

Coping with Stigma: Experiences and Responses of Former Youth in Care

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Abstract: This paper examines social stigma in relation to child welfare involvement. Drawing on interviews with twenty former youth in care, the paper highlights the participants' experiences with stigma and their adaptive responses. Notably, participants described pervasive stigma that accompanied their status as youth in care. To contend with the stigma they experienced, participants developed a range of responses, including concealment, challenging the stereotypes, physical retaliation, and seeking solidarity. The study aligns with previous research identifying concealment as a relevant strategy for mitigating the effects of stigma among foster care recipients. However, the results also extend the literature in this area by identifying additional adaptive responses. Moreover, the participants revealed that the stigma they experienced was pervasive, yielding long-term effects.

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In Canada, each year, an unspecified number of children and youth are placed in the care of child welfare agencies. Since child welfare falls under provincial and territorial jurisdiction (except for some services for Indigenous children), the exact number is not tracked nationally. However, in 2019, there were an estimated 54,139 Canadian children

in care (Saint-Girons et al. 2020). Individuals come into the care of child welfare agencies for a variety of reasons, most commonly when a child protection worker determines that they have been abused or neglected, or are at risk of abuse or neglect (Trocmé et al. 2019). Children may also end up in care if a parent is unable to care for them. For instance, death, illness, or an inability to cope among parents can sometimes lead their children to come into the care of a child welfare agency (Wegner-Lohin, Kyte, and Trocmé 2014). These children and youth, referred to as “youth in care,” may be placed in group homes, foster homes, treatment centers, or kinship foster homes (Anglin 2002:2). In some cases, they may be held in youth detention facilities if they conflict with the law.

Youth who enter care may be returned to their parents after some time or may remain in state care until they age out of the child welfare system. Whether a child returns home or not, being in care can present many challenges for those who experience it, and in some cases, can yield long-term impacts (Kessler et al. 2008). One such challenge stems from social stigma. Several studies have documented the stigma that youth in care experience in connection to their child welfare involvement (e.g., Festinger 1983; Snow 2013; Michell 2015; Rogers 2017; Dansey, Shebero, and John 2019). There are, however, relatively few qualitative studies examining this relationship in an in-depth fashion from the perspectives of those who have experienced it first-hand. The purpose of this paper is, therefore, to examine the degree and character of stigma experienced by former youth in care as they passed through the child welfare system. This paper is based on 20 semi-structured interviews with former youth in care and is part of a larger project examining the long-term impacts of care. There are advantages to examining their perspec-

tives from the vantage point of adulthood. The participants were able to look back on their experiences with the distance that time gave them. They were able to reflect more deeply on the experiences that made them feel stigmatized, discredited, devalued, and ‘othered.’ They also had insight into some of the ways that, as a youth, they developed approaches and strategies for dealing with stigmatizing experiences. The paper attends to the following research questions. First, how do former youth in care look back on how they were stigmatized as a result of their youth-in-care status? And second, how do former youth in care respond to these stigmatizing experiences? Following an overview of child welfare in Canada, the paper begins with a discussion of the theoretical framework used to analyze youth in care, with an emphasis on stigma and labeling processes. Next, I outline my methodology, describing how I conducted the study and analyzed my results. The methodology section of the paper also provides details about the participant interviews. The paper then turns to its two main themes: the experiences of stigma and the responses to stigmatization. The paper concludes with a discussion of the study’s findings and directions for future research.

Child Welfare in Canada

In Canada, child welfare is provincially mandated with no unified federal legislation to guide the provision of child welfare services (Trocmé et al. 2019). Consequently, child welfare practices vary considerably across Canada. For example, in some provinces, the age of majority for child welfare purposes—the age at which a child is no longer eligible for child welfare support—is 16 years (e.g., Saskatchewan, Newfoundland, and Labrador). In other provinces, individuals can receive child protective services until the age of 18 years (e.g., Quebec and

Alberta) or 19 years (British Columbia) (Trocmé et al. 2019). In Ontario, children can now receive protective services until the age of 18 years, which is an increase from 16 years in 2018 (Trocmé et al. 2019). Although child welfare legislation varies across the provinces and territories, some guiding principles are generally consistent regarding child apprehension and care provision.

Children who are considered to have experienced or be at risk of maltreatment may be apprehended by child welfare agencies and placed in out-of-home care. Child maltreatment generally refers to the abuse or neglect of children or youth by a caregiver, guardian, or person in a position of trust (Fallon et al. 2021). There are several types of maltreatment for which children may be apprehended, including physical abuse, sexual abuse, emotional abuse, neglect, and exposure to intimate partner violence (Fallon et al. 2021). There are several circumstances in which children and youth may become involved with a child welfare agency. The most common is when child protection workers determine that a child has been and/or is likely to be (further) harmed by abuse or neglect (Wegner-Lohin et al. 2014). However, children may also enter care if a parent is deemed unable to care for them (Wegner-Lohin et al. 2014). For example, death, illness, or the inability to cope for some parents may result in their children entering the care of a child welfare agency. In some cases, parents may voluntarily terminate their parental rights if they feel they are unable to care for their children. When an allegation is made that a child is suspected of suffering harm, child welfare authorities investigate the allegation. In Ontario, child welfare is governed by the *Child, Youth, and Family Services Act* (Fallon et al. 2021). Once an allegation is made, families are investigated by one of the 50 independent children's aid

societies (CAS) across the province. In cases where the report is substantiated, families may receive services while the child remains at home, or the child may be placed in residential care (Wegner-Lohin et al. 2014).

Although anyone can end up in care, certain groups are more likely than others to come into contact with child welfare agencies. In Canada, children from low-income families, children with disabilities, visible minority children, and Indigenous children are all significantly over-represented in child welfare involvement (Lefebvre et al. 2017; Trocmé et al. 2019). Some of the participants in this study fell into these categories. For instance, three of the twenty participants were Indigenous, two were visible minorities, and one participant volunteered that they had a learning disability. For individuals who belong to these specific groups, the experience of care will undoubtedly include unique elements that can only be understood with an appreciation of the larger picture regarding these groups.

The over-representation of Indigenous children in the Canadian child welfare system is particularly stark and cannot be understood apart from Canada's colonial history. As noted by critical scholarship in child welfare, Canada has a long history of separating Indigenous children from their families (Blackstock 2007; Sinha and Kozlowski 2013; Caldwell and Sinha 2020). The residential school system, which operated throughout the twentieth century in Canada, systematically removed children from their families and placed them in institutions (Milloy 2017). Survivors of these institutions report abysmal conditions that include overcrowding, malnutrition, general neglect, and severe abuse (Knockwood 1992; Sinha and Kozlowski 2013). Residential schools not only traumatized their pupils but also

served as a massive assault on Indigenous cultures, constituting a form of genocide (MacDonald and Hudson 2012).

