyone special to them, someone who 'had their back', or someone they would like to be like. Mothers had a hard time thinking about role models without characterising it to a specific time and age around parenting.

Some mothers may perceive the term 'parenting' to pertain exclusively to birth parents and may use other terms such as 'caregiving' to describe the tasks of nurturing and raising children. As mothers did not experience positive parenting from their birth parents, they may have had a difficult time understanding the concept of a 'parenting role model' as they did not place other people or caregivers in a position which was already linked to their

birth parents. Though foster carers were mentioned as supports mothers did not see them as role models. This may be due to most of the mothers having inconsistent and impermanent relationships within OOHC. Furthermore, mothers may not have understood the concept of 'parenting role model' and, yet another reason may be misunderstanding due to concrete, or literal, thinking. It is possible the mothers in the current study felt they could only place their birth parents in that role. This is exemplified by the two mothers in the study who were confused and upset when foster carers put familial language around their relationship by using the terms "mum and dad" and "adopted daughter".

It is interesting to note, however, some mothers did describe non-biological parents as 'mum' or 'dad' when there was no one else in that role. For example, one mother whose birth father was unknown and difficult to trace came to refer to a non-biological uncle as "dad". Another mother, whose partner had entered foster care as a child after his mother passed away, described her partner's foster carer as "mother" to him and "grandmother" to their children. For the most part, mothers still referred to their birth parents as 'mum' and 'dad' and therefore it may have been difficult for them to distinguish parenting role models from their picture of 'parent'. Future research may benefit from using different words than 'parent' or 'parenting' in studies with parents who have been raised apart from their birth parents, or for whom these words have negative connotations. Alternative terms could include "caring for your child" or "raising your child".

Another interesting finding related to parenting role models is that when mothers did describe other parents who they respected or looked up to, instead of applying it to their own parenting, they wished they had experienced that kind of parenting for themselves. As young adults and now as parents, they had a desire for someone to care for and nurture them. This may connect with the inadequacy they feel in their own parenting. Maybe they reason that

their child may be better off with a different parent as they wished they had had a different parent, someone who could have done better.

**Theme 2: Obtaining Support**

After complex upbringings each of the mothers came to experience supports in one form or another. Sometimes support was imposed, or other times mothers sought it out. Mothers had various perceptions of support with some support seen as valuable, some as unwanted, and other supports seemed inaccessible.

***Support Perceived as Valuable***

Valued support came from specific organisations or relationships, but also in the form of particular characteristics which could be boiled down to human dignity. Qualities such as kindness, availability, giving of respect, listening, and consistency were mentioned by the mothers in this study. Mothers often remarked on one person who had been kind. This is congruent with the positive experiences mothers described in Dominelli et al. (2005), characterised by cultural sensitivity and human dignity, people who listened and offered options.

Mothers spoke of how they had received general support from their place of employment and education facilities. More specifically mothers valued the support of compassionate social workers, midwives, foster carers, and non-government organisations. Mothers also described informal or social support such as sisters, friends, biological grandmothers, non-biological extended family members, and the paternal grandmothers to their children. One mother mentioned that her partner was a great support, and another said her father and stepmother came back into her life after they had made significant changes themselves. This finding is similar to other studies which found mothers gained new support from OOHC, education, social work organisations, and non-biological family (Aparicio et al., 2015; Chase et al., 2006).

While mothers described specific foster carers in positive terms, the placements were typically short. Though mothers referred to these carers as kind or nice, most did not speak of them as a support or supportive environment. However, similar to Haight et al. (2009), three mothers in the current study spoke highly of the caregivers they had toward the end of their time in foster care who were very supportive. Although only one mother in the current study was still in a foster home, her situation was similar to the mother and baby placements described in Knight et al. (2006b). Foster placements offering support to a pregnant woman or mother and baby would be an interesting area for further research as both the mother in the current study and the mothers in Knight et al. (2006b) spoke highly of these placements.

Similar to other studies (Aparicio et al., 2018; Haight et al., 2009), mothers in the current study recalled parenting groups and courses as a source of support, information, and a way to meet other young parents. Mothers said they were more open to support and engaging in one-on-one or group work when professionals seemed to care and want to help. Aparicio (2017) reflected the importance of open communication so mothers have a safe place to share their struggles. She stated that on-going, nurturing, relationship-based postpartum and parenting support is needed. It is important for mothers from OOHC to have opportunities to increase their social support and satisfaction of support, as satisfaction with social support was found to reduce parenting stress in one study and lower the risk of child abuse in another (Budd et al., 2000; Budd et al., 2006). Additionally, Aparicio et al. (2018) suggested a potential source of "othermothers" could come from training foster families or having families in the community who are willing to volunteer in teaching positive parenting and healthy communication.

