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**The Foster Caregiving Relationship with Newborns who have Feeding
Difficulties**

A thesis presented in partial fulfilment of the requirements for the

Master of Arts endorsed in Psychology

Massey University, Albany, New Zealand

Nari Hann

12105657

2018

Pepeha

I te taha toku māma

I te taha toku pāpā

Josephine Barnaby (nee Pryor)

Maxwell Philip Barnaby

Ko Putauaki te maunga

Tauiwi

Ko Rangitaiki te awa

Ko Mataatua te waka

Ko Nga Maihi te hapū

Ko Ngāti Awa te iwi

Ko Nari Elizabeth Hillary Hann toku ingoa

Acknowledgements

Ehara taku toa, he takitahi, he toa takitini

My success should not be bestowed onto me alone, as it was not individual success but success of a collective

Everything good in life stems from a firm foundation and a great upbringing. I am fortunate to have had both, so I wanted to start by acknowledging the role my beautiful parents have played in providing me with such great opportunities, and instilling into a young girl the qualities that have allowed me to persevere and achieve as an adult something that I never dreamed I could. My sister Beverley has also been an integral part of that journey, not only as my older sibling and role model, but also as my best friend. I thank her for her ongoing positivity and encouragement. The relentless support she and her husband James have given me throughout this process have never wavered. At times I think she believed more than I did that I could actually do it!

Although completing a thesis was always part of the course programme, I never imagined that I would be able to research a topic that I was really passionate about while being mentored by such a talented, generous, and encouraging supervisor. Veronica made this happen. She supported me throughout this journey and I feel very privileged that I was able to learn and be inspired by her. She is truly a great New Zealander, and someone I now call a friend. I look forward to many more talks with her about her love for Winston Peters and sharing stuff about our families. They are always great conversations.

There are many people who have contributed in some way to making this project happen. To all the caregivers: without your dedication to providing children in care with the love and nurturing they require, this project would never have happened. To Bianca and John: for being the best second parents anybody could ask for, and for John's invaluable contribution

to the final stages of this project. To my great friends and personal support systems, Gill and David Parrott, Katie and Brendon Pritchard, Sarah Williams, Linzi Heaney and Jo Stevenson: they have all played a fundamental role in supporting me to achieve, and for that I thank them. To the Health Research Council of New Zealand: thank you for believing in the importance of my research topic, and for providing financial support so I could focus on my studies.

Of course, I have saved the best for last: Michael, Oscar, Samuel, and Jesse, my beautiful, loving, supportive, encouraging, and amazing family. It is so difficult to put into words how they have contributed to this achievement. I am so blessed to have a partner in life who believes in me and encourages and supports me every day to accomplish my dreams. I know this journey has not been easy at times (as I am so often reminded by others who say, “Poor old Mike”). All I can say is, “Thank you for hanging in there,” and “Look out, my new psychology skills are going to help me win a lot more arguments!” Finally, to my three babies, who are my universe: I hope that watching Mummy “do her study” has provided them with some positive life lessons, taught them to strive to be the best people they can be, to always believe in themselves, and to work hard so all their dreams may come true. I look forward to now having every day to focus solely on being their mummy.

Abstract

The purpose of this study was to expand on foster care and attachment literature by investigating how the relationship is impacted between a foster caregiver and newborn who experiences feeding difficulties. The most common types of feeding difficulties experienced include reflux, allergies, colic, arousal to feed, and sucking problems, with prenatal methamphetamine exposure being the most frequently cited reason for causality. Newborns who have been prenatally exposed to methamphetamine are at higher risk of preterm births. Prematurity has been widely associated with developmental issues in newborns, such as poor sucking reflexes. All newborns discussed in this study were of Māori descent, highlighting a possible association between Māori children in care and feeding difficulties. This association is thought to be strengthened by the social determinants faced by many Māori, and the punitive neo-liberal nature of the welfare system. Phenomenological interpretive analysis was used to understand the experiences of seven foster caregivers who were highly skilled in caring for newborns with feeding difficulties, and how the feeding difficulties could impact the attachment relationship and contribute to placement breakdowns. Additionally, the strategies that foster caregivers used to minimise the impact of the difficulty and optimise attachment interactions were explored. The feeding difficulties of newborns were found to make attachment interactions more difficult to achieve, but due to the fortitude of the caregivers in providing the best opportunities for newborns in their care, attachment interactions were reportedly always accomplished. Although feeding difficulties placed extra demand on the caregiver role, the commitment and motivation of the caregivers, and the intervention strategies they used to reduce the impact, promoted bonding and stabilised placements. Therefore, feeding difficulties were not associated with placement breakdowns. Rather, unanticipated extended placement timeframes, which impacted the caregiver's ability to provide a consistent and stable environment, were found to be more detrimental to the placement stability.

Understanding feeding difficulties and their impact on attachment for babies in foster care is crucial when caring for the nation's most vulnerable citizens and ensuring that they have the greatest opportunities for healthy development from the start of their lives.

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Introduction

E tama, tangata i akona I te whare, te turanga kit te marae tau ana.

Children raised well in the home, will stand strong out in the world.

Children being uplifted from their biological parents is a contemporary issue in New Zealand due to the high number of children placed in foster care every year. Oranga Tamariki—Ministry for Children reports that the number of children and young people in the custody of the Chief Executive has increased by seven per cent since June 2016, meaning that actual numbers have increased by nearly 400, from 5312 to 5708 children (Ministry of Social Development, 2017b). Of these children, 3518 were of Māori descent, representing an extraordinary 66 per cent of children in care (Ministry of Social Development, 2017b). These statistics highlight not only the prevalence of social and child welfare issues in New Zealand, but also the commonality of the over-representation of Māori in the welfare system (Social Policy Research Unit, 2016). This over-representation has significant implications for Māori, as research shows that many children who enter the child welfare system experience adverse outcomes later in life. Therefore, changing the impact the system has on these individuals should be prioritised (Brown & Bednar, 2006).

Current research suggests that the adverse outcomes for children in care are often a result of constant placement breakdowns (Brown & Bednar, 2006). Placement breakdowns are thought to occur all too frequently for this cohort due to the complexity of their needs (Farmer, Moyers, & Lispcombe, 2004). An infant can be uplifted for a multitude of social issues and reasons, and the specific needs of each child are very different (Oranga Tamariki, 2017b). Often, children in care have experienced trauma, and as a result can experience medical, psychological, and behavioural vulnerabilities that can impact the stability of their placements

(Oranga Tamariki, 2017b). One example of these vulnerabilities is infants who experience feeding difficulties.

Feeding time is an important ritual in the infant's day, when nourishment is given and critical attachment opportunities are created (Chatoor, Ganiban, Colin, Plummer, & Harmon, 1998). Researchers suggest that the development of attachment bonds to significant others is an imperative milestone for the developing child (Bowlby, 1958). Adverse outcomes are thought to be minimised if attachment to a primary caregiver can occur (Dozier & Rutter, 2008). However, when feeding times are problematic, it is argued that extra strain is placed on the caregiver, which is detrimental to bonding and causes placements to be put at risk (Ainsworth, Salter, & Tracy, 1972; Chatoor et al., 1998). To date, research in this area has focused on the development of specific attachment patterns between the biological and foster caregiver (Dozier & Rutter, 2008; Dozier, Stoval, Albus, & Bates, 2001), and the importance of attachment interactions during feeding time has concentrated mainly on breastfeeding vs. bottle feeding (Britton, Britton, & Gronwaldt, 2006). There appears to be limited research with mixed results on the caregivers' experience of caring for children with feeding difficulties, and the contribution of these difficulties to placement breakdowns.

Several studies indicate that caregivers often become frustrated during problematic feeding times, resulting in diminished motivation to attach and increasing the risk of the placement breaking down (Chatoor et al., 1998). However, more recent research has shown that attachment can be achieved despite feeding issues, and that factors outside of the caregivers' control contribute to placement breakdowns (Ainsworth et al., 1972; Chatoor et al., 1998; Morawska, Laws, Moretto, & Daniels, 2014). The attachment relationship between a foster caregiver and infant is complex, and understanding how and if unsettled and problematic feeding behaviours may impact the caregiver's willingness and opportunity to attach is therefore under-researched, especially in New Zealand. This thesis will explore, through

analysis of interviews with seven foster caregivers, the impact of feeding difficulties on the attachment process in foster caregiving relationships in the New Zealand context, and if attachment is connected to placement breakdowns. Furthermore, it will explore what constitutes a feeding difficulty, the potential etiological causes of feeding difficulties, and strategies caregivers use to minimise the impact of problematic feeding times.

Foster Caregiving

Foster Caregiving in New Zealand

Prior to the inception of the foster care system in New Zealand in the 1880s, children without homes were cared for in orphanages and government institutions (Pollock, 2013). In the mid-1800s orphanages housed children who had been lost or abandoned by their parents, who had been maltreated, were difficult to manage, or were criminals. Orphanages were administered by religious orders and held the primary goal of teaching children Christian values. In the later part of the 1800s government institutions were also created to house and school these children. Institutions were a primary way of coping with this cohort until the inception of foster care or extended family care in the 1980s, when it was decided that children were better placed within their own extended family unit or with other families (Pollock, 2013). Foster care happens when legal custody or guardianship is given to the state in accordance with the Care of Children Act 2004. A legal guardian is a person who is responsible for all issues, care, rights, and responsibilities of a child. When the biological parent is deemed unfit to parent, guardianship is appointed through the New Zealand Family court under the Children, Young Persons, and Their Families Act 1989. Regarding the New Zealand foster care system, the new guardian appointed would be Oranga Tamariki.

Contemporary foster caregiving in New Zealand is varied, with five different types of care provided: emergency, respite, family home, home for life (or permanency), and transitional care (Oranga Tamariki: Ministry for Children, 2018c). Emergency care is when a child is placed with no notice, and is only for a very short period. Respite care happens when the foster caregivers of a child on placement require a short break. Family home care is when children are placed in a group home owned by Oranga Tamariki with up to six other foster care children. Home for life, or permanent care, is when the Family Court has decided the biological parents are unfit and the child or children require a permanent home. This is also referred to as home for life. Transitional care happens when a decision about the child's future is pending, and when the Ministry of Vulnerable Children is working with the biological parents and family to find a stable and safe environment for the child. These transitional placements are only up to six months. In that time Oranga Tamariki will develop a plan for the child. All foster caregivers can provide multiple caring services; they are not limited to one type of caregiving because the training and screening processes and the skills required are similar for each different type.

As previously mentioned, there are currently 5708 children in foster care, ranging from birth to eighteen years old (Ministry of Social Development, 2017b). Statistics show that eleven per cent of children in the foster care system are aged between birth and one year, with over three quarters of all children in care being Māori (Ministry of Social Development, 2017). The overrepresentation of minority cultures in child welfare systems around the world is a common circumstance, and not just applicable to Māori in New Zealand. From Australia and the Aboriginal and Torres Strait Island children, to America with the Native American and African-American children, indigenous children make up a disproportionate number of children in foster care (Holzer & Bromfield, 2008). There are differing opinions on why this overrepresentation occurs, ranging from reasons of discrimination to the negative impact of

colonisation, resulting in a high proportion of indigenous people experiencing socioeconomic hardship (Barth, Wildfire, & Green, 2006; Conn et al., 2013; Franz & Woodward, 2006).

The overrepresentation of Māori children in state care is a relatively new phenomenon due to the change in laws regarding whāngai adoption and urbanisation, which altered the way in which Māori could collectively care for their children (Somerville, 2003). Whāngai is a traditional Māori adoption system, whereby families gift children to other families for many different purposes (McRae & Nikora, 2003). Although in whāngai adoption a child lives with another family, they still have close contact with their birth family, and are raised in a collective society (Keane, 2011). Whāngai is used for a variety of reasons, such as when bigger families are struggling, or when kin are unable to have their own children. Grandparents often whāngai their mokopuna (grandchildren) for the purpose of passing on cultural knowledge and values (Keane, 2011). For any of these purposes, secrecy of the adoption is not a necessity, as the child was safe and treasured.

