Foster Parent's Experiences Caring for Infants in Aotearoa/New Zealand

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Abstract

While fostering of infants shares similarities with the fostering of older children, they also make unique demands on foster parents. Given that such infants often have encountered various forms of trauma, they further demand a specialised set of skills from those who foster them. Currently there is a large body of research related to the foster system and the provision of care. In particular this focuses on children's experiences and needs, with a growing focus on foster parent experiences, though usually in relation to primary age children and adolescents. Less represented is research related to the foster parents of infants, especially in the context of Aotearoa-New Zealand (A-NZ). This study therefore aims to contribute to this latter area, by further developing our understanding of the experiences and insights of foster parents in A-NZ who foster infants. Accordingly, this thesis explores the experiences of seven A-NZ based sets of participants. The participants were interviewed about their experiences and the transcripts analysed using thematic analysis. Five main themes were subsequently developed: Motivation and commitment, Nurturing from bud to bloom, External elements, Wellbeing and functioning, and Network of supportive relationships. Interwoven across these themes is the core notion of Relationships and interactions. The analysis demonstrates that fostering infants is more than just caring for vulnerable high needs infants, it involves being part of a complex dynamic system, a system that needs to support, train and equip, listen and include, and recognise the special work and contribution such foster families make in A-NZ. The analysis highlights the specific resources and support that need to be made consistently available to enable foster parents of infants to give the best care possible.

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Chapter One: Introduction

At the age of twelve my teacher set the class the task of writing a story about what we envisioned ourselves doing in ten years' time. My time travelling story focused on observing my future self, working as a maternity/Neonatal Intensive Care Unit (NICU) registered nurse (RN). Although I went on to become an RN, I never worked in obstetrics or NICU. The romanticised view twelve-year-old me had working in this field no longer exists. However, what I have not lost is my love and passion for the welfare of all children, their families, and communities. I seem to have come full circle in a way, with this thesis, in that one of its lead characters are infants.

This chapter commences with 'The journey of two nations and the protection and care of children'. This gives an overview of the history of family/whānau structure and childcare in Aotearoa/New Zealand (A-NZ), with a particular focus on foster and kinship care and some of the impact of colonisation on Māori family/whānau life and structure. 'Issues in question' then reviews relevant statistics related to foster care of infants, demonstrating why research on foster parents of infants is necessary. A section called 'Positioning', gives a snapshot of my own family's fostering experiences and why I connect to this study. Next is a short segment called 'Aim and scope of study', followed by a brief discussion of some of the terminology used. Finally a brief overview of the study as a whole is stated.

The Journey of Two Nations and the Protection and Care of Children.

Aotearoa/New Zealand is a relatively young nation in terms of the formal joining of two sovereign nations via the signing of the Treaty of Waitangi/Te Tiriti o Waitangi in 1840. A covenant that history shows was not fully honoured, causing a breakdown in Māori family structures, knowledge, identity, community, and trust in the Crown (King, 2003; Ruka, 2017). In relation to caring for and raising children, these nations historically had different approaches or tikanga/ways. Before the arrival of other nations, particularly the British and

subsequent colonisation, Māori children grew up in an environment surrounded by family/whānau and the wider family/hapu/iwi. As opposed to the general Victorian mantra of children being "*seen and not heard"*, Māori children were considered a valuable member of the whānau structure born with mana, they were interconnected, actively involved, in a closely intertwined system (Atwool, 2006; Moko, 2003). In regard to children requiring care beyond their immediate family, there is a process called whāngai, which involves a kinship framework through which family connections and networks are maintained (Atwool, 2006). Whāngai is child focused, seeking to ensure safety and meeting the child's needs, with children being considered a taonga/treasure (Atwool, 2006; Gibbs & Scherman, 2013). Whanaungatanga/family connection is very important in Māori culture and worldview (Atwool, 2006).

In 1881, the Adoption of Children Act was legislated, but was a closed process excluding the birth parents (Gibbs & Scherman, 2013). The child welfare system (CWS) in A-NZ was generally based on similar systems, that is Western models of child welfare, such as those found in the United Kingdom (UK), and Australia. Initially this was predominantly through residential care (Connolly et al., 2017).

With the arrival of the Europeans and the establishment of the British Crown partnership and later governance, the traditional ways of Māori childcare was disrupted, with Māori children being placed into the homes of non-kin foster parents, breaking the family connections and impacting their identity and culture (Atwool, 2006).

A shift in child protection and welfare occurred in the 1980s with the practice and outcomes of the system challenged (Connolly et al., 2017). Maatua Whāngai was created in 1983 by the Department of Māori Affairs and the Department of Social Welfare. Maatua Whāngai was designed so that the department worked alongside with Māori whānau, the wider family, and the community in regard to child welfare and the provision of home

(Atwool, 2006). Even with these measures in place it was observed that Māori children continued to be disproportionately placed in non-kin families (Atwool, 2006; Connolly et al., 2017). In 1989, legislation in the form of the Children, Young Persons, and their Family Act (CYPFA) was created to address issues raised by Māori (Atwool, 2006; Connolly et al., 2017). These changes initially had a positive impact on the numbers of children in foster care, however after this decrease in numbers there was a subsequent increase of children going into foster care, with children still being placed in homes that were culturally different to their culture of origin (Atwool, 2006; Connolly et al., 2017). The Act has undergone amendments and a couple of name changes since 1989, with the first name change being 'Vulnerable Children Act 2004' (New Zealand Family Violence Clearing House, 2019a; New Zealand Legislation, n.d.). The Act was then renamed the 'Oranga Tamariki Act 1989' in 2017 (Wali et al., 2018), with important amendments made including providing children more involvement with decisions, and improved information sharing and protection (New Zealand Family Violence Clearing House, 2019b).

The CYPFA focused on the centrality and value of the family, with the priority that children are homed with kin if placement with birth parents or immediate family is not possible (Atwool, 2006). Within the framework of this legislation is the Family Group Conference (FGC), which is set in motion when the welfare of a child needs consideration, planning in conjunction with the child's kin/whānau (Connolly et al., 2017). The Care of Children Act 2004 (COCA) was created to ensure that the voice and needs of children are heard and that they are provided with adequate and relevant legal representation (Atwool, 2010; Wali et al., 2018). In 2005 the 'New Zealand Care and Protection Practice Framework' was created, focused on being "child centred; family-led and culturally responsive; [and] strengths and evidence based" (Connolly & Smith, 2010, p. 17).

Prior to the 1970s, adoption as a form of permanency was common, with a preference of children to go to kin where possible (Jackson & Gibbs, 2016). The Home for Life (HFL) policy was created in 2010, aimed at enabling foster children being placed in a permanent home and having a stable environment, whilst still being able to maintain contact with birth parents, who keep their guardianship rights (Jackson & Gibbs, 2016). A review of the policy by Jackson and Gibbs (2016) raised some concerns and recommendations. It was argued that the policy potentially created a sense of insecurity for both child and guardians with the latter, though given a parental role, in essence still being seen as foster parents with the increased opportunity for difficult birth parents to destabilise the arrangement. Foster parents can go to the courts to request to have parenting orders, especially if it is evident that the placement will likely be long term with the child unlikely to return to the birth parents. Parenting orders give foster parents more say in the day-to-day cares and able to contribute even more if granted guardianship (Gibbs & Scherman, 2013).

The uplift of infants and foster care has been in the news front in recent years (Johnsen, 2020), with reviews and inquiries into Oranga Tamariki-Ministry for Children, especially in regard to the honouring of Te Tiriti o Waitangi and its principles and the care of Māori infants and whānau (Hyslop, 2020). There has also been an increase of foster parents voicing their concerns with how they are treated and the complicated situations they find themselves in regard to infants and non-kin care (Maas, 2019).

A-NZ 'statutory systems of care' currently consist of four main placement forms: foster care (short term, long term, therapeutic, and wrap around services); kinship, residential, and adoption (Connolly & Morris, 2012). This study is situated in the short and long term foster care and the kinship care environment. Kinship care is provided by the whānau/family of the infant/child and, according to Gibbs and Scherman (2013), this is usually the 'grandparents, siblings, aunts, or uncles'. Young children are more likely to be eventually

homed in kinship than older children, and therefore intermittent or short-term foster care for the infant is more likely to utilised in the interim (Connolly et al., 2013).

According to Schofield et al. (2012), in comparison to other nations the usage of foster care to provide and protect the child and where possible include the birth parents, is similar to that in other nations such as Australia, Norway, Sweden, France, Italy, and Spain; whereas the United States (US), UK, and Canada maintain using adoption as an option and the birth parents are not included in this process.

Issues in Question

According to Oranga Tamariki (2021a), 'reports of concern' has decreased from approximately 82,000 in 2017 to approximately 78,000 in 2021, and after investigations, assessments, and FGCs, 5,100 children placed into foster care in 2021. Of these 5,100 children, four percent were between the age of 0-1, comprising approximately 204 infants. Stats NZ (2022) recorded 58,659 live births in 2021, making it approximately 0.35 percent of the infant population in A-NZ that are in foster care. In 2021 there were 3,361 foster parents, of which 62 percent were whānau foster parents, and 329 with specialised training to care for children affected by trauma (Oranga Tamariki, 2021a). Of the 5,100 children in foster care 40% of then are placed in kinship care (Gibbs & Scherman, 2013).

Children are reliant on those responsible to care for them which makes them a vulnerable population, the most of whom are infants (Connolly, et al., 2007). Developing a healthy attachment to a primary carer is vital for the development of the infant, and their subsequent ability to form secure relationships throughout the lifespan (Fear, 2017; Gerhardt, 2015). Therefore vulnerable infants are at risk of this developmental process being disrupted (Connolly, et al., 2007).

Based on my review of the literature, current studies relating specifically to foster parents' experiences seem to be relatively small in comparison to other foster related topics

(Marcellus, 2008). There appears to be an even smaller number of studies on the experiences of foster parents caring for infants. This study focuses on foster parent experiences of caring for infants, with the possibility of including attachment and the impact of maternal substance use if it arose during the interviews. This study is set in the context of A-NZ fostering environment, which has a unique history and cultural context to consider. This project connects me to both my passion for the welfare of children and social issues.

Positioning

This study is somewhat personal, as my parents were foster parents through Open Homes for a period of time. When I was a child growing up, my family did not own much in terms of material belongings, yet we did not lack in a stable family environment, full of love, encouragement, and support. Even before my parents officially began fostering, the home often had other people staying with us. This included older teenagers who were in conflict with parents or who needed somewhere to board during the school/work week. The year I left home to study nursing, my parents tried their hand at foster care, initially starting with the respite of an energetic eleven year-old boy. I am the eldest sibling in the family, so when I left, my younger siblings were the ones who experienced the day-to-day aspects of foster care.

I would come home in the breaks and had the joy of meeting some of these young ones. Although I was not there to fully see the day-to-day aspect of fostering, I could also see it was not always easy, especially with managing some of the children's difficult behaviours. I could see the stress and toll some of this took on my family, particularly on my mum (who had undiagnosed hyperthyroidism). I was able to observe how each of my siblings coped with different foster children and the impact it had on some of them. The energetic pre-teen boy frustrated my then teenage brother at times. Being the only boy, I suspect the pre-teen sought his attention more, but in an unhelpful negative manner. As a relative outsider with

intermittent contact, I recognised that I carried less frustrations and was able to connect with this particular boy. This took some pressure of my brother for a time, giving him respite. There was an amazing child behind the behaviours with a delightful sense of humour. When I left to go back to Wellington he gave me one of his favourite toys (a fake spider). Which didn't seem much, but it felt like it was important to him, and I treasured this gift for many years. It was a reminder of those children who are less fortunate than me, yet still had much to give.

Although my natural instinct is to hear the child's voice and connect with them, children are not islands, they are part of a family system, set in community and culture. Foster children removed from a broken or dysfunctional family are still connected to it to some extent. They then become part of the foster system, which has systems within systems, with some functioning better than others. Part of this system are foster parents, and for both the foster parents and the foster children's sake they need their voice to be heard and their value to be recognised.

Aim and Scope of Study.

The purpose of this study is to better understand the experiences and perceptions of foster parents in A-NZ, particularly those who care for vulnerable infants in foster care. The first four months of an infant in care was the timeframe of interest.

Terminology.

Throughout this paper a decision to use the term 'foster parents' rather than 'foster caregiver' has been applied, for consistency. They both relate to the same role.

The term 'access' is widely used by the participants and some literature, which refers to 'supervised contact', the current preferred terminology. Supervised contact is held at prearranged time and location that is safe for all involved (Community Law, 2023; New Zealand Ministry of Justice, n.d.).

Overview of the Study.

Following this chapter, are two literature review chapters with one chapter discussing the journey and experiences of the foster infant particular in relation to trauma, prenatal substance exposure (PSE), and attachment. This then leads into the main literature chapter relating to foster parent experiences, where the general experience of foster parents is explored narrowing to literature specific to fostering infants. The methodology chapter flows on from there, detailing, among other aspects, the thematic analysis approach utilised to analyse the interviews conducted with participants. The analysis chapter discusses the various themes developed from the analysis, with the closing discussion chapter concluding the thesis.

Chapter Two: Infants in Foster Care

This chapter discusses research in relation to infants in foster care in general and, subsequently, in the context of A-NZ . Following this, how trauma impacts the infant, including prenatal experiences, will be reviewed. This then leads to a discussion of the impact of maternal substance use on the infant pre- and postnatally. Aspects of trauma that affect infants postnatally are then discussed. The fourth issue covered will be attachment and foster care. Concluding with tying this all together, will be a consideration of the interaction of trauma, PSE, and attachment in relation to foster infants.

Infants at risk from abuse, harm, neglect, or some other form of trauma are placed into alternative care, usually with a foster family kin or non-kin, to ensure they have a safe, nurturing, and stable home (Bruskas, 2010; Stovall-McClough & Dozier, 2004). The trauma, disruptions, and possible multiple placements can impact the infant's ability to form secure attachments, a significant part of development. International studies demonstrate that infants placed into foster care before the age of seven months are more likely to be in the foster system longer than older children and are less likely to be rehomed with the birth parents (Bruskas, 2010).

A study based in A-NZ by Keddell (2023) found that between 2013-2017 there has been a 48% increase in kinship/whānau placements compared to a 6% increase in non-kin placements, though it does not specify specific age groups. However, in regard to infants, this study found a 33% increase of infants being removed from family/whānau. Intervention providing family/whānau support, early intervention for infant and family, and measures put in place to decrease the likelihood of removal are necessary (Keddell, 2023). In the instance removal is necessary, the infant requires a secure foster placement until a permanent solution is found. It is important to facilitate a placement where the infant can learn to bond, and

recover from trauma. This should be with trained foster parents, particularly those trained in caring for vulnerable infants (Guy, 2011).

An A-NZ study by Connolly et al. (2007) found the median age of infants being 'notified' of being at risk was approximately six months of age, and the ethnicity of these infants were identified as 49% Māori, 33% Pākehā (European NZ), and 14% Pacific Island, with the remaining 4% not accounted for in their study. The main reason for the infants living environment being assessed was due to 'violence and neglect' (Connolly et al., 2007; Jackson & Gibbs, 2016), with other areas of concern including substance abuse, mental health issues, and unsocial behaviour (Connolly et al., 2007). Such environments can have a negative impact and outcome on the infant's immediate and long-term development, often due to the lack of care and attention (Connolly et al., 2007). Infants need to have the opportunity to develop attachment, and for those caring for them to understand the impact adult behaviour on them. Associated with the importance of the development of attachment is the need to establish a primary, safe, and permanent caregiver or guardian, especially if the possibility of remaining or returning to the birth parents is unlikely (Connolly et al., 2007).

Infants, Trauma, and Impact on Development and Behaviour

This section gives a brief overview of the prenatal stress response, the impact too much stress can have on a foetus and infant postnatally, and the behaviours that may be associated with infant trauma and stress.

Before an infant is born they have nine months in utero totally dependent on their mother providing what they need. There is an array of factors that can impact the infant's development prenatally and postnatally. These include maternal nutrition, substance use (illegal/recreational and prescription), mental and physical health, stress (particularly excessive or ongoing stress), environmental factors, and genetics (Gross, 2019). Related

recent research has particularly considered the factors that may influence or hinder the development of the infants prenatally (Bunston & Jones, 2020).

When a person is under stress, physiological changes occur. Associated with the fight-or-flight response is the activation of the Hypothalamic-Pituitary-Adrenal axis (HPA), which in turn increases the amount of adrenaline and cortisol hormones in the body, associated with increased heart rate and blood pressure (Gerhardt, 2015; Gross, 2019). When the mother has produced stress hormones, the placenta protects the infant, unless the hormones increase to a degree that it overwhelms this system and thus exposes the infant to increased amounts of adrenaline and cortisol (Gross, 2019). Prenatal stress potentially reshapes the HPA and the 'limbic-automatic nervous system', which forms neurological pathways to enable survival, called 'defensive relax activation' (Cortizo, 2020). This system also affects bonding with primary carer (mother prenatally), and emotional regulation (Perry et al., 1995).

Excessive cortisol has been associated with excessive activation in the frontal lobe (Gerhardt, 2015). The increased processing can cause the infant to present on the 'hyperarousal continuum', where the body responds with increased heart and respiratory rates, and raised blood pressure. This can present as hypervigilance, irritability, a startle response, difficulty with eating or sleeping, feeling fearful and distressed, separation anxiety, and being difficult to settle (Gerhardt, 2005; Guy, 2011; Perry et al., 1995; Sloan Donachy, 2017). Infants may also become withdrawn, or in state of being 'under-aroused' (Sloan Donachy, 2017). The term 'dissociative continuum' is used to describe this 'freeze/surrender' response, as opposed to the 'fight/flight' response (Better Health, 2021; Perry et al., 1995; Sloan Donachy, 2017). Infants are unable to physically activate the 'fight/flight' response (Perry et al., 1995). Better Health (2021) describes the 'freeze/surrender' rection as 'frozen watchfulness', and Blank (2007) describes this presenting as 'decreased movement' and

'decreased attention'. Infants in unsafe environments learn that crying is not effective, and may present with lack of eye contact, decrease in age appropriate vocalisations or 'cooing', and lack of age appropriate play and interactions (Better Health, 2021; Perry et al., 1995).

Repeated exposure to high stress postnatally, and thus stress hormones, potentially impairs development (Cortizo, 2020; Guy, 2011). However, if the stress hormones are reduced in the first part of the infants life, through safe and consistent care, this can reduce prior impairment (Guy, 2011).

Prenatal Substance Exposure.

Prenatally the infant is vulnerable to what the mother puts into their body. The substances of most concern for the infant's welfare are alcohol, illicit drugs, and certain prescribed medicines. Other behaviours associated with drug taking may also impact the infant. These include the reduced probability of seeking early prenatal assistance/care, having an unhealthy diet, and living in an unhealthy domestic environment (Gross, 2019). Illegal drugs are known to generally be 'potent teratogens" (i.e. substances that can cause birth defects) which decrease the likelihood of the prenatal infant surviving to birth, or of them being born with developmental issues, brain abnormalities and physical deformities (Gross, 2019; Sulik et al., 2011). Foster infants have an increased risk of having been exposed to drugs and alcohol prenatally and having their development negatively impacted due to exposure to a dysfunctional unhealthy environment (Wakelyn, 2020). The main reasons infants go into foster care are abuse and neglect, some of which are linked to substance use. For instance, the A-NZ a study by Connolly et al. (2017), found 71% of birth mothers had a history of substance abuse. The behaviours that PSE infants can subsequently present with can be challenging for the foster parents, and therefore specialised training is recommended (Burry, 1999).

Alcohol. Infants exposed prenatally to alcohol risk developing a range of impairments in the physiological, behavioural, cognitive, and neurodevelopmental domains (Barrow & Riley, 2011; Gross, 2019; Molteno et al., 2014; Thomas & Riley, 1998). Foetal Alcohol Spectrum Disorder (FASD) is a more severe outcome of prenatal alcohol exposure (Thomas & Riley, 1998). Infants and children who fall into the FASD spectrum may have distinct features and symptoms. These can include distinct facial features (such as midface hypoplasia), delays in growth and development, and cognitive and central nervous system (CNS) impairments (such as microcephaly and attention deficit) (Barrow & Riley, 2011; Gross, 2019; Molteno et al., 2014; Saddock et al., 2015; Thomas & Riley, 1998).

Illegal/Recreational Drugs. The impact of illegal/recreational drugs on infants is more difficult to observe than in alcohol, as polydrug use is not unusual, making it difficult to determine which drug affects the infant when and how (Gross, 2019). Internationally the recreational drugs often used include marijuana, methamphetamine, cocaine, and heroin (Gross, 2019). The predominant illegal drugs used in A-NZ, based on seizure rates and wastewater testing are cannabis, amphetamines (MDMA and methamphetamine), and cocaine. Women have a higher rate of overdoses from benzodiazepines or opioid use, with 66% of those discharged from hospital being women (Mercier & Jarrett, 2022). With this in mind and the wide range of drugs infants could be exposed to, the main focus here will be cannabis, amphetamines, and cocaine.

Cannabis/Marijuana. Cannabis is the most common recreational drug used by women of reproductive age in developed nations, and is often used where polydrug taking occurs (Huestis & Choo, 2002; Narkowicz et al., 2013). Newborns exposed to chronic maternal cannabis usage, present with symptoms which include tremors (Huestis & Choo, 2002; Saddock et al., 2015), exaggerated startle reflex, a high pitched and disproportionate cry, disrupted sleep patterns (Huestis & Choo, 2002; Merritt et al., 2016; Saddock et al.,

2015), low birth weight, decreased head circumference (Merritt et al., 2016; Narkowicz et al., 2013; Saddock et al., 2015), and hyperemesis (Saddock et al., 2015). Long term effects are thought to affect some executive functioning such as problem solving, working memory, decreased attention, and increased impulsivity (Huestis & Choo, 2002). There is a small amount of literature about the direct impact of cannabis on the infant and later development, and what is known gives a general impression of its most likely impact (Fried, 2011).

Amphetamine (Methamphetamine and MDMA). An A-NZ study found 1.2% the population use amphetamines over a 12 month period; or 40,000 people of the population (Mercier & Jarrett, 2022). Amphetamine consumption is widespread across the nation, being not limited to one part of society, rather is now found across all of society (Chamberlain, 2015; Mercier & Jarrett, 2022). In regards to methamphetamine use and pregnancy, in A-NZ there is no data available at a national level. However, there is data collected via some specific health providers, such as National Women's Health Services (NWHS). This data indicates that approximately 55% of referrals from NWHS for the Alcohol and Drug Pregnancy Team were related to methamphetamine usage and pregnancy (Abar et al., 2014; LaGasse et al., 2011). There is an incomplete picture, with limited knowledge on the impact of methamphetamine on the infant and longer term issues (Huestis & Choo, 2002; Ross et al., 2015). Developmental and behavioural issues that have been observed in infants include premature birth, atypical reflexes, oversensitivity to stimuli (Chamberlain, 2015), delayed infant growth (weight, height and head circumference) (Ross et al., 2015), along with some cognitive, emotional, language, and behaviour impairment (Moore et al., 2011).

Cocaine. Infants exposed prenatally to cocaine have been observed to present with microcephaly, premature birth, and are more likely to experience Sudden Infant Death Syndrome (SIDS) (Gross, 2019; Huestis & Choo, 2002). Other postnatal presentations caused by maternal cocaine use observed within the first month include diminished arousal,

decreased development in movement, difficulty with self-regulation, increased excitability, tremors, and abnormal reflexes (Gross, 2019; Huestis & Choo, 2002). Generally, it has been noted if these infants grow up out of their parental environment they have a more positive outcome than those remaining with birth parents, especially if there's no improvement in the parents behaviour (Eiden et al., 2007).

Prescribed and Legal Drugs/Medication. Irrespective whether a drug is prescribed or legal, caution should always be exercised, including with herbal supplements, as some medicines such as ibuprofen could potentially negatively affect the infant in the last trimester (Gross, 2019). Some medications used for medical conditions, including to manage mental health issues, can be continued with careful management. For the wellbeing and safety of pregnant mother and unborn infant, alternative strategies will need to be implemented in the management of medications that are known to cause harm to the foetus. This may include medications being ceased or decreased for the time required (Gross, 2019; Nulman et al., 2011).

Neonatal Abstinence Syndrome (NAS). Maternal substance use whilst pregnant often means the infant will be born addicted to the substance used, thus requiring detoxing, with the possibility of experiencing NAS (Gross, 2019; Johnson, 2014). NAS is a syndrome related to withdrawal and is predominantly found with infants exposed to opioids (Gross, 2019). The symptoms of NAS are associated with the central nervous system (CNS), the autonomic system, and the gastrointestinal system (Gross, 2019; McQueen & Murphy-Oikonen, 2016). NAS symptoms may present as irritability, tremors, decreased weight, seizures, and fever (Gross, 2019; McQueen & Murphy-Oikonen, 2016). These infants require a low stimulus environment with carers who are trained and equipped to address their specific needs and issues (Gross, 2019).

Postnatal Trauma

Trauma comes in different forms, from single events to ongoing experiences, such as PSE, violence, neglect, and maltreatment. True (2020) describes 'relational trauma' as when an infant/child's security (psychological and physiological) has been compromised by their primary attachment figure. This can be caused by various negative experiences, for example, abuse (sexual, emotional, or physical), observing violence (such as Intimate Partner Violence (IPV)), loss of a parental figure (through death or divorce), or neglect (physical, emotional, abandonment/supervision) and maltreatment (Rankin, 2011; True, 2020).

The trauma infants may experience occurs while the infant is still developing, and therefore if the trauma is not swiftly addressed, development can be compromised, particularly affecting the psychological and neurological domains (Bruskas, 2010). Complex traumas (caused by multiple traumas) can impact the whole being of an infant (physical, psychological, cognitive, and behavioural), and can negatively impact attachment, self-regulation, and the ability to form healthy relationships (Cook et al., 2005; Guy, 2011). Cook et al. (2005, p. 392) summarises this by identifying seven domains potentially impacted by complex trauma: attachment, biology, affect regulation, dissociation, behavioural control, cognition, and self-concept.

Violent Environments and Encounters. Infants may be uplifted from a violent home environment due to being indirectly exposed through observing incidences such as IPV. These environments are linked an increased probability of the infant/child experiencing physical abuse, neglect, and maltreatment (Jenney, 2020; Liel et al., 2020). The infants may directly encounter physical abuse such as being shaken which can lead to head trauma (Gross, 2019; Hung, 2020), being punched, burnt, biting, or being inflicted with broken bones, bruising, and cuts (Hines et al., 2021; Howe, 2005). Jenney (2020, p. 92-94) discuss the various ways in which infants and young children encountering violent situations may be

impacted long term. This includes trying to understand and make sense of the trauma and adversity they have experienced; presenting with trauma symptoms, such as hypervigilance and withdrawal; and disrupted or broken parent-child dyad and attachments.