One mother in the current study described having support when her first son, who is no longer in her care, was born. When asked if she thought support made a difference with her first child she said she felt it enabled her instead of helped as it allowed her to continue

with substance abuse. Though she was the only one in the study that spoke to this point, it is interesting to note. It also aligns with Aparicio's (2017) finding that mothers wanted to be nurtured themselves and support that takes over the care of the baby is not helpful.

***Support Not Perceived as Valuable or Wanted***

Similar to other studies (Aparicio, 2017; Haight et al., 2009), mothers in the current study perceived most care and protection workers as unsupportive. Haight et al. (2009) found mothers viewed this service as negative and stigmatising, and the mothers in Knight et al.'s (2006b) study said it was confusing and stressful. Mothers in the current study reported they often felt criticised and judged by those who were meant to be supportive. Most mothers felt care and protection services were detrimental during their upbringing and felt conflicted in the relationship they had with services once having their own children. All the mothers had care and protection involvement at some point since having children which may have contributed to their wariness of the system. This aligns with Connolly et al. (2012) finding that mothers who spent time in care were less likely to ask for help from agencies as they were fearful of social workers and felt they were being watched. Although they had strong negative feelings toward Oranga Tamariki (OT) and did not appreciate the approach taken by the agency, all of them reflected the value of the supports they were linked to through OT involvement. Most of them saw the involvement of these linked organisations and support as vital to their current experience of life and parenting. However, mothers described wishing care and protection workers would be kind and non-judgmental. This aligns with other studies that note the need for case workers to understand the multifaceted lives of young mothers and the importance of helping mothers access support (Bermea et al., 2018; Schrag & Schmidt-Tieszen, 2014). This is similar to Dominelli et al. (2005) and Radey et al. (2016) who found that although mothers wanted social services to be more available, case workers were overloaded.

***Wanted but Inaccessible Support***

Despite support mothers often continued to feel alone and felt desired support was not accessible. Some mothers described their gratitude for professional support while also wanting more from them. They realised professional boundaries were in place and they needed to find support elsewhere. Though the mothers had a great need for someone to love them unconditionally, trying to obtain it from professionals may point to the difficulty they experience in engaging intimate relationships because of the developmental trauma they have experienced.

Similar to Radey et al. (2016) who described the difficulties in trying to parent while also needing to figure out childcare, housing, and transportation, mothers in the current study also found the daily struggles to be overwhelming without supportive relationships. Although most of the mothers had somewhat secure housing when interviewed, most reflected obtaining housing had been a point of stress while pregnant and in their early days as mothers, a similar struggle found for mothers in Schelbe and Geiger's (2017) study. At times, this led mothers to make choices which could have consequences to their child's safety, like the mother who said she left her children with the neighbour whose children had been uplifted. This is similar to mothers' descriptions in other studies of making hard choices when trying to provide for their child while lacking support (Radey et al., 2017; Schelbe & Geiger, 2017).

Mothers in the current study wished they had somewhere to return to, as they viewed this as a normal experience for people who had not grown up maltreated and in OOHC. Instead, they continued to be disappointed by their birth mothers. They said they wished someone could fill the mother role for them and grandmother role for their children, even if they had given up on their birth mother being that person. None of the participants referenced their birth mothers as a source of support. This finding is seen in Dominelli et al.'s (2005)

study in which mothers wanted to be nurtured as they nurtured their baby. They wished someone would care for them and believed this would impact their parenting. However, it may be to the benefit to the mothers in the current study that their birth mothers are not part of their lives as Pryce and Samuels (2010) found there was a greater negative influence on parenting if the mother identified with her biological family, specifically her birth mother. This also aligns with Easterbooks et al.'s (2011) study that found mothers had better outcomes in breaking the cycle of maltreatment if the mother did not live with her biological family or receive emotional or caregiving support from her biological mother. It also highlights that it would have been better for the mothers in the current study to have had permanent placements from the start and be raised by alternative parents instead of going back and forth between their birth mothers and state care.