Although the majority of residential schools were closed in the 1960s, the systematic removal of Indigenous children from their families continued with apprehension by child welfare authorities with a large influx of Indigenous children placed in care in the years that followed (Gough, Shlonsky, and Dudding 2009; Caldwell and Sinha 2020). Many of these children were placed for adoption in what has been termed the “Sixties Scoop” (Gough et al. 2009:359). Over 11,000 Indigenous children were adopted in Canada by non-Indigenous families between 1960 and 1990 (Sinha and Kozlowski 2013). Current child welfare practices continue to remove Indigenous children from their families at disproportionately high rates (Trocmé et al. 2019; Caldwell and Sinha 2020).

There is a substantial body of literature examining the challenges associated with child welfare involvement. The existing literature firmly establishes just how deep and far-ranging the impact of being in care can be in terms of education, health, criminal justice, housing, employment, and general well-being during the time children are in care and during post-care years. For example, there is extensive research indicating that youth in care achieve lower levels of education and lower high school completion rates relative to their non-care counterparts (Snow 2009; Ferguson and Wolkow 2012; Barnow et al. 2015; Rutman and Hubberstey 2018). Youth in care also face disproportionately high rates of health concerns (Turney and Wildeman 2016) and are often medically fragile compared to their non-care counterparts (British Columbia Ministry of Health 2001; American Academy of Pediatrics 2015). Many

children from the care system have suffered from abuse or neglect, which can have long-term health consequences that last into adulthood (Kessler et al. 2008). In addition to physical health, child welfare recipients also experience disproportionate mental health challenges (Deutsch et al. 2015; Turney and Wildeman 2016). Depression rates are higher among individuals with a history of foster care placements (Palmer, Prindle, and Putnam-Hornstein 2021), and several studies have linked child welfare placements with elevated suicide rates (Evans et al. 2017; Brown 2020; Palmer et al.).

Youth in care also experience elevated rates of criminal justice involvement (Owen 2000; Barn and Tan 2012; Esposito et al. 2015; McFarlane 2018). Some studies have linked associations between foster care and criminality with trauma, strain associated with care experiences, shortcomings within the care system, and challenges associated with post-care transitions (Barn and Tan 2012; Yang McCuish, and Corrado 2017; McFarlane 2018). Michell (2015) links the criminalization of foster youth to the stigma associated with child welfare involvement. McFarlane (2018) argues that children in care experience disadvantages within their placements and that the care environments meant to protect them are instead criminogenic.

Finally, youth in care experience challenges associated with leaving the care system. Many youths experience their exit from the system as sudden and feel unsupported as they go through the process (Rutman and Hubberstey 2018). During post-care transitions, mental health challenges are often exacerbated, and many youths experience unmet health-care needs (Zlotnick, Tam, and Soman 2012). Youth exiting the care system experience severe economic challenges and are at heightened risk of becoming

homeless compared to their non-care peers (Nichols et al. 2017).

There is also research indicating that youth in care are subjected to stigma associated with their child welfare involvement (Kools 1997; Michell 2015; Rogers 2017). The following section addresses that theme, along with a theoretical discussion of stigma and labeling.

Stigma and Labeling

The importance of stigma as a focal point of this study makes it salient to highlight the work of Erving Goffman and the dramaturgical approach he developed. While the dramaturgical approach is usually considered a variant of the symbolic interactionist perspective (Meltzer, Petras, and Reynolds 1975), it is sufficiently distinct to qualify as a theoretical perspective in its own right. Like other interactionists, Goffman (1959; 1963) was concerned with face-to-face interactions and how social actors collaborate to construct definitions of reality. For Goffman, identities are produced, negotiated, and performed through situated encounters. Goffman (1959) used the metaphor of the theater to think about social life. Social actors are like actors in a theatrical production, performing their roles and presenting different aspects of themselves to the audience. As social actors, we engage in *self-presentations* and attempt to *manage impressions* through a variety of strategies and tactics.

According to Goffman, making concerted efforts to manage outward appearances can preserve one's sense of self and facilitate social interaction. Given that one's sense of self is closely tied to the perceptions of others, individuals tend to manage their behavior and deportment to convey a desirable im-

age (Goffman 1959; 1963). Goffman (1959) identifies impression management as a habitual practice that individuals engage in to present a favorable self-image. Using props (material objects, clothing, facial expressions, etc.), performances are enacted in the *frontstage* realm, where social actors tend to carefully script the role identities they present, while in the *backstage* realm of one's life, one can relax and reflect on one's performances. Performances can be solo acts or collaborative, with several actors working together, much like theater troupes, to uphold a collective group impression or definition of the situation (Goffman 1959).

It was Goffman's interest in presentations of the self and identity management strategies that led him to consider circumstances where identities are devalued by others and tarnished in the sense that individuals are negatively judged or labeled. In his classic work, *Stigma* (1963), Goffman focuses on the social processes involved in coming to terms with a stigmatized identity. Goffman defines stigma as a trait that is "deeply discrediting" (1963:3). Individuals who are stigmatized are "disqualified from full social acceptance" (1963:13). They move from "normal" to "tainted" and "discounted" (Goffman 1963:13). Their dilemma is not the attribute that elicits the reaction, but the social disgrace that accompanies the negative attributions of others. Goffman (1963) makes a critical distinction between discredited and discreditable identities. Discredited identities are outwardly visible, while discreditable identities can be hidden. The youth in care status falls into the latter category since it is an identity that can be hidden.

The distinction between the two categories becomes important as Goffman (1963) identifies some of the common responses to living with a stigmatized

identity and draws attention to the adaptive mechanisms used by individuals to cope with social stigma. Stigma management involves managing one's self-presentation specifically to avoid or minimize the negative effects of stigma and allow one's sense of self to remain intact.

Goffman contends that individuals can be severely impacted by stigmatization in terms of self-perception and identity. He uses the concept of a "moral career" to describe the sequence of steps that individuals may go through as a result of stigmatization—how they might internalize deviant labels. The concept is based on research that Goffman presented in his book *Asylums* (1961). The book tracks the experiences of patients in a psychiatric hospital. Goffman found that the individuals he observed underwent major changes in self-perception as they navigated the institutionalization process. The shift began with their entry into the hospital and a "mortification" stage where they were stripped of identity markers such as clothing, personal belongings, and their everyday routines and activities, to name a few. Through this stage, they passed from being a person to being a patient. They experienced a sense of loss at this stage, but as they moved into the in-patient stage, many began to perceive themselves in new ways, through the lenses that staff viewed them. By the time they reached the discharge stage, they were defining themselves as mentally ill. Through the ex-patient phase, they ceased to be patients, but given cultural understandings of mental illness as a chronic condition, many continued to use the mentally ill label to define themselves.

Goffman developed the concept of a moral career in the context of an analysis of institutional labeling. More specifically, he was interested in the identity

implications of life in a total institution—a strictly regimented institution that governs almost every aspect of one's life and restricts individual autonomy. The child welfare system is hardly a total institution (though some youth are placed in living arrangements that might come close). Yet there are distinct parallels between the circumstances that Goffman describes and participants' passage through the child welfare system, particularly concerning the initial mortification process, the sense of disorientation it generates, and how it makes those subjected to it vulnerable to re-evaluations of their character, moral worth, self-perception, and identity. Moreover, some residential placements resemble total institutions through features such as "a forced residence, schedule of daily activities carried out in a group, restricted contacts with the outside world, [and] a clear staff-inmate split" (Golczyńska-Grondas 2015:109).