The process of whāngai acknowledged the fundamental phenomena that contribute to the development of Māori identity and promote holistic wellbeing for Māori children in care. The Adoption Act 1955 was in total contrast to the principles of whāngai, as it emphasised the need for secrecy with adoption, promoting the importance of complete separation between the birth family and the adoptive family (Somerville, 2003). Further legislation such as the Child, Young Persons, and their Families Act 1989, the Guardianship Act 1968, and the Family Proceedings Act 1980 (Somerville, 2003) also failed to reflect Te Ao Māori, or the Māori worldview. The Child, Young Persons, and their Families Act 1989 outlines the rights of children and their families, but like the Guardianship Act 1968, it prioritises the paramountcy principle above all else. The paramountcy principle is when the safety and welfare of the child is fundamental and must always be the primary consideration when making decisions for the child (Somerville, 2003).

Wellbeing in Māoridom is closely linked with the individual development of Māori identity (Somerville, 2003). Identity is developed through knowledge and connection with whakapapa (genealogy). Whakapapa connects Māori to all things living in our world, whereby ancestral ties always originate with the gods Ranginui (sky father) and Papatūānuku (earth mother) (Taonui, 2011). Whakapapa is the foundation of the affiliation Māori have with whenua, which describes where they belong in the world. When children are placed in foster care with non-kin caregivers, their opportunity to learn about their identity diminishes (Somerville, 2003). Since the recognition of the principles of the Treaty of Waitangi in the 1970s, there has been some movement in legislation from a nuclear family view of child rearing to acknowledging the Māori worldview of a collective approach to parenting. These collective values are reflected in the addition of family group conferences in care and protection services, and the inclusion in the paramountcy principle of the importance of whakapapa and whanaungatanga, by making grandparents co-guardians of the child when in care (Somerville, 2003). There has been a shift to promote whānau caregivers and primarily place the children with whānau first (Murray, Tarren-Sweeney, & France, 2011). Reunification is always prioritised, and if a kinship placement is not available, the state tries wherever possible to place the child with foster parents of the same culture. Research shows that children who are placed in families of the same culture experience greater wellbeing and fewer externalising problems (Anderson & Linares, 2012; White, Havalchak, Jackson, O'Brien, & Pecora, 2007).

Maltreatment, Foster Care, and Adverse Outcomes

Uplifting a newborn from its birth home is seen by many to be the least preferred option of child welfare interventions, because of the potential impact on childhood development (Atwool, 2010; Barth et al., 2006; Biehal, Ellison, Baker, & Sinclair, 2011). However, consideration of which environment—the home or out-of-home care—is the safest and most nurturing for the child is paramount. Invariably out-of-home placements like foster care are

considered to be an effective intervention, and a protective factor, when the child's safety and wellbeing is at risk (Critchley, 2013; Horwitz, Chamberlain, Landsverk, & Mullican, 2010).

New Zealand has a significant child maltreatment problem compared with other countries in the developed world. In the year ending July 2017 there were nearly 15,000 substantiated cases of child abuse (Breslau et al., 2014; Child Matters, 2017). Given the significance of this problem, interventions that can improve the adverse outcomes experienced by children who have been maltreated are an essential role of the child welfare system (Schinitz, Shulman, & Vig, 2005). Children come to the attention of child welfare agencies for a multitude of reasons, all of which involve some form of maltreatment by their biological parents, including prenatal abuse (such as exposure to illicit substances in-utero), physical, sexual, and emotional abuse, domestic violence, trauma, exploitation, and neglect (Chicchetti & Valentino, 2006; Schinitz et al., 2005). The commonality of prenatal substance exposure among foster children in New Zealand is unknown, but anecdotal evidence suggests that it is a prevalent problem (Miller; 2016; Socialink, 2017). Evidence from the United States suggests that many children in care have been prenatally exposed (U.S. General Accounting Office, 1995; 1997). The consequence of childhood maltreatment can be extreme and lifelong and is associated with disruptions in the neurological, psychological, and social development of children (Breslau et al., 2014; Child Matters, 2017; World Health Organisation, 2016; 2017).

Maltreated children are thought to suffer up to seven times more acute and chronic health conditions compared with non-maltreated children. Many argue that these health conditions are a result of the gene by environment interaction, whereby ongoing maltreatment causes the child to experience chronic stress, which hinders the development of the brain, immune, and nervous systems (Breslau et al., 2014; Fisher, Gunnar, Dozier, Bruce, & Pears, 2006; Toth, Gravener-Davis, Guild, & Chicchetti, 2013). Consequently, as the child grows, he or she is at greater risk of experiencing behavioural problems such as substance abuse,

psychological issues like depression or anxiety, and health problems such as obesity, heart disease, cancer, and suicide (World Health Organisation, 2015). To complicate issues, many newborns who are removed from their parents have often experienced an abusive postnatal environment. This, coupled with an unnurturing prenatal environment, contributes to the child experiencing chronic lifelong health disorders (Barth & Brooks, 1998; Barth et al., 2006). Common problems experienced by children in care include chronic stress and medical conditions, poor mental health, and developmental delays/issues (Schinitz et al., 2005).

Stress alters the structures in the brain by the abnormal production of cortisol and neurotransmitters such as oxytocin and serotonin (Laurent, Gilliam, Bruce, and Fisher, 2014). This dysregulation affects the function of the hypothalamic pituitary adrenal (HPA), which is thought to be the emotion epicentre of the brain, where stress and emotions are regulated (Luke & Banerjee, 2013; Sadock, Sadock, & Ruiz, 2014). Consequently, the altered neurobiology of the brain is thought to contribute to psychological problems later in life. Laurent (2014) identifies a link between high cortisol levels and internalising behaviours such as anxiety and depression, and low cortisol levels and externalising problems such as anger and antisocial behaviour. Additionally, emotional dysregulation and disorganised attachment patterns are often consequences of maltreatment, when a child is not exposed to positive role modelling, boundaries, and socialisation processes from their caregiver, nor offered a secure safe base from which to explore the world. Furthermore, children who have been maltreated have often missed critical opportunities for bonding to occur (Fonagy, Steele, & Steele, 1991; Shipman et al., 2007).

Research shows that maltreatment has negative consequences on a child's development, but many argue that the foster care environment can also be detrimental to a child's development (Schinitz et al., 2005). Removing a child from their primary caregiver can have dire consequences on the child's ability and opportunity to develop secure attachment

patterns (Altenhofen, Clyman, Baker, & Biringen, 2013; Atwool, 2006). Newborns in foster care experience greater developmental, emotional, and behavioural problems compared with non-foster care children. As such, the complexity foster caregivers often face in caring for children who have health complications is thought to contribute to placement breakdowns, resulting in a perpetuating cycle of instability for the child (Barth, 1991). Contrary to this, foster care has shown to be the preferred living arrangement for maltreated newborns, as it optimises stability and safety compared with their home environment. Providing newborns with stability, consistency, and optimising opportunities for positive early life experiences is key in reversing the effects of maltreatment and preventing further adversity throughout their lives (Centre for Social Research and Evaluation, 2012).

The negative developmental consequences of uplifting a child into the foster care system can be minimised if the child is provided with a stable, nurturing environment (Atwool, 2006; Chicchetti, Rogosch, & Toth, 2006). Reduction of placement breakdowns and minimising the number of placements a child experiences while in care are thought to be vital (Centre for Social Research and Evaluation, 2012), as is the role of the foster caregiver in providing a nurturing environment whereby quality attachment interactions are prioritised (Bernier & Dozier, 2003). Providing a nurturing environment where bonding is achieved is sometimes thought to be overlooked in the foster care system (Stukes-Chipungu & Bent-Goodley, 2004). The challenges child welfare systems are faced with are thought to be extensive, and therefore the fundamental goal of foster care becomes primarily about safety (Barbell & Freundlich, 2001). Training and support is often centred around the paramountcy principle and physical wellbeing, while disregarding phenomena thought to promote emotional wellbeing such as bonding and nurturing. Factors which further confound this issue involve the short-term, temporary nature of placements and the health complexities many children in care experience (Jacobsen, Ivarsson, Wentzel-Larsen, Smith, & Moe, 2014). Foster caregivers are

often so consumed with dealing with special medical needs that important developmental interactions, such as bonding, are often neglected. (Fisher et al., 2006).

Ensuring the foster care system prioritises the factors that promote an emotionally nurturing environment within a primary caregiver-child relationship is critical for healthy development (Hillen & Gafson, 2015). The National Centre for Injury and Prevention (CDC) (Child Matters, n.d.) has developed a framework that identifies the essential factors children need in out-of-home care in order to achieve positive development and reach their milestones. The framework is closely aligned with the fundamental concepts of Bowlby's attachment theory, and advocates the importance of a stable, caring, and safe environment for children to grow, learn, and develop. When a child is taken out of a stressful environment and placed into a foster care environment, the role of the caregiver and the environment the caregiver provides the child both play a significant role in promoting positive childhood development and minimising the child's vulnerability to adversity.

Foster Caregiver Role, Responsibility, and Credentials

Given the vulnerability and complex needs of children in care, and the medical fragility of some children, the character and credentials of the foster caregiver are fundamental. When becoming a foster caregiver, individuals go through a screening process to ensure their suitability (Child Matters, n.d.). The screening process is used to ensure that the applicant can keep the child safe and has the right character to provide quality care to the child (Child Matters, n.d.; Oranga Tamariki, 2018a). Many argue that foster caregivers need to be well adjusted, have worked through any of their own family problems, and are able to provide an empathetic and nurturing home for the child (Dozier et al., 2001). Therefore, the historical background of the caregiver, their upbringing, and their family life are all relevant. Likewise, the caregiver's parenting style, emotional availability, mental health, and personality traits (Dozier et al., 2001; Lang et al., 2016) are also relevant. Although little is known about the relationship between

caregiver temperament and child adjustment, Dubois-Comtois et al. (2015) contend that the persona of the caregiver is closely linked to how successful a child in care adjusts to different situations. The screening process is carried out through a series of interviews in different settings, such as the caregiver's home. Screening is also undertaken through police vetting services and by checking that official documentation is authentic (Oranga Tamariki, 2018a).

Understanding the motivations behind why a caregiver becomes a caregiver is considered by some to be an integral part of the recruitment process (Bates & Dozier, 2002; Bernier & Dozier, 2003; Beuehler, Cox, & Cuddeback, 2003). While there is limited research on how a caregiver's motivation impacts the attachment relationship, Cole (2005) suggests an association between motivational factors and the quality of attachment interactions a caregiver can provide. Given the significant link between attachment and childhood development, foster care motivation is fundamental to optimising opportunities for attachment (Brown, Bakeman, Coles, Platzman, & Lynch, 2004). Caregivers have conscious and unconscious motives for caregiving. Those who are motivated to fulfil their own needs increase the likelihood of placement breakdowns, whereas caregivers who are motivated for the good of the community minimise the likelihood for placement breakdowns (Cole, 2005; Miller, 1993).

There are two prominent theoretical perspectives that help understand a caregiver's motivation: the altruistic model, and the exchange model (Kang, 2007). The altruistic model aligns with the Miller (1993) and Cole (2005) argument about caregiver motivation, whereby the caregiver is motivated by doing something positive for the people around them by helping and promoting wellbeing for others. Individuals who have altruistic motives are thought to make decisions based upon what is good for their community and those in need. Altruistic caregivers have a great deal of empathy, which provides them with a good foundation when caring for vulnerable children, and the altruistically motivated caregiver promotes placement

stability because of his or her commitment to providing the child with the best opportunities (Kang, 2007).