Many of the mothers said they went on to experience violent or controlling partner relationships. One mother said she believed this was due to the loneliness and rejection she felt during her childhood and adolescence. The fear of loneliness and abandonment may have outweighed their fear of violence as many mothers said they stayed in violent relationships because they felt they had no one else. This is congruent with findings from other studies that identified mothers from OOHC may lack knowledge around what a safe and healthy relationship looks like and therefore relationships with partners may actually be damaging to the mother's parenting ability (Chase et al., 2006; Radey et al., 2016). Other times mothers said they felt desperate to have someone in the parenting journey with them. Because the father of the baby would sometimes be available and supportive, mothers said they feared leaving as their partner was the only help they had at the time.

**Theme 3: Accessibility of Support**

***Support Accessed***

An important finding in accessibility of support was that sometimes mothers gained support because it was mandatory or required. Mothers said this forced support came from care and protection services and also loving caregivers. In the moment or circumstances surrounding support being compulsory, mothers did not appreciate it. However, looking back, mothers were able to distinguish the support as beneficial or necessary. Often the initial unwanted forced support gave way to other supports and greater networks. However, one mother said though she appreciated the outcome of forced support by a care and protection worker, she would have valued feeling she was listened to and understood. Instead she said she felt retriggered from past trauma and was not as open to the support offered.

Mothers also described occasions where they wished they had been "forced" to do something which would have benefitted them and their child, like going to counselling, getting parenting help, or leaving a violent relationship. This aligns with Aparicio (2017) who found there can be stigma around seeking therapeutic support (Aparicio, 2017). Mothers may have felt different about engaging in therapeutic support if it technically was not their choice.

The idea of 'forced' support resembles the 'gentle challenge' Mary Dozier writes about in which a worldview is challenged as a way of helping a child or, in this case, a late adolescent/young adult, revise their internal working model (Dozier, 2003). Dozier writes about using this approach for children in care, however it may be applicable to older youth and young adults who have been in OOHC but still need this type of interaction. The basis behind gentle challenge is that children may need something they do not want and the purpose is that children can develop a more trusting relationship with adults (Dozier, 2003). In Dozier's writing the adults are caregivers, but for the mothers in the current study it may be professionals providing necessary support. The comparison of the current study's finding of "forced support" with Dozier's idea of "gentle challenge" is a fascinating one, especially in relation to children in care regardless of their age, and could be explored much further.

However, it is worth noting that the current study finding incorporates mothers who had statutory interventions with their children and experienced only two options, either receive the support offered or their child would be removed into temporary care, which differs from the idea of "gentle challenge".

Other factors connected with support accessibility were ease and motivation. Mothers explained the importance of proximity, ease, and timing of support and how these related to accessibility. Living close to a bus stop or a government organisation made it easier for mothers to connect with services or employment. Motivation, though not directly related to accessibility of support, was an important finding as mothers were more motivated to access support because of their child. Therefore support seemed more accessible, or maybe more importantly, desirable and wanted. With a hope that life could be different for their child, they chose to reach out to the supports they were aware of. Similar to mothers in other studies, having a baby gave them a sense of purpose, the desire to do things differently, and motivation to make changes, not just for themselves, but because of their child (Chase et al., 2006; Pryce & Samuels, 2010; Rolfe, 2008). This connects with the principle of timing that came through the interviews, the idea that a knowledgeable or kind person at the right time can make all the difference to a mother accessing support.

***Inaccessible Support***

Young men and women who leave OOHC have need of a range of supports, regardless of whether or not they are also parents. Similar to other care leavers, the mothers in the current study faced mental health difficulties, isolation, and the sense that they had no one who cared for them (Courtney & Dworsky, 2006; Melkman & Benbenishty, 2018). The mothers in the study also had to navigate education and housing difficulties, similar to other young people who leave OOHC (Gypen et al., 2017; Wade & Dixon, 2006). However, once they became mothers, they had the additional weight of navigating early adulthood while

caring for a child. Additionally, they feared child protection services might remove their child just as they had been removed from their parent.

Support was perceived as inaccessible in various ways, including not knowing about it, being isolated by a partner, not meeting criteria, and mental health difficulties. Mothers said they simply did not know what was available to them. Most of the mothers left care at 16 and 17 years old and felt completely on their own. They shared experiences of leaving the care system and not hearing from care and protection services until they had their own child. Instead of having an adult that cared or someone to show them how to continue on in the world, mothers described doing it on their own. Mothers said they did not know how to get on the benefit and did not know how to navigate government services.