Separation From Birth Parents/Whānau Despite traumatic experiences the infant/child may have experienced with their birth family, there is still a sense of loss when they are removed and placed into foster care, as they cope with change and a sense of instability (Bruskas, 2010; Ward et al., 2006). Studies have shown infants removed from their primary parent/caregiver demonstrate 'acute separation responses', and these separation behaviours can make it difficult for the foster parents to settle and soothe the infants (Stovall & Dozier, 1998). According to Stovall and Dozier (1998, p. 70), the separation responses include: crying, screaming, and searching for missing parent, and seeking to be comforted by them only. The older an infant is when removed from their birth family/guardians the more acute and prevailing the separation behaviours are (Stovall & Dozier, 1998). The infant needs to adapt and recover from the trauma of pre-placement, the loss of and removal from the birth family, and being in a new environment and family unit (Bruskas, 2010; Guishard-Pine et al., 2007). Ideally infants are placed in a permanent home before the age of 6-8 months since after this age children have demonstrated a decreased capacity to adapt (Stovall & Dozier, 1998).

Infants and Attachment

Overview of Attachment Theory

Attachment theory has its origin in the work of John Bowlby starting in the 1940s (Atwool, 2006). Grounded in psychoanalysis, Bowlby's observation of mother-infant interactions led to the understanding of a child's relationship with their mother being important for development and functioning throughout the lifespan (Cassidy, 2016). He theorised that children need a primary consistent person/mother to bond with and who

provides nurturance, love, and a secure base (Atwool, 2006). Maternal deprivation was identified as compromising the developmental process: (Atwool, 2006; Fear, 2017). Bowlby was instrumental in developing the concept of internal working models. This is the process in which the infant forms internal representations that structures future experiences. In relation to attachment these internal working models are formed through relationships and impact the development of self-regulation, mental images of oneself and others, and affect interactions with others (Atwool, 2006; Talbot & McHale, 2003).

Mary Ainsworth built on this theory through her 'The Strange Situation' research in the 1970s (Atwool, 2006; Fear, 2017), where, in brief, different infant-mother dyads were observed in different situations in an unfamiliar environment with the introduction of a stranger at various points. Of interest was the infant's responses and behaviour in these situations (Ainsworth et al., 2015). From the Strange Situation research three attachment patterns were observed: secure, ambivalent, and avoidant (Atwool, 2006; Solomon & George, 2016). A fourth pattern called 'disorganised' was later observed by Mein, Kaplan, and Cassidy (Atwool, 2006).

The patterns/strategies of attachment are conceptualised as internal working models where an infant develops either secure, insecure, or disorganised strategies for coping (Atwool, 2006; Grey & Gunson, 2020). The secure and insecure strategies are said to be organised patterns because the parent/caregiver behave in a consistent way, enabling the infant to develop a consistent/organised response or coping mechanism. Disorganised attachments develop when a parent/caregiver is inconsistent and presents with distressing or unsafe behaviours (Benoit, 2004).

Secure patterns of attachment form through having at least one attachment figure the infant feels safe and secure with. This helps them develop the ability to explore and learn,

facilitates healthy brain development, and develops a sense of being loved and valued (Atwool, 2006; Grey & Gunson, 2020; Zimberoff & Hartman , 2002).

One of the insecure attachment strategies is the avoidant pattern. This develops when the attachment figure does not respond to or interact with the infant. Subsequently the infant learns to become self-reliant, considering the world unsafe, and themselves as undeserving of help. These infants become withdrawn and internalise (negative thoughts towards self), feeling safe when unseen (Atwool, 2006; Grey & Gunson, 2020; Fear, 2017).

Ambivalent attachment is the other insecure pattern seen as developing in response to inconsistent attachment figures, who do not attend to the infant attention when they are upset, and encroach on the infant's space when they are content. Such infants are predicted to grow to question their worth, externalise as a coping method, thus making sure others see them (Atwool, 2006; Grey & Gunson, 2020; Fear, 2017; Zimberoff & Hartman, 2002).

The last pattern of attachment is the disorganised pattern. The individual with this strategy does not form a consistent strategy to cope with their attachment figures behaviour. These attachment figures usually cause the infant to be fearful and anxious. Consequently the infant sees the world as a scary place in which they are helpless, becoming dissociative or reactive (an infant may scream, an older child may run away from stressor) when under stress (Atwool, 2006; Stovall-McClough & Dozier, 2004).

Foster Infants and Attachment

Ideally maternal bonding with the infants begins well before birth. However, this process can be hindered for a number of reasons, such as anxiety, mental health challenges, substance use, unplanned pregnancy, and past trauma. This can cause a 'high betrayal trauma'(trust is broken) for the infant (Cortizo, 2020).

Studies have found that foster children are at higher risk of developing disorganised attachment patterns compared to non-foster children, and have discerned an association

between psychological development and environmental casualty (Bernier et al., 2004). Permanence is an important part of developing secure attachment, as it provides stability and consistency (Atwool, 2006). Infants/children may feel anxiety and fear being transferred into a new unfamiliar environment, where attachments are yet to take form (Bruskas, 2010). Children from dysfunctional or unsafe environments may develop challenging strategies and behaviours to cope, which can then transfer to the foster care environment as they process experiences of helplessness, anxiety, and feeling abandoned (Bruskas, 2010).

For some children being in foster care is a positive experience where they experience feeling safe (Bruskas, 2010). Infants, in particular, are unable to verbalise the sense of loss, uncertainty, and fear they feel. If the infant does not get help to heal from the trauma, then they may develop long term developmental issues (Bruskas, 2010; Guy, 2011). The bond and relationship infants form with the foster parent is thus vital and, if properly managed, will increase the likelihood of subsequent healthy development. Realising that the foster parents are dedicated and can be trusted, enables the infant to form healthy attachments, promoting resilience and self-regulation (Bruskas, 2010). Children who have been abused and neglected are more likely to form insecure attachments, or a disorganised attachment, and the more serious the abuse the higher the risk of a disorganised attachment response (Stovall-McClough & Dozier, 2004). Foster infants thus need more than basic care, they need secure healthy relationships to assist with development and recovery (Bruskas, 2010).

Conclusion: The Trifactor

Foster infants are placed into foster care for a variety reasons. Trauma of some kind is a factor most foster infants experience, such as abuse, neglect, and PSE. The second factor in this trifactor is PSE, one of the most common reasons infants go into care. Trauma and PSE (individually and together) can potentially distress the infant and affect their ability to attach. Attachment, the third factor, is necessary for the infant to develop healthy

relationships, self-regulation, resilience, and growth in competence as they achieve developmental targets. Trauma, PSE, and attachment issues, can interact and hinder the psychological, physiological, and developmental growth of an infant. It can also affect the infants interactions with the foster family. Therefore, foster infants require specialised intensive care in loving secure homes, to give them the best start possible and to aide in overcoming the adversities they have often experienced both prenatally and postnatally.

Chapter Three: Experiences and Perceptions of Foster Parents

This chapter is focused on foster parent experiences and perceptions, starting generally with shared experiences of foster parents, and then focusing on experiences specific to fostering infants. There is a large amount of literature related to various aspects of fostering children. A number of studies have been from a foster system perspective particularly the social worker's (SW) perspective, and in regard to placement success or breakdown (Atwool, 2010). Other studies have predominantly been focused on foster children's experiences or needs, or aspects of the foster systems or interventions where the foster parent's experiences or voices have been intertwined with these and been less prominent (Andersson, 2001; Marcellus, 2008). The number of studies specifically focused on foster parents and their families are increasing. Research in regard to foster parent's experiences are predominantly focused on caring for children older than infants, particularly primary school age through to adolescents (Meetoo, et al., 2020), or infants are included as part of a general discussion rather than specific studies. Studies that specifically focus on the A-NZ fostering community are important so as to understand experiences, diverse cultural approaches, needs, knowledge, insights and how policy and frameworks specific to A-NZ impact foster parents' ability to foster. A significant amount of research has been produced in regard to the ideal characteristics of the foster family (Orme, et al., 2006). International studies may be useful to give a general understanding of foster parents' experiences, but may not recognise or address specific experiences, needs or expectations of foster parents within A-NZ, or have differing world views. Researchers such as Nicola Atwool, Marie Connolly, and Trecia Wouldes have contributed a range of studies in relation to fostering in A-NZ, including foster parents experiences, the foster system, and foster children's experiences.

The chapter discusses the main experiences and perspectives in the literature in regard to foster parents general and shared experiences across the foster child age span, along with a

few less mentioned experiences that are considered significant. International foster parent experiences alongside comparable experiences of foster parents from A-NZ are considered. The experiences of foster parents internationally and those from A-NZ specially related to fostering infants are finally considered.

Shared Experiences Across the Age Span

In relation to fostering infants, the literature demonstrates shared themes and issues with those who foster older children. These themes include motivation (Barton, 1998; Brown, et al., 2007 & 2012; MacGregor et al., 2006; Marcellus, 2008), commitment to fostering (Bernard & Dozier, 2011; Dozier, 2006; Lindhiem & Dozier, 2007), characteristics of foster parents (Andersson, 2001; Orme & Buehler, 2001; Zinn, 2009); learning to navigate and work in and with the foster system (Cooley et al., 2017; Meetoo et al., 2020; Spielfogel et al., 2011); being supported and heard by the foster agency (Brown & Calder, 2000; MacGregor et al., 2006; Spielfogel et al., 2011), receiving training and resources (Atwool, 2010, Cooley et al., 2017; Murray et al., 2011), receiving support from other sources such as family and community (Feeney & Colin, 2015), other foster parents (Cooley et al., 2017), and other organisations such as health providers (Khoo & Skoog, 2014); coping with complex needs and behaviours (Brown & Bednar, 2006; Meetoo et al., 2020); building attachments and healthy relationships with child (Brown & Campbell, 2007; Cole, 2005), whilst balancing foster family dynamics and needs (Barton, 1998; Marcellus, 2008; Meetoo et al., 2020), and coping with grief and loss (Coakley et al., 2007). Experiences that appeared more in literature in regards to older children and less about infants' foster experiences included: allegations directed at foster parents (Spielfogel et al., 2011), difficult behaviours, developmental issues and emotional needs of the child (Brown & Bednar, 2006; Brown & Campbell, 2007), cultural identity of the child (Brown & Calder, 2000; Buehler et al., 2006), kinship care (Andersson, 2001; Coakley et al., 2007; Fuentes-Peláez et al., 2016), placement

stability or breakdown (Brown & Bednar, 2006; Khoo & Skoog, 2014), retention of foster parents (MacGregor et al., 2006), safety and privacy of foster parents (Brown & Bednar, 2006; De Wilde et al., 2019), coping with the various stressors (Bergsund et al., 2020; Buehler et al., 2003; Lee et al., 2016) including transitioning the foster child to a new placement (Herbert et al., 2013), trauma (Taylor et al., 2008), and the foster parents own wellbeing (Blythe et al., 2013, 2014; Brown & Bednar, 2006).

Motivation, Commitment and Characteristics to be a Foster Parent

To become a foster parent a decision to commit to this role is required to start the journey. Why do people decide to foster children, specifically infants, and how do they remain committed to continue? A review of the literature shows the main types of motivation discussed are both intrinsic and extrinsic.

Intrinsic Motivators

Altruism. Altruism, the behaviour where a person purposefully assists another (Filkowski et al., 2016) is demonstrated as the motivator with the highest response for foster parents. In particular a dominant theme of various studies from Canada and the United States of America (US), is the motivation to make a significant and positive change in a child's life, in particular a child at risk (Barton, 1998; Daniel, 2011; MacGregor et al., 2006; Marcellus, 2008). Marcellus (2008, p. 1227) also categorised this as a 'Social Justice Endeavour', and states that, "social justice reflects the way human rights are manifested in the everyday lives of people". Dando and Minty's (1987) study of 80 foster mothers, indicated that the desire to nurture foster children had the highest indication in the sample. The motivation to tend to a child's needs, to be there in support and keep them safe is described by Khoo and Skoog (2014) as a 'caring perspective', which Mayseless (2016, p. 2) discusses as a form of motivation where, "the motivation to give or provide care is thus distinct from the motivation to receive care". The altruistic motivations in regards to fostering children present in various

expressions and intentions, these include providing a loving and stable home and environment (Atwool, 2010; MacGregor et al., 2006), ensuring the best possible start for an infant/child (Atwool, 2010; Barton, 1998; Cole, 2005), and providing a family environment (Brown et al., 2012; Dando & Minty, 1987; Khoo & Skoog, 2014). There are additional motivators expressed in the literature relating more to the societal future benefit of fostering, this includes breaking generational cycles (Atwool, 2010), moulding healthy well-functioning members of society (Khoo & Skoog, 2014), and preparing the child for transition and placement with either their birth whānau or their forever home such as adoption (Atwool, 2010; Cole, 2005).

Life Changes or Family Circumstances. Changes in a life stage or family circumstance has been found to be a motivating factor for some, indicating it was a factor to consider foster care, and for most it was linked to wanting to help children and contribute to their community (MacGregor et al., 2006). The life changes included experiencing biological children growing up, also known as 'empty nest' (Andersson, 2001; MacGregor et al., 2006); a variation of wanting to fill the empty nest with children in general is fostering to substitute a now adult child (Cole, 2005; Dando & Minty, 1987). Some people are motivated to foster due to being unable to have biological children (Andersson, 2001; Dando & Minty, 1987); are considering fostering as path towards permanency or adoption (Cole, 2005; MacGregor et al., 2006); have biological children and seek to have a larger family or have room for more children in their lives (Cole, 2005; MacGregor et al., 2006); and for some people a friend or substitute sibling for a biological child is a motivation to foster (Andersson, 2001; MacGregor et al., 2006).

Perceived Benefits to Biological Children. Some foster parents also perceive that their biological children benefit from being part of a fostering family. These benefits include: the biological child engaging with at-risk children and families, consequently developing

empathy and awareness of people different to themselves (MacGregor et al., 2006; Marcellus, 2008) and becoming part of their wider community, including those communities and cultures what differ from their own (Brown et al., 2012; Cole, 2005; Daniel, 2011).

Personal Past Experience. Foster parent respondents relating to past experiences predominantly spoke of either being a child of the foster system (Brown et al., 2012; MacGregor et al., 2006) or growing up in a fostering family (kin or non-kin) or knowing someone such as a relative who fostered (Brown et al., 2012; MacGregor et al., 2006; Marcellus, 2008). These past experiences motivated respondents to become foster parents to enable them to break negative cycles and prevent children experiencing negative state care experiences or traumatic home experiences that they themselves experienced or observed or conversely observed the difference their own foster family/parents contributed (Brown et al., 2012; Dando & Minty, 1987; Marcellus, 2008).

Opportunity to Parent. The opportunity to put parenting skills into practice overlaps with other motivations, such dealing with an 'empty nest'. Utilising parenting skills and developing or confirming the role and skill base was given as a motivation by some participants in studies (Andersson, 2001; Atwool, 2010; Brown et al., 2012).

Motivated to Continue. Canadian studies (Brown et al., 2012; Daniel, 2011) and a study for a report in A-NZ (Atwool, 2010) relating to fostering a range of ages reported some foster parents experiencing fostering as 'rewarding' and 'satisfying', particularly as the foster parent observed the foster children transforming and developing on a positive trajectory. Marcellus (2008) described the joy of observing and participating in the small improvements the child experiences as 'relational feedback'. Some foster parents thrive on the challenge of working with at-risk children and within a challenging system (Brown et al., 2012).

Extrinsic Motivator: Compensation. Compensation or fostering as a form of employment as opposed to a voluntary mentality, is a motivation for some foster parents,

though not generally the primary motivator for commencing or continuing fostering (Andersson, 2001; Brown et al., 2012).

Kinship Carers/Whānau Care and Indigenous Specific Motivations. Motivations discussed by non-kin foster parents are also shared by kinship carers and indigenous foster parents, particularly in relation to seeking to be there for a child in need and making a difference. With kinship carers and indigenous foster parents there is an additional element with either being related to the child and/or being from the same cultural community.

Kinship carers are not necessarily indigenous kinship carers. Becoming a kinship carer by nature can be unexpected. They are often meeting an immediate need within their family/whānau and can find themselves less prepared practically, emotionally, financially, with less training for any specialised care compared to non-kin foster parents who usually go through a training and selection process (Andersson, 2001). Some kin carers are approached by the state, whereas others are proactive in seeking to take care of their relative or a child known to the foster parent (Andersson, 2001). Motivators to foster are to ensure the child does not become part of the foster care system (Cole, 2005), observing issues with care the child received in state care (Andersson, 2001; MacGregor et al., 2006), enabling the child to remain within the family/whānau and not lose their identity or support network (Atwool, 2010, Gordon et al., 2003). The experience of kin care fostering inspired some to become non-kin foster carers (Andersson, 2001).

Brown (2012) interviewed indigenous foster parents in Canada in regard to fostering motivations. Indigenous foster parents sought to assist children to an improved life, specifically children from their community. This is with a long-term future view of the positive benefit this will have for the community as a whole by enabling the children to develop into healthy functioning members of the community and wider population, and thus becoming part of the answer to a community issue. Brown (2012) discusses how indigenous

children in Canada are disproportionately in foster care, a similar issue found around the world in regard to indigenous peoples and minority ethic groups, including in A-NZ with Māori foster children (Keddell & Hyslop, 2019).

Characteristics of Foster Parents and Foster Families. Commitment is a characteristic which works in tangent with motivation enabling foster parents to go beyond starting to foster children and continue even when a placement goes long term or the system and/or the child's behaviour becomes challenging (Lindhiem & Dozier, 2007). Lindhiem and Dozier's (2007) study related to predominantly primary aged children and found the level of commitment could impact the outcome of the placement stability or breakdown, or the outcome of the child's behaviour and development. Characteristics and behaviour of the foster child can challenge commitment to a placement.

There are numerous studies related to the motivations of foster parents, however in regard to the characteristics of foster parents the studies are far fewer (Berrick, 2015). The notion of characteristics is included in this section as not everyone is equipped or motivated to become foster parents, therefore the characteristics of a foster parent are an important aspect of their foster parenting journey. Characteristics that are discussed in the literature include: foster parents of infants being determined to persist and self-sacrificing (Marcellus, 2008); showing affection, kindness, selflessness (Andersson, 2001), unending love, and commitment (MacGregor et al., 2006), being proactive in the child's and, where possible, the birth parents' lives (Andersson, 2001), and being able to create necessary solutions (Andersson, 2001). Cole (2005), in relation to foster infants reported women in their senior years were more likely to commit to the first year, needs and wellbeing of a foster infant. Ideal attributes, skills and approaches discussed by experienced foster parents in a Canadian study (Daniel, 2011), and by a US foster agency (Ramierz, 2001) include: the foster parent having an awareness of their own boundaries and abilities and not taking on more than they

are able to, being determined to continue and not allowing setbacks or challenges to cause them to become disheartened, endeavouring to have a good relationship with the birth parents/whānau and agency, knowing where and how to access support, information, and resources, and being equipped for whatever challenges or situations may arise.

Navigating a Flawed Yet Necessary System

Foster parents become part of the fostering system mainly with the intention of caring for children and providing them with a home and love. These intentions may be challenged as they learn to work within and alongside a system with multifaceted layers and experiences (Cooley et al., 2017) that may not have been anticipated or for which the system had not prepared them for (Marcellus, 2008). The layers or cogs of the foster system which foster parents in A-NZ are expected to navigate include meeting the expectations and requirements of Oranga Tamariki (2023a), both prior to commencing fostering and through regular assessments (Marcellus, 2008). This includes the expectations and requirements of private agencies or charities (such as Barnardos and Open Homes), regional agencies and SWs, and health professionals (Meetoo et al., 2020). Birth parents and whānau come with rights such as access to the foster child and having to consent for medical decisions or procedures (Meetoo et al., 2020; Murray et al., 2011; Spielfogel et al., 2011), some of whom may be antagonistic towards the foster family (Khoo & Skoog, 2014). Furthermore, whilst attending to the day-to-day cares of the child (Meetoo et al., 2020); the foster parents have to manage tasks such as documentation, care plans, affidavits, and coping with allegations (Daniel, 2011; Marcellus, 2008).

Support, Resources, and Training

A reoccurring theme throughout foster care literature is in relation to the need of the provision of support and training for foster parents. This includes support from the foster agency (Brown & Calder, 2000; Cooley et al., 2017; Khoo & Skoog, 2014; Spielfogel et al.,

2011), family (Marcellus, 2008), other foster parents (Daniel, 2011), availability of other services (Khoo & Skoog, 2014), and social support (Fuentes-Peláez et al., 2016; Piel et al., 2017; Strozier, 2012). Murray et al. (2011) uses the phrase 'high burden of care' to describe the pressure a foster parent or family can experience, requiring support in their role.

Support From Foster Agency. Foster agencies in comparable nations to A-NZ endeavour to provide financial support and resources for the day-to-day cares of foster children, initial, ongoing and specialised training, and qualified staff (SWs) to support the foster parent and child (Oranga Tamariki, 2023a). The reality of the support experienced by foster parents as expressed in previous studies indicate experiences of insufficient support from the agency in the form of lack of information, guidance (MacGregor et al., 2006), communication (Spielfogel et al., 2011), and training or preparation (Spielfogel et al., 2011). The areas of support pertaining to the agency required by foster parents have been described as: financial support to meet the child's needs (Brown & Calder, 2000; Khoo & Skoog, 2014; MacGregor et al., 2006; Murray et al., 2011); support in regard to understanding the fostering role (Khoo & Skoog, 2014; Spielfogel et al., 2011), helping recognise the responsibilities of foster parents differ to non-foster families, training pre-fostering and throughout the fostering experience (Cooley et al., 2017; Murray et al., 2011); and respite and support to balance fostering and biological family needs (Khoo & Skoog, 2014).

Foster parents have expressed the conflicting experiences of unworkable expectations to care for high needs, challenging and vulnerable children with limited support (Daniel, 2011; Khoo & Skoog, 2011; MacGregor et al., 2006) whilst feeling excluded, not valued, or trusted with care decisions (MacGregor et al., 2006; Meetoo et al., 2020; Spielfogel et al., 2011).

Foster parents indicated the importance of the provision of appropriate information about the child and their care plan, and information post visitations with birth parents

(Spielfogel et al., 2011); support in obtaining assistance from other services and adequate communication between services (Khoo & Skoog, 2014); access to agency staff (usually SWs) that is consistent and prompt when having a query or crisis (Murray et al., 2011; Spielfogel et al., 2011).

A Child Youth and Family Service (Murray et al., 2011) survey in regard to foster parents' experiences in A-NZ found that foster parent support needs aligned with those found in comparable nations. Murray et al. (2011) also interviewed 17 foster parents from Christchurch A-NZ in regard to their experiences with support and training, with the following needs being identified:

- Interaction with children's agency SW
- Access to specialist services
- Birth family contact and involvement
- Foster parent wellbeing and respite
- Access to relevant training

A report commissioned by Oranga Tamariki (Nielsen, 2019) where 4,000 foster parents were surveyed, and indicated issues with feeling unheard and unvalued, lack of information, lack of agency communication, needing more financial support, and the difference SW support can make.

Social Workers (SW). The primary contact with the agency for foster parents are SWs. A correlation has been found between lack of support, valuing, and adequate communication and foster parent retention (Connolly & Morris, 2012; MacGregor et al., 2006). In regard to emotional support from SWs, studies report foster parents have varied experiences with some receiving inadequate support and others feeling well supported (MacGregor et al., 2006). The success of a placement or experience of being a foster parent

can be positively influenced through a healthy relationship with a SW who is supportive, dependable, contactable, and available (Brown & Calder, 2000; Khoo & Skoog, 2014). A difficult placement can be eased and become less negative by a reliable and supportive SW (Khoo & Skoog, 2014). Equally the opposite can occur if the SW is unavailable, distant, and unsupportive (Khoo & Skoog, 2014), leading to possible placement breakdown or the foster parent terminating their relationship with the agency (Khoo & Skoog, 2014; Spielfogel et al., 2011). Whilst needing support to foster children, foster parents also recognise the immense pressure SWs can be placed under within the system regarding caseloads and work requirements (Khoo & Skoog, 2014).

Training. Training as part of the foster parenting experience is considered of great value and support to the foster parent's journey and in equipping them to foster (Atwool, 2010; Cooley et al., 2017; MacGregor et al., 2006). Foster parents are usually provided with training prior to commencing fostering and provided with the essentials in general training (Cooley et al., 2017). Foster parents have expressed that they would benefit from an increased amount of training (Cooley et al., 2017). Attaining the relevant training is necessary to support and enable foster parents (Murray et al., 2011). Foster parents found their knowledge and skills increase if given the opportunity to implement, practice and test what they are being taught, along with having the opportunity to gain knowledge from more experienced foster parents (Cooley et al., 2017). The need for training and information in regard to managing children's behaviour, mental health issues, or specialised needs is an area foster parents requested more training in (Greeno et al., 2016; Spielfogel et al., 2011). In regard to A-NZ, Oranga Tamariki (2021b, p. 12) indicate three areas of training: preparing to care, needs based learning, and specialist learning. Caring Families Aotearoa (2022) (formerly known as Fostering Families) also provides foster care training online, with courses ranging from entry level, intermediate level and advanced, along with specialist courses.

Support From Other Sources. Non-agency related support systems foster parents mentioned in studies include general support, guidance and emotional support from other foster parents and health professionals (Cooley et al., 2017; Daniel, 2011; Murray et al., 2011); developing support networks via non-agency services such as play centres, schools, and local health providers (Khoo & Skoog, 2014); and support within the foster family and the wider family and community.

Social Support. Research has demonstrated people with healthy social and emotional support, particularly those with close relationships with supportive people, can be resilient and flourish even in the midst of challenges and adversity (Feeney & Collin, 2015). This has also been demonstrated in studies relating to foster parents (MacGregor et al., 2006). Piel et al. (2017) conducted a mixed method study in the US with 681 foster parents, twenty of which were later interviewed. The study investigated social support with Bronfenbrenner's ecological theory (as cited in Piel et al., 2017, p. 1032) used as a guide. The study found foster parents and families benefited from having numerous levels of social support, ranging from the microsystem (such as co-parenting, supportive biological children, wider family, and close friends) through to exosystemic levels (such as work and community groups), and macrosystem support in relation to culture and societal structures. Kinship carers have been found to flourish more with good social support, this being a protective factor (Fuentes-Peláez et al., 2016). Support groups such as Caring Families Aotearoa provide social support for kinship carers and non-kin foster parents (Strozier, 2012), with support groups, training, and other resources.

Experiences, Wellbeing, and Functioning of the Foster Family/Whānau Unit

There are multiple foster family structures that vary and are formed at different life stages, for instance, some foster families start with dependent children (biological or adopted) of varying ages; some foster families are couples with no biological/adopted children, or they

are fostering later in life and their children are adults with varying degrees of input or involvement. Foster families continually adapt and progress in their learning to function together as they care and interact with each individual child, meeting the child's needs, interacting with the birth whānau, and working with the SW assigned to each child (Marcellus, 2008). Foster parents described their main focus in fostering children as the day-to-day caring tasks such as feeding, and bathing, along with meeting emotional needs such as providing love, security, and empathy (Meetoo et al., 2020).