A final contribution informing this paper is Goffman's (1963) emphasis on the capacity of stigmatized individuals to demonstrate agency and push back against the labels they received. Even among the institutionalized patients he studied, Goffman observed that they found ways to assert their autonomy and personalities. More generally, Goffman insisted that individuals deploy specific strategies for preserving their sense of self when contending with stigma. They may conceal the attribute that has led others to label them. They may attempt to compensate for perceived inadequacies by overachieving in other areas. Conversely, some may engage in strategies of diffusion, for example, through the use of humor. Doing so allows individuals to avoid at least some of the consequences of labeling and to mitigate at least some of the damage that negative labels can inflict on an individual's sense of self.

Similarly to Goffman, the labeling approach in sociology shifts attention away from objective understandings of deviance toward processes of labeling and their consequences (e.g., Lemert 1951; Becker 1970). Beginning in the 1960s, and influenced by the tenets of symbolic interactionism, sociologists began questioning the objectivist view of deviance that had dominated the field up to that point. The objectivist or normative view rested on the assumption that certain behaviors are inherently deviant and that deviants are inherently different from non-deviants. From an objectivist perspective, the goal was to explain the existence of deviance to find effective remedial or ameliorative strategies for reducing deviance. In contrast, the labeling approach—as it came to be known—conceptualized “deviance” not as an inherent quality of certain behaviors but as a meaning or label *applied* to certain behaviors (Gibbs 1966). As Becker (1970:9, emphasis added) explains:

social groups create deviance by making the rules whose infraction constitutes deviance, and by applying those rules to particular people and labeling them as outsiders. From this point of view, deviance is not a quality of the act the person commits, but rather a consequence of the application by others of rules and sanctions to an “offender.” *The deviant is one to whom the label has successfully been applied; deviant behavior is behavior that people so label.*

Prus and Grills (2003:10) reiterate this point by saying, “it is in the definition of things that deviance is brought into play as a meaningful human essence.” That alternative conceptualization redirected the course of study in the sociology of deviance to how processes of labeling work and their consequences. According to Prus and Grills (2003:10), attention is drawn to “the human enterprise entailed in artic-

ulating, identifying, engaging, promoting, stabilizing, experiencing, and resisting definitions of deviance within the human community.” Among those consequences are the stigma connected with being labeled as “deviant,” the impact on one’s interactions with others, the internalization of others’ judgments and negative views, and how these internalizations affected individuals’ lived experiences and life trajectories (Lemert 1951; Becker 1970). Societal reactions are thus vital to the creation of deviance and sustained deviant trajectories. This view is consistent with Goffman’s work on the effects of stigma, except that Goffman highlights a broader range of labeling reactions and suggests that internalization may be only one step in the process of adapting to labeling.

Despite a decline in the use of societal reaction perspectives since the 1970s, their core ideas remain prevalent in various strands of contemporary sociology (Grattet 2011). Link and Phelan (2001:363-365) comment on the profusion of research on the nature, sources, and consequences of stigma that Goffman’s work has generated over the last several decades. Along the way, they point out that there has been some confusion about what is meant by “stigma.” They attribute the confusion partly to the enormous array of circumstances to which the concept has been applied—everything from urinary incontinence (Sheldon and Caldwell 1994) to exotic dancing (Lewis 1998). To Link and Phelan’s list one can add pornography (Jensen and Sandström 2015), HIV (Jugeo and Moalusi 2014), mental health (Bharadwaj, Pai, and Suziedelyte 2017), homelessness (Roschelle and Kaufman 2004) and scores of other stigmatizing conditions and situations. The confusion also results from the fact that much of the research on stigma is multidisciplinary, taking in social psychology, anthropology, political science, and

social geography. As Link and Phelan (2001) point out, different frames of reference have led to differences in conceptualization. That is not a problem, they conclude, so long as analysts specify how they are using the term.

Link and Phelan's (2001) conceptualization focuses on the relational dimensions of the term that Goffman himself stressed. For Goffman, one cannot talk about stigma without focusing on the interactional dynamics between those who do the labeling and those who are labeled. Stigma is enacted. Link and Phelan (2001:367) break that down into five interrelated components:

In the first component, people distinguish and label human differences. In the second, dominant cultural beliefs link labeled persons to undesirable characteristics—to negative stereotypes. In the third, labeled persons are placed in distinct categories so as to accomplish some degree of separation of “us” from “them.” In the fourth, labeled persons experience status loss and discrimination that lead to unequal outcomes. Finally, stigmatization is entirely contingent on access to social, economic, and political power that allows the identification of differentness, the construction of stereotypes, the separation of labeled persons into distinct categories, and the full execution of disapproval, rejection, exclusion, and discrimination.

Among the groups whose experiences with stigma have been investigated are children and youth in the care system. Dansey and colleagues (2019) argue that the stigmatizing aspects of being in care have long been acknowledged in the literature (Kools 1997; Hedin, Höjer, and Brunnberg 2011; Ferguson and Wolkow 2012). However, it has only been recently that researchers have examined how chil-

dren experience this stigma and what they do to manage it. In the study that Dansey and colleagues (2019) conducted, children talked about being treated differently from others and about being bullied. To avoid these reactions, they hid their care status from others.

Rogers (2017) found that children in care did not feel “normal.” They felt “less than.” In response, they tried to pass. They worked hard, as Rogers (2017:1088) observes, “to fit in with the in-group in their everyday interactions” and were careful in deciding “whom they disclosed their ‘in-care’ status to and the way they wanted to do this.” Another strategy Rogers identified was their efforts to form their “in-groups” with fostered peers.

Michell (2015) reviewed first-person accounts of the experiences of children in both private and public care in Australia between the 1920s and 1990s. She found that “stigma is a theme which threads its way throughout the twentieth century” and provides numerous examples of just how these “State kids” (as they are referred to in Australia) felt the “harsh sting of social disapproval” (Michell 2015:673).

Neagu and Sebba (2019) studied Romanian-born children who were taken into care in the UK and experienced different kinds of placements (residential care, foster care, domestic and intercountry adoption). While the researchers' interests included how these children felt with respect to their biological families, their study could not consider their experiences without noting that wherever they were placed, they were stigmatized. They were bullied in school, they were accused of misdeeds (stealing and begging) that they did not commit, had few friends among their classmates, and suffered from self-esteem issues as a result.

Drawing on impunity as a theoretical concept, Golczyńska-Grondas (2015) examined the social factors that contribute to institutional violence, focusing on the children's residential care system in the People's Polish Republic. Notably, Golczyńska-Grondas (2015) emphasized how the social exclusion and devaluation of care recipients contributed to their mistreatment in the system.