Having left care, or sometimes at the end of their time in care, mothers described further inaccessibility to supports due to abusive and controlling partners who isolated them from the few people who were in their lives. One mother who was with an abusive partner described being desperate for help, but felt it was not accessible because she was with a partner and seemed to be doing well enough. She described not meeting intake criteria for services. Another participant, a pregnant young woman, said care and protection services were pushing her toward independence just as she had entered into a supportive foster placement. She reported that they said she is doing well and can live independently once she has the baby and turns 18. However, this mother said does not want to leave care and her caregiver has said she can stay. She said she did not believe she could do it on her own and wondered if she would turn back to old patterns of drug use without the support of her caregiver. In this case "support" seemed to be intruding on this young woman's basic human need to be in a caring, permanent family who loves her.

At times mother's mental health difficulties made support seem difficult to access, not necessarily because it was not available, but it seemed unobtainable to a mother who was

already anxious and scared to engage in services. This may reveal a health equity issue where the government needs to proactively improve access to health services for those who are more vulnerable, for example making house calls. Other times, mothers described simply not being open to support. In those cases, support may have been available, but they were engaged in behaviours or relationships which made it difficult to want support. Again, this finding speaks to the need for the right person to be available at the right time when a mother is ready to accept support. However, it also seems important to ask the question of what kind of support is available to young people as they leave care, and do they know about it. If they are aware they may come back to it when they are open and the timing is right for them.

**Theme 4: Pathways to Support Outcomes**

The last theme described pathways that led to support for mothers, some negative and some positive. Negative pathways began with the mothers' childhood experience of maltreatment and led to other violent or unhealthy relationships. Mothers described wanting to feel that someone loved them after feeling alone and uncared for throughout their lives. Once mothers entered into unhealthy relationships, they were afraid to leave, felt they had no way out, and had no other options. If mothers did reach out to professionals but felt judged in the process, they described closing off even more, similar to findings described in Knight et al. (2006a) where mothers would isolate themselves further due to not knowing who they could trust.

Mothers also described experiences that led to gaining positive support. Ultimately it was someone who was available to them at the right time, typically when they felt they simply could not keep going the way they were. For some mothers this was when they were in hospital after birthing their baby, for others it was when they decided to leave an abusive partner. When mothers experienced kindness and compassion from professionals during that time, she was open to future support. Sometimes after receiving support and help from

professionals, mothers went on to find positive peer and social connections which became long-term informal supports for them.

Sometimes a positive pathway began with support that was forced. Though mothers were hesitant and even angry about this, as they engaged with mandatory support they found they enjoyed it and it led to other positive experiences like further education, finding work, attending groups at community organisations, gaining confidence, and making friends. One mother described the different place she was in at the time of the interview because of the support she has received along the way. She has one child, who will start school this year, she is part way through university, and she has good people around. She stated that this is the first time in her life that she can actually think about the future and dream. Similar to the mothers in Aparicio et al.'s (2015) study who described hopes and dreams they had for the future, mothers in the current study had also begun to consider the future with hope. However, the current study found mothers were not able to consider the future unless they had support and did not feel alone in their daily lives. Though every human being has the need for these relational connections, it was much harder to access for the mothers in this study who had experienced maltreatment and spent time in OOHC.

**Limitations and Strengths of the Study**

The current study has a number of limitations. The first limitation is the nature of all qualitative studies in which the findings cannot be generalised to the general study population. The mothers in the current study were from a specific city on the South Island of New Zealand. Mothers from other parts of New Zealand and other parts of the world will have varied experiences since care and protection systems around the world differ in policy and practice. However, the findings from the current study align with findings of other studies of mothers who spent time in care in Canada, the USA, and the UK. The small sample size also adds to the lack of generalisation. However, the number of participants adhered to

IPA guidelines (Smith & Shinebourne, 2012), created opportunity to gain deeper insight into the experiences of the participants, and aligned with the explorative aim of the study.

The accounts of the mothers in the current study indicate, for the majority, mothers had been through hard times and were able to offer insights from reflecting back to some of their more challenging experiences. Mothers who volunteered to participate had enough stability and support to respond to the invitation and prioritise it over other competing demands. One mother, the oldest of the participants at 29 years old, specifically said if the invitation to participate had come up five or more years ago she would not have been able to participate as she and her son were in the middle of a very difficult time. She went on to say now she was at a place where she wanted to participate as she could see the value of sharing her experience. However, most mothers were not as many years past their most difficult times and one was likely still in the midst of it. Though the responses may have been different if mothers were still in the midst of figuring out support as a new mother this is not seen as a study limitation as participants were able to reflect on their past experiences with a different perspective, possibly offering greater insight.