In contrast, the exchange model argues that caregiving is based on a reward/cost view of relationships. Social exchange theory provides an explanation of this model of caregiving (Homans, 1961; Kang, 2007; Stukes-Chipungu & Bent-Goodley, 2004). In this approach, a caregiver's motivation is formed from an individual's evaluation of the rewards versus the cost (Timmer et al., 2004). When the rewards outweigh the costs, individuals are thought to experience greater motivation to pursue a relationship. Rewards may come in different forms, such as approval from others, monetary gains, and greater social popularity. Costs involve such things as being condemned by others, monetary losses, and social rejection (Timmer et al., 2004). Social exchange theory is often applied to interpersonal relationships such as the dyad between a foster caregiver and newborn (Stukes-Chipungu & Bent-Goodley, 2004). Timmer et al. (2004) found that a caregiver's motivation changed when the needs of the newborn became more complex. Employing a rational decision-making process, caregivers are thought to consider the emotional and financial impact of providing care for this cohort, as well as how it will impact their personal responsibilities and their household. Kinship caregivers experience a different rational process because of the familial investment they naturally have when caring for a related newborn (Timmer et al., 2004). Kin caregivers are more likely to promote placement stability and optimise attachment interactions compared with non-kinship caregivers (Comp, 2018). However, Berrick (1997) disagrees, suggesting that non-kinship caregivers can be as emotionally motivated as kin-carers.

It is likely that there is an interplay of both altruism and social exchange theories in explaining foster carer motivation. Committing to foster caregiving is arguably more than making a rational choice between costs and benefits and incorporates a wide range of other considerations (Klein & White, 1996; Cole, 2005; Timmer et al., 2004). Welcoming a newborn

with complex needs into your home, providing high quality care, meeting the newborn's needs, and incorporating their complex needs into your day-to-day life is a significant commitment. The commitment required is two-fold; emotional and physical. The emotional commitment involves nurturing, empathy, understanding, and patience whilst also being mindful of creating space for quality attachment interactions to occur (Dozier & Rutter, 2008). The physical commitment is more practical in nature, whereby the caregiver needs to create flexibility within the home environment and a strong personal support network to meet the child's special needs. Likewise, consideration regarding the biological children or other members in the household is also important (Dozier & Rutter, 2008). Children who are medically fragile and vulnerable require a different level of care to other children, thus impacting households and the everyday life of the caregiver.

Foster Caregiver Training

To care for these often medically fragile and vulnerable children, initial and ongoing foster caregiver training is vitally important. Foster caregiving is an extremely challenging and demanding role, which requires caregivers to have specialised knowledge (Stukes Chipungu & Bent-Goodley, 2004). Caregiver training is often limited to induction training, which is compulsory for everyone as part of the recruitment process. However, Horwitz et al. (2010) argue that foster care training should be ongoing, encompassing much more than how to be a caregiver and how to provide a safe home for children. Horwitz suggests that training that acknowledges the importance of the emotional and psychological needs of the child should be standard practice. Children placed in foster care have the legal right to not only be provided with a safe home, but also to have opportunities for positive growth and development. However, research indicates that there is negligible training offered around complex needs and trauma, which so many children in care experience (Kinsey & Schlosser, 2012). It is reported that just under a third of caregivers feel confident in what they know and what they have learnt.

However, most caregivers report that they have received insufficient training from their agency and have often felt undervalued and underequipped to provide the right care for the child. Puddy and Jackson (2003) found that most introductory caregiver training packages were devoid of modules that encompassed the wide range of skills essential to caregiving.

Providing caregivers with specialised training on how to manage and care for children with complex needs is extremely important, as many children who enter foster care experience health complications that require special needs. Newborns, for example, are often prenatally exposed to drugs, and are experiencing withdrawal and other health complications such as difficulty with feeding and respiratory problems (Lenora, 2010; Marcellus, 2004). These babies experience a range of difficulties due to the non-homogenous impact of different drugs, alcohol, and tobacco, making their needs complex and divergent (Lenora, 2010). Providing caregivers with the skills to manage their unique requirements is a difficult task for foster care agencies. Caregivers require training and a good professional support network to help them effectively manage the child's care requirements (Barth, 1991) and reduce complex childhood behaviours (Barth, 1991; Fukkink & Lont, 2007). Regular respite with a consistent respite caregiver was also identified as a significant factor in promoting caregiver wellbeing and stability of placements (Fukkink & Lont, 2007).

The training offered to caregivers in New Zealand is varied and depends on the organisation. Oranga Tamariki (2018b) provides a non-compulsory national caregiver training programme that delivers workshops about different aspects of caregiving. Modules include: attachment and resilience, child development, understanding and managing behaviour, carer families, health and wellbeing, identity and belonging, legal issues, maltreatment and family violence, safety prevention, teamwork, and working with adolescents. While these workshops are optional for caregivers, Oranga Tamariki (2018b) recommends that caregivers should consider the attachment and resilience, child development, and understanding and managing

behaviour workshops as a priority. Besides the optional workshop of identity and belonging, only limited cultural training is compulsory and offered within Oranga Tamariki's induction package. There appears to be no mention of ongoing and specific cultural training regarding Māori cultural norms and protocols. Given the over-representation of Māori children in the foster care system and the adverse outcomes they are faced with throughout their lives, incorporating and prioritising cultural awareness and sensitivity in foster caregiver training should be mandatory (Brown, Sintzel, Arnault, & George, 2009).

Brown et al. (2009) showed that caregivers are willing and motivated to learn more about a child's culture and suggest that cultural training should occur on different levels, not only through education, but also through ongoing cultural supervision, support, and connection to the community. Culture plays a fundamental role in childhood development, particularly for the indigenous, for whom wellbeing is defined through a holistic lens (Brown et al., 2009). The collective nature of indigenous communities suggests that connection to the wider community and to their extended birth families is key to promoting holistic wellbeing (Chipungu & Goodley, 2004)). Identity is paramount in Māori culture, and although children in care are not residing with their biological family, they will always be Māori, and therefore should always be provided with opportunities to stay connected to ensure their holistic wellbeing, which is their fundamental right (Haenga-Collins & Gibbs, 2015; Marsden & Royal, 2003). Promoting cultural competence, awareness, and sensitivity should occur at an organisational level and be reflected in policies, assessments, and interventions, and at a frontline service delivery level, whereby caregivers are provided with the skills to properly understand how to develop a cultural connection for the child.

Feeding Difficulties

The Importance of Feeding

Feeding is the human process of acquiring food orally through the mouth and is a critical element of human neurological and psychosocial development (Hardy, Senese, & Fucile, 2018; Sanders-Phillips, 1998). Obtaining food is thought to be culture-specific, in that different cultural practices influence the way in which an individual interacts with his or her environment to obtain food (Rudolph, 1994). Throughout life, feeding provides individuals with nutrients that are critical for growth, development, and functioning. Many argue that feeding for a newborn is so much more, as it provides the mother-child dyad with opportunities to interact (Ainsworth et al., 1972).

Feeding and sucking skills are thought to evolve prenatally and usually develop rapidly in the first few days after birth (LaGasse et al., 2003). It is argued that disruptions in any part of the feeding process affect the entire human system, with many suggesting that newborns who are unable to learn to feed normally may experience adversity and struggle with feeding throughout their lifetime (Meadows, 2015; Williams, 2003; Yang, 2017). The feeding process is a biologically, neurologically, and psychosocially based process (Rudolph, 1994; Hardy et al., 2018). The neurologically and biologically based processes involve normal human brain development and growth (Ross & Browne, 2013). The psychosocial process involves the development of behavioural skills, social interaction, and emotional regulation (Hardy et al., 2018). Rudolph (1994) describes a systemic process that begins in-utero, where the foetus develops the sucking mechanism. Swallowing is the next part of the process, and is made possible through both psychological and neurological processes through which the individual requires purposive motivation and the digestive capability to cease breathing and swallow (Ross & Browne, 2013). From here the digestive system takes over and processes the food

through the oesophagus and stomach, resulting in digestion and nutrient absorption. (Rommel et al., 2003; Rudolph, 1994; Sanders-Phillips, 1998).

After birth, biological and neurological development still occurs and the psychosocial processes begin (Rommel, De Meyer, Feenstra, & Veereman-Wauters, 2003). For example, Sigmund Freud's oral phase of psychosocial development supports the concept of development occurring psychosocially as well as biologically and neurologically during feeding. The caregiver role is imperative in developing attachment and promoting psychological wellbeing for the newborn, which is thought to occur primarily during feeding time. Through interactions with a maternal figure during feeding, newborns develop an understanding of being in the world. They learn to explore within a secure base and receive feedback regarding appropriate and inappropriate behaviours (Bretherton & Munholland, 2008; Mooney, 2010). When issues occur during feeding, oral fixations may develop, which could impact the individual's view and experience of the world and behaviour throughout their lifespan (Mooney, 2010). These fixations parallel concepts discussed widely in the literature regarding the importance of attachment theory and the consequences of poor attachment interactions during infancy (Kronstadt, 1991; Rommel et al., 2003; Rudolph, 1994; Smith & Ellwood, 2011; Twomey et al., 2013).

Feeding Difficulties Defined

Feeding difficulties affect 25 per cent of all children and 80 per cent of developmentally delayed children (Manikam & Perman, 2000; Williams, 2003; Yang, 2017). The number of children in foster care with feeding difficulties is unknown in New Zealand and around the world. However, anecdotal information provided to foster caregivers suggests that feeding difficulties are a common problem faced by many children in care (Children's Hospital Philadelphia, 2018; Satter, 2018; Perpetual Fostering, 2018). Most feeding difficulties occur under the age of two, and the greatest difficulties are for children during the first year of life.

However, some feeding difficulties are lifelong and continue throughout an individual's lifespan (Meadows, 2015).

Differentiating between a feeding difficulty and a feeding disorder is considered critical to assessment and intervention (Yang, 2017). A feeding difficulty encapsulates all types of feeding issues that impact the process of an individual obtaining food. In contrast, a feeding or eating disorder is an enduring disturbance in eating behaviour that can be diagnosed through a set of consistent criteria (Yang, 2017). It is suggested that due to the impact on a child's neuro and psychosocial development, identification, multidisciplinary assessment, and ongoing intervention are critical to minimising the effects (Hardy et al., 2018; Meadows, 2015; Rommel et al., 2003). The impact of feeding difficulties can significantly change the feeding experience for both the caregiver and the newborn. The anxiety that both a caregiver and newborn may experience during feeding can cause further feeding maladaptation and secondary problems, perpetuating anxiety further. Therefore, early identification of feeding difficulties is described as a critical step in minimising the impact of the feeding difficulty on both the newborn and the caregiver (Hardy et al., 2018).

Williams (2003) identifies six different types of feeding difficulties: pickiness, refusal, overeating or undereating, slowness, painfulness, choking, gagging, and vomiting. In addition to Williams' identification, Yang (2017) recognises newborn aspiratory and respiratory issues, gastroesophageal issues, and allergies as types of feeding difficulties. Many authors refer to reflux as having the greatest prevalence. Reflux is not only described as a primary feeding difficulty, but also a secondary difficulty due to the biological nature of its aetiology and the further feeding complications created by it, such as refusal to feed, vomiting, and screaming (Meadows, 2015; Rudolph, 1994). Reflux is a gastroesophageal problem caused by a sphincter that does not close properly after ingestion (Meadows, 2015). Reflux occurs more frequently in babies under six months of age and manifests by causing pain and discomfort during the

feeding process, which often results in vomiting. The issues caused by reflux provide a good example of how one difficulty can lead to other difficulties through the development of maladjusted feeding behaviours which evolve to minimise the pain and discomfort caused (Meadows, 2015).

Allergies are also a common feeding difficulty, particularly for Māori compared with non-Māori babies, whereby 38 per cent of Māori newborns experience allergies (Crooks et al., 2010; Ministry of Health, 2009). Allergies are thought to be a prevalent issue for children in care, given the need for formula feeding and the significant connection between cow's milk and allergies in newborns (Luccioli, Verrill, Ramos-Valle, & Kwegyir, 2014).