All of these studies go beyond merely noting how stigmatizing it is to be a "kid in care." They all begin to fill out the picture of how stigma is enacted and how stigma looks and feels from the perspective of those who are in the care system. As this paper shows, however, it is possible to go deeper still. One of the components in Link and Phelan's conceptualization of stigma (the second component) is the linkage of the differences that individuals exhibit to undesirable characteristics and negative stereotypes. The particulars here are important because of the extent that individuals internalize the negative labels applied to them; these are the characteristics they begin to attribute to themselves. Moreover, while some of this recent literature recognizes the agency of children in care and their efforts to resist and/or negotiate the negative attributions others make, there is room to explore in more depth the range of management strategies they adopt.

Methods

This paper is part of a larger study examining how individuals are broadly impacted by child welfare experiences as they progress into adulthood. Since my objective was to capture the individualized ways that youth in care are impacted by their child welfare experiences, I was interested in first-hand perspectives and opted for a qualitative methodology based on semi-structured interviews. I devised

an interview guide with a set of open-ended questions to allow participants an opportunity to speak freely about their experiences.

The interviews were held in multiple locations throughout Southern Ontario. Following ethics board approval, participants were recruited through posters and brochures, as well as through social media sites, such as Facebook and Twitter. Posters and brochures were distributed in recreation facilities, universities, public libraries, laundromats, apartment buildings, and shelters. Participants who saw the recruitment materials and were interested in participating in the study contacted me to arrange an interview. Snowball sampling was also employed to further facilitate recruitment. To snowball, I asked each participant at the end of the interview if they knew any other former youth in care who might be interested in my study and if they would be willing to share recruitment documents with them. Several participants did that, resulting in four additional interviews.

Once participants contacted me for an interview, we decided on a mutually convenient time and location. The interview location was left to the participants to decide, although I suggested several options. The interviews were held in participants' homes, parks, libraries, university campuses, and coffee shops. One interview was conducted by telephone. I approached the interviews in a conversational manner, asking participants to begin by telling me a bit about themselves. That approach can enable participants to tell their stories more freely and allows them to steer the interview toward areas they consider important, potentially revealing unanticipated information (Marvasti 2004; van den Hoonaard 2018). In that case, it enabled participants to identify aspects of their care experiences that they identi-

fied as relevant. With some interviews, participants spoke freely and their narratives answered many of the interview questions without being asked directly. For these interviews, the participants' narratives guided the interviews, which were interspersed with my occasional questions from the interview guide and selective probing. While the study aimed to identify how the participants were impacted by their child welfare experiences and progression into adulthood, stigma emerged as a prominent theme early in the interview process. Although the interview guide included a question about whether participants had ever experienced stereotyping associated with their youth-in-care status, fourteen participants raised the issue of stigma or stereotyping in their narratives without being asked directly. Several participants were more reserved and responded more actively to specific questions. For these interviews, the interview guide was followed more closely. All the interviews, however, followed a general pattern in which participants began by discussing their earliest contact with CAS and their entry into the system before discussing their experiences in care and how they have been impacted by these experiences.

With the permission of participants, most of the interviews were audio-recorded and transcribed verbatim. Four of the 20 participants declined to be audio-recorded, despite the information I had provided about the steps I would take to protect their privacy and maintain the confidentiality of any data I collected. [That included keeping all recordings and written documents in a secure place under lock and key, and all digital material encrypted on a password-protected computer.] Their reluctance is understandable, given the sensitive nature of the experiences they would be recalling. Participants discussed emotionally charged encounters with CAS,

and for some, involvement in illegal activities. For these interviews, participants did allow me to take detailed notes, which I filled in as much as possible once the interview was over.

The interviews ranged from twenty minutes to two hours in length, with most being an hour and a half long. To protect the confidentiality of participants, pseudonyms were selected for the participants and any identifying information, such as names and places, was removed from the transcripts. Following transcription, the interviews were analyzed thematically. I adopted a grounded theory approach (Strauss and Corbin 1998; Glaser 2001), coding the data through an iterative process that involved grouping similar concepts and identifying common patterns and themes. There was some overlap between the data analysis and interview process, and I adjusted my interview questions to pursue emergent themes. While I was attentive to the themes that were emerging in the interviews as I was conducting them, I started a systematic analysis of my data once all the interviews had been fully transcribed.¹

¹ I began analyzing the data using an open coding process to identify relevant concepts and their properties. That involved writing notes in the margins of transcripts or field notes and creating documents compiling relevant observations to identify broad themes. I engaged in both strategies, analyzing the interview transcripts and notes, line by line to identify larger themes and subthemes. While this paper is part of a larger study examining care experiences, stigma emerged early on as a prominent theme. As such, I created a document compiling all the relevant information from each participant pertaining to stigma, which I referred to during the subsequent coding and writing stages of the project. Once this document was created, I then coded smaller subthemes detailing the processes by which the participants experienced stigma. I then divided the data into two categories: direct experiences with stigma and responses to stigma. Consistent with Strauss and Corbin's (1998) approach, I used axial coding to link categories and subthemes and selective coding to refine and integrate the emergent themes by scanning the transcripts repeatedly for data that relate to the core themes. The notes from the coding documents provided a base for this paper.

The participants experienced a variety of placements across Ontario (primarily Southern Ontario), which included group homes, foster homes, kinship placements, and treatment centers. Some participants also spent time in youth shelters, and two were placed in youth detention facilities following other CAS placements. The length of time spent in the system ranged from several months to twelve years or more. Some participants had difficulty determining exactly how long they spent in care due to having been placed in care and returned home multiple times. The age of participants ranged from 21 to 65, with most participants in their twenties or thirties. Participants were asked to self-identify in terms of their gender and race. Among the participants, there were 8 females and 12 males. Caucasians were the largest racial group, with 15 participants identifying as White or Caucasian. The group also included three Indigenous participants—one who self-identified as Métis, one as First Nations, and the other as “Native.” The other two non-White participants identified as Filipino and South American. The question of race was particularly significant for identifying some key differences between the Indigenous and non-Indigenous participants’ experiences of stigma, which is discussed in the following section.

Experiences with Stereotyping

Individuals experience stigma and devaluation in the context of specific types of interactions with specific others. Generally, the participants in this study did not talk about being “stigmatized” or “discredited.” They talked about messages they received in a variety of ways from others that told them the kinds of assumptions people were making about them and the stereotypes they felt were being applied to them. Stigma manifested itself in their lives

through these messages and their interactions with a broad range of individuals, including their caregivers and agency workers, but also teachers, neighbors, peers, and the families of their peers. In this section, I focus on some of those messages.

Bad

The most common label applied to youth in care was “bad.” Several participants commented on the stereotypical view of youth in care as bad kids who are in care because of problem behaviors or because they “have issues.” They conveyed a sense that youth in care are viewed as “troubled,” “delinquent,” and “untrustworthy,” and that they are somehow at fault for their entry into the system. Some people, participants claimed, tend to link care status with criminality. They described numerous instances where, once they divulged that they were in care, they were asked: “What did you do?” Dave, for example, was brought into care due to his mother’s mental illness, which at times prevented her from being able to care for her children. Yet, as early as the fifth grade, Dave recalls his classmates bombarding him with questions that implied that his entry into care was due to some transgression on his part.