Therefore, a strength of the study is that participants, for the most part, were close enough to the experience of the phenomenon to reflect back on it, but with the benefit of being slightly removed from the intensity of the experience. Although their experiences are still subjective, the recounting of it may be less subjective with time. This may be seen, for example, in their dual perceptions of care and protection services, which was likely not the case while they were in the midst of their involvement.

Another strength of the current study is that it can be used to supplement information gathered directly by governmental services. Services are often informed through focus groups and interviews with young people and clients, however these are not conducted independently. The current study provides an independent research perspective and offers an

opportunity to examine the findings from this study to the information gathered by government services to see commonalities and contrasts. Additional to this strength is the use of IPA as a methodology to gain greater insight into the phenomenon of support, specifically around support for mothers who have spent time in OOHC.

**Practice and Policy Implications**

Study findings have implications for both practice and policy. Findings suggest that mothers who have been in OOHC have complex needs. As many of the mothers in the current study mentioned, upon leaving care they did not know about support, or if they did know about possible support, they did not know how to access it. At the very least having access to a resource list, a mentor to go along to services, or someone similar to a guidance counsellor for those leaving OOHC would be helpful. Even more useful would be a team of people who could help care leavers navigate the next stage of life and be available for ongoing needs. Organisations specifically for care leavers have shown to be beneficial, especially when the service is holistic, consistent, and accessible (Chase et al., 2006). Smaller caseloads for professionals would help build the relationship with young mothers to create a collaborative approach, which is especially important in the adolescent years when they may be resisting authority figures (Schrag & Schmidt-Tieszen, 2014).

If young women, who have been in care and did not experience permanency, become mothers they are not only learning how to live independently but are finding their way in motherhood. Services designed for young mothers or parents that could help with practical and emotional support are vital. Findings suggest that mothers are open to support, especially when linked with practical help. Mothers in the study said they worried about housing and obtaining other basic needs. Practical help may open the door for mothers to access further support. Findings suggest mothers feel overwhelmed and vulnerable in the early days of mothering. This may be an ideal time to offer kind, compassionate support as the timing

might be right in their openness to receive help. It is important that support is holistic and is attuned to needs around parenting, mental health, and physical needs.

Mothers said they felt alone and wanted greater informal relationships. Again, the postnatal period may be a time when mothers are open to attending groups or courses, however, as a number of mothers suggested, they may need a gentle nudge in that direction from a compassionate professional who is first willing to go to them instead of the mother going to services. Pregnancy may be a time to expose women to support, as mothers mentioned midwives who were a great support during pregnancy and in their early days of parenting. Trying to engage mothers early with antenatal groups or groups that incorporate a focus on their baby (i.e. infant massage) might do well to encourage informal relationships in an environment that feels less intense with the attention on the baby.

As mothers said they want to parent differently and give their child a different life, connecting mothers from care with organisations that offer parenting groups, infant massage, and other life skills groups may be crucial. It may also foster peer relationships and mentoring opportunities. Parenting groups would do well to include sessions where facilitators or group mentors modelled positive parenting. In all of this work, it would be vital to incorporate nurturing the nurturer. The mothers in the current study said they wished there was somewhere for them to go to where they and their children would be welcomed and cared for. Community groups have opportunity to offer that space, providing hospitality, food, compassion, and kindness.

As findings from the study indicated, mandated support may be essential to mothers' access of support. However, the way and manner in which social workers and professionals present this is important. Mothers said they would appreciate a kind and non-judgmental approach. Attending to care and protection concerns with transparency and respect may create a more willing response from mothers. As mothers referred to the timing of the

support, if professionals and formal supports can stay compassionate while doing their job, it may lead to being the right person at the right time for that mother. Social workers are often overloaded and need support themselves. Smaller caseloads and therapeutic supervision within their work may allow them to be more consistently sensitive in working with young mothers with a care history. Though they are likely time poor, if care and protection workers had knowledge and understanding of community organisations who worked well with mothers from OOHC, they could work collaboratively and refer to those agencies. Mothers might be more open to community support if a social worker took them to meet service providers who work well with this population (i.e. teen parent units, community organisations for young parents).