Biological Children. Studies demonstrate some foster parents, where the biological children will be directly affected by a foster child in their home, will include the biological children in the process and decisions, as age appropriate, from the start of the fostering journey (Daniel, 2011; Marcellus, 2008; Younes & Harp, 2007). With the assistance of the foster parents, biological children learn to adapt to the changing environment, routine, their parents' focus on the foster child, and adjusting when a foster child enters the home (Marcellus, 2008; Younes & Harp, 2007). Foster parents indicate experiencing some internal conflict with meeting the complex needs of the foster child, whilst also meeting the needs of their biological children (Younes & Harp, 2007). Over time the biological children of foster parents have been found to perceive the foster child as part of their family (Marcellus, 2008). Studies have found biological children learn to adapt and cope with the stress of abrupt changes in their family, possible changes to their birth position, expectations with helping (Marcellus, 2008; Watson, 2002; Younes & Harp, 2007), uncertainly of the placement, and intrusions to their personal space (Marcellus, 2008; Younes & Harp, 2007). The impact of having foster children in their home has positive effects on some biological children, with some becoming more thoughtful and responsible; whilst other biological children have demonstrated more negative type behaviours such as anger or copying the inappropriate or negative behaviours of the foster child (Younes & Harp, 2007).

Coping With Stress. Foster children may come with a variety of issues which affects their behaviour and development, and managing this can increase stress and strain on the foster parents (Leake et al., 2019). The strain can have an impact on the foster parents' emotional and mental health wellbeing, along with physiological impacts (Jones & Morrissette, 1999). Foster care can be a highly stressful experience and research has found some foster parents are at risk of developing 'secondary traumatic stress' as they care for traumatised children (Leake et al., 2019; Whitt-Woosley et al., 2020). Jones and Morrissette (1999) discuss the various relationships foster parents have and the potential for each of them to have some kind of strain, such as in their relationships with the foster child, birth parent, other foster family members, and the SWs. Sloan Donachy (2017) discusses how some foster parents experience a 'loss of sense of self', especially with a foster child exhibiting traumatic behaviour, and when previous effective approaches utilised with other foster children are not having an impact.

Resilience. Foster families who demonstrate and have developed resilience are better equipped to cope and thrive with the various challenges, obstacles, and stressors that are associated with foster care (Cooley et al., 2017). Various factors can assist in ensuring a resilient foster family including having a good support network as a family unit and support from outside the family unit (Klein et al., 2006; Lietz et al., 2016), functioning from a 'strength based' frame of reference (Cooley et al., 2017), and an awareness of and managing risk and protective factors (Julien-Chinn et al., 2017). Resilience develops over time as the foster family journey together, going through various stages of growth as they learn to adjust to the various new experiences, challenges, and stressors of foster care, such as: transition, new placements, foster child behaviour, and expectations of others (Lietz et al., 2016). Skills recommended for development is the setting of limits or boundaries within the family unit, building a strong bond and purpose; also setting limits with the foster agency and knowing

when the family needs respite or downtime between placements, and being able to know they can say no to the agency and doing so (Julien-Chinn et al., 2017; Lietz et al., 2016). A study by Geiger et al. (2016) found foster parents who had developed empathy for the foster child, birth parents and SW developed greater resilience, and by having the foster child in their lives the foster parents could cultivate empathy within the family unit.

Grief, Loss and Letting Go. One of the ongoing challenges foster families experience is what Marcellus (2008) calls an 'emotional double bind'. This is where the foster family develop a bond with the infant/child, accept the infant/child into the home, nurture, love, and care for the infant/child and then having to let them go and detach healthily, when the child moves onto the next placement (be it with birth families, a forever home, or another foster parent). This especially if the child has been with the family as a newborn and has taken up a significant amount of time (Herbert et al., 2013; Marcellus, 2008). Both the placement of an infant into the foster families care and the later transition and placement into another home can be abrupt with little warning or time to prepare or adapt (Marcellus, 2008).

There can be variation of experienced loss within the foster family unit (Marcellus, 2008). Biological children may find it difficult after eventually accepting them as family only to possibly not see them again (Watson, 2002). After the child has physically moved on from the foster family, the foster family do not stop considering the welfare the child (Marcellus, 2008).

Research has found foster families experience what Marcellus (2008) called 'gradient effect' to grief. In relation to fostering infants, the strength or depth of grief and loss is related to both the age of the foster infant when they arrived and the length of time the infant remained with the foster family. Foster families can experience 'disfranchised grief', this being a hidden grief where the foster family are unable to express or have their grief

recognised in public, with other parties such as the foster agency or community misrepresenting their roles and expectations, not recognising they may be grieving and consequently not being given support or space to do so (Lynes & Sitoe, 2019; Riggs & Willsmore, 2012). Provision of support, grief training (Marcellus, 2008) and counselling (Herbert et al., 2013), from the foster agency can aide and prepare foster families for coping with such experiences of loss (Herbert et al., 2013; Marcellus, 2008).

Respite. Foster families have noted the importance of having respite, to allow them relief and time to recharge and be replenished to continue fostering (Marcellus, 2008).

Placement Stability and Breakdown

The success of a placement and whether the experience is positive for foster parents and family can be affected by various factors. Placement stability can be enhanced by provision of consistent support, communication with the SW, and receiving the necessary information to provide care (Khoo & Skoog, 2014). It can also be enhanced through a matching process that includes the foster parents, and sometimes the birth parents, in the decision on whether a child is placed in care with particular foster families, especially if the child requires specialised skills (Khoo & Skoog, 2014) or has cultural needs (Brown et al., 2009).

Placement breakdown literature is predominantly focused on fostering older children, particularly those exhibiting externalising and challenging behaviours. Placement break down occurs when an intended placement of a foster child comes to an abrupt and unexpected end (Vinnerljung et al., 2017). The decision to end a placement can come from different sources such as the foster family themselves, the foster child, the birth family, or the foster agency (Khoo & Skoog, 2014). Breakdown is for various reasons, such as having difficulty with the child's behaviour, or the foster child struggling in this particular placement, or change of birth parent circumstances (Vinnerljung et al., 2017). Vinnerljung et

al. (2017) found those children who started the placement as an infant had less risk of placement breakdown than those placed when older. Irrespective of why or when the decision was made to end the placement, it can have an emotional and physical impact on the foster family, such as a sense of loss, failure and helplessness, fatigue, and, if sudden, little time to prepare the foster family and foster child (Khoo & Skoog, 2014). If the foster family are not supported adequately through this process, there can be negative emotional trauma or scarring associated with the experience that can overshadow the whole foster experience and lead the foster family to cease fostering (Khoo & Skoog, 2014).

Birth Family/Whānau

Supervised contact is where the birth family/whānau, usually the parents, have a set time and place to be together physically under supervision, allowing the child and family the opportunity to maintain and build bonds or attachments (Burry & Wright, 2006; Fuentes et al., 2019). Foster parents have been found to understand the importance and benefits of birth parents and family involvement and contact with the foster child. Along with this, foster parents can have concerns and experience challenges and issues that arise with supervised contact (Atwool, 2010; Fuentes et al., 2019). There may be a concern of safety for foster parents and the foster child in relation to some birth parents (Atwool, 2010). The right for the birth parents to have contact with the foster child, and the stress and impact this can have on the foster child can sometimes be negative with conflicting emotions for them. Foster parents have to cope with any unsettled or negative behaviour from the foster child after visitation, with some foster parents have found the required frequency of visitations to be unrealistic at times, especially with multiple visits in a week for separate birth parents (Atwool, 2010, 2013). One of the SWs roles is to supervise contact and sometimes transport the child there, ideally they are trained in supervision, though sometimes birth whānau or foster parents are

expected to supervise birth parents, which for foster parents may not be ideal due to privacy and safety concerns (Atwool, 2010).

Foster parents may experience intense emotions or negative thoughts in regard to particular birth parents, depending on why the child is in care, such as exposure to violence or maternal substance use (Burry & Wright, 2006). Therefore, for the sake of wellbeing of the child and child's relationship with the birth parents, they may need to work through any negative emotions or trust issues towards the birth parents, whilst being attentive and responsive to any potential issues for the child (Burry & Wright, 2006; Fuentes et al., 2019). Studies have found foster parents sometimes have an awareness of negative perceptions from the birth parents in regard to them (Fuentes et al., 2019). Some foster parents in studies have found supervised contact to be a successful and positive experience, where they have been able to develop a positive relationship with the birth parents and are able to make a time to meet that suits both parties (Atwool, 2010). Any mistrust or prejudging from foster parents or birth parents can often be remedied through cooperation and working together, when safe to do so (Fuentes et al., 2019).

In regard to infants, although contact with birth parents enables bonding, if too frequent the infant may struggle to settle into a routine (Atwool, 2010, Schofield & Simmond, 2011) and become distant and unengaged (Schofield & Simmond, 2011). Infants need a routine for basic care such as feeding, sleep and developing a healthy bond with foster parents (Schofield & Simmond, 2011). This then falls on the foster parent to repeatedly cope and manage with the possible fall out with an unsettled infant. Depending on the infants experience with the birth parents prior to placement (such as abuse, neglect, PSE, mental health issues), the foster parent may be faced with various behaviours and challenges such as hyper-alertness, apathy, disengagement, insecure or disorganised attachments, and distress (Schofield & Simmonds, 2011).

Kinship Carer Experiences

Kinship carers have a range of experiences fostering, some similar to non-kin foster parents. Stewart (2021) discusses kinship carers in the US, where the number of kinship carers is not entirely known due to some caring for their kin informally, and without foster agency involvement. This is comparable to A-NZ with a number of kin/whānau informally entering an arrangement with the birth parents to care for the child (Davey et al., n.d). A large proportion of these kinship carers are grandparents, with these numbers increasing (Davey, et al., n.d; Stewart, 2021). There are various reasons children go into kinship care, this includes their birth parents experiencing mental health issues, imprisonment (Stewart, 2021), substance addictions (Gordon et al., 2003; Stewart, 2021), neglect of foster child, and IPV (Gordon et al., 2003). Kinship carers may struggle with financial resources due to their stage of life (such as retirement), not being engaged in the system (informal kinship), and not knowing how to engage the system (such as lack of support or training) (Gordon et al., 2003; Stewart, 2021). As with non-kinship foster parents, kinships carers need emotional support from those who understand their situation (Stewart, 2021). In A-NZ, for example, there is an organisation called 'Grandparents Raising Grandparents' that assists with this (Grandparents Raising Grandchildren, 2015). Studies have found large numbers of kinship carers are greatly impacted by fostering by having to rearrange and adjust their lives, the way they live, or revising the dreams and plans they may have harboured, such as travel (Gordon et al., 2003). The kinship carer carries an unending love and dedication for the child, whilst coping with the sudden upheaval and changes in their lives, so they can provide a home and stability for the child (Gordon et al., 2003).

Relationships with spouses/partners may become disrupted as they adapt and make changes to cope with the loss of expectations and ensure they are able to care for the child (Gordon et al., 2003). As with non-kinship foster parents, kinship carers have expressed a

need for support from the foster agency, with provision of information, training, financial support, and access to resources (Fruhauf et al., 2015). An A-NZ study by Campbell and Handy (2011) found some kinship carers, in particular grandmothers, experience a 'double bind', where in deciding to foster their kin they in turn find themselves in conflict with other family members, and unable to find a way to resolve the tension between them and the particular family members nor a way to resolve the internal conflict of both caring for the child and maintaining a relationship with other family members. Disruption of the family unit occurs in a large portion of A-NZ kinship care families where the birth parent had a substance addiction and the grandparents are now the kinship carer (Gordon, 2018). This group of kinship carers have been found to have more difficulty coping with kinship care (Gordon, 2018).

Experiences Related Specifically to Fostering Infants

Research focused on foster parents' perceptions and experiences of fostering infants is limited (Marcellus, 2008). Studies that have been located in regard to fostering infants appear to be predominantly focused on challenges in relation to developing attachment and/or PSE or NAS (Marcellus & Badry, 2023). A scoping review by Marcellus and Badry (2023), which focused on children affected by PSE across all ages (infants through to adolescence), investigated how intervention programmes for these children may or may not have improved their growth and development. The study included studies from six nations, which did not include A-NZ.

Day-to-Day Cares and Schedules

With each new infant that enters the foster family life there is a resettling or restabilising that occurs, as the infant's needs and routines are catered for while trying to continue to function as a healthy family. This is particularly a potential challenge if the infant has a high need (Marcellus, 2008). Studies have found some foster parents experience

limited parental involvement in terms of decision making whilst being expected to meet the needs of the infant, whereas other foster parents experienced a more inclusive involvement in regard to decisions (Marcellus, 2008). Fostering infants is a full-time role, meeting the foster infant's needs around the clock, along with meeting expectations of those in the foster system, which can cause stress and exhaustion for the family unit (Marcellus, 2008).

Fostering and the Community.

Foster families of infants noticed there was a regular resetting and changing of the family balance and dynamics as one infant leaves and another arrives. Their connections with non-foster families in their community was ever changing, as the children in their community grew older, and the foster family remained focused on foster infants (Marcellus, 2008). Foster families can find the outside world and its opinions and judgements can intrude, even if indirectly. This may be through misconceptions, misrepresentations, or generalisations by the media, with the reality of the foster parents' work not acknowledged (Blythe et al., 2014; Marcellus, 2008).

Attachment

Infants may have experienced trauma prenatally or postnatally, such as PSE or an abusive environment, affecting their ability to securely attach to foster parents (Bernier et al., 2004; Sloan Donachy, 2017). The behaviour associated with disorganised attachment can make nurturing and connecting with the infant a challenge, and for some foster parents it may lead to a 'sense of helplessness' (Sloan Donachy, 2017). Studies have shown foster children are at higher risk of developing disorganised patterns of attachment than other children (Bernier et al., 2004). To counteract the risk of the infant developing disorganised attachment, the Attachment and Biobehavioural Catch-Up Intervention was created specifically for foster infants to enable foster parents to improve their responsiveness to the infant (Bick & Dozier, 2013). Some foster infants will present with behaviour that appears to

ignore or keep the foster parents at a distance rather than indicating their need for contact or help, and this can affect the foster parents' response with unawareness of the need or irritation with the infant's behaviour especially if the foster parents are not trained in attachment (Bick & Dozier, 2013).

Fostering Infants With High Complex Needs.

As with non-foster children, some foster infants are born with high complex needs, such as issues from being born premature, trauma at birth, congenital disorders, disabilities such as hearing loss or disability, or impairment from maternal substance use such as FASD. Sloan Donachy (2017) discuss how foster infants may have additional challenges from in utero experiences such as maternal substance use, being exposed to a violent environment (prenatal or postnatal) increasing cortisol reactions and stress, and attachment issues. These infants require a foster parent who remains calm and peaceful, providing love, warmth, and patience to allow the infants neurological system and emotions to re-adjust more functionally.

PSE/NAS. Studies from the US show there has been a shift from infants predominantly entering fostering care from environments of neglect to now the predominant reason being due maternal substance misuse (Marcellus, 2006). Newborn infants affected by PSE require special care and treatment at the NICU and those with NAS are known to require a low stimulus environment (Johnson, 2014). Infants presenting with severe NAS have been observed to be more likely to go into foster care (Johnson, 2014). Foster parents from a study focused on infants affected by maternal use of cocaine described difficulties with the infant feeding due to reasons such as difficulty with coordination, and constant crying or high pitch screeching, along with difficulty to settle (Barton, 1998).

With the increase of infants with PSE, NAS and FASD being placed into foster care there is a need for more foster parents to be adequately trained and equipped, with studies finding specialised training is beneficial for the foster parents and the infants (Burry & Noble,

2001; Marcellus & Badry, 2023). Interventions and training observed to potentially equip foster parents caring for infants with PSE include approaches to assist with feeding, helping the infant to sleep or settle, and understanding the impact substances have on the infant's body and thus their behaviour (Marcellus & Badry, 2023).

Support and specialised training is important for foster parents working with infants, particularly those with complex needs, as it enables the foster parent to be more satisfied in their role, and foster parents are less likely to cease fostering thus the agency retains experienced and specialised foster parents, and the infant has a greater likelihood of improved outcome from newborn and throughout their lifespan (Marcellus & Badry, 2023). Along with support and training to assist foster parents cope with the stressful nature of caring for an infant with complex needs, a study by Kamaiko-Solano (2003) focusing on developmental outcomes of foster infants and young children (ranging from four months to twenty four months) affected by PSE, found one protective factor may be the age of the foster parent. It was found the infants and young children had improved development with older foster parents, and it was hypothesised this may demonstrate developed 'mature adaptive coping skills'.

Conclusion/Rationale

The purpose of this study is to give voice to a few foster parents in relation to their experiences with fostering infants. As discussed in this Chapter there are a small number of studies that have focused on foster parents and infants, and even less voices from foster parents of infants in A-NZ. It is possible their experiences will be similar to those in other studies around the globe. Equally there may be some experiences unique to foster parents of infants in A-NZ, informing future fostering practices and policies.

Chapter 4: Methodology

The purpose of this study was to explore the experiences and sense making of foster parents in regard to fostering infants in A-NZ. Foster parents are assumed to have useful insights and interpretations that can be shared with others who foster infants. The research aim informed the decision to take a qualitative approach and to use a reflective thematic analysis framework, which is typically aligned with a critical realist ontology and interpretative epistemology (Braun & Clarke 2013). A qualitative methodology enables the participants to give voice to their experiences, and create a space for them to share experiences, thoughts, and knowledge of the world of the fostering, particularly in the A-NZ system (Braun & Clarke, 2013; Willig, 2013). The reality of how each foster parent experiences fostering infants in A-NZ will vary but, as there may be shared experiences and perceptions, using a thematic approach is a useful way of analysing these experiences.

Method

Participant Selection and Recruitment

The participant sample size of six to ten is recommended (Braun & Clarke, 2013). The sample size consisted of seven foster units, totalling ten individual participants interviewed. An eleventh potential participant declined participation due to illness. Of the seven interviews, four participants spoke on behalf of the fostering couple, two interviews had both foster parents actively participating, and one interview had one foster parent as the main participant and the partner would contribute intermittently while managing childcare. Therefore, there were seven fostering units making up ten participants at the interviews.

In regard to recruiting the participants, the target group of foster parents had experience in fostering infants, particularly in the range of birth to four months of age. This limited the number of potential foster parents able to participate. In the initial stages of project planning there was discussion of focusing on foster parents experiences with infants

specifically affected by methamphetamine, however this was eventually deemed pragmatically too narrow. The recruitment and sample focus was also initially intended to be based on the fostering community within the Wellington region. However, this was extended to the entire A-NZ after it became evident that local potential participants willing to participant or aware of the study were too few. The recruiting process was a combination of snow balling via foster organisations and networking at psychology workshops, and personal contacts outside of the Wellington region, which resulted in more participants from outside Wellington region responding than within this region.

To summarise, the recruiting process included a combination of approaches: homogenous and criterion (all participants had experience fostering infants), snowballing (via foster organisations, and personal contacts), and voluntary (participants volunteer to participate) (Blaxter et al., 2010; Lunenburg, & Irby, 2008). Initially foster agencies, both government and non-governmental organisations (NGO), were contacted via e-mail and then with a follow-up phone call. The NGOs were generally more responsive.

Description of Participants. To enable the protection and privacy of the foster parents and the children in their care (past and present), specific details about the foster parents and the agencies have not been identified. A general overview of the participants demographics has been provided instead (see Table 1). The sample consisted of seven females and three males, consisting of three couples with the two of the males present for entire interview. All of the participants were in a heterosexual marriage and co-foster parenting. Two of the foster couples and two of the individual participants were retired or semi-retired with an age range 60-80 years. Of the remaining participants, one couple and two individual participants ages ranged from mid-thirties to early fifties. Two of the participants, one individual and one couple, lived within the Auckland region and one couple lived within the Manawatu region. Another participant lived in the Wellington area region

and another in the Wairarapa region. The remaining foster participants were based in the Otago region.

Five of the participants were recruited via NGOs they were connected to, of these a couple of participants were informed of the study by a supportive SW. The remaining participants recruited were connected to the Oranga Tamariki but were recruited via word of mouth, one as a personal contact and the other participant via a contact I met at a seminar. Six of the participants were non-kinship foster parents, with the remaining participant being a kinship carer of two years. At the time of the interview the length of time the non-kin foster parents had fostered varied from four years to 30-40 years. One participant commenced fostering in their retired/semi-retired years. Five of the non-kinship foster parents started fostering while they had a young family of their own. The kinship carer's children were young adults when they took the kin infant into their home.

In relation to fostering infants, one participant had ever only fostered infants (newborns to approximately one year of age). Three participants have fostered a range of ages from infants to teenagers with two now predominantly focused on infants and the third predominantly fostering young children but will take older children if able. The remaining non-kin participants fostered infants and young children only. Two of the participants have a medical background and experience with high-risk infants.

Ethics and Bi-Cultural Considerations

Approval was given by the Massey University Human Ethics Committee and the research was assessed as a low risk study. A copy of the approval can be located in Appendix B.

The principles as laid out in the '*Code of ethics conduct for research, teaching, and evaluations involving human participants*' (Massey University, 2017), along with the '*Code*

Table 1

Participant Demographics

Participant (P) **Units**	**Pseudonym**	**Gender**	**Age Range**	**Years Fostering**	**Age Range of Children**	**Geographical**	**Foster Agency**	**Work Status/History**	**Marital Status**
P1 (n=1)	Connie	Female	65-75	4 years	0-13 months	Auckland region	NGO	Semi-retired	Married (retired)
P2 (n=2)	Mary Bob	Female Male	35-45	13 years	All ages	Manawatu	OT	Stay at home Full time employment	Married
P3 (n=1-2)	Amy	Female Male	60-75	36 years	All ages originally. Currently infants only.	Auckland region	OT	Retired	Married (self-employed)
P4 (n=1)	Janine	Female	40-50	10 years	Did not specify	Wellington region	OT & NGO	Self employed	Married (self-employed)
P5 (n=1)	Debbie	Female	40-50	2 years	Kinship carer	Wairarapa region	OT & NGO	Unspecified	Married (part time)
P6 (n=2)	Barbara Barry	Female Male	65-75	30+ years	All ages originally. Currently infants only.	Otago region	NGO	Retired Part time	Married
P7 (n=1)	Robyn	Female	65-75	40+ years	Young children (not teens)	Otago region	NGO	Retired	Married (retired)

of ethics for psychologists working in Aotearoa/New Zealand' (Code of Ethics Review Group, 2012) include the importance of linking these concepts to the principles of the Te Tiriti o Waitangi. As part of this process a recommended Massey Māori cultural advisor and senior psychologist was consulted, and a letter of recommendation was written. A copy of the letter is included as Appendix A.

Most of the participants contacted me via e-mail after receiving the information sheet from their foster agency. One participant contacted me to inquire about the study after being informed of the study by a mutual contact, and was then sent the information sheet to ensure informed consent. One participant I knew personally, so I initiated direct contact via Facebook Messenger, and then e-mailed the information. Participants were again e-mailed an information sheet to read prior to the interview and were invited to read it again at the interview prior to commencing. They were given time and space to ask questions. They were informed in the letter and verbally that they can withdraw at any stage from the study, and no reason for this would be required. They were informed they will be kept informed on the study to the degree they wanted to stay engaged in the process. Every participant signed a consent form acknowledging that they understood what the study was about, their part in participating and what would happen with the information collected. None of the seven foster parent units participating withdrew from the study. An example of the Information sheet and consent form is included as Appendices C and D.

After the completion of the interview the participants were given the choice of two $20.00 vouchers from supermarkets as a thank you. They were not notified of the vouchers until after the completion of the interview to remove or minimise any sense of obligation to participate. The participants were also able to decline the gift. To maintain the integrity and accountability of the study the participants signed a form acknowledging they had received a gift voucher.

The identity of the participants and the foster children were kept confidential and private for their safety. Only the researcher knew the names and details of the participants. Pseudonyms were given for participants, any children mentioned and other identifying factors were given alternate names or more general descriptions or terms used. Part of protecting the participants was deleting the audio recordings at the completion of the study, as voices can be unique and identifiable and real names and details are used in real time. The participants were informed they were entitled to a copy of the recording at completion, however none indicated they would like a copy.

As far as I the researcher am aware there are no conflicts of interest.

Trustworthiness

Braun and Clarke (2013), Guba (1981), and Shenton (2004) discuss the concepts of validity and reliability in qualitative research in terms of 'trustworthiness'. This is broken further down into: credibility, transferability, dependency, and confirmability (Guba, 1981; Shenton, 2004). The criterion 'truth value', the equivalent of internal validity for quantitative research, is assessed via the concept called credibility, which ensures the data collected and recorded is faithful and accurate to the phenomena being studied (Guba, 1981; Shenton, 2004). This can include tools such as triangulation, where multiple data collection methods are used, or member checking where the data analysed is examined by the participants (Braun & Clarke, 2013; Shenton, 2004). The criterion 'applicability', the equivalent of external validity or generalisability, is discerned via the concept called transferability, which considers the degree to which the outcome of the study can be applied or 'transferred' to other situations or environments (Braun & Clarke, 2013; Guba, 1981; Shenton, 2004). This requires the researcher to provide a rich description about every aspect of the study (Braun & Clarke 2013). The criterion 'consistency', the equivalent of reliability for quantitative research, is assessed via the concept of dependability, which is focused on the extent to which

the research outcome can dependably reoccur, and is strongly linked to credibility with the use of multiple and similar methods of date collection (Guba, 1981; Shenton, 2004). The criterion 'neutrality', the equivalent of objectivity for quantitative research, is assessed via the concept called confirmability, which is focused on the extent to which the outcome is focused on the participants responses rather than any subjective influences or biases of the researcher, while recognising the researcher cannot be one hundred percent removed from the process in qualitative research (Guba, 1981; Shenton, 2004). Confirmability is strongly linked to applicability, with the application of rich detail and description, along with the reflective process such as journaling (Braun & Clarke, 2013; Shenton, 2004).

In terms of credibility, thematic analysis is a well-established standalone method, used in multiple studies, along with providing a base for other qualitative meaning finding methods, such as grounded theory (Braun & Clarke, 2013; Willig, 2013). Any mention of fostering related groups and, recommended articles of experts by the participants was followed up on to gain greater understanding of their experiences, perceptions, and insights. Throughout the research process I was accountable to my supervisor, who has the expertise to ensure I was following the process and interpreting the data appropriately. Transferability, dependability, and conformability has been supported through the detailed description of the research process of collecting and analysing data. There are some limitations to some of these factors, in regard to a similar study which will have different interactions, rapport or experience of the researcher impacting interview outcomes, they may be similar but obviously not identical data.

Data Collection

The data collection method involved semi-structured interviews. This enabled the participants to share their experience and perceptions through the use of a combination of

open ended and general questions through to more focused questions on a particular phenomenon such as attachment (Galletta, 2013; Willig, 2013).

Pre-Interviews Preparations and Considerations

Before commencing the interviews, an interview schedule was constructed and reviewed by my supervisor (See Appendix E). It was designed to have some structure and direction, while allowing some flexibility to enable the participant to lead discussions and thus enabling a richer relevant narrative (Banister et al., 2011). The schedule started off with a more general focus and became more specific as the interview progressed. For example, starting with, "Can you tell me a bit about yourself?" "How you came to be foster parents?" Later asking questions such as, "What are your experiences with connecting with the infant, building a relationship with the child?" The design of the interview schedule was also to aide in establishing rapport through the more general questions. The schedule included prompts for the interviewer such as ensuring going through the consent process before commencing interview. Along with the interview schedule, as mentioned earlier, the information sheet and informed consent schedule was developed.

A digital recording device was procured via Massey University to record the interviews and spare batteries were kept with the recorder and the battery level checked prior to each interview.