“Oh, you’re in foster care? Why, what did you do? Did you burn down a house or something?” You know? That’s what they automatically think. Or, you know, “Did you come out of jail and you can’t go back with your parents?” Or, “Did you kill your parents?”

Dan had a similar experience:

One of the worst [reactions] is when you finally summon the guts to tell one of your closest friends that you’re a foster kid. One of the worst responses that

I got was, “What did you do?” You know? Like I did something.

Karl made reference to the suspicion with which kids in care are regarded once their status becomes known:

I think right off the bat, if you were to tell someone that they were in a situation where they were taken in by a foster home, maybe they would think, “Maybe I shouldn’t trust this person.” Maybe he’s automatically been a criminal or something, which is not always the case.

The negative reactions came through not only in their interactions with peers but also in the responses of their peers’ families. Janice recalled how after hearing that she was in foster care, a teammate’s mother jumped to the conclusion that Janice had done something to warrant her removal from her family. She admonished her to start behaving if she wanted to be returned to her parents.

I remember when I was in baseball, this one lady was driving us to our destination or whatever, and she asked what my parents did or something, and I told her I was in foster care, and she was like, “Oh, you know, you just have to listen to your mom and dad, and you can go home.”

In some cases, families tried to discourage friendships because of their suspicions and fears about the influence that the participants might exert on their children. Amber described how her friend’s mother banned visits to her friend’s home because she feared Amber would steal something.

I had a friend, and his mom refused to let me in the house. She refused to let me in the house because

I was a Children’s Aid kid, and she thought that I was going to steal something from her. I went to a Catholic school, I had good grades, I was friends with her son, but she refused to trust me—those were the only things she knew about me other than I was a Children’s Aid kid—but she refused to trust me to be allowed in her house because she thought I would steal from her because I was a Children’s Aid kid.

Many of the negative assumptions about the participants persisted even after they were returned to their families. In his now classic study on the effects of negative labeling, Rosenhan (1973:184) observed that “labels can be sticky.” The phrase captures the experiences of participants in this study. Having been defined as “bad,” participants continued to bear that label even after their circumstances changed.

Sometimes, even when we went back to our parents, we would go to our friend’s place, and their parents wouldn’t want us there. They thought we were bad kids, you know? [Tyler]

Assumptions about the degree to which the behavior of the children accounts for their entry into care are often reinforced by the circumstances under which they are taken into care. It is not uncommon for police officers to be present during CAS apprehensions. Though the apprehension of a child may have nothing to do with the child’s behavior, the mere presence of a police officer feeds into others’ inclination to wonder what the child might have done. Amanda was in a situation where her mother was having difficulties dealing with the challenges of being a single parent. Her mother’s troubles meant that Amanda often had to help care for her younger brother. She was forced to assume adult responsibilities that few of her peers had ever experi-

enced. Yet, she was taken into care while at school, with two police officers present during her apprehension. The memory of the incident was vivid in her mind. She recalled, “I mean *everyone* looked at me [emphasis original].” She also reflected on the impact that the incident had on how others saw her from that point on, even years afterward.

And what’s sad is when I go back [to my hometown,] these people still exist. My friends that were my friends back then, they’re people that have grown up, and the stigma of that is something that I’ll always have with me. Because they remember me as that troubled teen where *those two police officers apprehended her* [emphasis original]. So it’s very embarrassing. It’s just so embarrassing.

Harold Garfinkel (1956:420), another sociologist who contributed to the development of labeling theory, has coined the term “degradation ceremony” to describe the symbolic point at which individuals are stripped of their status as a “normal” member of their social group and relegated to a devalued status. These perceptions of children in care as “bad” and “not to be trusted” are not limited to outsiders who might have little knowledge of the circumstances under which children are taken into care. Even caregivers can engage in this kind of stereotyping. That fact became clear for many of the participants right from the moment they were taken into care. In scenes that echo Goffman’s description of mortification processes, they recalled being stripped of their possessions and subjected to strict rules and procedures designed to regulate them. Amanda described it as akin to being in jail. She described the intake process in the following way.

It was like we went to jail...What they do is they pretty much strip you of everything, like all your human

rights. Even though I didn’t deserve that. Like I didn’t do anything at that point, right?

In her first group home, Amanda was not able to attend regular school and was homeschooled in the basement instead. Moreover, she was not permitted outside without staff supervision. Community time had to be earned by demonstrating compliance and was limited to a maximum of 15 minutes.

Participants provided numerous specific examples of situations where they were regarded with suspicion and where their workers and caregivers assumed they were lying and were not willing to give them the benefit of the doubt. Stephanie recounted how it was often assumed that she was “faking it” when she complained of not feeling well, even when it was subsequently determined that she was suffering from chicken pox. Lily recalled a routine visit to the dentist that became an attack on her motives and credibility.

They filled a cavity for me, and I came out of the dentist’s office, and they had put me under because I was really afraid to go to the dentist, so they gave me gas or whatever, and I came out of the dentist, and my lip was frozen, and I was making faces, like being funny ‘cause I couldn’t smile—it was just completely drooped, and I remember the receptionist from the dentist being like, “She’s not still under the influence; she’s just faking it.” And I was like, “But, that’s not even what I was doing!” I was just playing with my lip and, like, being funny about my lip. And that’s an obvious stereotype—like even at the dentist we’re just group home kids. We’re just acting out for attention or whatever.

Contrary to the ethos of ‘innocent until proven guilty,’ these youth felt they already had a mark

against them simply by being in care. Lily linked the assumptions that staff often made about them to the abuse that occurs in care settings. She reasoned that if staff tended to see youth in their charge as “bad,” they would be more inclined to treat them harshly.

I think even within care there is the perception that we’re all liars, we’re all bad people, we all shouldn’t be trusted, we’re all messed up so don’t listen to them ‘cause they’re wrong, and that leads to, like, abuse.

Sick

In some cases, the “badness” of participants was medicalized and treated as illness; a trend previously identified in the treatment of youth (Conrad 2007; Bosk 2013). Participants were seen as having “mental health issues.” Rather than punishment, participants received treatment, though as Conrad (2007) points out, both are simply mechanisms of social control. In these cases, too, the message sent to participants was that *they* were troubled in some way and that it was *their* issues that required attention. Stephanie explained:

What was just inculcated into you was that there was something wrong with you. Just something wrong with you...It was that you removed [kids] from the home for intensive treatment when there wasn’t actually a need for treatment of the kid. It was the environment that needed to change.

Lily’s time in care was interspersed with regular stints in hospitals, where she would be placed for a few days at a time until her social worker could find her a placement. That practice, especially in combination with the heavy medication she was required to take, made Lily feel in hindsight like the

mental health problems she might have experienced were largely induced by the professionals she encountered while in care and the medications they prescribed.

I wasn’t really given a choice. I just went with it. It [the medication] started when I was 14, and I was really depressed. Like, I’ve had kind of a rough upbringing and stuff, and it was obviously circumstantial. I think my doctor was just like, “Here’s some Paxil. Just take this!”