Aetiology of Feeding Difficulties

Aetiology of feeding difficulties is often discussed in terms of organic or non-organic causes (Burklow, Phelps, Schultz, McConnell, & Rudolph, 1998; Rommel et al., 2003; Williams, 2003; Yang, 2017). Organic feeding difficulties are issues with structure abnormalities in the digestive process, such as tongue tie or cleft palate, and neurological disorders such as cerebral palsy (Yang, 2017). Non-organic feeding difficulties, on the other hand, are more behavioural, and develop through environmental and social origins (Burklow et al., 1998). There is ongoing debate regarding organic versus non-organic aetiology, with some researchers arguing that feeding difficulties always have organic causes, others contending only organic causes, and some suggesting that feeding difficulties occur on a continuum of both organic and non-organic causes (Manikam & Perman, 2000; Williams, 2003; Yang, 2017). Due to the complex manifestation of feeding difficulties, a comprehensive assessment to identify the individualised organic and non-organic factors contributing to the problem is best practice (Burklow et al, 1998).

Research shows that determining the cause of a feeding difficulty involves consideration of multiple social, neurological, biological, and behavioural factors (Burklow et

al., 1998; Mahony & Murphy, 1999). Sanders-Phillips (1998) argues that understanding the aetiology of a feeding difficulty is a critical element of successful management. To understand the factors that need consideration during assessment, specific variables have been identified which are thought to be significantly related (Meadows, 2015; Rommel et al., 2003; Sanders-Phillips, 1998). Social influences such as poverty and maternal health and wellbeing during and after pregnancy are thought to be fundamental (Sanders-Phillips, 1998). The negative effects of poverty show that impoverished individuals are often less educated, have poorer health and wellbeing behaviours, are more likely to experience mental illness, and are at greater risk of engaging in criminal activities and antisocial behaviours (Luccioli et al., 2014; Rommel et al., 2003). Maternal adoption of unhealthy habits and substance abuse during pregnancy are two significant issues for at-risk individuals, and are prevalent aetiological factors among newborns with feeding difficulties in foster care (Jadcherla et al., 2017; Mahony & Murphy, 1999).

Nutritional intake and prenatal and antenatal care are important factors for any expectant mother to prioritise during pregnancy. The lack of an appropriate diet and regular check-ups to ensure the unborn baby is thriving in utero increases the likelihood of foetal abnormalities (Jadcherla et al., 2017; Maya-Enero et al., 2018). Poor maternal nutrition restricts the amount of nutrients and oxygen going to the unborn baby, increasing the risk of negative effects on the baby's growth and structural neurological development (May-Enero et al., 2018). Substance abuse during pregnancy is another maternal health problem that is frequently linked to causation for newborns with feeding difficulties in foster care (Mahony & Murphy, 1999). Breastfeeding is also critical for a child's healthy development, with bottle feeding considered by some to be a cause of feeding difficulties due to the allergies that babies can develop on cow's formula. Breastfeeding is also thought to be a basic human right of the baby and should be encouraged wherever possible (Gribble & Gallagher, 2014). Given the secretive and

personal nature of these maternal lifestyle choices, differentiating between which factor is more significant in influencing the outcomes for the newborn is generally problematic (Kronstadt, 1991; Mahony & Murphy, 1999).

Prenatal exposure to substances is thought to be a significant aetiological factor for many vulnerable newborns in foster care (Eiden, 2001; LaGasse et al., 2003; Smith & Santos, 2016). Research is limited in this area, particularly in New Zealand, which many authors argue is due to the lack of disclosure and impossibility of disentangling the what, when, how much, and for how long of issues related to drug and alcohol use (Jaques et al., 2014; LaGasse et al., 2003). The chaotic lifestyles of drug users place drug-dependent mothers at greater risk of parenting problems as well as financial, social, and psychological problems, all of which contribute to the critical factors underlying abuse, neglect, and abandonment of children (Regan, Ehrlich, & Finnegan, 1987).

The polydrug issue only consolidates the problematic nature of determining what effect the substances have had (Kronstadt, 1991). Given these complexities, a small body of research has identified several common themes to maternal substance use and outcomes for newborns. Studies show that many polydrug users abuse alcohol and cannabis and smoke cigarettes (Shannon, Blythe, & Peters, 2016; Smith & Santos, 2016). There is extensive evidence describing the impact of alcohol on the unborn foetus, but less is known about the impact of cannabis and nicotine. Some foetal alcohol spectrum disorders (FASD) in newborns are similar to the effects of feeding difficulties, such as short height, low body weight, and small head size (Kronstadt, 1991). Similarly, nicotine is associated with low birth weight and decreased length and head circumference in newborns, and current research suggests no apparent relationship between cannabis and feeding difficulties (Barros, Guinsburg, Mitsuhiro, Laranjeira, & Chalem, 2011; Edens, 2016).

Alcohol, nicotine, and cannabis are the substances most widely abused by expectant mothers, but methamphetamine (meth) is fast becoming a drug of choice, especially in New Zealand (Edens, 2016). Meth is an illicit drug that stimulates the central nervous system, and is the strongest and purest form of amphetamine type stimulants (ATS) (Community Alcohol and Drug Services, 2017). The short-term physical effects of meth use can escalate blood pressure, pulse, breathing, and body temperature, causing increased alertness, wakefulness, restlessness and energy. The long-term effects of meth use can include addiction, chronic fatigue, mental illness, heart failure, stroke, changes to brain structure and function, deficits in thinking and movement, and dental problems (NZ Drug Foundation, 2017).

The effects of meth use on an unborn baby are considered to negatively impact a baby's healthy development. Prematurity, low birth weight, small head circumference, and delayed motor development are identified as three of the most common consequences associated with prenatal exposure to meth (Kronstadt, 1991; LaGasse et al., 2003; Ross & Browne, 2013; Wallace & Belcher, 1997). Furthermore, chronic medical conditions linked to meth use during pregnancy include cardiac and respiratory issues, seizures, developmental issues caused by premature births, and birth defects. (Schinitz et al., 2005; Schmidt et al., 2018; Smith & Santos, 2016). Emerging information regarding the impact of meth on newborns suggests that babies who have been exposed to meth usually experience sleeping and feeding problems (Schmidt et al., 2018). Meth-related feeding difficulties cause disorganised-type feeding patterns, wherein newborns can be difficult to rouse to feed and difficult to settle once fed. Feeding time is thought to be interrupted for prenatally exposed infants due to the complications of their conditions on the actual ritual of feeding, and on the patience and responsiveness of the caregiver (Kronstadt, 1991).

The commonality of preterm births in newborns exposed to meth is closely linked to the aetiology of feeding difficulties. Although research is limited in this area, existing studies suggest that premature newborns are at greater risk of experiencing feeding difficulties due to the preterm impact on the development of such things as their cognitive and digestive system function, and their sucking ability (Jadcherla et al., 2017). Prematurity is associated with neurodevelopmental issues, and premature newborns are at greater risk of encountering sucking and swallowing issues due to the disruption to neurological and biological development and the impact of tube feeding (Jadcherla et al., 2017; Williams, 2003). Tube feeding is often an intervention used on preterm babies when they are too young to feed for themselves. Although tube feeding for some newborns is the only way to ensure they are receiving nutrients, research suggests that it can have some detrimental consequences on the development of feeding skills such as sucking (Williams, 2003; Yang, 2017).

Some babies who have been prenatally exposed to drugs may experience neonatal abstinence syndrome (NAS). NAS is the withdrawal process that affects the central nervous system, and although the drug source has been removed, their dependence remains (Smith & Santos, 2016). Symptoms are experienced differently by every newborn, and depending on the severity of symptoms and medical complications caused by the drug, the baby may be kept in the hospital for monitoring (American Academy of Pediatrics, 2002). Symptoms of withdrawal are shown in Figure 1. It is purported that babies who experience withdrawal are unsettled and require a high level of postnatal care (American Academy of Pediatrics, 2002). The complexity involved in caring for newborns while they are withdrawing can be extremely difficult on even the most responsive caregiver, impacting the opportunity for important caregiver-newborn bonding time and increasing the pressure and demand on the maternal role (Kronstadt, 1991). The symptoms of withdrawal can also perpetuate further health complications due to the potential risk of malnutrition, resulting in failure to thrive and stress for the newborn (Smith &

Santos, 2016). The stress that is experienced by the newborn at such a young age has shown to be associated with altered neurodevelopment, increasing the likelihood of adverse outcomes later in life (LaGasse et al., 2003; Sanders-Phillips, 1998; Smith & Santos, 2016; Twomey et al., 2013).

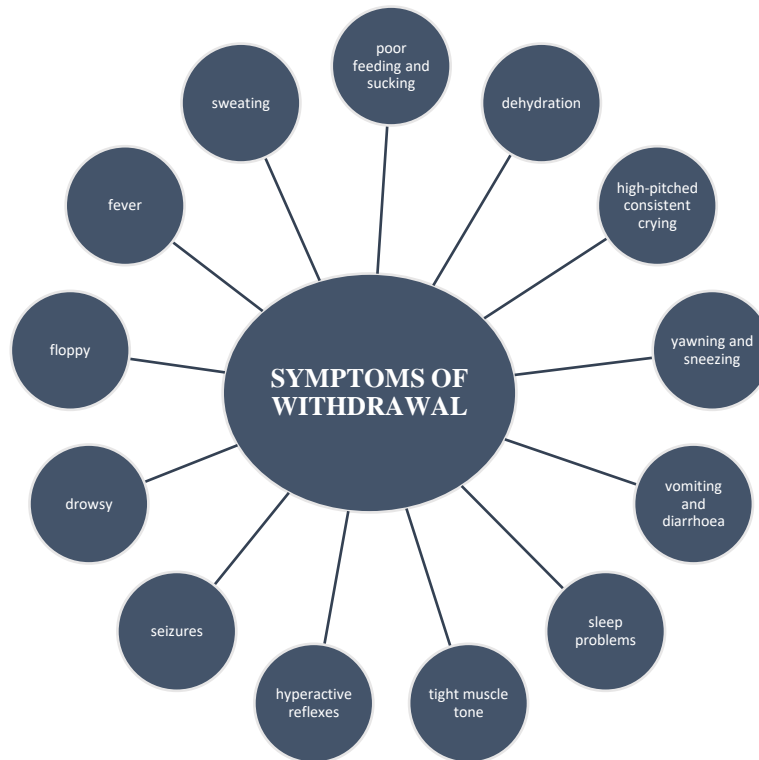


Figure 1: The Symptoms of Withdrawal

Source: Kronstadt, D. (1991). Complex development issues of prenatal drug exposure. *The Future of Children*, 1(1), 26-49.

Due to the complex aetiology of many feeding difficulties, there is no standardised understanding of how each type of difficulty will manifest. Every child experiences feeding difficulties in different ways. Therefore, a thorough assessment and individualised intervention plan is imperative to minimise the impact of the difficulty on the newborn and the caregiver, as well as to ensure the newborn is thriving (Meadows, 2015; Yang, 2017). The importance of a multidisciplinary approach to assessment and intervention is vital, with speech therapists,

occupational therapists, medical staff such as doctors and nurses, dieticians, and behavioural psychologists all critical for the best outcomes (Rommel et al., 2003; Rudolph, 1994; Yang, 2017). Undertaking an assessment process that involves obtaining the detailed historical and background information of the newborn and the parent, including their medical, feeding, and dietary history, is the first necessary step. Furthermore, a physical examination and observation during feeding time will help identify what is going on for the newborn during feeding (Bache, Pizon, Jacobs, Vaillant, & Lecomte, 2014; Meadows, 2015; Rudolph, 1994; Williams, 2003). A thorough assessment is thought to promote best management by identifying the primary and secondary problems occurring, and informing the types of interventions required.

Interventions for Feeding Difficulties

Interventions may take on many different forms. Depending on the cause and the type of feeding difficulty, caregivers may use a multitude of strategies to help minimise the impact during feeding time. Some babies require behaviour modification, as they have developed maladjusted feeding behaviours in response to negative past feeding episodes (Meadows, 2015). Other strategies include altering the way the baby is fed, such as the position in which they are held, and the surroundings, including the noise, brightness, and temperature (Williams, 2003). Using different products, such as different teats and bottles, or sleeping aides to slightly raise the baby's head or keep them on their side is beneficial for some newborns.