A location to meet was arranged in discussion with the participants. Initially neutral places were arranged that were convenient and known to the participants. This was for the safety of both the interviewer and participant, as most of the participants were unknown to the interviewer. The neutral location was also intended to provide a sense of professionalism, to minimise distractions, and provide privacy. Due to various circumstances, by the third interview this approach became more flexible, and for the sake of the participants and their preference some interviews occurred in their homes. As many of these participants were

recommended or contacted by their foster agencies, the risk factor to safety was considered low. An allocated amount of time was set aside and the participants notified of this so they could plan ahead, with this was also being indicated in the information sheet.

Interviews: On the Day

Prior to Recording: Before commencing the interview, introductions were conducted, aiming to build rapport and put participants at ease. The information sheet was then reviewed and the consent form signed. Participants were generally engaged, appeared to want to be actively involved with the interview, and showed appreciation for the opportunity share their experiences. A couple of participants appeared to be tired or stated they were tired for various reasons, but chose to persist rather than reschedule.

During the Interview. Every location had different factors that may have had some influence on the interview. Interviews at participants home had household activities that created some distractions and potentially impacting the flow and engagement. Conversely most of the participants appeared to have been relaxed in their home environment. In the pre-arranged neural locations there were some aspects unfamiliar to both interviewer and participant which may have added some initial tension to dialogue. One of the locations was limited by time due to bookings and self-locking after an allocated time which affected the flow near the end of interview. Although the participant suggested continuing with door open there was concern over privacy by the interviewer, and the interview thus occurred within the expected time frame. Interviews with both foster parents in attendance provided a different dynamic where a richer description of an experience could be provided and, conversely, sometimes one of the foster parents would cause conversations to go on a tangent, at times needing to be brought back on topic.

During the interview minimal note taking was taken to minimise the possibility of distractions or making the interviewees self-conscious and affecting the flow. The digital recorder was able to catch the interactions and interview context.

Each interview enabled interviewing skills to develop, with the first interview being the most anxiety producing for interviewer which was countered with having a confident participant.

Conclusion of Interview. At the conclusion the interview, the recorder was switched off and participants were informed as to what would happen next with the interview and again reminded that they could still withdraw their contribution at any stage, and that they would be kept up to date to the degree they preferred. They were also given space for any queries they may have had. Appreciation for the giving of their time was verbalised and then through the offer of a food gift voucher.

Post Interview. After the formal part of the interview some participants shared other experiences of fostering. This is may have occurred due to both parties being more relaxed. A couple of participants gave permission for the off record comments to be used if necessary. After leaving the interview location and as soon as able the interview was reflected on via journalling by the researcher.

Data Analysis

Data analysis utilised Thematic Analysis as set out by Braun and Clarke (2006, 2013). There are six phases they recommend using along with 15 check points.

Phase One: Familiarising Yourself With Your Data

This phase involved listening to the audio recordings, transcribing the interviews, and reading and re-reading the transcripts whilst making notes of thoughts and ideas (Braun & Clarke, 2006). Confidentiality and safety was addressed through the keeping of the recordings on a personal laptop that only the researcher had access to, and password

protected. A back up of the data on a USB stick that was specifically for the study, along with the transcripts and other private items were kept in a lockable filing cabinet that only the researcher had access to. The recordings on the digital device were deleted once a copy was safely uploaded on the laptop, and these in turn will be deleted once the project is completed.

During the transcribing phase, notes were made on a white board, memo pads, and digital or physical notebooks in regards to possible themes or points of interest. The process of transcribing started with listening to the audio and making notes, then listening again, and transcribing the dialogues. The transcriptions included pauses, sighs, and various vocalisations. The transcription format was orthographic (verbatim), also utilising symbols from the Jefferson transcription system (Bailey, 2008; Brinkman & Kvale, 2015) were incorporated for speech sounds, for example, laughter, overlaps in speech, and pauses. After completing the transcription it was then reviewed and checked a few times to ensure any errors were addressed.

Phase Two: Generating Initial Codes

This phase involved going through all the transcripts and coding extracts across the whole data set and then gathering the relevant codes together. This tied in with check point two as stated by Braun and Clarke (2006, p. 96): 'each data item has been given equal attention in the coding process'. As beginner researcher it was decided the codes generated would be predominantly data-derived or semantic codes and inductive, therefore being more data lead and experiential rather than conceptual and theoretical (Braun & Clarke, 2013). The coding for this project was applied in two phases or cycles to ensure data was treated appropriately.

The first stage of both coding cycles involved actively creating codes from the transcripts. The first cycle of coding was more manual with colour coding extracts and handwritten codes in the manuscript margin. The second cycle of coding used a Macro called

'Extract All Comments to New Document' (Fredborg, 2013), to digitally add revised codes to a Word document. From this a separate document was generated by the Macro, with specific codes aligned together with columns displaying the associated extracts and transcript lines. An example of an initial code was line 1342-1346 coded 'substance withdrawal concerns'. The transcripts were re-read and adjusted accordingly.

The second stage of both cycles involved creating Excel documents charting alphabetised codes for each participant, and a document with all the participant's codes combined.

In the third phase of the coding cycles, created colour coded print outs of the codes, with a different colour for each participant. These were made into movable cut outs and grouped together with like codes, for example one grouping was titled 'access/visitation'. From there the second cycle of coding commenced, after which there were 2441 codes. The codes were sorted into clusters and those unrelated to the research question were removed, documented separately and double checked. Clusters were organised under four main groups: foster parent experiences, infant related, general foster experiences, and infant narratives. After the 'not related' codes were removed there were 2,097 codes which became 319 clusters and of these 28 were narratives about the infants.

Phase Three: Searching for Themes

As part of the process for developing themes I attempted to visualise the codes, clusters, and potential themes conceptually. Braun and Clarke (2013, 2016) discuss the forming of themes as akin to sculpting rather than being discovered like diamonds. As a musician and songwriter this enabled me to initially view the codes, clusters, and potential themes as an album of songs. Whilst engaged in the process of developing the themes, I found that although the overall picture of the data and the smaller details of codes made sense, the spaces or potential themes between these two perspectives and how they

differentiate were more difficult to conceptualise. This led me to create a digital mind map using an app called InfoRapid KnowledgeBase Builder (Straub, 2011-2019), to enter the clusters and potential themes, enabling to me see clearer potential themes and how they connect. I was also inspired by the Tī Kōuka tree outside my study window to visualise the themes as a Thematic tree. This approach fitted well with a systemic and ecological perspective generally and in relation to the foster system the experiences of the participants within this system. Central organising concepts (COC), which is a concept which draws the various ideas within a theme together, giving the theme structure (Braun & Clarke, 2006, 2013), could then be developed. Five candidate themes were created along with a few subthemes.

Phase Four: Reviewing Themes

In this phase the themes, COC, and definitions were reviewed and reframed. As mentioned above the themes changed slightly as the COC's were developed, with one theme, for example being split into two themes. Whilst reviewing themes and extracts it became evident that there was a thread linking the themes that itself could not be separated as a theme. This thread was eventually constituted as an overarching theme, akin to a leitmotif in music.

Phase Five: Defining and Naming Themes

This phase, while overlapping with the reviewing themes phase, was part of a refinement process to enable themes to be more clearly defined and coherent. Part of the process involved referring to dictionary meanings of words to ensure the themes had not become too abstract. A flow diagram was created to display the themes and show how they link together to further aid in defining the themes, their COC, and descriptions. A description of the themes and subthemes was developed and adjustments to themes and names were made as any discrepancies or concerns were brought to light.

Defining and naming also involved determining whether aspects of a proposed theme or subtheme were linked and to what degree. All through the entire process I asked whether what was emerging was addressing research question

Phase Six: Producing the Report

Analysis continued during the write up of the analysis. During this process specific extracts from the interviews were selected to describe and support the themes, and to give voice to the participants fostering experiences. This is part of the descriptive approach of thematic analysis where the participants' experiences are the focus (Braun & Clarke, 2006, 2013). Relevant literature was woven into the analysis to support the analysis or to discuss any anomalies or different findings in similar studies.

Reflexivity

Throughout the research process, reflective commentary was implemented. I aimed to engage in reflection throughout the process to recognise and work through my own biases and endeavoured to remain faithful to the themes and topics shared and to ensure that the voices of the foster parents were foregrounded. Some of the reflection in relation to data collection and analysis included questions recommended by Braun and Clarke (2013, p. 205), for instance, "How does a participant make sense of their experience?" or "How would I feel if I was in that situation and is it different/similar from the participants?" It is acknowledged that another researcher may develop or express themes differently.

After each interview I reflected through journalling on any issues or emotions that arose for me due to the nature of the topic, such as hearing about abuse of infants. Along with this, I reflected on any impact or influence I may have had on the participants' responses. Did I insert myself too much? Did any of my own biases influence the interaction? Did past history with one of participants or shared life experiences with other participants have an influence on responses, and did this matter? This process continued

throughout the production of transcriptions and the analysis. How did the information and narratives shared impact my own world view and thus interpretation of their experiences? Whose voice am I hearing? I recognised that some comments made by participants could potentially be a trigger for me and so I reflected as to why this was so and as to whether this affected any of the analysis and extracts chosen.

Chapter 5: Analysis

This chapter discusses the salient themes developed from the seven interviews with foster parents in A-NZ. Although the themes relate to the foster parents' experiences and perceptions of fostering infants, some aspects of the themes relate to fostering children more generally. Due to the nature of qualitative research and the thematic analysis process, the author recognises that their own perspectives would have an influence on the development of the themes (Braun & Clarke, 2013; Richards, 2015). Five themes are discussed in the analysis. Throughout these five themes a leitmotif or overarching thread connects them together, this being 'relationships and interactions within the foster system'. There are many components that impact the foster parent in varying and different ways, and are interconnected to varying degrees. Like the human body, a car engine, or the ecological system in a forest, there are interacting and interconnected parts which can hinder or enhance the role, work, and wellbeing of the foster parent. Some of the interacting components identified included the foster agency and organisations, SWs, policy and law, court systems, foster infant/child, birth parents/whānau, other foster carers, health professionals, foster parents family/whānau, friends, and community. These components and systems could be compared to an ecological system such as expressed in Bronfenbrenner's ecological systems theory (Piel et al., 2017). Shelton (2019, p. 10) describes Bronfenbrenner's system as, "a system of concepts: the person exists in a system of relationships, roles, activity and setting, all interconnected". A thematic tree was created as part of the process to visualise, develop, and refine the concepts, with the foster parent as a tree within a forest, providing nurturance to the infant, like that of a grafted plant. Figure 1 is a representation of the thematic tree. Theme Two and Four has one subtheme branching off from them. A breakdown of the themes and subthemes are found in Table 2

Figure 1

Thematic Tree: Foster Parent's Experiences and Perceptions of Fostering Infants

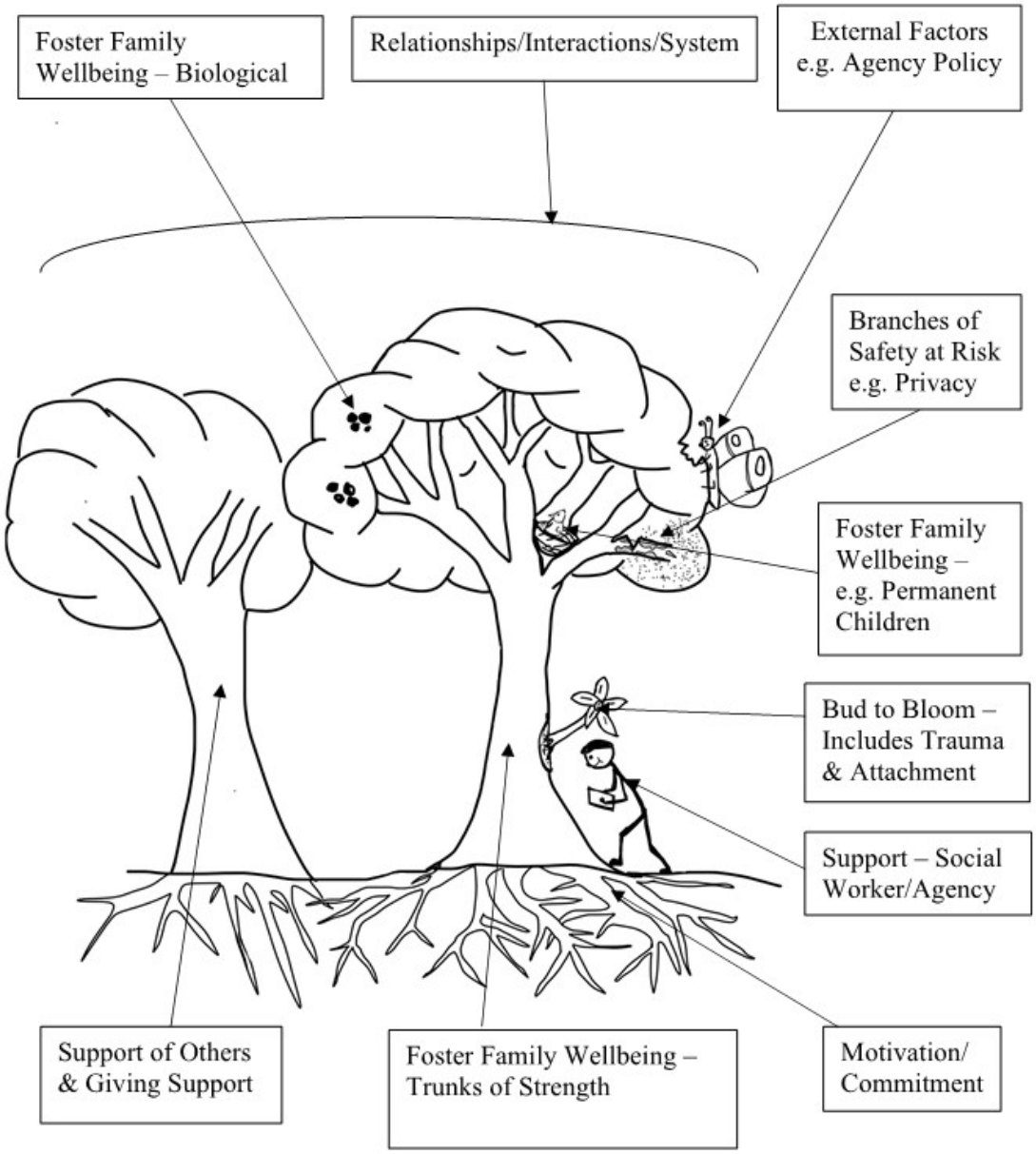

Table 2

Overview of Themes

Theme	Tittle/Description	Subthemes
Theme 1	Motivation & commitment: It is about the child	
Theme 2	Nurturing from bud to bloom: Journeying with the foster infant through day-to-day cares and challenges	Grafted, connected, and growing: Journeying with the infant through adverse and traumatic experiences
Theme 3	External elements: Interacting and navigating the exo/macro expectations and challenges of the foster system.	
Theme 4	Wellbeing and functioning: Strengthening and nourishing the foster family/whānau unit	Branches of safety at risk of being shaken and damaged
Theme 5	Network of supportive relationships	

Theme One: Motivation and Commitment: It is About the Child

The theme 'Motivation and commitment', relates to the idea of the foster parents engaging in a child focused lifestyle that is committed to making a difference. The phrase 'It is about the child' was chosen as this phrase or similar ones were expressed a number of times by the participants and captures a core aspect of what motivates the foster parent to start and commit to caring for someone else's child for a time.

Being Motivated and Committed to Start Fostering

The seed of the idea to foster, the opportunity to foster, and attributes are part of the experience of becoming motivated and committed to foster children. Although each unit's story differed, there were noted similarities, these similarities include all the participants wanting to make a difference and indicating a love for children. More than one motive was mentioned by many of the participants, which helped them decide to start fostering. Some of these motives also appeared to remain like a thread of commitment from the start and onto further fostering. To become motivated and committed foster parents, the participants

obviously each had a starting point along their journey. However some starting points were more explicit whilst for others it was a gradual process.

Table 3

Overview of Participants Motivations

Motivation and Commitment to Commence Fostering Infants	Participants (P)						
Seed of an Idea							
Parental example		P2	P3		P5		
Having fostering recommended	P1						P7
Being requested to foster (kinship or informal)				P4	P5		
Cultivated Ground: Intrinsic Motivators							
Love and passion for infants/children	P1	P2	P3	P4	P5	P6	P7
Altruism:							
Make a difference in child's life	P1	P2	P3	P4	P5	P6	P7
Provide love and a home	P1	P2	P3	P4	P5	P6	P7
Making a difference in society, community, and future generations	P1		P3			P6	
Life Events Activating Fostering							
Personal life events:							
Empty nest	P1						P7
Unable to grow family biologically				P4			
Whānau or friends life events.				P4	P5		
Exposure to other's needs via occupation		P2	P3			P6	

Seed of an Idea to Foster. One of the motivating factors to start fostering that many of the participants discussed was the influence of others, such as the parental example, or the mentioning or suggesting of fostering by another person. Two non-kin and one kinship foster parent all shared examples of parents who fostered. Bob experienced growing up with parents who fostered and this *"sowed a seed"* (P2, 20) to also foster, whilst Amy started fostering a child previously in her parents permanent care.

> *So when Mum died, he was going to end up in back in a foster home. So we decided it better that we took him on cause he knew us…And then we sort of never really stopped (P3, 9-11, 15).*

Home environment and parental influence through the lived example of fostering in which the participants experienced, demonstrate how generational continuation into foster parenting may occur. Seeds were sown in their childhood that were then activated later in life through other motivating factors, such as seeing a need. Literature cite is parental example as a motivation to foster, with some respondents directly experiencing foster care through being part of a foster family (Baum et al., 2001; Brown, et al., 2012; De Maeyer et al., 2014).

For a few of the participants the idea of fostering was sown by someone they knew, such as a family member. For Connie, her daughter made the recommendation recognising her parents may enjoy fostering, and "*that sort of sparked" (P1, 44).* A friend of Robyn's recommended becoming a foster parent, and this resonated with her:

> *My friend talked about fostering, so I rung and I went along to a meeting of new intakes of foster parents. We did everything that we were meant to do while we were there. They told us to go home and think about it, but I went up to them and said well I've already thought about it and that's why I was here (P7, 9-14).*

Literature supports the journey of some foster parents going from someone who had not considered fostering in the past or unaware of this as a possibility, to someone becoming passionate and motivated to foster after the idea is sowed by another person or through some other means such as advertising (Baum et al., 2001; Marcellus, 2008).

Debbie grew up with her parents being kinship carers, however, she had not considered kinship care herself until the fostering agency requested she foster her niece as a newborn. Generally people who decide to foster have time to consider and prepare, this was not the experience for Debbie and her family.

> *We were rung and asked to go up to the hospital and so we went up and by the end of the visit it was like 'can you take her?' (P5, 22-24).*

Debbie's experience is consistent with that of other kinship carers who find themselves confronted with a of sense of urgency and little to no time to adjust and be ready to foster (Atwool, 2010), whilst having a sense of obligation (Andersson, 2010) and motivation to ensure they enable the child remains in the whānau unit (Brown et al., 2012).

Intrinsic Motivators. All the participants discussed being motivated to commence fostering infants/children predominantly by aspects related to internal drivers. These included: having a passion and love for infants and children ("*we've always been keen on children" (P6, 14))*, wanting to make a difference, having a purpose, and doing something useful in life. These factors appear to overlap and influence each other, for example, Connie spoke of a love for infants, wanting to make a difference, wanting to have a purpose, and wanting to use her retirement years productively.

> *So we were looking for something. I love babies so much, that is where my real passion is, and just thought I really could offer something here, and be able to give (P1, 60-64).*

A reoccurring theme to foster in literature is a love for children, including for a specific age group such as infants (Andersson, 2001; Baum et al., 2001; Brown et al., 2007; Delfabbro et al., 2002). Foster parents may prefer a particular age, such as infants; some for practical reasons whilst some are more comfortable with that age group. As stated by Mary, [I]*"definitely prefer the littlies" (P2, 2963).* Growing up in a large family or wanting to have many children is a motivation discussed in fostering literature (Andersson, 2001), which is a motivation shared by Barbara.

> *Barry comes from quite a big family and I don't, but I wanted to marry a farmer and have thirteen children, but it didn't happen (P6, 16-21*).

Love and passion for children is a thread that ties motivation to commencing fostering through to that of continuing to foster.

Altruistic motives and worldviews thread throughout the participant's voicing of their experiences in regard to commencing and continuing to foster infants/children. The participants saw a need and indicated wanting to make a difference, recognising they are in a position to provide love and a home for children, as stated by Barbara, "*we had room in our home and love in our hearts, we would bring other ones in" (P6, 31-33*). This is consistent with the literature where the majority of foster parents studied wanted to provide a safe home, filled of love, and recognised that they have the means and skills to do so (De Maeyer et al., 2014; MacGregor et al., 2006; Rodger et al., 2006). A caring perspective (Mayseless, 2016) or motivation is demonstrated by the participants, expressing empathy and compassion with their actions towards children and families who are vulnerable and needing a safe loving environment to thrive.

> *Amy: So many needy kids and I just think if I can give them something like a bit of love and a bit of security and a grounding to start off with, why stop really (P3, 78-83).*

As well as providing a home for foster infants, some participants were also motivated to make a difference in terms of the future of the infant.

> *Connie: My aim is to take them as well whatever condition they come in and turn them into nice happy well-adjusted babies, that then can go on and be grown on with the next carer or back with their parent or whatever and that's my reward that's my challenge (P1, 1585-1589).*

In a similar vein, some participants recognised fostering infants had a wider positive impact for society as a whole, including making a better world for future generations.

> *Amy: If I can give these kids six months of my time or more, and they become a better child, then that made a better kid in the world. They're going to be at school like our grandchildren are (P3, 419-424).*

Some of the literature focused on foster parent motivations found some foster parents expressed altruistic motivations in regard to wanting to contribute to society and the community by meeting a need, and making a positive long term wider impact (Brown et al., 2012)

Personal Life Events. Significant life events appear to have encouraged some of the participants to commence fostering. One of these life events experienced by a couple of participants was the feeling of an empty nest. Robyn stated, "*my youngest had gone to school and I had that empty nest syndrome" (P7, 6-7),* and for Connie this feeling was later in life, *"even the grandchildren are so busy with their lives" (P1, 40).*

Janine's journey to fostering involved some heartache and pivoting from lost dreams, with initially the desire to have more biological children not being possible. Still wanting more children in their home and lives, other options were considered such as international adoption. However, she was able to pivot through helping a friend with an infant, a new perspective and pathway formed. Commitment to raise and help children in need, even if not in the form initially envisioned demonstrates adaptability and resilience.

> *Both options were the same motivation but very different paths. Children who didn't have parents or didn't have parents to love them and to give a home, a permanent home to just loves them kids that didn't have that (P4, 38-45).*

This aligns with other studies where people have fostered or adopted when unable to have biological children (Andersson, 2001; De Maeyer et al., 2014; Rodger et al., 2006). In Janine's situation, she was in a good place psychologically to foster instead of adopt. However, Amy and literature caution fostering when unable to have biological children (Berry, 2017; Cole, 2005). Sometimes it is a matter of timing, not a never foster, but not yet.

> *I put myself in their position, because for five years we couldn't have children, and if I had been fostering then and had to let them go it would have devastated me, because I*

wanted children. I said, 'so if you're going to foster, don't foster thinking these kids are yours because they're not (P3, 1233-1240).

There is little literature on foster parents' experiences in regard to those who are unable to have biological children, and whether motivation and commitment are affected if still coping with the loss of the idea of having own children, although Cole (2005) does link wanting to adopt with issues of attachment due to the unknown outcome of foster placement. Berry (2017) cautions potential foster parents against fostering with idea of fostering to adopt, rather the focus needs to be on the child's needs. Trauma and grief may arise for foster parents and the foster child if foster parents are not ready to foster.

Life Changing Events in Whānau or Friends Lives. Janine was introduced to the idea of possibly informally fostering through a life event of a friend who needed assistance with a kin's infant.

We had a friend of ours whose niece was not coping with her three -month-old baby. She knew we were looking at adopting and asked us if we would be interested in just fostering her, it was just an informal thing that we did between us (P4, 22-27).

Baum et al. (2001) interviewed 264 foster parents after they received specific training, to ascertain if this would help foster parents remain fostering. Some of the questions related to motivation, of which 30.7% participants identified under the category of 'relating to meeting a need'. Within this category some participants expressed they wanted to help a friend or associate in relation to fostering a child.

Exposure to Other's Need Via Occupation. Bob, Amy, and Barbara worked in jobs that gave them skills and exposure that increased the likelihood they would encounter a family or child in need.

Mary: There was one particular little family that you saw very much night after night on the streets. We were in a position where we could take two of three at a time (P2, 31-34).

A few studies discussed foster parents motives being triggered through their work such as health workers or those in the front line of helping people (Baum et al., 2001).

Symbiotic Relationship Between Foster Parents and Infant as a Motivator

The participants spoke of their commitment and intention to continue fostering. Some participants recognised there are shared benefits for both foster infants and foster parents, as demonstrated by Robyn:

You get a lot out of looking after a child and it fills the child's needs, but it fills your needs as well, I enjoy it so its beneficial to have the child (P7, 382-385).

One benefit expressed by some of the participants is the joy and satisfaction they experience caring for and interact with the infants.

Amy: Don't know how many babies we would have had by now, they just seem to coming, and coming and they're not slowing down at all, but I mean they just give me so much joy (P3, 149-153).

The expression of joy and satisfaction is supported by literature of studies with foster parents (Atwool, 2010, Daniel, 2011), with some respondents in the study by Brown et al. (2007, p. 203) describing it as "*get given love in return*". Some participants described the satisfaction and positive experience of physical connection and interaction with the infants, such as shared by Robyn: "*I quite like when they go to sleep on you and you just sit there and cuddle" (P7, 320-321).*

A number of the participants use the words rewarding and challenging in tandem, "*it comes with its challenges but it's the most rewarding thing we've ever done" (P1, 180-181)*. One of these areas of the dual experience of rewards and challenges is caring for a high needs

infant and then seeing the steps of improvement and development, making the hard work pay off. Amy shared about a permanent foster child with global delay whose now primary aged, and the transformation observed when she was an infant:

> *When we saw her she just looked dead, and then within a week of the stimulation she started, this light came on and you could see her eyes sparkle and she's not looked back. That to us is when we see her, that is to us a reward in fostering (P3, 1127-1135).*

While discussing the signs of an infant developing healthy attachments, Amy shared how observing the development has a positive impact on her as a foster parent.

> *You can tell, because if I walk into the room and I speak they go try to turn around to get my voice to see where I am. So that makes me feel good knowing that I'm giving them what they require at the moment (P3, 305-309).*

The concept of relational steps was discussed in studies regard to foster parents being motivated by the little positive changes and developments observed in an infant or child and celebrating these moments (Brown et al., 2007; Marcellus, 2008).

Purpose, Capacity, Capability.

Through the journey of fostering some participants expressed how they have found purpose through fostering, such as Robyn and her husband who are still fostering in their retirement years, *"I just love fostering, I think that I'm serving a purpose, that I'm not just wasting my time" (P7, 868-871).* For kinship carer Debbie caring for her niece gave a new possible purpose and pathway for her skills and knowledge in the form of non-kin fostering, "*we thought well why can't we do this for others" (P5, 647).* Bundgaad and Roy (2014) discuss the idea that maintaining motivation and commitment can have limitations. They recommended, ideally to maintain motivation the combination of the concepts 'purpose' and 'talent' work together increasing motivation to commit, and enables the ability to adapt to

changes. Barry and Barbara share how years of experience of fostering various ages has enabled them to know how to confidently foster, along with knowing that fostering infants is where their skills and hearts lie.