Stupid

Another common assumption that participants believed others made about them had to do with their intellectual abilities. There were numerous stories about the various ways they were made to feel “dumb,” as some participants put it, or simply not capable. Rarely did their caregivers or teachers expect them to do well in school and most assumed that they would never attain a college or university education. One participant succinctly stated, “I’ve had people treat me like I’m stupid.” For Janice, the sense she had as a child that she was viewed as slow or deficient in some way was affirmed for her years later when a friend considering fostering said the following about foster children.

My friend said that she wanted to be a foster parent, but she didn’t know if the kids would be able to mentally and physically keep up with her three-year-old. I don’t think she knew that I was ever in foster care...I know some people have some really weird-formed opinions of certain groups in society, but I never thought that if I was in foster care I’m supposed to be in remedial classes or something!

Even gestures on the part of well-intentioned teachers, probably meant to be generous and accommodating, reinforced the impression that participants could not succeed academically on their own. Amanda described a situation where one of her teachers gave her credit for work she had not completed. Amanda appreciated the gesture, but took away from it the message that the teacher did not have confidence in Amanda's ability to succeed without assistance or accommodations.

When I was in my senior year, I was given like three free credits. I mean, I'm grateful that she did it, but it made me think that by giving allowances and breaks, are we increasing that person's autonomy?...Because I feel like if I didn't get that stigma, I wasn't going to get that outcome.

This incident reveals the subtle forms stereotyping can take. Even well-intended adults can inadvertently relay the message of intellectual inferiority through their attempts to be helpful.

Inferior/Pitiful

The third component of stigma that Link and Phelan (2001) identify is status loss.

Participants were keenly aware through their years in the care of their devalued social status. Many of them recalled feeling "inferior," "lower than" or "less than" others. Karl asserted, based on his experience, that youth in care are viewed as "worthless." Amber used the term "defunct" frequently throughout the interview to describe how youth in care are viewed by society in general. Colin referred to how being in care was "very pride taking-awaying." Janice's reflections powerfully captured what it felt like using the symbolism of the "trash" bag

she was forced to use for her belongings every time she was moved from one home to another.

How people look at you—the poor kid coming to our house with the bag full of her clothes. You feel like trash when you're walking up with a trash bag full of your clothes!

Jess put it this way:

I think a lot of the times they think that we're low, that we don't—I can't even describe it... we're less educated, we're not bums, but lower than average people, and I think it's not fair at all.

The sense of being "less than" for several of the participants placed with foster families was reinforced through the differential treatment from the biological children in the family they received at the hands of their caregivers. For instance, Savannah described being excluded from family vacations and holidays throughout the ten years she spent with her foster family. At Christmas, she would return to her biological family, and she would be sent to a respite home when the family went on vacation.

Christmas is what stands out for me the most. They would often encourage me to go with my family whether or not—there were actually a couple of years where I was like, "You know what, it'd be really neat to stay with you folks." I think out of the ten years I spent maybe two Christmas mornings with them. So not a lot. They would always celebrate birthdays with me. But, I felt like there was always a difference between their biological kids' birthdays and the foster kids' birthdays... whether or not they didn't actually want me or they couldn't get permission to take me out of the province or the country, but the foster

family would go on vacation, and I'd go to another foster home until they got back.

For Savannah, being treated differently in all of these ways contributed to a keen sense of being devalued.

Janice had similar experiences. She recalled how one particularly abusive foster mother would treat her and her sister as servants, expecting them to cater to her biological children.

She would, like, take us to the fair and we [Janice and her sister] would have to carry her kids' bags and stuffed animals while they did stuff. We were basically the wagon.

The sense of exclusion and devaluation was even stronger among those who experienced instances of abuse in their care placements. Being mistreated made them feel further diminished.

In some cases, the sense of being devalued had an obvious class dimension to it. Colin recalled how "the rich, snobby kids looked down on [him]." Stephanie described herself as a charity case.

I've always felt like you were just a charity case. You know, people from the community would give you presents at Christmas and stuff like that. And they would come in, and we became the project for nursing students.

Unwanted

When asked about the kinds of stereotypes he believed are applied to youth in care, Karl said "unwanted." For Karl, being "bounced around," as he put it, "can only make you feel unwanted."

Never having stability or secure parental relationships, Karl felt "thrown away—like a piece of garbage—just tossed away." Several other participants echoed this sentiment. Savannah remembered being chided by classmates when they discovered her care status.

People would say things like, "Oh, you're not really loved, or your parents don't want you, that's why you're in there." Or they'd call me "orphan." I mean, this is when I got a little bit older, but once people find out, they go for it.

For some participants, the sense of not being wanted extended beyond their families of origin and was also applicable to their caregivers and to the community more generally. Lily explained that while she was in care, there was a campaign on the part of residents in the neighborhood where the group home was located to have the home moved.

You perceive that nobody wants you there for sure, but then it doesn't help when staff are like, "Yeah, they don't want us here, and they're trying to get us kicked out of the town."

Summing up, I have described some of the more common labels and stereotypes that participants felt were applied to them by virtue of their care status. There were others, closely related to these—that youth in care came from conflict-ridden and dysfunctional families and that given their family circumstances, foster children must be fundamentally unhappy and "damaged." When Kevin told a classmate that he was in foster care, the reaction was, "You look too happy to be in care." Savannah perhaps encapsulated all of the stereotypes best when she said:

That we are poor. That we are troubled. That we come from very dysfunctional broken homes. Often questions like, “Are you a crack baby?” The whole perception is that it was an unwanted pregnancy, or your parents are addicts, or you must have been abused or very much neglected. The one that affects youth the most is that people assume that you’re trouble...there’s the perception that kids in care are trouble and have issues.

One of the central concepts in labeling theory is the notion of a master status (Hughes 1945:357)—a social status that overrides all others concerning one’s social identity and that constitutes the lens through which individuals are viewed by others. And if internalized, the lens through which one views oneself. It is clear that in this case, being in care comes to act as a master status for youth in that situation, significantly coloring how others view them and the assumptions that others make about their character, capabilities, and potential.

Before turning to how participants attempted to manage the stigma they encountered, I want to discuss the case of two participants for whom questions about the stigmatizing aspects of being in care did not resonate. Both participants were Indigenous. Cody explained that being visibly Indigenous meant that he experienced stigma from a young age, so entering the child welfare system did not make a big difference. He was used to feeling different and left out. It was difficult for him to identify how much being in care exacerbated his situation. Kayla said that she did not find being in care that stigmatizing, in part because she had been placed with a family member and many people did not know that she was in care. However, even where others knew, she observed, it all blended in with the stigma of being a First

Nations person. Going back to Hughes’ (1945) concept of a master status, for these two participants, being Indigenous overrode being in care as a status marker. That makes a telling statement about racism in Canada. It also makes a telling statement about the relative strength of different status markers. According to Link and Phelan (2001:377), stigma can be a matter of degree. The labeling of human differences can be more or less prominent. The connection between labels and undesirable attributes can be relatively strong or relatively weak. Some groups are more stigmatized than others. The experiences of these two participants illustrate these points. They also point to the importance of aiming for an intersectional approach to studying stigma, one that considers how different sources of stigma (based on race, gender, sexuality, ethnicity, religion, disability, etc.) may interact to shape an individual’s care experiences (Choo and Ferree 2010).