At times newborns will require medical intervention of some description, for example tube feeding or special medication. Oral stimulation of some form when a newborn is tube-fed will minimise the impact by promoting the sucking reflex to develop (Bache et al., 2014). A fundamental strategy for successful feeding begins with the caregiver's responsiveness and wellbeing (Williams, 2003). Remaining calm and relaxed during feeding is also a critical strategy to calm the baby and promote attachment interactions (Yang 2017). When caring for newborns who have been prenatally exposed to meth, strategies often relate to creating a

soothing, relaxing, and quiet atmosphere, dimming the lights, and reducing the stimulation in the room (Smith & Santos, 2016).

Attachment

Grand theories of human development try to explain various aspects of development from birth to adulthood, including social, emotional, and cognitive growth (Cherry, 2017). Mini theories, on the other hand, are used to explain a specific aspect of development, such as self-esteem, and are often preferred in the face of modern research because of their specificity (Cherry, 2017). Grand theories contain comprehensive ideas about development, use a stage-like progression, and are often used as the basis for further exploration and mini-theory development. Grand theories are generally proposed by big thinkers, like Freud and psychoanalysis, Skinner and behaviourism, Piaget and cognitive theory, and Erikson and psychosocial development (Cherry, 2017).

Early ideas of attachment during human development emerged in the 1900s from Freud's psychosexual theory (Sadock et al., 2014). According to Freud, children develop in five stages, each stage focusing on a different body part, which provides the child with an opportunity to seek pleasure (Sadock et al., 2014). In the early stages of development, the pleasure-seeking behaviours are reliant on the mother or primary caregiver, considered central to the child's healthy development. Freudian ideas were developed further within object relations theory, wherein early relationships with significant caregivers are thought to be the foundation of an internal working model, which is the fundamental way in which individuals perceive relationships throughout their lifetime (Sadock et al., 2014).

Object relations theory (Mary, 1969) purports that the experiences that infants have of others and their environment during these early stages determines the way in which a child's psyche develops and the way in which they perceive the world. When the infant's needs are being met, the child moves on to the next psychosexual stage, and has a well-adjusted object

relational image of the mothering role. When the mother is neglectful, the child can become fixated at this stage and form an abnormal object relational image. The performance and behaviour of the primary caregiver becomes an unconscious image in the child's mind. This image is held throughout their lifespan and determines how they predict, understand, and behave in social situations and interactions (Mary, 1969). This psychoanalytic interpretation of a child's development has been widely critiqued over the years, but it is important to note because of its foundational contribution to Bowlby's theory of attachment.

Attachment theory (Bowlby, 1958a) is a widely used and extensively researched theory regarding the mother-child relationship and the link between this relationship, childhood development, and any adverse outcomes experienced throughout the lifespan. Within this theory, attachment is seen as a phenomenon experienced between an infant and primary caregiver that is said to provide the infant with the tools to navigate relationships and regulate behaviours (Prior, Glaser, & Focus, 2006; Rees, 2007). Bowlby (1982), known for his comprehensive work around the mother-infant relationship, defined attachment as an innate and universal emotional connection, where an enduring bond connects one person to another. Attachment is said to develop gradually over time with an early objective of maintaining proximity to the primary caregiver, who provides safety and security. The feeling of security allows the infant to explore the world from a safe and secure base. Within this interaction, the child also learns how to behave and regulate their emotions in various social situations (Ainsworth, 1973; Sadock et al., 2014). The process is facilitated by both the primary caregiver and infant and is strengthened by the quality of attachment interactions rather than the amount of time spent together (Klaus & Kennell, 1976). Children who have not attached to a primary caregiver are thought to be at greater risk of social, emotional, and cognitive maladjustment (Bowlby, 1982; Hillen & Gafson, 2015). Subsequently, attachment theory has become a widely researched and extensively used theory for childhood development.

Bowlby argued that attachment is biologically driven and is inherent and innate in everyone (Sadock et al., 2014). In contrast, behavioural theories propose that attachment is learnt through both classical and operant conditioning, and the provision of food (Dollard & Miller, 1950; Klaus & Kennell, 1976). Bowlby disagreed, suggesting the mother-infant relationship is based upon more than just feeding as a reward.

Bowlby was influenced not only by psychoanalysis and object relations theory, but also by Harlow's (1958) work with monkeys, and Ainsworth's seminal work on attachment in the strange situation (Mooney, 2010). Harlow's (1958) studies were significant to Bowlby's theories by showing the emotional and behavioural effects on monkeys who had been isolated from their mothers. The isolated monkeys were more withdrawn, and unable to socialise, mate, and care for their offspring, compared with attached monkeys (Sadock et al., 2014). Ainsworth et al., (1972) went on to develop Bowlby's theory further by analysing the mother-infant relationship in an experimental condition called the strange situation. Ainsworth discovered that infant attachment could be classified into three categories: secure, insecure, and ambivalent. Disorganised is a fourth category which was added later by Ainsworth's colleague Mary Main (Mooney, 2010).

The strange situation identified common behaviours related to the four different attachment styles (Mooney, 2010). Securely attached children feel confident their primary caregiver will respond to cues and provide a safe base, so that they can explore their environment. Proximity is a primary goal to ensure comfort and protection if distressed. Secure attachment develops when a caregiver is available, responsive, and sensitive (Ainsworth, 1991). Insecure avoidant children, on the other hand, do not prioritise proximity with a caregiver. They display both physical and emotional independence and do not seek comfort when distressed. Insecure avoidant children have a caregiver who is withdrawn, unhelpful, and unavailable (Ainsworth, 1973). Insecure ambivalent or resistant children display clingy and

dependent type behaviours, but will also reject the caregiver when they try to engage or provide comfort. This group of children failed to develop security when in proximity to the caregiver. Parenting behaviours are thus said to be inconsistent and do not meet the child's needs (Ainsworth, 1973). Children with a disorganised style of attachment exhibit disorientation such as wandering, confused expressions, freezing, undirected movements, and disorganised interactions with the caregiver (Main & Solomon, 1990). Parents of infants with disorganised attachment are said to be abusive and neglectful, resulting in a paradox being created between the child's secure base and the origin of negative experience (Main & Solomon, 1990). Attachment theory provides a framework for understanding the emotional reactions of infants and the attachment style of the adult.

Attachment interactions are characterised by specific behaviours that prompt and encourage maternal responsiveness and proximity (Dozier et al., 2001). Infants are born with behaviours aimed at getting adult attention. Such behaviours manifest as crying, smiling, eye contact, grasping, clinging, and reaching (Prior et al., 2006). Attachment is thought to develop in stages, beginning in pregnancy and enduring throughout the lifespan (Klaus & Kennell, 1976). According to Bowlby (1989), the first three years of life are the most informative attachment years. Shaffer and Emerson's (1964) four-stage model of attachment is commonly referred to in the literature and aligns with Bowlby's four phases of attachment. The asocial stage lasts from birth to six weeks old and is when the mother and child orient themselves to each other. The infant learns to signal caregivers, who in return learn to identify the baby's cues, respond to its needs and provide comfort. Indiscriminate attachment is the next stage, from six weeks to seven months. Here, the mother and infant have established their routine and the infant's sleeping and feeding needs are becoming regulated and predictable. Infants at this stage are also developing the skills to show and respond to emotional expression and talking.

At seven to nine months the infant is becoming attached in the specific attachment stage. When attachment occurs separation anxiety emerges, where the infant becomes increasingly wary of strangers and maintaining proximity to the caregiver becomes a priority. The fourth stage is the multiple attachment stage, when the baby is 10 months. This stage continues throughout its lifetime. The infant becomes independent and begins to form attachment with several individuals, not just limited to their family. Receiving encouragement, support, and guidance from the caregiver during this stage is important. By age three, children should have developed good social skills, be socially confident, autonomous, and affectionate. Based upon the four stages of attachment, milestones are met at certain ages that promote the development of a positive internal working model (Bretherton & Munholland, 2008). The internal working model sets the child's expectations about attachment figures, the support they can expect to receive during times of stress, and the individual's interactions with others. The internal working model is thought to be the underlying mechanism that shapes personalities and determines the types of relationships individuals experience throughout life (Bretherton & Munholland, 2008).

The real-life application of attachment theory sees the role of the mother as fundamental to the attachment relationship and process. Attachment literature often refers to the mother-child relationship, however in contemporary times the caregiver-child relationship has been greatly endorsed, recognising the modern-day diversity of the maternal figure (Van den Dries, Juffer, van Ijzendoorn, & Bakermans-Kranenburg, 2009; Dozier et al., 2001; Pittman, Keiley, Kerpelman, & Vaughn, 2011). Pittman et al. (2011) argue that attachment theory does not discriminate between who takes on the role of a mother as long as that person responds to and meets the infant's needs. Although Bowlby's theory concentrated on the mother-child dyad, Bowlby himself conceded that children can attach to multiple caregivers (Bowlby, 1958b). This is a contentious issue, with some arguing that bonding for the mother begins during pregnancy,

and is optimised within a biological mother and baby relationship (Mirick & Steenrod, 2016). This is because of the intrinsic factors that promote a mother-child connection that evolves during pregnancy, as well as the extrinsic factors such as skin to skin contact and breastfeeding, which occur in the first few hours after birth (Mirick & Steenrod, 2016). These factors are said to contribute to a mother's ability to bond with a baby, and are developed at birth and through interactions with the baby (Klaus & Kennell, 1976). Attachment, on the other hand, is more about the baby's journey, and according to Bowlby (1982) is inherent and innate. Bonding is thought to be impeded when a primary caregiver is not the gestational carrier and is incapable of performing natural motherly duties such as breastfeeding (Mirick & Steenrod, 2016). Walker (2008) disagrees, suggesting that substitute caregivers can bond as effectively as biological mothers if they are open to it.

Substitute caregivers can replace the biological mother and be as successful in developing secure attachment bonds with the infant. Walker (2008) argues that for substitute caregivers to optimise the opportunities to bond with the infant, their background and personal growth history is important. Maternal sensitivity and responsiveness, which are determined by the mother's early childhood experiences and beliefs about parenting, is a major determinant of a successful caregiver-child relationship. Dozier et al. (2001) argue that the nature of attachment will vary according to the caregiver's own attachment history, psychopathology, and parenting style. Research shows that caregivers who are aware of their own attachment history, can identify attachment issues, and are able to work through their issues, are more likely to provide the infant with a secure attachment relationship (Lang et al., 2016). Parenting styles have also been identified as important to this relationship. Caregivers who experience mental health issues tend to display more inconsistent parenting type behaviours, resulting in more insecure, disorganised attachments (Lang et al., 2016). Research shows, therefore, that

given the right circumstances, substitute caregivers can provide optimal attachment opportunities compared with biological mothers.

Kinship and Non-Kinship Caregiving and Attachment

Foster care is one example of when a substitute carer takes on the role of the biological mother. Although foster care seems to be a good alternative, whereby infants are protected and provided with a safe environment, the separation from their family/whānau and the emotional toll this takes on the infant is thought to have a huge impact on their future development (Mercer, 2006). There is ongoing international debate as to whether kinship or non-kinship caregivers provide the best attachment opportunities, and opinion is divided. Keeping infants within their wider family group is thought to be less traumatising compared with placing them with complete strangers (Worrall, 2001). Kinship care is also reported to be longer-lasting and more stable, which promotes better opportunities to attach, and may encourage important contact with the biological parents (Lawler, Koss, Doyle, & Gunnar, 2016; Testa, 2002; Vanschoonlandt, Vanderfaeillie, Van Holen, De Maeyer, & Andries, 2012).