> *Barry: The babies are our thing, we've been doing that for about 15 to 20 years and just focusing on the babies, it feels a lot better for us…It's something that we know we can do and do well (P6, 2170-2173; 2368).*

Fostering for some of the participants has become part of their identity, it is interwoven into their lives, the fabric of who they are, Amy describes it as part of her: *"I couldn't imagine not fostering, I just couldn't, it's part of me and has been for years" (P3, 446-448)*.

Fostering for the Right Reasons

The participants in this study all demonstrated strong feelings, thoughts, and concerns in regard to the importance of fostering for the right reasons. Fundamentally it came back to the focus being about the children.

> *Bob: It was about the kids, and our goal, focus was, it wasn't about us either, it was always about that kid and their needs (P2, 186-191).*

The focus and motivation is about providing a home and environment where their needs are meet consistently and they can know love, security, and attachment, as stated by Amy:

> *The right reasons are you are fostering them because you want to give them the love and support and the connection, knowing they will probably go (P3, 1276-1278)*.

Most of the foster parents discussed in varying degrees concerns with other people fostering for the wrong reasons, the main issue being those who foster for money or resources provided by the foster agency, as demonstrated by Amy:

> *It really irks me, I get mad if I hear someone talking about how much money they are going to get (P3, 1376-1377)*.

For some participant's having a job like and financial perspective on fostering is the wrong focus and is a barrier for some considering becoming foster parents.

> *Mary: Some people say, 'oh it's not worth the money if you break it down to an hourly rate.' It's not a job, you don't do this as a job. You do it because you want to help these children (P2, 1015-1020).*

Of the literature reviewed there was no evidence of foster parents indicating money or compensation being the primary reason to foster, even amongst those who considered it a form of employment, or those who would appreciate more financial support or compensation, this did not affect the central reason to foster, which was to meet the child's needs (Andersson, 2001; Brown et al., 2012; Kirton, 2001; MacGregor et al., 2006).

Conclusion.

Theme One discusses the participants' motivations and commitment in starting and continuing to foster parent. An overview of motivations to commence becoming foster parents can be found in Table 3. Although this theme was written in a somewhat linear way, the reality is the participant's journeys were unique and not linear. For instance, Connie experienced an empty nest and the idea of fostering followed this. Whereas Bob had parental examples of fostering and starting fostering after seeing a need through his occupation. The altruistic aspects, along with a love and passion for children threaded through from prior to commencement through to continuation of fostering. Discussed in 'Symbiotic relationship between foster parents and infant as motivators' was finding joy and satisfaction from fostering, and the reward of observing steps of improvement. Another benefit and motivator of fostering discussed was finding purpose in life though the combination of skill, knowledge, and a love for the fostering role. Lastly, 'Fostering for the right reasons' was discussed where the two main and opposing topics were: fostering for the right reason being 'it is about the child', and fostering for the wrong reason being 'it is about money'.

Theme Two: Nurturing From Bud to Bloom: Journeying with the Foster Infant Through Day-to-Day Cares and Challenges

The theme 'Nurturing From Bud to Bloom' was inspired by a comment participant Amy made post-interview, in regard to infants being like rose buds that with tender care open out to reveal themselves. This was initially visualised as an Epiphyte, such as a Raupeka (Easter Orchid) attached to a Rimu tree, which developed into the general concept of a plant grafted into a tree. There are limitations with this analogy, for although the grafted plant receives nourishment once it is grafted it can no longer be separated from its host. Foster infants are nourished and nurtured and usually move onto either birth whānau/family, another foster parent, or a permanent placement such as adoption or HFL.

According to Cambridge University Press (n.d.) to nurture is to, "to take care of, feed, and protect someone or something, especially young children or plants, and help him, her, or it to develop". This aptly describes the experiences of the participants in regard to their roles, cares, and interactions with a foster infant. Theme Two encompasses the journey the foster parent takes with the infant. This can start from the day they are born, or when the infant is a few weeks or months older. For the sake of this study, the form of the theme will be based on the placement commencing within the first six weeks of birth, and predominantly focuses on the experiences involved in providing care during the first four months of the infant's life. This journey can vary in length from days, weeks, and months, until the infant transitions ideally to a safe permanent home. Even after the infant has left the foster parents' home, there may be ongoing contact and input depending on the circumstances. Some infants go onto being permanently in the care of the foster parent/s. Participants spoke about the normal day-to-day demands of caring for an infant, along with complicating and challenging factors, such as substance withdrawal, regular contact with the birth parents, or palliative care and other high needs. The subtheme 'Grafted, Connected, and Growing' will discuss trauma,

PSE, and attachment in more depth, with aspects of these topics arising throughout the main Theme Two sections.

Pre-placement

Prenatal and Birthing Experiences. The prenatal and birthing experiences of the infant are usually preplacement in foster care. Experiences and challenges which occur at this time are like a thread that potentially continues beyond the reach of the first four months of this study. Prenatal experiences may impact the infant's behaviour which in turn affects the foster parents experience of interaction and the care required.

Janine spoke of a couple of scenarios in which loud noises or muffled loud voices, triggered distressed and startled behaviour in an infant in the first three months postnatally.

> *He just got beside himself and it took us ages to calm him down. I realised afterwards that would have been what shouting sounded like to him in utero, just this muffled sound. His father was a very violent man and there would have been heaps of cortisol coursing through him in utero (P4, 610-619).*

The birth mother was exposed to a violent, loud, and stressful environment. Her cortisol levels and emotional state, would have been heightened, with the stress response and associated noises impacting the prenatal infants own cortisol levels and later postnatal reaction. Robyn spoke of how prenatal maternal rejection may have affected an infant's behaviour postnatally.

> *[*fos.infant B] we got at eleven days and he cried sixteen hours a day and he hated being touched, he had a thirteen year old mum and I think it was I think he felt rejection before he was born (P7, 551-556).*

The infant's behaviour of constantly crying and recoiling from any attempt to physically soothe him may have made bonding difficult. An ongoing prospective study is looking at "pregnancy denial and early infant development" (Auer et al., 2019, p. 1), and other studies

investigated whether infant temperament is influenced by maternal mental health and stress whilst pregnant (Nomura.et al., 2019), or post birth variables (Takegata et al., 2021).
The experiences of Janine and Robyn demonstrates understandings foster parents develop in regard to infant behaviour and observing a parallel with prenatal experiences. Bright et al. (2020) argue that infants exposed prenatally and postnatally to 'toxic stress' such as IPV, are at increased risk of developing neural pathways which create an increased responsiveness to the infant's surroundings.

A couple of participants discussed complications at birth, that potentially could cause issues, such as described by Debbie, "s*he had the cord wrapped around her neck and lack of oxygen in the brain" (P5, 546-548).*

Prenatal and birth complications can add to the issues for the foster parents to manage, especially if there are co-morbidities such as PSE, or other traumas. Foster parents may also have to deal with the uncertainty of not initially knowing the infants history or the extent of any long-term damage that may have occurred.

Neonatal Intensive Care Unit (NICU)/Special Care Baby Unit (SCBU). Some foster infants remain in NICU/SCBU for some time due to complications such as premature birth, substance withdrawal, birth trauma or other health/medical concerns. Barbara and Barry discussed the impact the NICU environment can have on infant behaviour, which as foster parents they then work to undo.

> *Barbara: They teach you [foster infant A] bad habits and not sleeping at night cause its light, all the time.*
>
> *Barry: Just let us take him home, get him into a routine, we'll sort him out (P6, 990-997).*

A study by Jordão et al. (2017) found the activity, noise, and lights of NICU/SBU have been observed to have a physiological impact on infants, such as increased heart rate. Some of

these infants were also coping with factors such as being premature and/or PSE, thus requiring a calmer environment (Jordão et al., 2017).

Janine discussed the behaviour of a premature infants in NICU in regard to possible attention seeking behaviour.

> *She didn't have any apnoea episodes once she came home. She was just in a cot, the nurses in the hospital would do what they can, but they are busy seeing all the other neonates, they don't have the time to just sit and hold a baby. If a baby stops breathing then they get held. I kind of felt that once she came to us she was being held, she was being loved, she didn't need that anymore (P4, 656-672).*

Infants seek interaction, reassurance, contact, attention, help to learn how to self-regulate, develop, and socialise, which requires those around them to provide this (Gerhardt, 2015). This is more difficult to obtain in NICU/SBU. Once the foster infant gets the one-one care of the foster parent recovery and growth can more fully occur.

Birth Family/Whānau Environments. Amy provides an overview from her collective experience of fostering infants who have come from dysfunctional unsafe environments.

> *If they live in a house of violence they're very unsettled. If they live in a house where there's no communication, the babies won't be talked to or stimulated, they come to us like a vegetable. Within a week you just start seeing that sun coming through them and you see it in their eyes (P3, 1031-1040).*

Pre-placement experiences are potentially traumatic, affecting the infant's behaviour and development, thus the care and expertise foster parents provide is vital. The newborn may be moved around from place to place for various reasons before arriving in the foster parents' care. The impact of these experiences are not always measurable, but the stability of a good foster home is aimed to counter any negative experience.

Drop-Off, First Home Encounter

The beginning of the physical journey with the foster infant usually commences with the drop off at the foster family's home, pick up from hospital, meeting the newborn while in NICU, or at the hospital while the foster parent received extra specialised training to gain the necessary skills to care for the infant. Some of the participants discussed a few of their challenges and experiences in regard to the initial drop off and settling the infant into their home. One of these challenges related to the short notice and time of day in which drop offs can occur ,*"[*foster agency A] they'll phone you up at five o'clock on a Friday night" (P6, 2328-2329),* and being unable to access resources, especially with their first foster infant, *"it was so hard we didn't have any bottles, or any nappies" (P2, 2517).*

Lack or little information about the infant, such as possible allergies or substance exposure prenatally, upon drop off was discussed by as an issue by some participants.

> *Mary: We get rung up, there's a baby due to be born or a baby's that been born, don't know any issues, don't know family history (P2, 798-801).*

Previous literature discussed the impact of being given short notice, and the lack of or partial provision of information, where this information may have helped with settling the foster infant, and the quality of care (Lanigan & Burleson, 2017; Marcellus, 2008)

Janine shared how an infant required the SW and a police escort to be at the drop off, for the protection of the infant and the foster family.

> *So our little boy arrived he was less than two hours old and he arrived with a police escort and a social worker, and we were told we would have a police alert on our house while he was with us, and it would probably be about a few weeks (P4, 310-314).*

Safety concerns at drop off illustrates some of what foster parents may experience at the beginning of their journey with the infant.

Mary shared that despite years of experience, sometimes it is difficult to be fully prepared to see evidence of physical abuse, when first giving infant cares.

> *Another hard one when you get infants, the first bath, I know it sounds weird but you get the kid and you're told if they've got any major injuries but then you strip them…It doesn't matter how many times you've seen it, it's hard, cause they're infants, like how do you do that to a baby (P2, 2525-2532; 2538-2543).*

Visually seeing evidence of trauma and directly relating to the infant who experienced this has a deeper impact than hearing about the trauma verbally or in notes and may be challenging and confronting for the foster parents.

First Four Months of Care

This section encompasses some of the participants experiences caring for a foster infant through the developmental stages and needs of a newborn through to 2-4 months of age. Although the developmental changes, needs, and cares that occur in the first six weeks of an infant differ slightly to that of an older infant, it became evident the cares established and discussed commenced in the first six weeks continued onto the following months, and a crossover occurred with narratives and infant ages.

Settling in: Time and Routine. All of the participants discussed the importance of routine to settle infants, especially at the beginning of the placement. Routine *"takes time"* (P3, 1399-1400), requires consistency in care, structure, and providing a stable environment, which is important for every infant-parent/guardian relationship or dyad (Golding, 2014; 2INgage, 2023), and *"Babies need a routine to feel secure," (P3, 888)*. Neither the infant nor the foster parent are familiar with each other's rhythms and characteristics at this stage.

> *Barbara: It takes a few days to realise what the needs for that particular one are. They might want to feed every two hours or they might want to sleep longer (P6, 2040-2045).*

Participants spoke of dedicating significant time to settling infants into the environment and routine, "w*henever we get babies I stay home for about five to six weeks, for them to get settled" (P3, 935-936).* Various participants spoke of the importance of being in a position to give time to the infants, their cares, and wellbeing.

> *Connie: It's certainly helping these children that have got slight disadvantages with their issues they're born with, and so you're going to give them the start. You can really only do it if you've got the time to do it (P1, 1401-1408).*

The practical care and routines discussed included feeding, sleeping, playing, and bathing. Additionally, the participants emphasised the importance of providing warmth, consistency, love, attention, and a sense of security. As expressed by Connie: "*they'll settle if they feel safe and they're warm and they feel held and they've got everything they need and they've got that extra security blanket around them" (P1, 285-288).*

The absolute necessity of providing basic physical and emotional care is consistent with the responses identified in other studies (Meetoo et al., 2020).

A few participants spoke on unhealthy behaviours and habits foster infants may have developed, which can be located pre-placement in origin.

> *Amy: They keep wanting feeding because what they learn is, 'I've got it now let's just keep drinking it', and that's not good for them cause they'll either spew it back or they get a belly ache (P3, 964-969).*

The foster parent needs to help establish new healthy habits, behaviours, establishing appropriate expectations and behaviours through time, consistency, structure, bonding, and love. Barbara spoke in regard to their time not being their own, be it focusing on the infant's needs, or the wider aspects of fostering that involve the infant.

> *Your time's not your own. A lot of people don't realise that we give a lot of time, transporting, meeting with the family, and meeting with social workers (P6, 86-90)*

Health Related Issues and Cares. Various health related issues were discussed in relation to the foster infants, many being typical childhood health issues such as colic (P1, 712), asthma and eczema (P5, 277), allergies (P1, 623; P6, 2052), being underweight (P1, 160), bronchiolitis (P5, 411), and reflux (P5, 370). Barbara shared how being uninformed of milk allergies affected care and intervention.

> *I had six weeks of him pooing blood, this should have all come out when they interviewed, cause the other kids are in care. That information should have been there to us (P6, 2088-2100).*

Some of the health issues such as the reflux, allergies and being underweight occurred within the first six weeks of the foster infant's postnatal life. Foster infants being underweight can be linked to PSE, where drug and alcohol can impact the development of the infant prenatally, increasing the likelihood of premature birth (Ross, et al., 2015; Starship, 2018).

Aside from the typical assessments and appointments with Plunket, midwives, and General Practitioners (GPs), participants specified extra health related layers including caring for multiple infants with different needs, requiring consent from the birth parents, complex needs, and specific foster agency provided assessments.

Monitoring the infant's behaviour and health day-to-day is part of foster parents' role and it is an aid to assist understanding and infant's behaviour patterns.

> *Connie*: A*nd look for clues, cause it is a bit of detective work, especially with a baby, they can't talk so they talk to you in other ways (P1, 1282-1286)*.

High Needs. Mary spoke of a premature newborn infant who required tube feeding and one of the expectations of the foster agency was, *"to get her off the tube" (P2, 545),* along with some unrealistic expectations.

> *She had to be feed every three hours, if you went over she just spewed…I had her drinking eighty mls, the first three or four days she didn't have any visits just to settle*

*her in at home…Then someone in there, bright idea mum and dad are seeing her three times a week, so you have to bring her to [*city/ town E], which is only a 15 minute drive, but that's 15 minutes out of our three hours and then it's 15 minute home out of our three hours, then an hour visit, and she went backwards so far, she started losing weight (P2, 546-578).*

This scenario demonstrates the extra demands involved in fostering, with outside factors such as the foster agency expectations and birth parents' rights, which can impact on both the infant's welfare, and the foster parents' ability to provide best practice foster care. It would appear there needs to be balance between all these factors.

Janine spoke of a high needs infant with reflux issues, taking multiple medicines (some causing side effects), and an apnoea machine.

*The first baby we had through [*foster agency A] was really high needs and so my whole time was taken up with her. She had terrible reflux and was most comfortable when I just carried her all day. Basically I'd have her in a front pack or whatever, I'd carry her all day at night. We had her for a month and in that month there was seven nights that I got no sleep at all (P4, 423-461).*

Coping with sleep deprivation is an example of the balancing foster parents may experience with their own wellbeing and functioning, whilst providing the necessary and extra day-to-day cares for a high needs' infants. The time and commitment devoted to the welfare and specific care of the infant, also came with a financial cost to provide a warm environment, *"it cost us an extra two hundred dollars in heating that month" (P4, 507-508)*.

Barry and Barbara are known to be skilled and experienced in caring for high needs infants, in particular due to Barbara's medical background. One of the high needs infants is described by Barbara as follows:

> W*e got this very sick baby, he had a chromosomal disorder and he was tube feed and screamed, real scream, for hours at a time. You just paced and paced and paced, it was the only way to get sanity for yourself and comfort for the child. We just took turns (P6, 412-426).*

Even with all their years of experience, Barry and Barbara expressed how difficult this placement was, though the infant had a protective factor with his temperament, *"he was the wee loveliest boy" (P6, 442),* most likely easing frustrations, and bonding issues the participants may have been experiencing. Barry and Barbara's reputation in meeting infants physical, emotional, and practical needs mean they are more likely to be placed with infants for palliative care.

Multiple Infants. Some of the participants discussed their experiences fostering children simultaneously. This may be an infant with an older sibling, such as a newborn and toddler brother (P2, 2050), multiple infants simultaneously, or siblings such as twins (P3, 833) or triplets (P6, 486). Amy is comfortable fostering more than two if the situation so arises, *"it's no different because you're getting up for one you might as well get up for three" (P3, 452-453).* The difficulty of fostering multiple infants Amy has experienced is in regard to taking a specific infant to an appointment, *"we can be at the hospital twice a week with some kids…if you've got an extra one as well you've got to take them along" (P3, 762-765).* However, Amy and Mark plan ahead and coordinate tasks demonstrating years of experience in coping with the demands of cares.

> *I try to leave one day that I can use for anything, taking to the doctors, or whatever, and just to go. For vaccinations I need *Mark to help me cause there's three of them...I'm used to it now…That's just part of fostering (P3, 791-804).*

Janine described the struggle within herself and practically for caring for unrelated infants simultaneously, who've had some kind of trauma such as PSE, or neglect. One of the infants appeared to need to be held more, possibly due to the PSE or temperament or both.

> *It felt wrong to not hold the baby to feed them and once [*fos. infant A] arrived I couldn't do that cause there was the two of them unless there was someone else there then we could have a baby each, but for the majority of the day there was just me (P4, 734-742).*

Although Janine managed to provide their cares, nurture them, and give them both some form of attention, it appears this felt inadequate and she struggled with her sense of feeling like she wasn't giving them enough one-to-one time.

Supervised Contact. Some of the participants shared their concern in regard to the negative impact supervised contact can have on the infant's wellbeing, such as being unsettled by a disrupted routine (especially if there are multiple visits during the week), as per Mary's following comment: *"when they're little they can't be going every second day to visitation, it's just not good for their health" (P2, 2382-2383).* This is consistent with literature where multiple interruptions have been found to unsettle infants (Atwool, 2010).

Amy shared a scenario where she advocated for restricted supervised contact for twin foster infants.

> *I said to the social worker the other day, 'if the fathers coming in for access he's not to bring all his relations'. Cause the week before that there were a whole pile of relations and they were all holding the twins. I said 'they were there whole time, when we got home they were worn out they didn't want to be held' (P3, 829-836).*

The large number of family may have been a potential obstacle to the infants bonding to their birth parents, in this case their birth dad. Being around so much activity, particularly that is focused on them, most likely was overstimulating and overwhelming (Raising Children

Network, 2023). Although not discussed by the participant, the temperament of the infant may also affect how much cuddling and touching by other people they can tolerate, especially from unfamiliar people (Sauer, 2023). Participants mix of positive perspectives and concerns in regard to the importance of supervised contact, and observations of infant behaviour post supervised contact, aligns with other foster parents studies (Atwool, 2013).

Space In-Between

There are times the foster infant remains in the foster parents care after four months. This is while the necessary arrangements and processes take place, such as birth parents preparing themselves to be ready, court processes, or difficulty in locating an appropriate permanent placement or home. Some of the participants proactively advocate throughout the placement, reminding the foster agency for the need of a permanent solution for the infant, sooner rather than later, as expressed by Amy.

> *This is what I want to do with these lot [current infants] pushing pushing but it's not because I want to get rid of them. It's because I want what's best for them and what's best for them is to be in a permanent home (P3, 1267-1271).*

Both the literature and participants discussed concerns with maintaining dependable care and stability for the infants, with discussions focusing on how unsettling multiple placements can be, and instability can impair infant/child growth and development (Dozier et al., 2013; Jones Harden, 2004).

> *Barry: We'd rather they take a little bit longer and try and get a good placement rather than just on three months and put them out. What you don't want is for the baby to go from us, then he gets placed with another couple for another couple of months, all before he goes into permanent care. It's very unsettling (P6. 272-285).*

Transition: Detaching and Rebalancing

Eventually the time comes for the foster infant to transition to their next placement. They may go back to their birth parents or family/whānau, to a permanent placement with another family such as HFL or adoption, or to another foster placement. Other than the kinship carer, all the participants shared various experiences, expectations, coping strategies, and the emotional impact it can have on the foster family.

It was very important to the participants that the transition process is done well, with a gradual process of handing over, an example is described Robyn, *"the people start coming in and seeing them and taking them out somewhere that's pleasant to the child" (P7, 645-646)*, and Amy states, *"about four or five months of age, you have to do a proper transition…I make sure we do it right, the transition takes about a week" (P3, 163-170).*

Barbara detailed a process she called 'detachment'. This is implemented once they have been notified of the infant's new placement and enables them to mentally prepare both themselves and the infant for the transition.

> *So when we're told okay he's having a meeting on Thursday he could be moving, we start to detach, just move him out a little bit, lay out his clothes start packing his clothes his toys and that mentally to us is detaching (P6, 830-840).*

In anticipation of the infants leaving, a couple of the participants spoke of preparing items in advance to leave with the infant.

> *Connie: I also do a life story book for all the milestones, and I do photos. and it's just a record so that when they get older they can go back and say this is me as a baby, this is my lock of hair, this is my thing I had in the hospital (P1, 1239-1245).*

Other items are familiar to the infant, such as a dummy, assist with the transition, and can be used to self soothe, as described by Amy, "*quite often I give them one of their blankets as well so they've still got that smell about who they are" (P3, 219-221).*

Many of the participants shared that although the transition can be a sad time, as there is a sense of loss, the grief of letting go can be eased knowing the placement is the best and right place for the infant, as described by Robyn: *"any time a child is returned to a parent is a positive outcome and when they're happily resettled into another home that's a positive" (P7, 740-743).* However, the opposite is also true where participants shared the difficulty of having concerns and disagreeing with the foster system about a particular placement, as demonstrated by Mary: *"As soon as you know where they are going, like you know going back to mum's not the answer, what the hell the courts thinking, so you struggle a little bit" (P2, 3038-3041).* These participants want to make a difference in the children's lives and are compassionate empathic people. This is consistent with literature where foster parents display a continued a concern and interest in the infant/child's wellbeing (Marcellus, 2008).

Some of the participants discussed the various foster family members responses and coping to the emotional impact of letting go. Some displayed more emotions, some avoid the handover, and some starting to emotionally step back from the infant. Some relationships and bonds will be stronger with some infants and may vary between members.

> *Mary: *Bob didn't come he knew he wouldn't cope. These were the first ones we'd had for any length of time... *Olivia wouldn't come out and say goodbye. I was like, 'you've been through this before *Olivia, if you don't say goodbye you are going to regret it' (P2, 2422-2423; 2442-2445).*

The participants' experiences of letting go align with the studies of disenfranchised grief and foster parents, where they experience loss privately within the family (Lynes & Sitoe, 2019), and some members grieving deeper than others (Herbert et al., 2013; Marcellus, 2008).

The nature of fostering infants sometimes means there is little time between letting go and grieving the loss of one infant, while embracing another infant requiring foster care. This experience is briefly described by Janine: *"It is really hard when they go but the next one*

comes pretty quickly and then you put that love into them" (P4, 1011-1013). Marcellus (2008) describes this experience as 'rebalancing', which occurs whenever an infant leaves and another arrives.

Ongoing Relationship: Different Roles and Parameters.

For some participants the journey with the infant continues beyond the transition and into the new placement, albeit in a different form. These interactions can range from remaining actively involved in the child's life, to sporadic involvement and updates.

Permanence with the Foster Family. Most of the non-kinship participants have at least one prior foster infant who now is permanently part of their family. Some of these children have ongoing developmental or health issues, such as FASD (P3, 623), and are more equipped to overcome their challenges due to the participants input and dedication. The motivation to decide to accept the infant as a permanent part of the family may include a strong developed connection with the infant or may come from a place of compassion for an infant in a desperate situation.

> *Robyn: He was just so insecure when we took him back. When he was placed for adoption they sent him back, he went to the hospital and we chose to have him back again. I thought somebody else might kill him (P7, 584-591).*

Kinship. Though some kinship placements may be temporary, Debbie will be caring for the infant now toddler, permanently. According to Debbie, the advantage of kinship care in regard to looking towards the future is knowing the family history, including medical and mental health. This includes the increased likelihood of having the knowledge and skills to cope and manage any possible issues that may arise.

> *There are things we also have considered because mental health issues run through the family both sides, so we look ahead as well (P5, 1274-1275).*

Keeping in Contact Beyond Placement. Some of the participants shared their experiences in regard to remaining in the lives of some previous foster infants, and a positive relationship with the guardians/family. Connie spoke of an ongoing relationship with a child in a HFL arrangement with non-kin permanent guardians: "*we've got the best of both worlds now he's got a Home for Life…whereas he's got his family he grows up with, and we get to see him like a grandparent" (P1, 1600-1612).* Mary and Bob discuss remaining committed to support particular children and their birth mother.

> *Mary: We see them at least every six weeks and in the school holidays we'll have them for a bit longer. We'll have them when they play up, when they're struggling a lot…I don't think they'll be as stable as they are if we weren't still around (P2, 1502-1507-1524).*

For the most part remaining in contact, be it sporadic or regular intervals, does not appear to be a burden rather it is depicted as satisfying. A few of the participants have expressed the positive ongoing experience as, *"we like to stay in contact" (P2, 1567),* and "*I'd love to see them as much as do [*fos. infant C]" (P1, 1597).*

Subtheme: Grafted, Connected, and Growing: Journeying Day-to-Day with the Infant Through Adverse and Traumatic Experiences

'Grafted, connected, and growing' is a subtheme of 'Nurturing from bud to bloom' This section focuses on the trauma journey with infants, followed by foster infants and attachment. Both trauma and attachment are intertwined due to the impact trauma can have on attachment and development. This requires foster parents to have specialised expertise and knowledge to care for these infants day-to-day, from basic physiological to complex psychological needs. The subtheme links with the analogy of a nurtured grafted plant, focusing on the experienced trauma, bonding and recovery through the nourishing and nurturing of the foster parents.

Trauma. All of the non-kin foster parents discussed their experiences and insights to caring for infants who have encountered some kind of trauma. The participants spoke of the challenges and concerns they encountered as they journeyed together with the infant, through trauma related events which were predominantly focused on PSE and physical abuse.