Responding to Stigma

In line with symbolic interactionist understandings of agency, Goffman’s work pays as much attention to how individuals manage stigmatized identities and cope with repressive conditions as it does to labeling and mortification processes. As noted earlier, even those in total institutions designed to stamp out their individuality, residents will fight to assert themselves in responding to stigma and control. While the ability to do so and related consequences can vary by circumstance, Goffman (1961; 1963) draws attention to the ways that stigma and labeling are resisted. Goffman’s work, and subsequent literature in the area of deviance, have revealed that individuals can be endlessly creative in responding to stigma. Along with the stigma management strategies identified by Goffman, the literature in

this area has identified a long list of ways that individuals respond to, manage, and try to reduce and resist their stigmatization. Many of them are similar to strategies that participants in this study adopted; others are different.

Concealment and Selective Disclosure

Goffman (1963) asserts that concealment is often the preferred strategy in managing deviant identities because it is the most efficient way of avoiding stigma entirely. If one conceals potentially damaging information about oneself, others cannot react negatively. Concealment, however, is a strategy only available to those with discreditable attributes, not those whose difference is obvious. As Cody, one of the Indigenous participants remarked, his care status was not outwardly apparent in the same way as his race. The visibility of his race may be another factor explaining why Cody felt the stigma attached to his race so much more keenly than that associated with his care status. Since the youth-in-care status is a discreditable stigma that can potentially be hidden, it is not surprising that some participants dealt with the possibility of others reacting negatively by at least trying to hide their status from others whenever they could. "I didn't tell anybody at school. That I remember," said Lily. Amber explained: "At the time, nobody knew I was a foster kid. I purposely left that as quiet as I could."

For Dan, concealment proved more challenging after he was placed in a group home since the move now meant having to ride a school bus. Anxious to avoid questions from his peers, he found a way.

They had one of those handicapped buses come to my place every morning to drive me and drop me off. And it was embarrassing because, you know, rid-

ing with the handicapped kids and then, you know, I had to, like, run off the bus. I was, like, hiding from other students, my peers, 'cause I thought, like, if they saw me, they would make fun of me, and this would be the worst. So, I'd find myself hiding that this was going on. And it was a real, real source of embarrassment and shame for me... Like I'm not living with my parents, how do you explain that? I'm living in this random house far away, how do you explain that, right? And, like, you know, so I was living this double life almost, in the shadows, too.

However, concealment as a strategy for youth in care often meant counting on the complicity of others. In some cases, they were able to secure others' cooperation. Savannah, concerned that the social workers who visited her at school would give her secret away, asked them to hide their badges when they visited.

The social workers would often come to see us during school times, which I never fully understood. So getting called out of class to go chat with your social worker. I remember telling my social worker, like, put your badge away! 'Cause I didn't want anyone to identify him or know—like, it was obvious that he was a social worker.

Stephanie, on the other hand, had less success with her teachers.

The teachers at school would make sure other people knew because I was saying something about being a fee-paying student and the teacher said [name of treatment center] girls are not fee-paying students.

Amber's efforts at passing failed when she was 'outed' by her ex-boyfriend.

At the time [grade nine] nobody knew I was a foster kid. I purposely left that as quiet as I could. But, he [ex-boyfriend] knew because we were dating, and he met my confusing-as-fuck family. Yeah, so he said in the middle of the cafeteria that he would never be caught dating some sort of fucking retard CAS kid. In front of hundreds of kids! So, at that point, everyone knew.

Little wonder, then, that those who attempt concealment live in a constant state of anxiety, particularly in their school situations. They never know when they will be outed. The repercussions can be dire when this point is reached. Other studies (Michell 2015; Dansey et al. 2019) on the stigma experienced by children in care have found that they are often bullied by their peers. Both Savannah and Amber experienced physical confrontations and bullying once their peers discovered they were in care.

The power of concealment as a strategy is underlined by the deep sense of shame participants felt when others were aware of their care status. Lily describes it as being branded.

Everyone knows you're a group home kid. So, if you're in school, it's in your file. The teachers know. Everybody just kind of knows that's who you are and where you're from. You feel like you're wearing it across your forehead, too. Like, when you go out and it's two staff and this group of girls, you feel like everybody knows. And maybe they don't. Like, maybe they wouldn't look at a group and be like, "That's a group home group!" But, at that age, you feel like it's written across your forehead. Like everybody knows, and everybody judges you for it.

Stephanie expressed it in similar terms. She said she felt "marked."

The thing is, everyone knew you were from [name of treatment center,] so you were marked... You couldn't hide it. That's where you lived.

Challenging the Stereotypes

Another stigma management strategy involved attempts to counter the stereotypes of the typical youth in care. Some of the participants talked about making concerted efforts to do well in school, just to prove that they could, and in doing so, to challenge the stereotype of youth in care as academically weak. In fact, it became Savannah's goal to eventually acquire a post-secondary education. Toward this end, she also became active in school clubs and extracurricular activities while in care. She was motivated by her future goals, but she set those goals against the backdrop of messages she received that advanced education was beyond the limits of what most youth in care were likely to achieve. Similarly, Amber excelled at her studies. Both participants were proud to have been touted as "the golden girls"—in Savannah's words—of their respective children's aid societies.

Connor explained that he, too, worked hard at his studies to defy assumptions about his capabilities. The fact that he qualified for a math competition in Grade 10 stands out for him still as an accomplishment in which he takes great pride. He also boasted about his success in sports. He had to stop his participation in sports when a foster care placement took him away from his teams and new arrangements could not be made. The point in all of these examples is that these participants strived to stand out for their excellence and success in certain endeavors in a situation where not much was expected of them.

Some of the examples of this strategy are revealing in their subtlety. Stephanie, for instance, described

a dress that she made for a sewing competition. As she finished the design, she decided to add a belt. She was concerned that without it, the looseness of the dress might suggest teen pregnancy. Sensitive to the stereotypical image of youth in care as troubled and sexually promiscuous, she took steps to forestall any such speculation. That example highlights how efforts to combat stigma can find their way into even the most mundane activities, such as choice of clothing styles.

Physical Retaliation

In cases where participants' care status was generally known, and a source of taunting or bullying, other strategies were adopted. Several participants reported being mistreated at school by peers and, in some cases, teachers when their care status became known to others. Some participants reported getting in fights at school when teased by their classmates. Colin explained: "[I needed to] stand up for myself, you know? Not back down." For Colin, teasing about his care status would sometimes lead to physical confrontations. His comments about 'not backing down' reflect a desire to preserve and assert a sense of pride. Amber, the lone female participant who volunteered stories of fighting, described how she resorted to physical retaliation on two occasions when bullied at school due to her care status. One was the cafeteria incident described earlier, where she punched her ex-boyfriend in the face. The second incident involved "almost punching" a fellow student for some derogatory remarks about foster kids.