There are a number of policy implications from findings of the current study. If possible, young mothers in care, or up to the age limit for receiving state care, should have opportunity to be in a foster home with her baby. The pregnant young woman in the current study was grateful for this option. While she had not been pregnant when first arriving at the placement, she came to greatly value her caregiver and the fact that she would be able to stay when she had her baby. The experience of this mother is confirmed in other studies where mothers valued mother and baby foster placements in either foster homes or in a residence (Bermea et al., 2018; Knight et al., 2006b). In addition to this, foster carers would need to receive specific training to support needs of mothers in care. Care and protection social workers would need to be aware of the holistic nature of motherhood, with a focus on the relationship between the mother and her baby and that the mother's needs will be supported as these needs impact her parenting capacity.

Additionally, this study shows the need for greater permanency in OOHC. While this is a massive task with a scope well beyond this thesis, findings from the current study

emphasise this need. Along with permanency, children and youth in care need therapeutic services to be able to work through their adverse experiences and complex emotions.

**Research Implications**

Mothers in this study had complex upbringings, both prior to and once in OOHC. Only one of the mothers had a long-term placement while most of the mothers moved multiple times throughout their time in care with one mother having 47 different placements. Future research with mothers who spent time in OOHC could focus on mothers who experienced long-term permanent placements to compare their experience of or need for support with mothers who did not experience permanency. Further, all of the mothers had their children in their care, with the exception of one mother who had one of her two children in her care. Exploring support with mothers who no longer have care of their children would be another interesting comparison group to see if it provides insight into what is helpful or not helpful in a mother being able to care for her child.

Although Budd et al. (2000, 2006) looked at correlations between various factors (including support satisfaction) and risk of child abuse and parenting stress, further research could include exploring if/how support is linked to positive parenting outcomes. Additional research could include longitudinal studies on the longer-term effects of positive supports.

Another interesting finding from the current study was the mothering guilt and feelings of inadequacy. It is difficult to distinguish whether what mothers reflected in the current study is similar or different to what the general population of mothers experience. It would be interesting to compare this group with mothers who have not been in OOHC and then to investigate what relationships or supports foster contentment and self-appreciation as a mother. Lastly, research around foster care placements for mothers and their babies would be helpful in exploring what works and what makes these placements more difficult as well as how that could be scaffolded.

## Conclusion

The current study gives insight to the experience of support for mothers who spent time in OOHC. It contributes to the existing research on the experiences of this population and adds knowledge to how support is accessed. The mothers in this study had complex upbringings but were thankful for the compassionate people along the way who were there at the right time for them and their children. The hope of this study is that it will offer insight to professionals working with this population and give voice to the experiences of these mothers at a policy level.

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## Appendix A

Information Sheet for Participants

*Note: The name of the Canterbury organisation which aided recruitment has been blacked out with* [redacted] *in this thesis to protect the anonymity of participants.*

UNIVERSITY OF CANTERBURY
*Te Whare Wānanga o Waitaha*
CHRISTCHURCH NEW ZEALAND

# Information Sheet

# Becoming a mother after foster care

Child & Family Psychology
Email: jmu71@uclive.ac.nz

10 September, 2020
HEC Ref: 2020/70

Hello, my name is Jamie Ussher and I am training to become a child and family psychologist at Canterbury University. As part of my training I am doing a research study of the experiences of mums who spent time in foster care when they were children.

I have experience working with many mums in the community and worked at [redacted] for 7 years, running groups for mums.

This study looks at what relationships are supportive and if/how those supports were available to you. I hope an outcome of this research will be to highlight where further support is needed for mums who have spent time in care and their children. I am writing you to ask if you might take part in my study.

**Who can take part in the study?**
I asked [redacted] to send this information out to mothers who might possibly take part in this study. If you grew up or spent time in foster care, are 30 years or younger, had a baby before you were 25, and your child lives with you, you are eligible to participate in this study. The study is not being carried out for or by [redacted].

**What does it involve?**
If you choose to take part in this study, it means I would interview you for about an hour, maybe a bit longer. We can do the interview at [redacted] or at the University of Canterbury. If it's not possible for you to come to one of these places, the interview can happen in your home as long as

there is a place we can talk privately. I will audio record what we say in the interview so that I can write it out later. This can be sent to you if you would like to see it. On completion of the interview you will receive a $35 movie voucher as a thank you for your contribution to the study.