Barbara spoke of the impact the age at which an infant is removed from the trauma source and placed into the foster parents care.

> *They are harder if you get them say six weeks old than they are when you get them from birth. From birth they've had the nine months of the trauma but it's a new environment everything's new so you can break through that much quicker. With a six-week-old they've had the trauma of six weeks in the environment whether its abuse or whatever (P6, 956-969).*

More effort, specific strategies and care are then required to care to rebuild positive neuropathways.

Physical Abuse. Some of the participants spoke about caring for infants who had experienced physical abuse including, being shaken (P3, 327; P6, 495) and having broken or fracture bones, such as ribs, kneecaps, and skulls (P3, 336-337). For Robyn's husband, the fragility of the infant with injuries and day-to-day cares caused him to be very cautious for fear of causing further harm or discomfort.

> *There has been a baby that *Raymond was too frightened to feed. Had her at six weeks old, her arms and legs and her ribs broken and permanent brain damage. She was fitting a lot and he was a bit scare of her, was a bit scared to pick her up in case he broke something else, but he came right with her (P7, 269-283).*

Barbara spoke of a particularly emotionally frustrating situation where an infant had been in their care, and then was placed into an environment that turned out to be abusive.

*[*fos.infant G] she ended up in an abusive situation, that makes your heart cry. It's all wrecked what you've done, they've got to start again and then the attachment is going to be so much harder (P6, 1092-1105).*

Prenatal Substance Exposure. Participants described various behaviours that are common indicators amongst infants mostly likely affected by PSE, including withdrawal. These included a piercing cry (P3, 520) which Mary described as sounding *"like a strangled cat" (P2, 2849)*, the infant struggling with *"any little change"(P2, 132)*, being irritable and agitated (P3, 65, 479; P6, 1588), difficulty feeding and sucking (P3, 485; P6, 66-67), being jerky (P3, 496), being inconsolable (P3, 513), and being lethargic or very sleepy (P4, 1237; P6, 1585). Such behaviours are noted in other studies focused on infants affected by maternal substance abuse (Gross, 2019; McQueen & Murphy-Oikonen, 2016). Developmental issues are not always evident during the infant stage, first becoming observable in older children (Gray, 2011).

In regard to NAS/PSE and cares, Amy states, "*it takes a lot of patience and a lot of time cause it takes just about double the time to feed them" (P3, 508-510)* and the discomfort and distress the infant experiences particularly with withdrawal means there are limitations to what will soothe them for long periods of time. Being held was an approach many of the participants implemented and as discussed by Amy, "*having foetal alcohol or drug abuse there's nothing absolutely nothing you can do, so basically what you do is what worked wrap them up and cuddle them" (P3, 530-533)*. This was described as important for infants, as *"they like being held, that's particularly for the drug ones" (P6, 382-384).* According to Amy, withdrawal*" happens in a week or so, but sometimes it can go on for a while" (P3, 483-484).* Other methods recommended by some participants to soothe and relax these infants included water (*"water's good, you bath them that relaxes them but can't keep putting them in the bath every hour" (P3, 606-610)),* routine *("it takes extra, but it's more important*

for the drug ones" (P6, 363)), and personal items to self soothe *("he knows he can get his dummy he'll just snuggle in and go to sleep" (P6, 381)).* Participants did not specify if these strategies were learnt via experience, or via specific training provided by the agency, or elsewhere.

Lethargy and sleepiness of infants affected by PSE can present other challenges with feeding as the infants may not show sucking reflexes which then requires more attentive care.

> *Janine: The first two weeks after he was born, he just slept all the time he would wake about two hours a day that was usually between about ten and midnight. So I would feed him, wind him, change him and he wouldn't even wake up (P4, 1237-1246).*

Infants with PSE may become overstimulated and as a consequence become irritable and distressed. Calm stimulating tools, techniques and interactions benefit these infants and enable healthy rewiring of the brain (Johnson, 2014), such as a mobile hanging over the changing table (P3, 1009) or talking calmly to them (P3, 981).

> *The stimulation you give them is important. They get that talking to, and you sit them on your knee and you read a book to them. All that stuff starts from this age [2-3 months old], they're not going to sit there that long but sometimes they're just fascinated with the colours (P3, 979-996).*

Attachment. An important part of foster care is providing a safe, warm, and consistent environment enabling the foster infant to ideally develop a secure attachment pattern. In particular the hope is to prevent the development of a disorganised form of attachment, which foster children are at higher at risk of developing than non-foster children (Bernier et al., 2004). Secure attachment is an important part of development, "*that secure base is so important it can overcome so many hurdles that these children come with" (P6 , 539-541).* The strength of the bond can be affected by the placement's length of time *"you*

get ones that you have for a week, it's hard to get a real bond going and in short time" (P1, 1513-1516). The bond can be stronger with particular family members.

> *Debbie: My husband spent the nights with her up in up at the hospital, while I did the day shift. She was more restless at nights, so they connected quite well (P5, 833-843).*

The foster parents own ability or motivation to form an attachment with an infant, can be affected by various factors, which can delay or hinder the process, such as knowing the infant will eventually leave, or in Debbie's case, *"not being her biological mum at first I think I was a bit standoffish and didn't wanna get at first too connected" (P5, 811-814).*

Other factors that can affect bonding include an infant's temperament and behaviour. Barbara shared how underlying autism spectrum disorder (ASD) of an infant impacted initial bonding: *"he was very hard to attach, being autistic, arm's length, couldn't cuddle him" (P6, 1924-1933).* Sometimes bonding issues due to infant behaviour can affect the placement experience negatively.

> *I had one wee boy that I had trouble bonding. He had lots of problems and he was awake half the night. He wasn't easy, he was very difficult. In the end I just found it impossible going (P7, 669-678).*

Depending on how a placement breakdown is managed, there can be a negative impact on both foster parent and infant, with any bond formed severed. Literature discusses how placement breakdowns can emotionally impact foster parents as they work through why the placement failed, a sense of loss, and sometimes a sense of relief and replenishing (Khoo & Skoog, 2014).

Janine observed one of the foster infants display behaviours that in hindsight she could tell were indicators of attachment issues. The infant displayed good eye contact which may have masked any underlying issues.

She didn't get held as much as I would have liked, but she seemed quite happy, she made good eye contact it was as long as I was looking at her and talking to her she was really happy…She was really stiff but and didn't seek physical contact (P4, 745-750, 1494-1495).

A possible protective factor enabling most infants to develop secure bonds with their primary carer and overcome trauma, is the fact that they are infants.

Robyn: I think that with a baby it's just so easier to bond with them because you're got cuddling them all the time (P7, 776-777).

There are indicators the infant is developing a healthy attachment pattern, and some of these are discussed by the participants include: good eye contact (P4, 1493, P6, 1622-1623), smiling, and the infant turning their head towards the foster parent (P1, 1519). These behaviours align with literature which describes secure infant attachment behaviour as including following and responding to human faces and voice, and learning to discern differences between primary carer and other people; smiling, crying, and reaching are also indictors of bonding (Lightfoot et al., 2018; Marvin et al., 2016).

Conclusion.

Theme Two focused on the day-to-day cares and the journey of the foster parents with the foster infant in the first four months. Of particular interest were aspects of care which are extra or complicated by the infant being part of the foster system. The theme was arranged in terms of the infant's stage of development, although the reality is the infants go into care at varying stages and ages.

Preplacement aspects were discussed such as prenatal experiences (maternal stress, PSE), postnatal experiences such as birth trauma, NICU, and living in the birth parent environment, and how this may impact development and behaviour. Following this was the participants experiences relating to the infant drop off and the initial cares such as bathing,

seeing evidence of physical abuse, along with managing expectations and interactions with those from the system such as SWs and police.

Some of the day-to-day cares and experiences related of caring for the infant in the first four months were then discussed, predominantly focusing on the first six weeks when time is given to routines, settling, and establishing a bond with the infant. This section also discussed health issues, high complex needs, fostering multiple infants simultaneously, and the impact of supervised contact on infant behaviour.

The section 'space in-between' briefly shared a few experiences related to caring for infants after four mouths, with continued care provided, whilst advocating for the infant until a good permanent placed becomes available. The various experiences of the foster family and infant transition ranged from positive, well executed transitions to difficult unexpected transitions. Detaching and saying goodbye to foster infants can be an emotional time, and complicated by the nature of fostering in that there will be another foster infant needing their attention.

Some foster families maintain a relationship with certain foster infants beyond placement. This may be in the form of permanence with the foster family (non-kin or kinship) or maintaining a relationship after transition but in a different form such as grandparent like figures.

Discussion of this theme concluded with a subtheme, 'Grafted, connected, and growing', which focused interaction between trauma, attachment, and day-to-day care. Trauma can negatively impact the infants development and cause behaviour such as being withdrawn, or hypersensitive. Attachment is thus potentiality hindered as the infant tries to cope with the effects of too much cortisol and feeling safe.

Vulnerable infants require skilled, knowledgeable, and empathetic foster parents to recognise what is happening and then journey with the infant day-to-day through to recovery.

Theme Three: External Elements: Interacting With and Navigating the Exo/Macro Expectations and Challenges of the Foster System

This theme relates to the participants' experiences within the foster system and the various contributing factions. These are elements that generally have no direct impact on the infant's day-to-day cares, whilst having some impact on the foster parents/family experiences as they navigate and interact with the various systems within the foster system. These experiences can be considered in the context of Bronfenbrenner's ecological systems theory (1979, 1994). The exosystem relates to external social, community environmental elements that do not have a direct influence on a person (Berk, 2013; Lightfoot et al., 2018; Shelton, 2019). Elements or components, such as Oranga Tamariki, the health system, community support groups, the court system, and their interactions as systems within systems have some influence on the lives of the core person or micro group such the foster parents/family and less of a direct influence on the infant. The Macro system perspective has been linked to the Exosystem in this theme due to aspects such as the legislation in which the foster system is grounded, and organisational culture within the foster agencies and systems that can impact the foster parents' experiences (Berk, 2013; Lightfoot et al., 2018; Shelton, 2019).

Foster Agency Policies.

A few participants discussed specific foster agency policies which impacted them, their family, and potentially the care they provide infants. In particular, policies from Oranga Tamariki, who also work in partnership with NGO foster agencies. Of the polices discussed by participants, only those which have influence on fostering infants are included.

Mary spoke of a policy change, where the focus changed from birth family/whānau of foster infant/child focus, to that of being more child focused (Oranga Tamariki, 2017). This policy change ensured the child is now given more of a voice, though for an infant who are not equipped to give voice they are more reliant on others to advocate for them.

> *[*foster agency A] they were really family oriented, sometimes to the detriment to the child (P2 193-194).*

A couple of participants spoke about an agency policy which related to prioritising of placing an infant/child in a culturally similar home. Participants were concerned these placement expectations were not always an ideal solution, and were frustrated with the agency's persistent stance. The narratives particularly related to the placement of infants with Māori whānau, even if whānau were not in a position to take the child, or the birth parents/whānau were supportive of the foster parents being the main carers. In the following scenario, the birth family/whānau did not have strong connection to their Māori culture.

> *The [*foster agency Aa] main thing with placing her with us she's not going to grow up Māori, and our argument is well if she was living with her Nana or her parents even she still wouldn't have grown up Māori. She'll still have Māori family around (P2, 360-367).*

This family/whānau cultural policy was established in conjunction with the principles of the Te Tiriti o Waitangi and is focused on 'keeping family together' (Oranga Tamariki, n.d.b). If this can be achieved safely then it is better for the infant/child to remain connected to family/whānau, and helps them with their identity. More recently, a 2019 review lead to improved processes to protect the infant and ensure where possible they will remain with family/whānau (Oranga Tamariki, 2023b). The participant's experiences pre-date these policy changes.

Social Workers (SW).

SWs are an integral part of the system. Their interactions and support of the participants is discussed in Theme Five. The foster parents reported that they tend to be assigned the same SW throughout their fostering journey, called a *"caregiver social worker"(P4, 1783)*. The foster infant/child is also assigned a SW, but as Janine explains

multiple children could each have their own which involves co-ordinating with more than one SW.

> *They were initially two social workers but they had it changed it so that they both had the same social worker. Every child that comes in will come in with whoever is trying to find them a place (P4, 1784-1792)*.

Foster Parent Shortage.

Many of the participants discussed the issue of the shortage of foster parents, such as Amy: *"I think they are short everywhere" (P3 724)*. For some this was a general statement with no indicator of the direct impact it has on them as foster parents, other than concern for potential foster infants. According to Amy, *"there are babies everywhere coming (P3, 739)*, and according to Mary, "*not a lot of people want babies because they're working or they don't like getting up at night or whatever" (P2, 731-733)*. It is unclear if there has always been a shortage, or whether the shortage has increased over time.

Another issue discussed by some participants was the concern that shortages may mean the agency will accept foster parents who are not be ideal or are not prepared for a particular placement.

> *Robyn*: *There are some foster parents out there that leave a lot to be desired but I hope there's not many of them (P7, 746-749)*

Processes and Checks.

Becoming a Foster Parent. Connie and Debbie were the only participants to discuss in depth the process to become a foster parent. They were the foster/kinship parents who have been fostering the shortest amount of time, so it is possible that this experience is clearer in their memories. To become a foster parent there are processes which involve checks such health reviews, along with police vetting for both foster parents and those related to or closely associated with the foster family to ensure potential foster parents are suitable and equipped

to cope (Oranga Tamariki, 2019), all these checks being mentioned by both participants. Oranga Tamariki (2019) state they "*have 90 days to complete the assessment process after applicants agree to go forward with a full assessment*", however for Connie the process took seven months.

> *They look into your family background and meet your family in a sort of a casual manner, so they can get to meet the family as they truly are. They interview people as referees and things like that, so it's quite involved (P1, 84-92).*

The final part of the process involved a board meeting where Connie and her husband were interviewed and then waited a few days for the approval to come through (P1, 115-120). Debbie's checks and processes for approval occurred considerably quicker than the 90 days due to the nature of the situation, with becoming a kinship carer to a newborn great niece.

> *Everything was done from the time we said yes in a week, so by the so she was born the Friday I think it was, and the following Friday we took her home (P5, 35-38).*

Ongoing Processes and Checks as a Foster Parent. The checks and processes discussed focused on two aspects, the first being the regular checks on the infant by SWs, and the second being the reviews and checks conducted on the foster parents. Debbie spoke of how initially very aware she was, "*looking after somebody else's child" (P5, 344)*. This awareness was amplified by regular infant welfare checks by the SW.

> *So I was, I wouldn't say wary of it, but you knew they're [agency] there. Like she bumped her head or something, you're like oh no, but it's like but after a while that sort of went away, these are the things kids do (P5, 355-361).*

Connie mentioned an annual general check:

> *These checks [general checks like health] are done every year, I think police check and [*foster agency A] checks are done every two years so. You don't just become a*

carer and then that's it, they're still checking you up like all the time making sure that nothing untoward has happened in the meantime (P1, 105-111).

Home For Life (HFL)/Forever Homes. A few of the participants shared their experiences with the HFL process. One of these experiences was in the capacity as an advocate for the infant during the Life Appreciation meeting, where the agency arranges for the SWs, lawyers, and prospective permanent guardians to meet and ensure the child is going an appropriate home (P1, 1616-1629). Another HFL experience relates to participants who applied to become a HFL for an infant in their care.

Mary: After Home for Life's done everyone steps away, and it becomes between us and her immediate family (P2, 350-351).

These experiences pre-date, or occurred in the midst of, legislation changes to Section 7AA of the Oranga Tamariki Act, which relates to the Te Tiriti o Waitangi principles. The changes focused on children being placed or returned to family/whānau/iwi where possible (Oranga Tamariki, n.d.c). These changes initially caused some controversy and distress for non-Māori foster parents of children they believed were permanently placed with them (Reid, 2020). The current policy and framework is called 'Ensuring a safe, stable and loving home for tamariki in care' and includes a process to ensure that, where possible and safe, children are placed with family/whānau/iwi (Oranga Tamariki, 2022).

Birth Parents/Whānau

Relationship and Interactions With. The relationship of participants with the birth parents/family of the foster infant varies from placement to placement. It also varies between the foster families, some had little direct contact. According to some participants the foster agency recommends limited contact with the birth families, though I was unable to locate specific policy regarding this. Some of the participants have formed good relationships and connections with particular birth families/whānau.

Mary: We've always tried to have a good relationship with the family, no matter what they've done or bad they've been. When you're with them we try to, for the kids' sake really (P2, 2486-2491).

Some participants connected with one or two members of the birth family/whānau, who they positively worked and interacted with. Janine describes *"a safe aunty who I trust and we've got lots of photos of family from her" (P4, 284-285).*

Other birth families may be more difficult to interact with, for example: "*they were quite anti foster carers in the start" (P2, 2454)*. Robyn spoke of reports given about certain birth parents which conflicted with her lived experience: "*his father was deemed to be unsafe but he's been nothing but respectful to me" (P7, 228-229)*.

Participants demonstrated an understanding of the dynamics and reasons as to how birth parents' behaviours or situations lead to the infant being in foster care. They also addressed misconceptions that may exist in society.

Mary: They're not necessarily all bad parents that we've had kids from, there's definitely been kids from violent homes and stuff, but a lot of them it's just parents, just aren't mentally capable of having them for whatever reason (P2, 3611-3616).

The compassionate insightful perspective demonstrated by these participants may enable the foster parents to continue fostering. There are also expressions of frustration and indication of the emotional impact due to birth parent behaviours. Amy spoke of her frustration of pregnant women using substances such as drugs and alcohol and seemingly not caring about the foetus or infant later.

These young girls they get themselves pregnant and don't want to stop no matter how much you tell them that it's going to affect the babies. They don't really see it because nine times out of ten it's the dysfunctional, a child having a child. They don't

actually get to see the baby maybe for an hour a week or whatever it is, to see how damaged they get, that's the sad part for these kids (P3, 638-647).

Robyn spoke of the difficulty of being part of the infant's life and then observing a birth parent choosing not to engage in the infant/child's life; "*you get quite emotional, especially when you have a parent that doesn't give a damn about them, I find that really hard to cope with" (P7, 294-297).*

Birth Parent Rights. Part of navigating the system for foster parents involves the rights of birth parents. The predominant aspect of this shared by the participants related to parental guardianship and consent. Birth parents retain their parental guardianship whilst their child is in foster care. Under the COCA 2004, foster parents are given the day-to-day responsibilities of the infant, while the birth parents retain the rights to make important decisions (Grandparents Raising Grandchildren, 2015). Birth parent's rights can include health related decisions including immunisations and procedures at the hospital or GP. For Barbara birth parent rights impacted travel plans: "*if you want to go away you've got to get permission and the mother may not want it, so your life's not your own" (P6, 101-104)*. The balancing of the birth parent's rights, the limitations experienced by participants whilst trying to access health care for infants, "*you can't do anything" (P6, 93),* can be a source of frustration for foster parents, "*it annoys me" (P6, 98).* This frustration aligns in general with studies on foster parent experiences. Consent from parents is not specifically discussed but rather various aspects of interactions and expectations relating to birth parents, particularly contact and why the child is in care (Burry & Wright, 2006).

The experiences of the kinship carer, Debbie, in regard to parental permission for immunisations was a more positive outcome and interaction compared to some of the non-kinship participants. This is likely due to the relationship with these particular birth parents and their temperaments, who Debbie describes as *"adaptive" (P5, 1262).*

They go 'yeah nah go it's all good with us you don't have to come to us every time' (P5, 462-463).

Literature is not one hundred per cent consistent with the experiences of Debbie, with some kinship carers in previous studies, particularly grandmothers, experiencing conflict and resistance from the birth parents (Campbell & Handy, 2011).

Barbara and Barry shared an experience where twins were hospitalised and the birth parent refused treatment. However, Barry advocated for the children knowing the counsel of the child has the power to override the mother when child's welfare at stake.

I just rung counsel for the child and told her. So she came straight down, she had finished work so was looking at half past five. We went into the nurses' office and for a quarter of an hour she tore the strip off the girl and said 'I have more rights than you do because I have counsel of the child and so go home, these kids have to be treated' and so she went outside to see the doctors, 'go do what you've got to do' (P6, 550-595).

An issue that relates to birthparent guardianship and HFL is the concern that the birth parent may try to regain custody after the process of permanency and guardianship has been handed to non-birth parents. Connie voiced her concerns with this in regard of a particular child: *"I've only one slight niggle in the back of my mind with his mother is trying to get a lawyer to go for custody" (P1, 1659-1660).*

In regard to foster parents own rights and the rights of birth parents Janie advises, "*around contact with family or whānau, having a clear understanding of what's involved and what your rights are around that as well" (P4, 1593-1598).*

Courts and Law

Some participants spoke of the role of legislation, in particular in relation to custody and guardianship. Debbie spoke of her about legal guardianship of a now, toddler: "*so we*

*have more of a say, it means anything done like she has to go to the doctors, it's fine, but we still have to let like [*foster agency B] know" (P5, 469-472).* The legal guardianship allows more freedom in making decisions about the child's care but there is still some accountability to the foster agency.

A few participants discussed various experiences and interactions with the court system. Part of foster care involves engaging with the court system, including writing affidavits in conjunction with advocating for the foster infant.

> *Barbara: We have had to go to court for these children, and affidavits that we've got dates and times and I never ever let them have the original I always keep that as my back up cause we've got to protect ourselves we're in a vulnerable position when things go wrong (P6, 1284-1296).*

Robyn shared how she does not always find it easy to navigate and engage with the court system, experiencing a push pull with receiving information and forward momentum from court decisions.

> *The court system takes so long to get anything decided. It is a long time that the children wait to get into their permanent placement. Sometimes being kept in the dark about what's happening, but then again it can be my fault because I usually ask what I want to know, but I think sometimes you need to be advised on what's going on, not be the last person to know (P7, 456-479).*

Working with the Health System

Along with the GP and hospital there is Gateway which is an interagency health and education assessment service available via referral, specifically for children under the care of Oranga Tamariki (Oranga Tamariki, 2023b).

> *Connie: They say every child in care is supposed to through Gateway assessment I've only had one and we've had eleven in care. There was the little one we had twelve*

and a half months. Mum was an alcoholic, on drugs, a prostitute and had Hep C. She had more issues than most, he was at risk and so they wanted him checked out (P1, 1311-1321).

Some participants spoke of the foster agency's expectation to document the infant's development. One of tools is the 'Well Child Tamariki Ora My Health Book' (Ministry of Health-Manatū Hauora, 2023), which is a typical part of infant care. This enables health professionals such Plunket and GP to monitor growth. Oranga Tamariki (2021b) lays out the expectations of maintaining a 'caregiving journal' under the 'day-to-day care' section of their manual for foster parents. The NGO foster agency Connie is connected to provides a diary to assist with recording of details, and is a tool providing information for others in the system.

Once a year they will send a diary. This is a vital tool, everything gets written down about them. Everything from what feeds he has, when he has it, and this is like gold because of the end of the placement I do a report on them which goes with them to their next carer (P1, 1232-1238).

Parallel to the expectation of the extra documentation is the reality of its application. Janine shared how difficult she found keeping up to date with the records and journal, even with the best of intentions.

As a foster parent you would intend to write these things down, but it never just never seems to happen. I mean if you're an extremely organised person you probably would, but for the majority of us there's so much going on and you're trying to get through the day (P4, (383-392).

Conclusion

Theme Three, addresses various aspects of the foster system which foster parents navigate, and demonstrates the complexity of the foster system. Polices were discussed, specifically those relating to fostering infants, their impact on care, and the impact foster

parents when policies are changed. The following sections discussed working with SWs, the impact of foster parents shortages, navigating processes to become and remain a foster parent and, finally, some experiences relating to HFL were covered. Birth parents/family are an integral part of the system, and in this section the foster parents' relationships with various birth family/whānau members, followed by the impact of birth parent rights on foster parent's care and lives, were covered. The last two sections relate to the court system and the health system, which can have their own complexities and frustrations, which foster parents require knowledge and skill to navigate.

Theme Four: Wellbeing and Functioning - Strengthening and Nourishing the Foster Family/Whānau Unit.

Theme Four 'Wellbeing and functioning' focuses on the foster family/whānau system as a whole and it's wellbeing. This includes the various dependents, including biological and adopted children still at home, and fostered infants who have legally become part of the family.

A tree needs to be well grounded in good soil, full of nutrients and water, needs a strong healthy trunk and branches to withstand any adversity. It must also be able to bend in the wind and adapt, and be able to and provide for the needs of the whole tree, including those who depend on it in various ways, such as the grafted buds.

Whānau/Family Systemic Unit: Ensuring Stability in the Root System and Strength in the Trunk.

This section discusses the experiences of the participants in providing care and support for their children during the fostering experience. The foundation of the foster family/whānau is the foster parent unit/dyad, as they work together to provide stability, warmth, basic cares, and consistency for their dependents and foster infant. Most of the experiences shared relate to dependents under the age of 18.

Inclusion and Prioritising in Decision Making. Many of the participants discussed the importance of including their children in the decision making process, as age appropriate, right from the start of the fostering journey. For example, Debbie with her adult children in regard to the possibility of their parents becoming kinship carers: "w*e came home and talked to them first, 'this is what we've been asked, how do you feel about it?'" (P5, 46-49).* Participants prioritised their children's inclusion in decisions throughout the fostering journey.

> *Mary: If our kids are struggling or they don't want a kid for whatever reason, we don't care what the reason is, they don't want them in the house, sorry our kids have to come first (P2, 1357-1360).*

The wellbeing of the foster family/whānau unit and the success of the foster infant's placement increases when the whole foster family/whānau unit are in agreement, supportive of one another, actively involved and included in decision-making, thus creating a unified functioning foster family aligned with the intention and purpose of the family as a fostering family (Brown & Calder, 2000; Daniel, 2011; Roche & Noble-Carr, 2017; Younes & Harp, 2007).

Prioritising Needs. Some participants spoke of the valuable resources Caring Families Aotearoa/Fostering Kids provided to assist them in supporting their children (e.g., training and family events).

> *Barbara: In Fostering Kids, the organisation, we have workshops on your own children, the needs of your own children (P6, 1789-1792).*

When a foster infant/child becomes permanently part of the family, they sometimes have extra needs to be considered.

Amy: We've gone to babies, purely newborns now, because of our seven year old whose got a global delay. She's better with newborns than she is with children cause she's not very socially good (P3, 20-23).

Acceptance and Assistance. The participants indicated that, for the most part, their children accepted being part of a fostering family.

Amy: Our kids just accepted kids coming into care, they'd get up in the morning and we might have an extra baby or an extra kid and they just accepted it. They would move their rooms to accommodate whatever kid we were getting (P3, 403-408).

Children of the participants demonstrated acceptance by choosing to practically engage with the infant's cares, such as Amy's daughter, *"our daughter would just come home from school and she'd just take over sit there and rock them"(P3, 489-492).*

Sacrifices and Retrospective Consequences.

Barry discussed the impact and sacrifice his biological children made and trying to ensure their wellbeing:

We were always asking our kiddies, hey you know, this still alright with you, and those sort of things. Cause they shared their toys and shared their mum and dad and this kind of thing, shared car rides. It was a big thing for them (P6, 1528-1535).