Despite not being the preferred option for substitute care, non-kinship caregivers have been shown to provide a more stable, nurturing environment for children (Brown, Bakeman, Coles, Platzan, Lynch., 2004). Vanschoonlandt et al. (2012) evaluated the differences between kinship and non-kinship placements and found that although behavioural problems are lower for children in kinship care, it is not the role of the non-kinship caregiver that impacts behaviour, but the number of placements they experience and the trauma they experience before they are placed. Rubin et al. (2008) concur, emphasising the increased threat of unofficial access to the biological parents, and the parental dysfunction being inherent in other family members. The Vanschoonlandt (2012) study also found that foster caregivers could develop better relationships with key stakeholders involved in the child's life, which promoted a stronger bond with the infant. In New Zealand, family/whānau caregivers are preferred by

Oranga Tamariki, as stated in the Children, Young Persons, and Their Families Act 1989, that “where possible, the family, whānau, hapū, and iwi are responsible for care and protection of a child.” This is preferred because of the importance of maintaining continuity and to ensure that cultural identity is protected (Ministry of Social Development, 2007). If for any reason the child is unable to be placed in the care of whānau, the child should be placed “in an appropriate family-like setting, where personal and cultural identity are prioritised” (Children, Young Persons, and Their Families Act, 1989). Atwool (2006) contends that non-kinship caregivers in New Zealand are competent in establishing relationships that provide plenty of attachment opportunities and a secure base. Furthermore, the indefinite nature of placements, as well as the many placements a newborn might experience in its first years of life, impact the attachment relationship more than the caregiver’s willingness and ability to attach. Moreover, it appears that placements with kinship caregivers are fraught with their own issues, which can impact the attachment quality and caregiver-child bonding opportunities.

Attachment research has identified many factors that can diminish the success of secure attachments developing. Much of this information focuses on the substitute caregiver and their inability to perform tasks of which only a biological mother is capable. Carrying the baby is one such factor. It is argued that the bonding process begins during pregnancy. Grace (1989) highlighted the progression of maternal foetal attachment in a longitudinal study that assessed a mother’s connection with the baby in the antepartum period. Grace found that a mother’s attachment did develop and intensify during different stages of her pregnancy, however the study did not determine how this materialised into attachment in the postpartum period. Smith and Ellwood (2011) recognised the importance of the perinatal period, suggesting that there are biochemical processes in both the mother and infant that enhance bonding prior to and after birth. Klaus and Kennell (1976) also discuss the hormones released after birth that promote the mother and baby to feel a connection with each other. Dozier et al. (2001) disagree, implying

that research is limited and what is most important is the caregiver's state of mind, and their availability and sensitivity to the infant. Non-biological caregivers who have chosen to care for newborns may not have developed the intrinsic motivation to bond, but experience an extrinsically based motivation to provide for and nurture, which can be just as advantageous (Bick, Dozier, Bernard, Grasso, & Simons, 2013). Furthermore, Bick goes on to highlight the association between bonding and the release of oxytocin, and how the release is not exclusively experienced by a biological mother, but can take place for a non-biological caregiver as well.

Attachment theory prioritises feeding time as a prime ritual for attachment interaction, suggesting that the quality of interactions during feeding is an important factor in successful attachment (Ainsworth et al., 1972; Bowlby, 1982). Feeding time has become the focus of much attachment research because of the modern-day diversity of the maternal figure and the transformation of breast to bottle feeding. The importance of the intimate interactions during feeding, such as eye-to-eye contact, cuddling, smiling, and touching is prioritised instead. A great deal of literature proposes that it is these interactions that are essential to attachment rather than whether the infant is breast or bottle fed. Smith and Ellwood (2011) disagree, arguing that there is a link between breastfeeding, cognitive development, and attachment, which is promoted by the biochemical components of breast milk. However, breastfeeding research suggests that while breastfeeding does promote greater maternal sensitivity, breast-fed babies are no better attached compared with bottle-fed babies (Britton et al., 2006). Furthermore, the focus should be on the quality of the feeding interactions, which are thought to encourage positive brain development and attachment (Wilkinson & Scherl, 2006).

It has been well documented that multiple placements are a significant factor impacting the caregiver-foster child attachment process. The vulnerability of a child increases with every new placement. The constant disruption to the infant's primary caregiving relationship results in insecure attachment patterns and behaviour problems in later childhood (Atwool, 2006;

Newton, Litrownik, & Landsverk, 2000). Placement breakdowns become a perpetuating problem; breakdowns occur and impact attachment, and the lack of attachment produces adverse outcomes such as behaviour problems and, in turn, the behaviour problems are thought to cause the placements to break down (Brown & Bednar, 2006; Newton et al., 2000). Attachment theory posits that the anguish and distress of losing a primary caregiver can impact an infant's willingness to attach, and can only be resolved if the infant is provided with consistent opportunities to attach to alternative caregivers (Bowlby, 1982; Oosterman, Schuengel, Wim Slot, Bullens, & Doreleijers, 2007). Oosterman et al. (2007) concur, showing in their meta-analysis study of disruptions in foster care that caregivers who are non-responsive are at greater risk of placement breakdown, indicating that attachment interactions do strengthen bonds and provide greater security to infants.

There is extensive literature discussing the impact of childhood abuse and trauma on attachment patterns (Ainsworth, 1991; Mennen & O'Keefe, 2005). Infants who have been exposed to maltreatment are often exposed to unresponsive caregiving, resulting in few to no quality attachment interactions (Morton & Browne, 1998). Morton and Browne found that maltreated children are less likely to form secure attachment bonds, and are more likely to display disorganised/disoriented attachment patterns. Their internal working models are more than likely to be cautious of close relationships due to the paradox of mother as abuser. Because of the maladjusted internal working schemas these children tend to experience difficulties in attaching, and therefore struggle in foster care placements (Mennen & O'Keefe, 2005). Marcus (1991) concurs, finding a relationship between the quality of attachment to caregivers and positive outcomes. Dozier and Rutter (2008) expand on these findings and highlight the impact of maltreatment on the developing brain by showing that maltreatment in the first few weeks of life can alter neurobiological development, increasing the risk of attachment disorganisation.

Age is thought to be a significant moderator for attachment security (Van den Dries et al., 2009). Several studies show that infants who are uplifted in their first few months of life have greater success of secure attachment development compared to children who are uplifted after one year of age (Dozier & Rutter, 2008). It is thought that the earlier experiences of forming bonds create stronger foundations for core beliefs (Van den Dries et al., 2009). It is these core beliefs that influence our thought processes and perceptions, therefore having a more powerful impact (Beck, 2011). As attachment stages tell us, attachment begins to consolidate around seven to nine months of age, and it is after this period that attachments grow stronger (Howe, 2001; Marcus, 1991; Mennen & O'Keefe, 2005; Shaffer & Emerson, 1964). Mercer (2006) suggests that infants who have been uplifted before six months of age are not at greater risk of experiencing insecure attachment relationships because the attachment bond has not yet developed. In addition, Dozier, et al. (2001), suggest that infants who display unsettled behaviours in their first week in a new placement are more likely to develop insecure attachment patterns. The unsettled behaviours may also interfere with the foster caregiver's opportunity to provide quality attachment opportunities, particularly during feeding time.

Maternal substance use during pregnancy is also said to influence the attachment outcome for infants (Miller, 2016; Tait, 2012). Attachment theory provides a framework that helps us understand how emotional and relational development is impacted by prenatal drug exposure (Irner, Teasdale, Nielsen, Vedal, & Olofsson, 2014; Parolin & Simonelli, 2016). Research shows that infants who have been prenatally exposed to drugs tend to demonstrate insecure and disorganised attachment patterns (Bada et al., 2008; Swanson, Beckwith, & Howard, 2000). The teratological effects of the substance, maternal characteristics, separation from the mother, or the multiple caregivers with whom they are placed in their first year of life have all been associated with possible causality (Rodning, Beckwith, & Howard, 1991; Swanson et al., 2000). Attachment theory asserts that mothers who use during pregnancy are

more likely to display parenting habits, styles, and interactions that are incongruent with the development of secure attachment patterns (Parolin & Simonelli, 2016; Rodning et al., 1991). This is thought to be because of the drugs' effects on the mother's maternal behaviours, as well as the personality traits inherent in a mother who chooses to abuse during pregnancy (Parolin & Simonelli, 2016). Emerging research is showing that the teratogen of the substance can be mitigated if the infant receives a nurturing, responsive caregiving environment (Bada et al., 2008; D'Angiulli & Sullivan, 2010).

Attachment theory emphasises the negative developmental effects of poor attachment relationships on a developing child. A lack of attachment interactions in the first year of life is said to play an etiological role in the development of psychopathology. Disorders related to attachment are said to arise when a child sustains emotional and relational damage, which is said to change the neurology of a developing brain, resulting in greater susceptibility to adverse mental health outcomes (Atwool, 2006; Sadock et al., 2014; Van den Dries et al., 2009). The work of Gunnary and Kertes (as cited in Brodzinsky & Palacios, 2005) shows that poor attachment interactions with a primary caregiver can cause a change in the structure and function of the brain. This is thought to occur in three major ways: through severe maltreatment and malnourishment, lack of stimulation, and neurochemical malformations due to an adverse environment. Furthermore, Rees' (2007) study of childhood attachment shows that neuronal plasticity, cognitive development, and regulation of stress responses are all influenced by the quality of primary caregiving. In addition to greater risk of psychopathology, insecure/disorganised attachment patterns can influence the quality of relationships throughout adulthood. Secure attachment promotes more stable, successful relationships without fear of rejection or jealousy.

Māori Culture and Attachment Theory

Many argue that attachment theory can be universally applied, and the fundamental concepts are immune from cultural influence. Bowlby's argument was based upon the idea that the phenomenon of survival is universal and inherent in all human beings. Van Ijzendoorn and Kroonenberg (1988) disagreed, investigating global attachment patterns across eight countries, finding that cultural variations in childrearing do in fact impact the development of attachment. Van Ijzendoorn attributed this to how the strange situation protocol was fallible when used with other cultures. Moreover, Pryor (2005) critiques the narrowness of the early writings of attachment theory and the focus being on the dyadic nature of attachment. Subsequently, contemporary thought associates attachment with a wider interpersonal network of people with whom attachment can occur (Morelli & Henry, 2013). It is through this contemporary position that attachment theory can align with some indigenous traditions about child development and child rearing. Māori culture is one such indigenous group that values the importance of relationships from a more collective perspective (Marsden & Royal, 2003).

Te Ao Māori views traditional child-rearing practices holistically, where connections are made not only with others but also with extrapersonal phenomena (Marsden & Henare, 1992; Marsden & Royal, 2003; Mead, 2016). It is the connection to these concepts that is fundamental to Māori wellbeing. These concepts weave together to define Māori identity (Mead, 2016). Contrary to a western view of identity, the Māori worldview of identity is genealogically (whakapapa) based. Mead (2016) discusses how the characteristics of identity involve genealogical, spiritual, and kinship attributes. This way of defining identity shows the way in which Māori are connected to the rest of the universe. Due to the widely regarded Western acceptance of attachment theory as a childhood development model, contemporary thinking in New Zealand must impart the fundamentals of tikanga (practices/rules/traditions) to attachment theory, to ensure applied appropriateness for Māori (Fleming, 2016).

Unlike Western theories of attachment, traditional Māori tikanga (customs and practices) views attachment as more of a collective process. Parenting is an important concept that is the responsibility of whānau (family), hapū (subtribe), and iwi (tribe) (Marsden & Royal, 2003). Whānau is comprised of an extended family group, hapū is usually made up of more than one whānau connected through whakapapa (genealogy) and whenua (land), and iwi is many hapū groups connected through ancestors and whenua (Fleming, 2016). A child does not solely belong to the parents, but to the whānau, hapū, and iwi. Childrearing is the responsibility of everyone, not just the parents alone, and pēpi (babies) and tamariki (children) are often raised by their Kaumātua (grandparents) (Marsden & Henare, 1992; Marsden & Royal, 2003).

The Kaumātua role is integral to a child's development because Kaumātua are viewed as the holders of knowledge and can pass the treasures from the ancestors down to the new generation (Marsden & Royal, 2003; Mead, 2016). This is an important process, as tamariki are considered treasured gifts and are the future of the lineage (Wirihana & Smith, 2014). Furthermore, bonding with other members in the whānau occurs from birth, rather than Western notions that state that wider attachment occurs in latter childhood (Jenkins & Harte, 2011). Akin to Western ideals, attachment is achieved through Māori concepts such as whakawhānaungatanga (establishing relationships) and tūrangawaewae (the place where we belong which can provide safety), with the child developing relationships in a safe and secure environment (Royal, 2007; Waiti & Kingi, 2014).