**What will we talk about in the interview?**
During the interview I will ask you about what it was like for you growing up, what pregnancy was like, what it was like to become a mother, who has supported you, and what support you hope to have in the future.

I have worked at [redacted] in the past in running groups. I will be respectful and kind. I will only ask you to tell me what you are comfortable sharing during the interview. If there is something you don't want to talk about, then you can say no. I will offer the same confidentiality that [redacted] offers, including that I would have to tell someone if what we talked about made me worry that you or someone else might be hurt.

**Can I withdraw from the study?**
Participation is voluntary. You may withdraw from the study up to two weeks following the interview and any information you provided will be removed. I can remove the information from your interview, but if I have written up how it connects with other stories it will be more difficult to delete that after those 2 weeks.

**How will my privacy be protected?**
The interviews will be written up. I will look at all the interviews separately and together to see what patterns come from the stories. It will be written up as a Master's thesis. A thesis is a public document and will be in the library at the University of Canterbury. The results of the research may be published, but since I am the only person who will know you took part in the study, your information is completely private.

To make sure you are kept anonymous and that the information you share is confidential, data will be kept in locked and secure facilities and/or in a password protected electronic form. The data will be destroyed 5 years after completing the thesis. The only person who will know that you took part in this study is me. No identifying details of yourself or your family will be included in the thesis. Pseudonyms, a made-up name so people will not be able to identify you, may be used as part of this.

If you would like to get a copy of the results from the study, just let me know and I will send them to you when the research is finished.

**What if I need help?**
You may feel sad or upset when you tell me about growing up and becoming a mum. Since I have worked with many mums and am training to be a psychologist, if you feel sad or upset I am available to listen. If you need further help after talking with me, you can contact my supervisor who is a psychologist. We can also connect you with ongoing support.

**What if I have questions?**
If you have questions now or at any time throughout the study, please feel free to contact me or my supervisor (see below).

The project is being carried out as a requirement for a Masters of Child and Family Psychology by Jamie Ussher (jmu71@uclive.ac.nz) under the supervision of Professor Michael Tarren-Sweeney who can be contacted at michael.tarren-sweeney@canterbury.ac.nz. He will be pleased to discuss any questions you have about taking part in this.

Thanks for considering! If you agree to participate, please complete the attached consent form and return it using the reply-paid envelope or you can give it to me when we meet.

Kind regards,

Jamie Ussher

This project has been reviewed and approved by the University of Canterbury Human Ethics Committee, and participants should address any complaints to:
The Chair, Human Ethics Committee (human-ethics@canterbury.ac.nz).
University of Canterbury; Private Bag 4800, Christchurch

## Appendix B

Consent Form for Participants

UNIVERSITY OF CANTERBURY
Te Whare Wānanga o Waitaha
CHRISTCHURCH NEW ZEALAND

### Consent Form for Participants

### Becoming a mother after foster care

☐ I have read the information sheet for this project and asked questions if I had them. I understand what it means to take part in this research.

☐ I understand that participation is voluntary and I may withdraw up to two weeks following the interview, which also includes the withdrawal of any information I have provided.

☐ I understand that any information or opinions I provide will be kept confidential to Jamie, the researcher, and that no information will make it that people can identify me. I understand that the research will be written up as a Master's thesis, which will be in the University of Canterbury Library database, and that further publication is possible.

☐ I understand that the interview will be audio-recorded.

☐ I understand that all data collected for the study will be kept in locked and secure facilities and/or in password protected electronic form and will be destroyed after 5 years.

☐ I understand that in talking about my life I might feel sad or upset and need help. If I feel this way, I understand that Jamie will do her best to help me and can refer me to further help if I want it.

☐ I understand that I will be emailed or posted what was written up from the interview (transcript), and that I can also see the complete thesis.

☐ I understand that I can contact Jamie (jmu71@uclive.ac.nz) or her supervisor (Professor Michael Tarren-Sweeney - michael.tarren-sweeney@canterbury.ac.nz) for further information. If I have any complaints, I can contact the Chair of the University of Canterbury Human Ethics Committee, Private Bag 4800, Christchurch (human-ethics@canterbury.ac.nz)

By signing below, I agree to participate in this research project.

Name:_____

Signed:_____Date:_____

Email address *(to send you the transcript)*:_____

Please return this form using the reply-paid envelope or give it directly to Jamie when you meet.