In later years Barry and Barabara learnt retrospectively of sacrifices at least one of their children made:

*Barry: *Barbara said to our daughter, whose now 38, what was one thing she regretted about us fostering. She said the only thing is that both mum and dad couldn't go to any school events that she was in, no prizegiving's, no performances that she was in, things like that. Because one always had to stay home (P6, 1752-1763).*

Stoneman and Dallos (2019) discuss biological children experiencing the love of their parents being 'spread out' whilst developing a sense of self value knowing they were helping their parents and children in need. Other biological children spoke of having some of their toys or belongings being damaged by a foster child (Watson, 2002), and experiencing less one-on-one time with parents (Marcellus, 2008).

Bending in the Wind: Resilience, and Coping Strategies.

Every placement carries its own set of challenges and each foster family/whānau and family member copes with stress and situations differently. Those with less experience will approach situations differently to more seasoned foster parents.

A couple of the participants discussed the importance of being prepared when starting out as a foster parent, with Barbara commenting, *"don't go into it blindly"(P6, 2191).* Preparation was described as*, "do your homework and ask plenty of questions, then you'll sort it out yourself"(P6, 2226-2229).* Mary acknowledged there are limits to being prepared, "y*ou don't know what you're getting, even in a newborn"(P2, 2920-2921).* One of the ways she described coping was by having, *"no expectations, just go into it with an open heart and open mind" (P2, 2932).*

For Debbie, one of the challenges was once again caring for an infant 24/7, *"it was like nineteen years since we've had a baby in the house, so we had a lot of adjusting to do" (P5, 148-150).* A couple of the participants spoke of coping by prioritising the infant's needs overs tasks that can wait.

> *Amy: What goes is your extra stuff that you need to do, because if they're going to sleep they'll only sleep for about half an hour and then they wake up and your time basically with them (P3, 573-577).*

Every infant comes with a unique personality, temperament, and issues and according to Barbara this means*, "love, if you can give that love, but you don't actually have to like*

them (P6, 2269-2270). Some participants indicated that not every placement will be the same and that some will be easier than others.

> *Barabara: It's not all a bed of roses. Don't think that you're going to get another little Johnny who just does what he's told cause it won't work (P6, 1697-1703).*

Many of the participants shared the same approach to caring for infants and coping, which is treating the foster infant/child, *"as I would have treated my own child"(P1, 1571),* and "*as part of the family" (P2, 647)*. Robyn spoke of figuring out strategies that will work for both the foster infant and foster parent.

> *You've got to persist. I found that I'm learning all the time, you don't know everything. You have to listen and you find out (P7, 609-613).*

Some participants spoke of the importance of advocacy for the infant, however, this can cause conflict with the foster agency, which some foster parents cope better with than others.

> *Mary: I don't really like the conflict*
>
> *Bob: I don't mind, if they're doing something wrong I won't back down either (P2, 259-266).*

Speaking out on the infant's behalf can be out of the foster parents comfort zone, and a skill that takes time to develop, as shared by Robyn, "*if you've got something to say, say it, not hold onto it but just say it, that's the other thing that I've learned" (P7, 524-530).*

Sometimes the foster parents also need respite for various reasons such as health, family issues, a change in circumstances, or as shared by Barbara: "*we have put them into respite to go to conferences, cause you're not allowed to take them" (P6, 1444-1446).*

Grief and Loss. The grief and loss foster families can experience during transition is discussed in Theme Two. Knowing ahead of time that the infant/child in their care will eventually be leaving, helps the participants cope with the departure of a child. Some spoke

of keeping the bigger picture of why they are fostering in view; that it is for the child's wellbeing.

> *Barbara: You've always got it in your mind, 'he's not ours', but when you're caring for him that's not on your mind. You're focused on him his needs that's it (P6, 903-910).*

Robyn shared a more specific experience of loss and grief that related to the death of an infant in their care, a twin who passed away from Sudden Infant Death Syndrome (SIDS). Although she could rationalise this knowing there was nothing they could have done to prevent this, there is still a deep sense of grief and loss, that took time to accept and cope with, but never fully left. The foster family did not receive any counselling, and it is unclear if any was offered.

> *It wasn't fun when we lost when we had a cot death…The scar's still there you never ever get over it. *Raymond's checks the babies all the time to make sure they're still breathing. You're very careful, very aware. You read about it and do everything they say…Lots of people blame themselves for a child dying, never felt guilty about it because I knew that I had looked after that child well (P7, 914-950).*

Locating studies connected the death of an infant in foster care and how the foster parent griefs and is supported was difficult. Though PSE is not specially mentioned in the above scenario, some studies have found SIDS is more likely to occur in infants exposed to opioids prenatally (Kuschel, 2007). General information for parents experiencing loss from events such as SIDS exist but are not specific to foster parents.

Boundaries and Limitations. Many of the participants shared the importance of knowing their limitations and setting boundaries for their wellbeing and that of their family/whānau, and the foster child. In particular they referred to this in relation to the agency. As shared by Mary, *"be strong and say no" (P2, 3290).*

One of the boundaries discussed related to fostering specifically infants. This may be due to the participants' age and life stage.

> *Connie: We make the stipulation that they would only be up to a year, I didn't want little two and half three year olds running around and climbing into this and into that. That's just too much pressure and stress trying to keep track of them and running physically (P1, 66-76).*

Boundaries with age can shift according to circumstances, such as Amy's family who went from all ages to just infants in order to protect their permanent child's needs, "*we carried on fostering since then newborns, we've had numerous" (P3, 37-39).*

Different participants had different skill levels and knowledge. Relating to high need infants, a couple of participants have a medical background, whereas other participants had no such training or background.

> *Connie: We had been offered a placement of a little baby that was on oxygen, but the worry was that he had quite a severe lung problem where he needed oxygen all the time. I would have had to go in and have two weeks training to use all the machines and things. Apart from the fact I'm not a trained registered nurse and I would be a bit uncomfortable trying to handle all these machines (P1, 130-136).*

Some participants spoke on the importance of not accepting placements if they do not feel ready or equipped for it, especially when new to fostering.

> *Janine: Don't be pressured into taking on responsibilities that you're not really prepared to do or you're not feeling ready to do (P4, 1806-1809).*

Whereas Barbara and Barry have expertise in caring for high needs infants, so usually only focus on short term placements.

> *Barbara: Normally we only take the short terms straight from parents so that we can give them some stability until all the court processes are put in place for them to move*

on, hopefully to a permanent position whether that's with family or with other caregivers (P6, 242-249).

A few participants discussed respite care as the ideal way to commence as foster parents. This is another form of boundary setting which allows limited exposure as foster families adjust, learn how to cope, and figure out what age group they prefer.

Mary: We said we don't know what we want, we don't know how it's going to work, so we'll just do respite for all ages and then we'll come back to you (P2, 3282-3287).

Marcellus (2008), who interviewed foster families of infants refers to 'honouring [the] limits' determined by foster families across various placements.

Past Experiences and Learnings. Participants spoke of how their past experiences throughout life, both pre-fostering and as foster parents added to their toolkit of resilience and coping. Most of the participants shared that their parental experiences enabled them to be better equipped to foster children. Janine shared how obstacles that arose with her own children's development and wellbeing equipped her to better cope and advocate for the foster children in her care.

I suppose having had kids that had some special needs, and kind of learning to be their advocate and doing extra stuff with them has trained me for our little girl who is full on (P4, 1478-1488).

A few of the participants' occupations enabled them to work closely with people in different capacities, including infants/children, such as Barbara: *"because of my nursing and neonatal experience they tended to give us the babies and very often very sick babies" (P6, 43-46).* Debbie acknowledged her Early Education training as a resource to help with fostering:

I did an early childhood course, about two or three years ago now. That's actually helped when I got into this, so I'm sort of glad I'd done that (P5, 1079-1088).

With time and experience over the years, according to Debbie, comes a maturity which enables them to approach situations more calmly and with flexibility.

> *We're more mature, I'm in my forties and taking on a baby you think how much have you grown you know since your own, and it's helped with [*fos. infant A] (P5, 288-294).*

Positioned and Equipped. Janine expressed how being free of financial concerns gave them access to purchase resources as required, and provided the head space to focus on the infant rather than worry about monetary provision and practical items needed.

> *Not having to worry about money that is a huge help, because if you've got all this and you've also got financial pressure that makes it a lot harder too (P4, 1533-1538).*

Some of the participants shared how they have accumulated equipment and items over the years ranging from nappies to a van for multiple children (P3, 1564-1569), so they are prepared practically for any child placed with them.

> *Mary: They know they that can give us a newborn through to five or six or seven year old and we've got absolutely everything (P2, 909-913).*

Characteristics and Attributes. Some of the participants shared various attributes that enabled them to cope with fostering, some of these were innate such as "*a cool temperament" (P7, 162),* while some attributes, such as competence, developed over time: "*they saw that we were pretty capable" (P4, 1638).* Amy utilised her organisational skills: "*I'm an organised person I know what I'm doing from day-to-day, the kids are in a routine and I don't stress about things not being done" (P3, 1572-1575).*

Personal Life

Some participants spoke of the impact fostering infants had on various aspects of their personal life, such as their social life.

Barabara: If we went out at night we would have to take the baby, but that's never bothered us…or one of us can go out" (P6, 1453-1455; 1747).

Other aspects a couple of participants shared related to taking care of their own health concerns, such as Amy, *"I had five months of chemo recently, I didn't have any kids with me it was weird (P3, 437-439).* Some of the participants discussed various life transitions and future hopes, such as Bob and Mary now with grown children, there was some anticipation of a new freedom. However, they have instead decided to provide a permanent home for one of the foster infants.

*Mary: We're starting again, it's meant to the years where we're enjoying ourselves, but I wouldn't give *Layla up for anything, not now (P2, 2315-2319).*

Amy spoke of the dual desire to foster whilst still having other dreams in retirement, *"I can't ever see me stopping…I want to get a bus and travel around the south island" (P3, 1521-1527)*. Connie who is also of retirement age shared about a smaller simpler dream whilst appearing content with fostering infants: "*I'd give anything to have a day where I'd just sit and watch telly and knit but that doesn't happen, but I'll do that when I retire, when I'm old" (P1, 54-59).*

Subtheme: Branches of Safety at Risk of Being Shaken and Damaged

This subtheme refers to the foster family's wellbeing and safety under threat from factors outside the family/whānau unit.

Amy: It's not just you go and you look after the kids, it's a lot of other little side lines like, the safety, the allegations. I think its fostering babies is easy, but you're still got that branches of safety (P3, 1719-1726).

Confidentiality/Privacy. For the sake of both the foster family and foster infant/child's safety, details pertaining to the foster parents such as contact details are kept confidential by the agency, foster parents, and associated organisations. However, breaches

can happen, such as with hospital staff accidently giving out private details to the birth parents.

> *Connie: So the mum and dad got there first and apparently went in and said oh yes we're [*fos. infant C's] parents, and this woman [hospital staff], they just carry on, ' oh yes [*Connie's address]', and they said 'no that's not our address.' So they immediately knew our address (P1, 942-949).*

Amy and Mark who diligently protect their privacy, discussed privacy breaches that occurred by professionals that work with the children and birth parents.

> *Amy: I tell them every time its confidential, and it's the bloody lawyers*
>
> *Mark: Not only the lawyers, but social workers and also psychologists*
>
> *Amy: You can tell them over and over again don't put our name in it. Refer to us as *A and *M (P3, 1689-1694).*

Allegations. No matter the nature of an allegation, where it originates, the agency is required to investigate it, as stated by Mary: *"when they have a complaint, they have to come to us, no matter how small it is" (P2, 872-873).*

Some of the participants demonstrated a heightened awareness and were proactive in taking precautions to minimise the possibly of an allegation, or having evidence and procedures in place so they can dispute false allegations.

> *Amy: I've always been aware of allegations and never put *Mark into a position for one to come against him…I'm so aware now that if *Mark's got the babies I'm around. Not that he would ever do anything but that that is a major (P3, 1178-1186).*

With infants the accusations usually come from the birth parents or family/whānau, who question the care being given, including every normal bump and bruise.

> *Barbara: You still get allegations from the parents. He's scratched his face. 'I beat him up'...You almost wrap them in cotton wool (P6, 1374-1384).*

False allegations do not only impact the foster parents but potentially the whole family unit.

> *Mary: These people dressed their babies in labels. They had this little girl's brother, so they were asked to take the sister on as well. *Ben ((biological child)) overheard this conversation at school and like he was like sounds like the kid we had and like. *Ben he doesn't bother about much, he exists. He came home really upset and said, 'Mum they were talking about her and she said her clothes were all grubby and said she had no toys and that the caregivers are only in it for the money'. I got really angry (P2, 823-836).*

A couple of the participants shared how they diligently file, record, and backup their correspondence, interactions, notes, and paperwork, as a form of self-preservation.

> *Barbara: I never ever let them have the original I always keep that as my back up cause we've got to protect ourselves, we're vulnerable, we're in a vulnerable position when things go wrong. We can be accused of all sorts of things (P6, 1288-1297).*

Safety and Birth Parents. Most of the participants discussed their safety in terms of the birth parents' behaviour. As a general policy the foster agency recommends foster parents have little or no contact with the birth parents, although it does depend on the birth parents and their relationship with the foster parents.

> *Barbara: If we do meet, we're not allowed to discuss anything. It's all just baby's fine, needs a bottle blah dee blah that's all. So that's a social worker's job and some parents we don't even have that contact we are totally in protection (P6, 311-323)*

Janine shared of the importance of a neutral meeting place for visitation.

> *We preferred it to be in the [*foster agency A] office, so we were prepared to take them in. Sometimes they are safe enough to have the contact go directly between you and the birth family, but you need to kind of negotiate, you need to know how to deal with different issues that can come up with that (P4, 1867-1874).*

Ideally the home of the foster parent can be considered a safe place for the foster family and foster infant/child: "*that's important that's big to have your home and the kids are safe in it and we're safe in it" (P3, 1668-1670).* However, there can be incidents where the safety of home is at risk, such as after an uplift from a violent environment. On rare occasion, a birth parents manages to locate the foster parents' home and physically visits, which, can be very unsettling for the occupants.

> *Amy: There was one time when [*fos.child B]'s father found out where we live and that was really scary. I didn't want to leave our kids at home on their own in case he came in. He never came onto the property…Knowing that they know where we live it unearths you, cause you never know when they're going to turn up (P3, 1672-1687).*

Some of the participants spoke of times where they are hyperaware and cautious when out and about.

> *Amy: I'm very weary when I leave home or getting taxis and coming home. I make sure cars aren't following me cause that's what you've got to be aware of. They could be sitting out there waiting watching you come to the office coming out of the office and then follow you (P3, 1703-1709).*

Although some unpleasant narratives have been shared in regard to safety and birth parents, there were only a few of these accounts throughout the interviews, which suggests most birth parents are unlikely to cause harm. Though it is wise to err on the side of caution for the sake for the foster family, foster infant, and birth parent's sakes.

Conclusion.

Theme Four focused on the journey of foster family, considering the wellbeing and functioning of the family/whānau unit as they encountered different aspects of fostering infants. The family unit as whole was discussed with particular focus on the participant's dependents, such as biological, adopted, and permanent children. The dependent's

experiences were examined, this included: being included in decisions, having their needs prioritised, the children's acceptance of being part of the foster family, joining in with the cares, and the sacrifices they made at times.

The various stressors and challenges the participants' encountered were then considered, including, how they coped and demonstrated resilience. Grief and loss is a part of the fostering experience, with the departure of infants, or a deeper grief when an infant dies in their care. Foster parents can experience emotional trauma after observing the effects of physical abuse of an infant. Factors which increased resilience were discussed, including boundaries/limitations; starting with respite; past experiences and learnings; being prepared practically; and the characteristics and attributes of foster parents.

Consideration was given to the social lives of foster parents, their physical health, and the future possibilities of what life not fostering could look like. Finally, the subtheme, Branches of Safety, discussed the darker side of fostering including taking extra precautions to protect the foster parents' confidential information and privacy, the reality of false allegations, and safety from potentially dangerous birth parents.

Theme Five: Network of Supportive Relationships

Common amongst the participants was the theme 'Network of supportive relationships'. They indicated the importance of good support as they foster infants, particularly from the foster agency and their immediate family. Support can be available in various forms and at various levels of connectedness, such as the close relationship of foster parents with biological children compared to the SW. Support available appears to be fluid and not set in place, moving as situations change. For example, as biological children grow, the support they can or want to give may change. There is an element of reciprocity within the support network, both towards and from the participants to others in the system.

In varying degrees, all of the participants discussed the value and need for support, "*support is really good, it doesn't matter what it is" (P1, 1220-1222)*. Support can include inter-support of spouses/life partners (Cooley & Petren, 2020), biological children (Marcellus, 2008), extended family/whānau, fellow foster parents (MacGregor et al., 2006; Marcellus, 2008), foster agencies (Andersson, 2001; MacGregor et al., 2006), organisations and specific foster or disability support groups, and general community supports such as police or Plunket. Fostering literature discusses foster parents recognising the importance and need to utilise general parenting support services in their community, such as play centres or schools (Khoo & Skoog, 2014). Due to the diverse and complex nature of fostering support in any form is gratefully received and valued, as expressed by Janine, *"being part of, having a support group or having somebody that you can speak to is always helpful" (P4, 1508-1512).* The combination of specialised support services, and also utilising those support systems for day-to-day cares and issues set up in the community is deemed beneficial.

Inter-support of Foster Parents and Immediate Whānau/Family Unit.

The inter support between foster parent spouses/partners is paramount, as simply stated by Connie, *"I couldn't do it without him" (P1, 246).* A common dimension shared with the majority of participants is the importance of sharing roles and cares of the foster infant.

> *Robyn: It's hard work, but Raymond and I share it. Raymond is a wee bit of a night owl and I'm not so I go to bed early and he does the night feed and then I do the next two feeds (P7, 258-263).*

Sharing includes juggling the cares and needs of both foster children and their own children.

> *Amy: Mark would finish the dinner, because it's just so disruptive in the house, because it's constant crying or noises they make (P3, 587-589).*

These foster parent dyads demonstrate the importance of being able to coordinate to enable the successful functioning of biological family whilst addressing the foster infant's needs. Built on the foster parent dyad as a foundation is the support from the dependants of the foster parents, such as biological/adopted/permanent children, with the day-to day cares.

> *Barbara: You can't do it on your own, the whole family's got to be committed (P6, 1224-1228).*

Adult biological children, who will have been vetted by the foster agency, are able to support their parents through activities such as babysitting, as shared by Connie: "*go out and leave him with my daughter for a couple of hours, go to a show or something like that" (P1, 195-196).*

Support Network of Extended Whānau/Family and Close Friends.

The associated factor that is next in the level of support experienced by the participants is through their wider family/whānau and close friends, this includes emotional support, for example during the transition and handover of an infant.

> *Mary: Mum and Dad came up and they said 'oh you know if you're in too much of a mess Dad can drive you home'. They're such a big part of the kids' lives as well (P2, 2438-2441).*

Supportive whānau become richly involved with the foster children's lives, some playing roles such as foster grandparents, and are aware of the emotional toll and strain certain aspects of fostering can induce.

There is also practical support by family and friends, for instance when the first foster infant arrives and thus some participants had limited age related resources.

> *Mary: At this stage we didn't have a cot, we didn't have a bassinet, nothing. So I was quickly on the phone, Mum can we come through, get the bassinet, have you got anything? (P2, 940-944).*

Participants of both kinship care and non-kin foster parents discussed the value of the wider family support, even if it took some time to come to a place of understanding and accepting as to why the participants wanted to foster.

> *Janine: We've always had family support. Initially, my father couldn't understand it, but he was fine. We had all this free time up to this point of time in our live. They got use to that and then they were his grandchildren too (P4, 1664-1674).*

The fostering family, particularly the non-kin fostering family, will have had more time than the extended family to process their decision and the possible consequences. Given time to process, the extended family are described as becoming part of the fostering system, accepting the foster children as family.

Kinship care may elicit resistance and questioning from family/whānau due to the familial connection to the infant.

> *Debbie: My sister is her grandmother. We had a couple of people, well my sister's ex said, 'oh she should have gone with the Nana.' but I said "well theoretically it was the mother's decision' (P5, 918-924).*

Experiencing the support and acceptance of close friends was discussed by some participants, this included accommodating the infant socially, "*that's fine, got an extra bed" (P2, 706)*. Some friends are fellow foster parents where friendships have formed through the shared experience of fostering.

> *Amy: She's an ex foster parent, and comes around and just look after the twins, while I whatever (P3, 1442-1444)*.

Some participants shared how people not involved in foster care appear to have constructed a negative image of the fostering experience is, such as the loss of freedom, and in turn may impose these misconceptions on those with lived experiences of fostering.

Robyn: People think you're mad, you're stupid taking on somebody else's problems, but they're not problems, they're children (P7, 739-742).

Barbara shared how people can have unrealistic expectations of what is involved with fostering infants, not realising how much time and commitment is involved.

People say, 'oh come visit me', and I'm like, 'well look I haven't sorted this baby out', 'oh, but you get plenty of babies, you must know what they need' (P6, 2031-2035).

This could be experienced as a more subtle and unintentional form of lack of support.

Inter-Support of Foster Parents and Support Groups.

A few of the participants spoke of the network of foster parents that provide support.

Barbara: I can't go to the neighbour next door and start talking about my problems with this child, it's confidential. But I can go to another caregiver and talk about it, it's within those parameters (P6, 1233-1248).

Overtime foster parents may develop a core group of foster parents that connect and support informally.

Amy: There are about three or four of us still going, some only take an older child now or whatever. There is support out there if you choose to use it (P3, 1613-1616).

Specialised or fostering specific groups, such as provided by Caring Families Aotearoa/Fostering Kids, give the foster parents space and time to share experiences with like-minded people, and is valued and of benefit to foster parents. This is supported by previous research where foster parents have spoken of the value of connecting and learning from more experienced foster parents (Cooley, et al., 2017), a place where they can share struggles and joys and receive advice for specific issues (Daniel, 2011; Murray et al., 2011). Some of these support groups are specific to special or high needs children.

Amy: We're in a special needs groups that's got lots of support if you need it, just give them a ring. You support each other (P3, 1601-1608).

Reciprocated support to other foster parents was given by some of the participants including babysitting, as per Connie: "*another carer's little boy, she dropped him off for a few hours while she went to an appointment" (P1, 1006-1007).* Barbara recognised that different foster parents have different strengths and backgrounds that they can pull from as a resource, and support on another.

> *Anything medial she'll [*another foster parent] be ringing me up, and what's this what's that. That's why they give us the sick ones (P6, 180-183).*

Some participants reciprocated support to other foster parents through involvement with training days run by the foster agency or Caring Families Aotearoa.

> *Barbara: We go and talk to new caregivers if they have classes supplied. They have to go through training and they get us to go in and talk to them about our experiences (P6, 1688-1692).*

Foster Agencies and Organisations Support.

The next level of associated factors is that of the fostering agencies, such as Oranga Tamariki, or support organisations such as Caring Families Aotearoa. In regard to the foster agencies, this can refer to the system, specific agency offices, and staff located in the geographical area of the foster parent. Most participants discussed the foster agency's support in the form of provisions, advise, acknowledgement, and moral/emotional support; or in contrast, the lack of support in not being heard, listened to, or valued.

Social Worker (SW) Support. All the participants discussed in varying depth their experiences with SW support in some form.

> *Barbara*: *There are good social workers and there are not so good social workers, and it can make all the difference in what happens to the child (P6, 1203-1210).*

Participants found that navigating and adjusting to the system has its challenges. SWs are part of this system and are the point of contact for foster parents. The support from SWs can be variable and vital.

Communication. One reoccurring topic related to communication with the SW, with varied experiences. This includes being able to contact them and be provided with the necessary advise or information, or the SW returning a call and communicating with the foster parent. Some participants spoke positively in regard to communication, *"most of them are pretty good and listen too" (P2, 301).* Some participants indicated experiencing non-communication, such as "*when you need to know something and they won't get back to you" (P4, 1193-1194)*. As a consequence of limited communication some participants spoke of contingency plans in the form of careful record keeping *(communication is just very non-existent with social workers and you always back things up with a e-mail (P6, 1265-1268)).*

Assistance, Information, and Guidance. Some of the participants felt unsupported or unable to rely on the system or agency in regard to assistance or information, for issues or queries that may arise.

> *Janine: So getting support wherever you can get it, and knowing that you may not get much support from [*foster agency], where you'd expect it (P4, 1768-1773).*

In regard to receiving information that foster parent needs from the agency, Barbara describes it as, *"like getting blood out of a stone" (P6, 2107).*

Debbie, in contrast, expressed only positive experiences with the agency and system, though it is unclear whether this is related to kinship care, geographical location, less experience with system compared to the non-kin foster parents interviewed, or outlook on life.

> *If you're working in the system, like we are with [*foster agency A], remember that they are there to support and help give you the best information. I mean the*

experiences that we've had with them, you can't complain. They've been marvellous, they've backed us up to the hilt since we've had this one (P5, 985-997).

These participants expressions of the importance of a supportive, reliable, consistent, and responsive SW that communicates and listens to the foster parents is consistent with fostering literature (Brown & Calder, 2000; Khoo & Skoog, 2014).

Supporting Social Workers. Many of the participants recognised the huge workload SWs carry.

Mary: We always bagged social workers, and then we realised after the hospital thing that it's not actually the social worker a lot of the time, its further up the chain (P2, 303-309).

This recognition is consistent with research where foster parents in other studies recognise SWs have large workloads and themselves are trying to negotiate the expectations of the system (Khoo & Skoog, 2014; Spielfogel et al., 2011). Some of the participants try to ease some of the social worker's workload.

Amy: I take the babies[to appointments] myself...and also the social workers are overladed and overstressed, so that if I can help them out that's what I do (P3, 756-760).

Resources and Financial Support. Provision and financial support is not the main focus or motivation for the participants fostering. However, there is some hope or expectation that the agency would provide the required equipment or compensation to assist, as demonstrated by Barbara:

W*e're not financially compensated enough. All the gear we've had to buy. We get nothing, we get a bit of board support, twenty dollars a day. But if you're really doing for the children that doesn't matter, and that's what we do it for (P6, 1731-1743).*

Some of the participants have accumulated the equipment they need to foster through their own means and have taken responsibility for provision upon themselves, and ensuring they are self-sufficient.

> *Mary: Being prepared, otherwise you're going to find it really hard, cause like some social workers are really good, they'll bring you everything, others (P2, 2508-2512)*

There appeared to be an acceptance that the agency cannot be relied on. Therefore solutions and resources are found in alternative ways, which is consistent with literature where foster parents tap into other resources available in the community, such as schools (for older children) or Plunket (Khoo & Skoog, 2014).

In terms of financial support, the participants tended to talk more in general and about the kinds of allowances and board the agencies are responsible for providing. According to Amy and Debbie, this includes birthday and Christmas allowances (P3, 1340-1344; P5, 758-765). Amy also mentions the provision of a clothing allowance: *"we use to get a clothing allowance every three months"(P3, 1329).* For Debbie the realisation that there is financial support lifted the stress of figuring out how they would suddenly be able to provide for the infant: *"*w*e didn't know that you get an allowance, so we sort of thought, okay we'll have to re juggle our budget" (P5, 699-702).*

Support with High Needs Infants and Specialised Care. A few of the participants have medical training that enabled them to foster specific high needs infants, such as those for palliative care. Barbara discussed how they can feel unsupported and left to their own devises with these infants.