Attachment theory and Māori beliefs diverge regarding the importance of connections for wellbeing being established beyond just interpersonal relationships with others. Connections to other phenomena such as whakapapa (lineage), whenua (land) and wairua (spirituality) are also paramount (Haenga-Collins & Gibbs, 2015; Jenkins & Harte, 2011). The complexities of how these concepts are woven into Māori culture and identity is beyond the scope of this thesis topic, but basic definitions are given to provide context. Whakapapa

connects the individual to a wider context involving tribal groupings and geographical regions (Wirihana & Smith, 2014). Whenua provides a space for whānau to be together, and is also an integral part of the tūrangawaewae process, which connects the individual to a place in which they belong. This space provides important connections to ancestors. Furthermore, whenua provides the iwi with food and medicines for healing and sustenance, both important in wellbeing (Te Ngaruru, 2008). Wairuatanga (spiritual realm) plays an integral role in the Māori worldview of wellbeing. It provides protection by connecting people to their ancestors, knowledge, the land, and the universe. Wairuatanga is the connection between the physical and spiritual worlds.

It is through the connection with ancestors that knowledge is passed down from generation to generation, and the connection with ancestors can only be achieved if the individual is connected through whānau, whenua, and wairua (Mead, 2016). These connections are passed on using language and song, where Māori myths and legends, pepeha (a form of introduction which establishes identity), and waiata (Māori songs) are used to tell stories about creation and connectedness to the natural and spiritual worlds, all of which intertwine and are fundamental to many aspects of the Māori worldview (Royal, 2005). In traditional Māori culture children were exposed to these practices from birth, establishing and developing a connection to the wider universe from the moment they were born (Mead, 2016).

The Treaty of Waitangi is New Zealand's founding document, signed in 1840 by the British Crown and a collective of Māori chiefs (Orange, 2012). The document was meant to outline a partnership agreement between the two groups and unify Māori and Pākehā (white people of New Zealand). However, due to the different translations, and the breaches of the Treaty by the Crown, Māori have been negatively impacted (Durie, 1989; Orange, 2012). The Treaty was supposed to protect Māori resources, including tikanga, as well as offering partnership in decision-making processes, and equality. When this did not happen, the process

of colonisation overwhelmed Māori culture, and Western practices began to dominate (Durie, 1989; Marsden & Royal, 2003). Marsden (2003) discusses as far back as the 1850s when Western practices were taking over the traditional Māori way of life. Marsden writes that tikanga was forced to change, and Māori had to adopt many Western practises such as church and schooling practices. Child-rearing was also forced to change because the collective nature of Māori society was quickly diminishing. Māori urbanisation during the twentieth century further contributed to this problem by lessening whānau collective child-rearing practices (Higgins & Meredith, 2011). Whānau no longer lived in their communities and on their land, which provided for them. The land was taken away, and Māori were forced to participate in Western cultural practices which disconnected them from their whānau, whenua, and wairua (Te Ngaruru, 2008).

Given the fundamental nature of these concepts and their link to wellbeing throughout the lifespan, the disconnection from these concepts has been shown to have a significant impact on Māori (Durie, 1989). The overrepresentation of Māori in the welfare system in New Zealand indicates how this disconnection has influenced the wellbeing of Māori (Fleming, 2016). Through colonisation, Māori have been unable to live by traditional practices, which are the essential links to development, identity, and connections. Te Reo (language), tikanga, and Te Ao Māori have become difficult for Māori to access and use readily, and without connection to these practices, Māori experience greater socioeconomic and health issues (Mead, 2016). The high numbers of Māori children being uplifted from their parents demonstrates how the consequences of colonisation have ruptured Māori families and led to childrearing practices that fall outside of culture. Raising children in a foreign way has resulted in poor parenting practices and childhood maltreatment (Herbert, 2011). This problem is further perpetuated within the foster care system by the disregard of

the importance of interpersonal as well as extrapersonal connections in the development and wellbeing of the child (Mead, 2016).

Although many Western theorists argue that attachment theory can be universally applied, many disagree, suggesting that for indigenous cultures such as Māori, attachment is still a relevant phenomenon containing different meanings for different cultures. Within Te Ao Māori, attachment is seen as a much wider concept involving connections not just to a primary caregiver, but to the wider whānau and ancestors, the gods, the land, the spiritual realm, and the wider universe. All these connections are fundamental to the Māori view of holistic wellbeing and are associated with minimisation of adverse outcomes for children in care. Although the New Zealand child welfare system prioritises reunification and kinship placements wherever possible, the short-term temporary placements are often insensitive to Te Ao Māori values, and therefore diminish the opportunities that Māori children in care have to develop their identity and their attachments to the world around them, resulting in adverse outcomes for Māori children throughout their lifespan.

Conclusion

The experience of foster caregivers who care for vulnerable newborns with feeding difficulties is an area that has been under-researched. While there is extensive research on foster caregiving environments, kinship and non-kinship caregiving and attachment, and a small body of literature on infant feeding difficulties, there appear to be gaps in the literature regarding how these phenomena are associated and how they influence one another. Given the critical role foster caregiving plays in developing healthy children, and the importance of secure attachment for wellbeing, understanding the experience of caring for a newborn with feeding difficulties and how that experience may impact the caregiver-newborn attachment relationship would be constructive. The objectives of this study, therefore, are to understand the caregiver's

experience of caring for an infant who experiences feeding difficulties, and how problematic feeding times may impact the attachment relationship and contribute to placement breakdowns, and how these difficulties are minimised and attachment optimised. Fundamental to these objectives, and interwoven throughout the different concepts, is the acknowledgement of the importance of Te Ao Māori and how the Māori worldview is connected to achieving holistic wellbeing for Māori children in care.

Methodology

Aims and Rationale

The objectives of this project were to understand the caregiver's experience of caring for the newborn that experiences feeding difficulties, how that may impact the attachment relationship and contribute to placement breakdowns, and how these difficulties are minimised and attachment optimised by caregivers. This chapter discusses the actions taken to investigate the research problem and outlines the rationale as to why the specific techniques were chosen to collect, process, and analyse the information in relation to the research objectives.

Research Design

The chosen qualitative analytic method for this study was interpretative phenomenological analysis (IPA). This type of analysis proposes that access to an individual's inner world becomes achievable through systematic interpretative methods. Therefore, through IPA it is possible to understand the experience of caregivers (Eatough & Smith, 2008). These underlying assumptions of IPA assert that each individual experiences the world differently, and that therefore experience is subjective and influenced by our environmental, social, and cultural contexts (Willig, 2013).

Husserl (1982), one of the main phenomenological philosophers, argued that experience should be investigated reflexively and independently of predefined human classification systems. Husserl suggested that to investigate experience a phenomenological attitude is required, which involves stepping out of our natural way of thinking and being more reflexive. Reflection, intentionality, and bracketing are all fundamental concepts from Husserl's transcendental phenomenological approach, all of which are commonly used in contemporary qualitative research methods. Although it is impossible to directly access others'

experiences, thoughts and perceptions, IPA acknowledges that the interpretation of their meaning-making is possible. Consequently, the participant role is fundamental as the knowledge holder, but the researcher is also integral and heavily implicated in the process as the interpreter (Willig, 2013).

Smith, Flowers, and Larkin (2009) define hermeneutics as the theory of interpretation, and the hermeneutic circle is a process of understanding text that is fundamental to the IPA process. The hermeneutic circle is concerned with the dynamic relationship that occurs when interpreting text, wherein to understand the whole, one must understand each individual part, and to understand each individual part, one must understand the whole. Movement back and forth between these layers occurs during interpretation. This repetitive process encourages the investigator to employ different ways of thinking about the data and allows the idiographic richness of the experience to unfold (Smith et al., 2009). Whilst IPA does allow for generalisations to be made, they are developed through a more systematic process, where the emphasis is on the specific details within the data (Smith et al., 2009).

Data Collection

Participant Sample Size

The sampling strategy was consistent with the analytical underpinning, and the data collection techniques aligned with IPA requirements. The sample size for this study was small due to the idiographic focus and the importance of ensuring a close and in-depth examination of the caregivers' experience. The richness of the data is optimised when small sample sizes are used, and analysis can be more intimate and in-depth (Smith et al., 2009).

IPA is concerned with the quality of information collected rather than the quantity of information, so the aim in this study was for at least six participants (Willig, 2013). Ensuring the participants were a relatively homogenous, purposive group was imperative. The purposive

sampling method aligned with IPA requirements and meant that it was important to undertake a screening process to ensure that there was convergence between caregivers (Smith et al., 2009). Due to the unique focus of the study, the sample needed to be contained to ensure that caregivers had cared for infants with feeding difficulties, rather than infants without feeding difficulties.

Snowball sampling

Snowball sampling can also be referred to as chain sampling or referral sampling (Biernacki & Waldorf, 1981), and is often chosen when the participant group may be difficult to identify (Biernacki & Waldorf, 1981). Snowball sampling also allows participants to be recruited via recommendation by already participating subjects. Existing participants often know of or are acquainted with others who have had similar experiences and can recommend additional participant, (Biernacki & Waldorf, 1981; Langdrige, 2007).

The first caregiver was recruited through Oranga Tamariki. In addition to the Oranga Tamariki contact, an email was sent out to other caregiving agencies in New Zealand. These agencies were identified through word of mouth recommendations and an internet Google search, New Zealand-wide. Once the first caregiver had been interviewed the most successful method of recruitment was to ask the caregivers themselves: the snowballing technique. After each interview, caregivers were asked if they knew anyone who would be suitable for the study. If the response was yes, the caregiver was asked to make initial contact and obtain consent to pass on their contact details. Once these avenues had been exhausted in the Bay of Plenty region, contact was made with a known caregiver in the Auckland region, resulting in a total of seven interviews. Each caregiver had a different level of experience and offered different types of foster care. This is shown in Table 1 below.

Table 1: *Caregiver Characteristics*

Caregiver	Type of Caregiver	Years Active	Home Town
Sue	Transitional	>20	Te Puke
Penny	Transitional	>5	Auckland
Lisa	Whānau and respite	>5	Tauranga
Gill	Transitional, whānau, and respite	>20	Tauranga
Jen	Transitional and respite	>5	Auckland
KMG	Transitional, respite and permanent/ home for life	>20	Australia – current Auckland – past
Nell	Transitional and respite	>10	Auckland

Screening and criteria

Initial contact was made via telephone. Each participant was offered the option of meeting for this initial discussion, but all were happy to talk over the phone. During the phone conversation the researcher introduced herself and explained the aims of the research and what the study entailed. Housekeeping information such as time commitment and ethical issues pertinent to the study were also discussed. Once the caregivers had expressed a willingness to participate, a screening conversation was conducted to ensure they met the criteria of the study, and an information sheet was emailed out (see Appendix A).

Limitations to the sampling strategy

Limitations with this sampling method included a misunderstanding around the criteria. Some agencies and caregivers did not fully comprehend the definition and scope of feeding difficulties. Common childrearing issues such as reflux and allergies were often disregarded as

feeding difficulties. This was overcome, in most cases, by clarifying the definition and giving examples over the phone. It was overwhelming how interested the caregivers were in participating in the study. All caregivers expressed their willingness to participate and recognised the benefits of research for this cohort of children. Furthermore, because of the caregivers' motivation to participate, rapport was easily established, and caregivers appeared to speak freely, without concern over being judged or information being passed on to their agency of employment.

Semi-Structured Interviews

Semi-structured interviews are a fundamental component of IPA data collection (Smith et al., 2009; Willig, 2013). A single occasion, semi-structured interview was the chosen data collection technique that used predetermined, open-ended questions. The schedule was developed around four major themes that all related to answering the research question (see Appendix B). The semi-structured interview was used to facilitate a conversation whereby the participants felt comfortable to speak freely and tell their stories from their own perceptions (Kvale, 1996). Unlike in a structured interview, where the questions are predetermined and predefined into human categories, the semi-structured interview allowed the caregivers to identify what was meaningful to them and to make sense of that (Kvale, 1996). The benefit of a semi-structured interview was that it allowed new ideas to be identified and explored.