When I was in high school, I almost got suspended for punching a girl in the face. I didn't actually punch her in the face. My music teacher stopped me from punching her in the face, but it nearly happened.

Like Colin, Amber also felt compelled to challenge the bullies she encountered and occasionally resorted to physical retaliation as a means to do so. Standing up to bullying about their youth in care status can be understood as a way for these participants to preserve their sense of self when confronted by stereotyping. If nothing else, these physical displays left participants feeling tough, strong, and powerful. Aaron, Karl, and Connor also described similar encounters as a youth in care, although, for these participants, fighting was primarily a survival tactic in environments where violence was commonplace.

Seeking Solidarity

A final strategy aimed to foster interactions with others who, in addition to sharing the experience of stigmatization, did not judge or stigmatize. Instead, they provided positive affirmations. Some participants talked about finding companionship and forging friendships with others who were similarly marginalized and/or stigmatized. Lily, for example, described how she mostly hung out with other group home kids throughout her time in care.

I don't really remember having any friends that were outside of group home kids, not when I was in there. I think that I had one friend that I started hanging out with. She knew, but she had like a really messed up life anyways, so it really didn't matter.

As Lily described, the one friend she had that was not from a group home also had difficult circumstances in her life, which facilitated their bond. Particularly, if they were of an age and in circumstances where they had more freedom, the participants spent a lot of their time on the streets where they sought out other street-involved youth. Janice explained: "I always hung out with the rejects and

rebels and everything, so I wasn't weird." Amanda explained that she often gravitated toward other marginalized individuals, a habit that continued even after leaving care: "I always find the misfits in every group that I'm in." Both Janice and Lily use language—"rejects," "rebels," and "misfits"—that acknowledges and ironically reinforces or reifies the stereotypes linked to youth in care. But, their larger point about finding companionship among these individuals speaks to their desire to find a group where they feel they fit in.

Discussion

The stories shared by participants reveal the extent and severity of the stigma they experienced. The findings are consistent with other studies that have looked at youth in care (e.g., Golczyńska-Grondas 2015; Michell 2015; Rogers 2017; Dansey et al. 2019; Neagu and Sebba 2019), but go further in specifying precisely what stereotypes they face and how the assumptions that others make about them are communicated to them in ways that underscore their diminished social status. To a greater or lesser extent, they have all been underestimated, devalued, and often written off as not likely to amount to much. To many, they were nothing more than a "CAS kid," with all of the negative connotations described in this paper. The devaluation they experienced occurred both at the interpersonal and structural levels. At the interpersonal level, some were taunted, bullied, and abused—by peers, teachers, caregivers, and social workers alike. However, participants also felt devalued by institutional features, such as the policies and procedures in child welfare settings that made them feel criminalized or otherwise diminished. Examples include the practice of involving police presence during apprehensions, strict, punitive rules in care placements, and medicalization.

As Goffman (1961) argues in *Asylums*, individuals subjected to stigma, especially in rigidly controlled environments like those many of the participants experienced, are primed to undergo significant shifts in self-perception and identity as they begin to internalize others' views of them. Consistently receiving messages about their diminished status from others sets them up to question their character, capabilities, and moral worth. Given that our self-perceptions are intrinsically linked with how we think others see us, we are often inclined to see ourselves through the lens of the labels we receive (e.g., Lemert 1951; Goffman 1961; Becker 1963). For individuals who are subjected to persistent and pervasive stigma, the impact can be profound. This was certainly the case for the participants in this study. They expressed powerfully the effect that the negative attributions they experienced had on how they felt and how they saw themselves. They felt branded.

At the same time, their accounts reveal the extent to which they attempted to protect themselves, salvage a more positive sense of self, and respond to their circumstances. In this regard, too, the paper confirms findings in the literature, but also extends them. Dansey and colleagues (2019) found elements of defiance in the youth they studied, who tried to protect themselves from the negative judgments of others. Rogers (2017:1088) has written that youth in care are "active social agents who are problem-solvers" as they try to manage their spoiled identities. Rogers' (2017) study also observed how foster youth carefully manage disclosure and added that they often form their in-groups to lessen the impact of social exclusion.

The findings presented in this paper identify a broader range of strategies. Concealment and selective disclosure certainly did work for the participants in

this study to minimize damaging encounters with others by managing information about their care status. Countering the stereotypes, however, provided an additional means to mitigate stigma, as they challenged others' negative assumptions about them head-on. Within the tightly constrained and highly controlled circumstances they often found themselves, some of the participants made decisions and behaved in ways that defied expectations and forced others to see them in a more favorable light. Physical retaliation, as a strategy, allowed some participants to show that they were not willing to acquiesce or passively accept others' judgments and actions. Finally, seeking solidarity represents a strategy whereby participants proactively sought out associations and relationships with others who were similarly socially devalued and therefore provided a source of understanding and non-judgemental encounters. Link and Phelan (2001:378) concede that stigmatized individuals sometimes attempt to resist playing the "helpless victim" to the labeling forces around them. They nonetheless point out that there are relatively few stories of resistance in the literature. Participants in this study offered stories of resistance.

Of course, from the point of view of securing validation and inclusion, some of these strategies worked better than others. Physical retaliation, and, in some cases, seeking the company of marginalized others (like street-involved youth), often set participants on a course that only created more problems for them and led to encounters with the law and the criminal justice system in ways that entrenched their status as "deviants." In terms of consequences, these strategies bear some resemblance to what other authors have found. In his study of marginalized, inner-city male youth, Anderson (1999) showed that when confronted with limited opportunities for self-affirmation, male youth marginalized by race and class some-

times adopt a brand of masculinity that emphasizes toughness and physicality. Anderson (1999:175) calls the strategy "going for bad." Adopting this demeanor can help one feel powerful, gain respect, and facilitate self-protection. An outcome of "going for bad," however, is that it can contribute to escalating violence, involvement with the justice system, or, in some cases, heightened stigma.

Roschelle and Kaufman (2004) document the same strategy among homeless children. The homeless youth that they observed would often adopt threatening demeanors and body language. They swaggered in exaggerated ways, spoke louder than usual, and engaged in "ghetto talk." In both the Anderson (1999) and Roschelle and Kaufman (2004) studies, the authors argue that besides offering individuals some measure of physical protection in environments that are often dangerous for them, the threat of physicality is one of the few means available for poor, socially marginalized youth to assert themselves and make them feel powerful. Therefore, they adopt manners of speech, demeanor, and style associated with gang culture, sometimes "code-switching" to fit into specific environments (Anderson 1999:36). However, both studies also point out that while physical posturing might provide protection and some satisfaction in terms of how the youth view themselves, the satisfaction is often fleeting and short-lived. Physical posturing, in many cases, has the longer-term effect of only further stigmatizing, marginalizing, and alienating them for the very groups from whom they are seeking inclusion. Such is certainly the case for many of the participants in this study, who continued to pay the social price for their actions well into adulthood. For many participants, stereotyping affected them well beyond their time in care, highlighting the degree and intensity of the stigma they faced. A future paper will address these long-term impacts.

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