## Appendix C

Original Interview Schedule

Sample interview guide/questions:

Tell me what it was like growing up…

- What was it like growing up in foster care?

Tell me about mothering…

- When you think about a mother, what comes to mind? Where did this idea come from? (or) Who gave you this picture?
- What does "mother" mean to you? Where did this meaning come from?
- What has been your experience of becoming a mother?
- What was happening in your life when you found out you were pregnant?
- How has it been since having your baby?

Tell me about your supports prior to and since having your child…

- Antenatal care – partner, groups, classes, other pregnant women, whānau, community
- Postnatal – same as above
- What do you make of your supports?
- How did you know or find out about that support? How were you able to access it?
- Who is it that thinks well of you and your child?
- What supports do you wish you'd had or wish you had now?

Tell me about what kind of support you will want as your child gets older…

- What do you think you will need? Why?
- How will you access it?
- What advice would you give to other mums who have had similar life experiences?

Looking back now, what supports would you like to have had when you were pregnant and in your first year of mothering?

## Appendix D

Interview Schedule (Revised Version)

Topics/open-ended questions to guide the interview:

Rapport building – their age, name and age of child, what they do on normal days, have they always lived in ChCh, etc.

Topic 1: Valuable supports/relationships to a mother who grew up in care

- What was happening in your life when you became pregnant? Who was around?
- What have been the best parts of becoming a mum? Hardest parts? (what stage?)
- What kind of relationships or support did you want when you became pregnant or had your baby? (Could be any kind of support… from friends/family/groups or agencies; could be emotional, around parenting, financial, educational, housing, etc.)
    - Who did you hope would step up/be involved? Did they? If not, did others?
- *So if we thought about all your relationships at that time… (Eco map – IF TIME)*
    - *Who was in your life at the time? Place circles to represent those people.*
        i. *Add all supports – friends, family, doctors, counsellor, faith groups…*
        ii. *Lines representing strong, tenuous, stressful, broken, changed…*
        iii. *Draw arrows to show which way the support goes.*
        iv. *Draw bigger circles for those who give you significant support or put them closer to you…*
    - What relationships were most valuable to you? Who did you feel close to?
    - When you think of support as: give strength, cheer on, advocate, stand up for, encourage, be there for… Who did you feel supported by and why?
    - If you could have anyone on this paper (whether they are on it or not), who would that be?

Topic 2: The influence of growing up in care on parenting

- Tell me about growing up…what was it like?
    - Age of entry into care
    - Lots of placements or just 1 or 2? Did you return to mum or dad?
    - Was it a whānau placement or other?
- Tell me about the adults in your life growing up, was there anyone special to you? What were they like?
    - Who "had your back"? Tell me about them…
- Who were your role models? Was there someone you would have liked to be like?
- When you became a mum who did you hope to be like – maybe someone you knew or someone you'd heard about or seen somewhere?)
- What are you like, as a mum? Describe yourself as a mum…
    - What do you wish you were like? Why?

Topic 3: Identifying and accessing support as a mother who grew up in care

- What support was the most helpful/least helpful when you had your baby? Why?
- Did you go about looking for help/support?
    - What was that like? Was there anyone who helped you figure it out?
- How did you know what kind of support you needed when you became pregnant?
    - Was that available? How did you find out about that support?
- Looking back now, thinking of yourself then, what do you wish you had?
    - If you could wave a magic wand, what would you have really appreciated when baby was born? OR if you had this wand for a friend, what would you give them?
    - Is there anything you look back on and just couldn't have done it without "_" OR the new-born period would have been way easier if you'd just had…

- What kind of support do you want as _ grows up? How will you get it, do you think?

Check in to see how they are feeling…

Reorient them to the day…

# Appendix E

Ethics Approval

HUMAN ETHICS COMMITTEE

Secretary, Rebecca Robinson
Telephone: +64 03 369 4588, Extn 94588
Email: human-ethics@canterbury.ac.nz

Ref: HEC 2020/70

31 August 2020

Jamie Ussher
Health Sciences
UNIVERSITY OF CANTERBURY

Dear Jamie

The Human Ethics Committee advises that your research proposal "Exploring How Women Perceive Motherhood and Supports After Foster Care" has been considered and approved.

Please note that this approval is subject to the incorporation of the amendments you have provided in your email of 19th August 2020.

Best wishes for your project.

Yours sincerely

Dr Dean Sutherland
***Chair***
***University of Canterbury Human Ethics Committee***