> *What about [*fos. infant E]. It was a month and he was a really sick child, he came for palliative care. The social worker contacted us one month after we got him (P6, 2339-2344).*

The feeling of being unsupported by the foster agency particularly with vulnerable children is described in literature as 'broken promises', leading to the foster parents struggling to subsequently trust the organisation (Blythe et al., 2013).

No Voice, Value, or Rights. Some of the participants discussed their experiences in regard to feeling like they have no voice or are not being heard. They felt their input and experience was not being valued despite being the primary carer for the foster infant and whose care had been entrusted to them. Barbara stated, *"we have no rights"* (P6, 625) when discussing how their life is disrupted by biological parents' rights and expectations, which can be detrimental to child. The agency interviewed Barbara and Barry about their concerns in regard to foster parent rights and care retention.

> *Barbara: We got this phone call from someone in [*city/town D] who said that the chief, the CEO of [*foster agency A] is sending someone down to interview us about the rights of caregivers and the care and the retention of caregivers, because they lose them…We're still not getting heard (P6, 740-755).*

One area that some participants felt they were not listened to or had their input valued, was in regard to transitions and placements after being in their care.

> *Barbara: It's when they are going to places that you know it's not going to work.*
>
> *Barry: And yet you can't tell the social workers anything (P6, 1062-1068).*

Throughout the interview Janine shared her experiences and frustrations in regard to the placement of one particular high needs infant placement. Despite all the hours of care and understanding the infants need, it appeared her input was not valued.

> *You've got no say in what happens to them. We were so frustrated because nobody seemed to be listening to us. We did not think this was a good move for this baby and with all her needs. Nobody was listening to us (P4, 1018-1019).*

Support Through Training and Development. The majority of the participants discussed training and its value as a supportive way to develop networks, tools, and understanding with fostering infants.

> *Janine: Get as much training as you can. You're talking specifically about babies so particularly ones around attachment because that also deals with people not wanting to get too attached, and that's really important for the babies, and so getting some understanding (P4, 1696-1707).*

Foster parents participants of numerous studies confirm the value and need of training through the fostering journey (Cooley et al., 2017). Literature discusses a few training programmes or interventions which focus on foster infants. One of these being Project T.E.A.M.S in the US, set up to equip foster parents of infants affected by PSE (Edelstein et al., 1990).

Training is especially a vital support for those starting out as foster parents, as it can provide a support system when in crisis or when unsure how to handle a particular situation.

> *Amy: There is some training and I think for the new ones it's a necessity, because if they get this child into care and they know nothing about how to support him then this training can, 'oh I remember that in training' and it can help. Or they can find a contact number that they can ring and say, 'look we've got this kid and he's doing da da da'. That kind of things are really good for them, the new ones (P3, 1624-1634).*

Participants indicated the benefits of attending training courses as learning tools or gaining insight that has a positive impact on both the child and foster parent. This may only be one gem of knowledge gained but can make a huge difference.

> *Janine: Just think you can't ever know it all and you go to a course and you learn one thing that's going to make your life or your child's life easier, then it's worth it (P4, 1112-1117).*

There are various courses and training the foster parents are given access to so that they are more supported and equipped. These courses include topics such as identity, attachment, child development, challenging behaviours (P4, 1143-1145), safety and prevention (dealing with allegations and complaints) (P1, 1064-1073), first aid (P3, 1617-1621), and documenting behaviours (P1, 1272-1280).

For some more experienced participant's motivation to attend training has decreased due to a combination of actors, as discussed by Amy:

> *They have a lot of training , support training, and I've done some, but a lot of the ones that are out there, getting done now is, I don't say I know it all, but I've dealt with them and I think to myself 'oh it's too much of a hassle trying to organise to get there, to sit through something I already know and I've done (P3, 1588-1595).*

Training gives the foster parents support and tools, especially at the beginning of the fostering journey, however, can also create other issues where support is needed to attend the training, due to the nature and complexity of fostering children.

Conclusion

Participants in this study have shared of the importance of support, and it's various forms from general to specialised. They have experienced positive and appropriate support from family, community, the foster agency, foster organisations and associated support networks, and other foster parents. They have also experienced a lack of support or being heard, whilst recognising the limitations of the system. The largely beneficial aspects of training as a support for foster parents was covered.

Chapter 6: Closing Discussion

In this concluding chapter, a summation of the findings are provided in addition to a brief discussion of some of these findings. This is followed by a consideration of the implications of these findings for future research and practice in this area. A reflection on the limitations of the study and future avenues for research brings the thesis to a conclusion.

The purpose of this study was to better understand the experiences of, and gather insights from foster parents in A-NZ who care for infants, particularly those infants up to four months of age. Foster parents in A-NZ are embedded in a cultural and historical environment that differs to that of other nations. Though aspects of the system and approaches are comparable to similar Western nations, there are unique aspects that are linked to the principles of the Treaty of Waitangi/Te Tiriti o Waitangi.

Findings indicate there are shared experiences between foster parents as represented in the international literature and those A-NZ, as well as between those who foster infants and of those who foster older children. These include reasons for deciding to and continue to foster, the journey to becoming a foster parent, building a relationship with the infant/child, managing the challenges of foster infant/child behaviour or complex needs, general day-to-day experiences, and experiences of grief/loss when an infant/child departs. Also included are the experiences of available or lacking support, complexities in navigating the foster system, and the resilience and functioning of the foster family as whole.

In relation to the fostering of infants, there are fewer studies that target this demographic. The issue of PSE and other trauma experienced by the infant, and resulting complex needs and future outcomes is discussed in similar studies, with more recent studies considering the impact of stress in-utero to development and attachment postnatally (Bunston & Jones, 2020; Cortizo, 2020). The majority of A-NZ foster parent studies are not specific to

infants but, as with the international studies, similar experiences to those articulated in this study were described.

Participants were interviewed with a semi-structured framework, and a thematic analysis methodology was applied to generate themes from these interviews. A systematic ecological approach was a component of the derivation of themes. From the analytic process five main themes were developed, all of which overlapped and linked by various forms of relationships, particularly the relationship with and within the foster system.

Making a Difference Through Providing a Home

The 'Motivation and Commitment' theme discussed why the participants started and continued fostering. Previous studies discuss a range of motivations, including intrinsic and extrinsic (compensation), with the primary motivations being altruistic (making a difference, providing a home), benefits to biological children (learning compassion), personal experiences of foster care as a child, and wanting to parent (Barton, 1998; Brown et al., 2007; Marcellus, 2008). Those who fostered with extrinsic motivations, such as for an income, did not indicate this as their primary motivation, but rather that they could see the benefits for the child (Andersson, 2001). This study found that, although participants had experienced different journeys and triggers to commence fostering, the salient and primary reasons indicated were altruistic in that they wanted to make a difference and provide a home for an infant/child. Making a difference went beyond helping an infant/child, to positively contributing to communities and the next generation. Participants spoke of contributing to the infant's security, healthy development (such as through secure attachment and self-regulation), and overcoming trauma so that the infant/child can focus on learning and developing in every domain (physiological, cognitive, psychological, social). This is comparable to other studies, both internationally and from A-NZ, with some foster parents wanting be part of breaking dysfunctional generational cycles, or helping build healthier

communities (Atwool, 2010; Khoo & Skoog, 2014). Challenges were outweighed by these altruistic motives and the rewards of observing positive changes in the infant's lives, with even small steps being a cause for celebration. In regard to fostering infants, the foster parents demonstrated both love and passion for infants, with some equipped with specialised skills to care for infants with more complex needs, such as PSE, palliative care, or tube feeding.

High Needs, Needs Specialised and Special Foster Parents.

The 'Nurturing from bud to bloom' theme articulates the participants' day-to-day experiences as they journey with the developing infant. It focused on managing various challenges caring for foster infants, such as complex needs. The subtheme 'Grafted, Connected, and Grafted" focused on trauma and attachment interactions and the impact on aspects of care and experiences, for example, PSE, and challenging behaviours.

One of the findings was the extent to which foster parents care for infants with complex needs. These needs include PSE and withdrawal, palliative care, traumatised infants (including those who have been physically abused and neglected), in utero trauma and stress, bonding issues, and medical conditions (such as brain injuries or severe reflux requiring tube feeding). Managing PSE and withdrawal symptoms are a consistent part of the foster parents' role. This is consistent with the literature, with PSE currently being the primary reason infants go into foster care (Marcellus, 2006). A study by Oranga Tamariki (n.d.a), which ranged from 2011-2020, found the two primary reasons for fostering as PSE and IPV (Oranga Tamariki, n.d.a). The foster parents commit time, resources, and knowledge to nurture the infants, which is particularly intensive when caring for those affected by PSE. This includes settling infants into a healthy routine, comforting and soothing them, especially when agitated and distressed, enduring the piercing relentless cries of the PSE infant, providing a calm low stimulus environment to soothe, and providing stimuli to promote the

development of healthy neural pathways. Literature show infants affected by NAS are more likely to require a calm low stimulus environment (Johnson, 2014; Sloan Donachy, 2017). Ultimately, foster parents provide a secure warm environment to build and nurture healthy development including secure attachment.

It was found that within the foster parenting of infants demographic there is a more specialised group, who through past experience and training are able to foster high need complex infants. These foster parents present as competent, resilient, resourceful, and skilled in caring for these particular children. They however indicated being taken for granted at times, left to address the infant's specific needs with little contact or information from the agency after the initial drop off. A review by Oranga Tamariki (2019) survey of 4,000 foster parents, recognised the need for more support for foster parents, however this a general overview rather than addressing the specific needs of foster parents caring for infants. Within this there are also those who recognise their lack of specialised training and experience and thus their limitations, though they spoke of being able to care for infants with milder issues such as uncomplicated PSE. Lying between these two groups are those who undergo specialised training for a specific infant, such as learning the regime and techniques to tube feed an infant with severe reflux.

This study found that it is not uncommon for foster parents to foster multiple infants, some who have high needs of varying degrees. Although the foster parents provided excellent care, some found there was a payoff, such as decreased sleep or downtime for the foster parent, or less time to devote to bond via ways such as holding when feeding, especially if one infant is more needy or complex than another. It is unclear whether the multiple infants are due to a shortage of foster parents, or specialised foster parents, as some are quite comfortable and cope with multiple infants. My survey of the literature regarding the simultaneous fostering of multiple infants indicated a lack of research on this topic.

Systems Within Systems

The theme 'External elements' deals with the experiences of the participants as they navigate being part of an imperfect but necessary system, which includes aspects such as agency policy, SWs, birth parents, and the health system. The findings in this section relates to the systems, relationships, and interactions within this system which is a presence throughout the themes, with Theme Three providing a specific focus on navigating the system. The study found that, like an ecological system, the foster parents are part of many systems within the larger foster care system. Some indicated that learning to navigate this system can at times be more frustrating than any challenging behaviour or issue associated with the infant. This aligns with prior research which discuss the multiple complexities that arise within the foster system (Cooley et al., 2017). Oranga Tamariki (2019) have acknowledged improvements can be made to improve the support and processes for foster parents navigating the system.

Cyclic Nature of Fostering Infants and Grief

The theme 'Wellbeing and functioning,' considered the experiences of the participants as a family unit, including how they worked together, how they coped with the changes and unexpected challenges that arise in foster care, and how they adapted to the arrival and eventual departure of infants. The wellbeing and health of the foster parents and how this impacts on decisions and care was also briefly discussed. A subtheme considered the darker side of foster care and the risk it can entail with potential impacts on privacy/confidentiality breaches and the making of false allegations.

Within Theme Four, one of the findings relates to the letting go of infants when they go into a new placement, be it permanently with birth parents/whānau, non-kin guardians, or with another short-term foster placement. Foster parents spoke of feeling expectations from the foster agency to simply disconnect from the infant and not experience intense emotions.

The reality of the foster parent's experiences, is they can experience loss after forming a bond with an infant, having invested time and love, especially over an extended period of time. Literature also refers to these experiences of grief and loss. This has been described as 'disenfranchised grief' where such grief is difficult to discuss or acknowledge openly (Lynes & Sitoe, 2019). Marcellus (2008) describes the 'gradient effect' which foster parents experience according to the depth and length of relationship with infant. The findings also demonstrate that foster families develop strategies to assist them in coping with letting go and the resultant grief. For some, this is taking steps to mentally prepare and detach, such as laying infants clothes on the bed, whilst preparing the infant for the transition. For others it is a matter of acknowledging the intense emotions and allowing them to flow and be processed over time. Knowing this is part of fostering and holding onto the fact they will be leaving, whilst nurturing and loving them is a coping method used by some foster parents.

The above also links to the cyclic nature described by participants with having one infant leaving, whilst another infant arrives needing love and security. This aligns with a study by Marcellus (2008) which focused on fostering infants, and found that the foster family experiences a process of 'constant rebalancing'.

Some foster parents experienced a greater depth of loss and grief, with the death of a foster infant under their care, such as with SIDS. Although they acknowledged this was out of their control, it still leaves them hypervigilant and cautious in relation to future infant care. Literature in regard to this kind of loss specific to foster parents, and the counsel and support required appeared to be sparse. Foster infants are a high risk group with various complex health issues and complexities, and therefore potentially at a higher risk of death. Pugh et al. (2023) found in a recent study that children in foster care are hospitalised in A-NZ more than non-foster children. Oranga Tamariki (n.d.a) briefly discuss the vulnerability of infants and the complications and complexities these infants come with.

Being Heard, Valued, and Included.

The last theme, 'Network of supportive relationships', focused on the various aspects of support provided by the foster family/whānau, wider family/whānau, community, other foster parents, foster organisations, and the foster agency (including training). The lack or limited aspects of support provided were discussed, including not being heard. Interwoven and entangled throughout the theme was the reciprocity of support, where the foster parents both received and gave support within the system.

Within this theme, one of the findings relates to foster parents feeling unheard or undervalued for the work they do. Despite being entrusted with the care of infants, including high needs infants, they felt their knowledge and input was not acknowledged or their input and advise was not taken on board. Literature from international studies have similarly found foster parents have experienced feeling unheard and undervalued (Spielfogel et al., 2011). The survey of foster parents by Oranga Tamariki (n.d.a) was conducted after the interviews with the foster parents in this study were completed. In their study they also found that foster parents experienced issues with being unheard and feeling undervalued with the Ministry indicating that are seeking ways to remedy this. The experience of not being heard or valued was however not consistent across participants and across their time fostering, in that some foster parents relate well with and work closely with certain SWs, who recognise their years of experience and even seek their input at times. This is aligned with similar studies where foster parents have experience mixed interactions with SWs, with some feeling supported and other less so (MacGregor et al., 2006).

Implications

The themes developed from the analysis of the interview transcripts provide a range of insights into the experiences of foster parents of infants in A-NZ. They indicate a group of care providers that are specialised, dedicated, resourceful, and passionate about the wellbeing

of both foster infants and those around them. They are a small group whose voices often get lost in the wider foster system, and yet they play an important role in the early development of infants, providing a foundation for these vulnerable children's future development and wellbeing. As indicated above, the results generally align with current similar studies, and demonstrate the systemic ecological nature of foster care.

In regard to specialised or unique fostering groups, such as foster parents of infants, the implications of the findings in this study highlights the need for more these foster parents to have opportunity to share their needs and experiences. Their voices and experiences need to be added to hear the diverse experiences of this specific group of foster parents, and more resources, training, inclusion in decisions, and support will benefit the foster parents, infants, and system as a whole. There are foster parents who have great expertise and knowledge in regard to fostering infants. Giving them the opportunity to share their recommendations and experiences to the agency, will potentially help them care for infants better. This should benefit the foster family's well-being, the infant's development and future, birth families/whānau, and healthy communities. Some may be more comfortable sharing in a group environment somewhere such as a marae, church, or community group, and having groups run by people they know and trust. This also provides an opportunity to network and provided support.

Limitations

The narrow criteria for inclusion and the specific infant focused nature of the work foster parents and kinships carers undertake, made it difficult to locate people willing and able to participate. Sickness hindered one potential participant who had been interested. This study gave voice to the experiences of non-kin and kinships foster parents, but is missing the voice of the indigenous peoples, Māori. It was not possible to learn about or give voice to the experiences of new or relative new foster parents/kinship carers, nor to foster parents/kinship

carer of ethnicities other than NZ European. Especially missing was the voice of the tangata whenua who foster or provide kinship carer/whāngai. It is possible those who made themselves available to participate are more inclined to be involved, or in a position where they have resources to free them up to participate, or are more likely to value research and want their experiences known. There may have been unknown limitations to other foster parents of differing demographics to participate, such as access, time, and access to details regarding the study. Only one participant was a kinship carer. I recognise being more proactive in meeting organisations or groups rather that rely on word of mouth may have lessened some of the limitations. Time was also a limitation in how much travel and recruiting and connecting could be conducted.

Future Avenues

As mentioned above, future research where the experiences of Māori foster parents/kinship carers with foster infants in their care would add significant value and increase our understanding of the experiences and needs of this particular group of foster parents. A multicultural understanding of those who foster should include understanding how they navigate the current system, and how the foster care system aligns with their worldview. A diverse understanding of caring for vulnerable infants and the needs of various foster parents would be beneficial. There may be a space for research by someone who can better relate and connect with Māori foster parents or kinship carers with foster infants.

The experiences of new foster parents in A-NZ with foster infants would add nuance to our current understanding, in comparing this group's experiences to those of more experienced and seasoned participants.

Conclusion

All five themes developed in this study may be considered parts of an ecological system or cogs in a machine, linked together, overlapping, and influencing each other. Like a

tree has a system within itself to grow and function, it is part of a wider complex system that it contributes to whilst ideally receiving healthy resources to enable it to continue functioning and supporting life. The experiences of the participants in this study have added to understanding the joys and challenges of caring for foster infants. There is more to be done to support, equip and understand the needs of foster parent of infants, and what is required to successfully foster a vulnerable infant, whilst maintaining foster family/whānau balance and wellbeing.

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Appendix A: Cultural Advisor Letter

MASSEY UNIVERSITY
SCHOOL OF PSYCHOLOGY

2nd August 2017

Research Ethics Office
Courtyard Complex
Turitea Campus
Massey University/Te Kunenga ki Purehuroa
Private Bag 11222
Palmerston North 4442

Tēnā koutou,

Re: **MUHEC Application**
Foster parent's perceptions of the experience of caring for new-borns/infants in Aotearoa/New Zealand
Sharlene Vere-Jones

The co-ordinating investigator, Ms Sharlene Vere-Jones is seeking ethical approval to conduct a study which will explore the experiences of foster parents/carers who have cared for new-borns/infants in New Zealand. Ms Vere-Jones plans to take a phenomenological approach to interviewing 8-10 foster parents/carers and the data will be analysed using Interpretative Phenomenology Analysis (IPA).

Ms Vere-Jones research has particular bicultural significance in Aotearoa/NZ as Māori have unique perspectives, protocol and values that are brought to bear in relation to childcare. I have had an opportunity to read the students research proposal and was particularly impressed with her sensitivity to these issues and in that regard I would be hopeful that she is successful in recruiting Māori participants into her study. Furthermore, Mr Vere-Jones' proposal has given commendable consideration to issues associated with kaupapa Māori approaches to research which, although outside the methodological scope of her study, are likely to facilitate successful engagement with Māori stakeholders.

I don't have any outstanding concerns regarding bicultural ethics and am very comfortable that Ms Vere-Jones has given due consideration to bicultural issues that may arise for the participants in her study. Finally, I have informed Ms Vere-Jones of my willingness to have an ongoing consultative role in this project should she require assistance in engaging with potential Māori participant communities or advice pertaining to cultural issues that may arise for Māori participants during the course of her research.

If you have any further enquires please don't hesitate to contact me.

Noho ora mai rā,

Simon Bennett, PhD
Ngāti Whakaue, Ngāti Wai, Ngāi Tahu
Kaimatai Hinengaro Matua: Maori Clinical Psychologist, Senior Lecturer
School of Psychology, Massey University Wellington
Telephone: +64 (04) 801 5799 ext. 63609
Email: S.T.Bennett@massey.ac.nz

Appendix B: Ethics Notification

MASSEY UNIVERSITY
UNIVERSITY OF NEW ZEALAND

Date: 25 July 2017

Dear Sharlene Vere-Jones

Re: Ethics Notification - **4000018200 - Foster parent's perspectives on the experience of caring for newborns/infants in Aotearoa/New Zealand**

Thank you for your notification which you have assessed as Low Risk.

Your project has been recorded in our system which is reported in the Annual Report of the Massey University Human Ethics Committee.

The low risk notification for this project is valid for a maximum of three years.

If situations subsequently occur which cause you to reconsider your ethical analysis, please go to http://rims.massey.ac.nz and register the changes in order that they be assessed as safe to proceed.

Please note that travel undertaken by students must be approved by the supervisor and the relevant Pro Vice-Chancellor and be in accordance with the Policy and Procedures for Course-Related Student Travel Overseas. In addition, the supervisor must advise the University's Insurance Officer.

A reminder to include the following statement on all public documents:
"This project has been evaluated by peer review and judged to be low risk. Consequently, it has not been reviewed by one of the University's Human Ethics Committees. The researcher(s) named in this document are responsible for the ethical conduct of this research.

If you have any concerns about the conduct of this research that you want to raise with someone other than the researcher(s), please contact Dr Brian Finch, Director - Ethics, telephone 06 3569099 ext 86015, email humanethics@massey.ac.nz. "

Please note, if a sponsoring organisation, funding authority or a journal in which you wish to publish requires evidence of committee approval (with an approval number), you will have to complete the application form again, answering "yes" to the publication question to provide more information for one of the University's Human Ethics Committees. You should also note that such an approval can only be provided prior to the commencement of the research.

Yours sincerely

BJ Finch

Research Ethics Office, Research and Enterprise
Massey University, Private Bag 11 222, Palmerston North, 4442, New Zealand **T** 06 350 5573; 06 350 5575 **F** 06 355 7973
E humanethics@massey.ac.nz **W** http://humanethics.massey.ac.nz

Appendix C: Information Sheet

MASSEY UNIVERSITY
COLLEGE OF HUMANITIES
AND SOCIAL SCIENCES
TE KURA PUKENGA TANGATA

Foster parent perspectives on the experiences of caring for newborns/infants in Aotearoa/New Zealand

INFORMATION SHEET

Tēnā koe, greetings. My name is Sharlene Vere-Jones and I am completing my Master's degree in Psychology at Massey University.

Children/infants in state care can potentially have various disruptive and unsettling experiences. These may include multiple placements, substance withdrawal, delayed development, and separation from biological whānau/family. This in turn can affect the child's behaviour, interactions and ability to form secure attachments with other people. The responses and interactions of the child and carer with each other can be influenced by many factors and can affect future interactions and behaviours.

The aim of this study is to give a voice to foster parents/carers' experiences and perceptions of caring for infants. I would like to invite you to participate if you have experience of fostering infants from birth to four months. If you have received this request to participate, it is likely you have been recommended by an organisation or person associated with fostering.

If you choose to participate in this study, I will ask you to take part in an interview of approximately one hour in duration. In the interview you will be asked questions related to your experiences of fostering an infant(s). The interview will be recorded with an audio recorder to enable transcription of conversation later. A time and venue will be negotiated that allows for your schedule and preference. At the conclusion of the interview you will be given a gift voucher as a thank-you.

For confidentiality purposes, your personal details, interview recording and transcriptions will be securely stored, and a code will be used to protect your identity. Only myself and my supervisors will have access to any identifying information. The transcription will be carried out by myself, and the analysis by myself and my supervisors. The recordings will be erased at the end of the study. The highest care will be given to ensure your information and details are kept confidential throughout the process, including in the use of any quotes from the interview in the thesis or any publications.

You are under no obligation to accept this invitation. If you decide to participate, you have the right to:

- decline to answer any particular question;
- withdraw from the study (specify timeframe);
- ask any questions about the study at any time during participation;
- provide information on the understanding that your name will not be used;
- be given access to a summary of the project findings when it is concluded.
- ask for the recorder to be turned off at any time during the interview.

Te Kunenga ki Pūrehuroa

School of Psychology – Te Kura Hinengaro Tangata
Private Bag 102904, North Shore Mail Centre, Auckland 0745 T +64 9 414 0800 extn 43116 F +64 9 414 0831
www.massey.ac.nz

Project Contacts
If you have any questions about this project, please feel free to contact me or my supervisors.

Researcher:
Sharlene Vere-Jones
[redacted]

Researcher Supervisors:
Dr Clifford Van Ommen.
C.VanOmmen@massey.ac.nz,
(09) 414-0800 ext 43114

Dr Veronica Hopner,
V.Hopner@massey.ac.nz,
(09) 414-0800 ext.43101

This project has been evaluated by peer review and judged to be low risk. Consequently, it has not been reviewed by one of the University's Human Ethics Committees. The researcher(s) named above are responsible for the ethical conduct of this research.

If you have any concerns about the conduct of this research that you wish to raise with someone other than the researcher(s), please contact Dr Brian Finch, Director, Research Ethics, telephone 06 356 9099 ext. 86015, email: humanethics@massey.ac.nz

Appendix D: Consent Form

MASSEY UNIVERSITY
COLLEGE OF HUMANITIES
AND SOCIAL SCIENCES
TE KURA POKENGA TANGATA

Foster parent perspectives on the experiences of caring for newborns/infants in Aotearoa/New Zealand

PARTICIPANT CONSENT FORM

I have read the Information Sheet and have had the details of the study explained to me.

My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I agree to participate in this study under the conditions set out in the Information Sheet.

Signature: _____ **Date:** _____

Full Name - printed _____

Te Kunenga ki Pūrehuroa

School of Psychology – Te Kura Hinengaro Tangata
Private Bag 102904, North Shore Mail Centre, Auckland 0745 T +64 9 414 0800 extn 43116 F +64 9 414 0831
www.massey.ac.nz

Appendix E: Interview Schedule
Interview Guide/Schedule and Prompts

Preliminary

Introduce self & thank for coming & being part of this study

Discuss overview of study, & address any questions (if necessary give information sheet)

Consent form sign

Interview (ensure recorder is on)

Can you tell me a bit about yourself? How you came to foster parents/carers?

- How long/much fostering?
- How many infants/children have you fostered over this time?
- What is the longest you have fostered over this time?
- What age range of infants/children?
- What kind fostering have you been involved in? (e.g. kin, non-kin, intensive foster care)

Has fostering infants been how you expected it to be? Please explain.

What does caring/fostering for infants involve?

- day-to-day care/needs (physical, emotional)
- cultural/spiritual aspects
- biological family, agencies, others

What was beneficial/helpful for you when fostering an infant?

- social support/networks
- system/organisational support/training
- emotional support

What did/do you find difficult/challenging or unhelpful with fostering infants?

What are for you are important lessons you have picked up over time as a foster parent when it comes to caring for infants?

What are your experiences with connecting with the infant, building a relationship with the child?

- aspects that made it easier/difficult

Can you describe negative experience you've had fostering infants?

Can you describe positive experiences you've had fostering infants?

Have you encountered or had yourself any misconceptions about fostering infants, and could you share some of these?

What would you like other people to know about fostering infants?

Is there anything else you would like to discuss or add in relation to your experiences fostering infants?

Conclusion of interview

Thank for time & assistance, & remind interviewees are free to contact myself or supervisors with any queries/concerns

* Gift voucher – needs to be signed off