The semi-structured interview process was directed by the participant rather than the researcher. Building rapport at the beginning of the interview was imperative in order to allow the participant to feel confident enough to take the lead. During the rapport-building process housekeeping was completed and the participant consent form was signed (see Appendix C). Due to the willingness and motivation of the caregivers, the interview schedule was not often referred to, as many of the questions were answered in the natural flow of their accounts. It was imperative that the researcher remained engaged with the participants throughout the

interview. If a caregiver brought up a point of interest that needed further exploration, the researcher would make a note and refer to it at a later stage. It was important that the caregivers' flow and concentration on a topic was not interrupted, as this would have impacted the richness of the data.

Data Analysis

Interpretative Phenomenological Analysis

Analysis

The interviews were transcribed, and analysis of the transcripts aligned with the philosophies of IPA as described by Willig (2008) and Smith et al. (2009). There were many advantages to the chosen methodology in the current study. The use of IPA meant that the study could focus on capturing the individual experiences of participants and generate rich idiosyncratic data regarding a specific phenomenon. This methodology allowed the phenomenon to be investigated through a different lens. Changing the context generated data that could contribute to a field that is relatively under-investigated. A large majority of the studies about foster care focus on statistical analysis rather than having an experiential focus. It could be argued that using a qualitative methodology yields a more realistic view of a phenomenon. Furthermore, interacting with participants in their own environments and on their own terms gave greater insight to their experiences and allowed the researcher to enter their worlds for a moment in time. All the participants were experienced caregivers, which strengthened the validity of their accounts and experiences. Another advantage of a qualitative methodology was the ability to work from a holistic viewpoint. Although much of the

information may not have been immediately pertinent to the research question, it provides a strong argument and direction for future research and investigation.

For the current study the transcripts were initially read with the audio tape of the interview to remind the researcher of the feeling and tone during the interview (Smith, 2009). The transcripts were read and re-read. This is an important process to ensure the researcher engages fully with the text, producing a detailed analysis that is idiosyncratic rich (Willig, 2013). In the initial stages of analysis, the researcher made notes of any thoughts and ideas that came to mind when reading, regardless of their relevance to the research question. Furthermore, any questions about what was being said, the language used, contextual thoughts, and linkages to attachment theory were noted (Biggerstaff & Thompson, 2008). As per Smith et al.'s (2009) direction, these initial notes were made in the left-hand margin of the transcript and included notes such as "the caregiver role", "emotional impact", "carer distress at this moment", "always refers to Ministry", and "changes tone when speaking of newborns".

Once the initial analysis was completed, the transcript was then re-read to identify broad themes. This is where the hermeneutic circle was evident, moving from smaller parts to the entirety of the discourse to gain a richer meaning from the text (Smith et al., 2009). These themes were written in the right-hand column of the transcript (Smith, 2009). A table was then developed on paper to organise the themes that had been identified in each transcript, with their line numbers. After the themes had been identified in each transcript, broad categories were created that clustered each theme into a group. This produced a cluster of themes, which were named according to their subject matter. As detailed in Willig (2013), this phase promoted the researcher to think about the themes in relation to one another. The interpretative perspective moved from identifying any themes to understanding how each theme related to the research objectives. This is a different direction for interpretation, where the analysis moves from descriptive to more conceptual and interpretative.

A summary table (see Table 2) was developed that separated each participant, the categories, themes, and corresponding line numbers in the transcripts. The summary table allowed the researcher to understand what themes were discussed most and by whom, and was used as an indicator of theme importance (Smith et al., 2009). Furthermore, the researcher could identify which caregivers spoke about particular topics and re-read any transcripts to ensure none of the themes were missed. There were two themes identified—feeding difficulties and attachment—and subordinate themes that each contained a variety of subtopics.

Table 2: *Example of Theme Summary Table*

Theme One:	Sue		
Feeding Difficulties	quotes	Page numbers	
Types of feeding difficulties	Overeating, allergies, reflux,	17, 51, 61-62, 89	
Causes of feeding difficulties	Drug exposure made him premature	63-72,	
Impact of feeding difficulties and the strategies used to minimise them	Go through multiple clothing, have lots of washing, spilling. Trial-and-error approach, holding upright	204	
Theme Two:	Need to work hard to		
Attachment	establish attachment		155

Once themes were identified and interpreted in relation to the research question, the data was compared to the theoretical constructs of attachment theory. Although Willig (2013) suggests that theoretical comparisons within qualitative analysis are hypothetical and unsubstantiated, the analysis is enhanced to provide new insights into existing theoretical

constructs. For example, attachment theory purports the significance of parental actions and behaviour in promoting a bidirectional relationship between caregiver and newborn. This was applied to the current study by analysing whether the quality of interactions between a caregiver and newborn is impacted by feeding difficulties and how this may influence the development of attachment bonds.

Reflexivity

According to Willig (2013), reflexivity requires the researcher to be aware of his or her own personal footprint on the analysis process. In this sense, if the researcher does not practise reflexivity, a multitude of potential problems may ensue. In IPA, during the research the researcher draws upon his or her own knowledge of the topic to enrich the meanings within the discourse. For the current study, the researcher referred to her own knowledge of foster caregiving, the attachment relationship, and the complexity of care required by newborns with feeding difficulties, to allow a deeper analysis to unravel. The researcher's knowledge was gained through postgraduate study in the field of child psychology, and fifteen years' experience working as a social worker in the child welfare sector.

It is imperative, however, that the researcher is always aware of the participants' meaning-making and the researcher's interpretation of the participants' meaning-making. This was a challenge for a new researcher. There were certainly some instances during the analysis where preconceived notions and knowledge of the topic needed to be disregarded in order for the experience of the participant to be the sole focus. Ensuring that the researcher did not analyse the data through a tainted lens (where the results were already predetermined because of the outcomes the researcher thought she would see) was important. Furthermore, the latter phases of the analysis allowed the researcher to draw upon previous knowledge, particularly regarding attachment theory. To enrich the analysis, comparisons were made between

attachment theory and the participants' meaning-making. Comparison helped the researcher understand participant experience and identify points of convergence and divergence with attachment theory. The analysis was not used to change how the participants experienced caring for newborns with feeding difficulties, but simply to help the researcher to understand the experience better.

Answering how the experience of caring for a newborn impacts the caregiver-newborn relationship, rather than focusing on what other factors impact the relationship, was a potential limitation for a new researcher. During the interviews participants offered many other factors that contribute to poor bonding or placement breakdowns. Once the transcripts had been analysed and before the data had been organised according to the research topic, it was important for the researcher to focus on answering the research question, rather than attempting to answer a different question about why the relationship is impacted if not by feeding difficulties. Ongoing consultation with the study supervisor as well as revisiting what the research question was asking aided in overcoming this potential limitation.

Validity

Validity in qualitative research can be a potential limitation (Willig, 2013). Validity refers to how well the design of the research study achieves the goals of the research and explains the phenomena in question (Smith, 2009). Unlike quantitative studies, which can include controls in their designs that anticipate threats to validity, qualitative research is different (Willig, 2013). Validity in a qualitative research study is strengthened by checking the assumptions identified by the researcher with the participants (Willig, 2013). In the current study, throughout the data collection and analysis process the researcher ensured validity by investigating alternative explanations of the assumptions (Willig, 2013). This was achieved through a variety of mediums. Re-reading the transcripts and moving between the whole

document and parts of the document (the hermeneutic circle) safeguarded the themes that were emerging by ensuring they were analysed in the correct context. During the interviews, participants were given the option to read their transcripts to check that their articulation of a topic captured how they had experienced it. All the caregivers declined this offer. The participants were also offered the opportunity to receive a report of the findings and provide any feedback, which they all accepted. All participants reported that they were happy with the findings. As previously discussed, reflexivity strengthens validity. Therefore, although validity can be problematic in qualitative research, it was not considered a limitation in the current study because of the processes undertaken.

Ethical considerations

Due to the human participants involved in this study, there were several ethical considerations employed. Avoidance of harm to the caregiver and the infant was paramount. Consideration was given to how the questions and interview process might impact and affect the caregiver. The researcher continually ensured that verbal and non-verbal responses placed no judgement on the caregiver, and that the caregiver was offered sufficient support to talk through any issues that the interview may have raised for them. To ensure no harm was placed on the infant, infant names were always suppressed, and the interviews were scheduled when the caregiver was not caring for any children. Informed consent was another important ethical issue. Caregivers not only gave consent to participate, but were informed about audio recording of interviews, how the information would be transcribed, what happened to the data during analysis and reporting, and the potential for published reports to be written and what information would be used. It was made clear that confidentiality and their anonymity was paramount.

Storage of confidential information was another ethical issue for this project. The audio interviews and transcribed information were treated as extremely sensitive, and therefore kept on a locked computer that was only accessible by the researcher. Once transcriptions were printed and consent forms were signed, they were secured in a locked cabinet at the researcher's residence until analysis was complete. They were then securely stored with the research supervisor and will be kept for five years, as per Massey University's requirements. Another ethical consideration included the safety of the researcher during interviews. Some interviews took place in the caregivers' homes. When this was the case a risk assessment was completed over the phone prior to the interview. The risk assessment included who else would be present in the house, animals present, and physical risks on the property. Caregivers' privacy was also considered, and they were always asked where they felt most comfortable being interviewed.

Ethical Approval was received by the Massey University Ethics Committee as per the statement below:

1. MUHEC APPLICATIONS

Committee Approval Statement

This project has been reviewed and approved by the Massey University Human Ethics Committee: Northern, Application NOR 17/45. If you have any concerns about the conduct of this research, please contact Dr Ralph Bathurst, Acting Chair, Massey University Human Ethics Committee: Northern, email humanethicsnorth@massey.ac.nz

Cultural Considerations

Due to the nature of this project and the focus being predominantly on Māori infants, cultural considerations were prioritised. Although the study did not work with Māori participants directly, the research was interested in understanding a phenomenon which indirectly impacts the Māori babies who are over-represented in the foster care system in New Zealand. The Massey University Kaumātua and cultural advisor were consulted, and the

researcher was also of Māori descent and familiar with Te Ao Māori. The guiding principles of the Treaty of Waitangi were acknowledged throughout the interview process to ensure the rights and dignity of Māori were given precedence. Although only one caregiver identified as Māori, all the babies discussed were of Māori heritage, and the researcher is also Māori. As a Māori, the researcher felt it was important to engage in a process that was sensitive to the Māori babies who, while not being the participants, were the focus of the study. Therefore, engaging in a reflexive process that considered the issues and needs of Māori was fundamental. It was paramount to acknowledge that when an infant was not culturally matched with a caregiver and was not living with its whānau, he or she was still Māori, and would always be Māori. Appreciating the Māori worldview and what that meant for the infants' development was always prioritised from the researcher's perspective. During the interview and analysis processes, consideration was given to the holistic approach Te Ao Māori values by delving into how different aspects of the infants' being was impacted by feeding difficulties and the foster care relationship.

Results of the themes found and discussion of the findings are presented in the following sections.

Findings

The objectives of this study were to understand the caregivers' experience of caring for an infant who experiences feeding difficulties, how problematic feeding times may impact the attachment relationship and contribute to placement breakdowns, and how these difficulties were minimised and attachment optimised. The study yielded two different themes: feeding difficulties and attachment. Table 3 shows a list of the main themes and their subordinate themes.

Table 3: *Main Themes and their Subordinate Themes*

Main Theme	Subordinate Themes
Theme 1: Feeding difficulties	
	Types of feeding difficulties
	Causes of feeding difficulties
	Impact of feeding difficulties and the strategies used to minimise them
Theme 2: Attachment	

Theme One: Feeding Difficulties

Subordinate Theme One: Types of Feeding Difficulties

The participants identified fourteen different types of feeding difficulties and every participant identified at least one newborn they had cared for who had experienced feeding difficulties (see Figure 2).

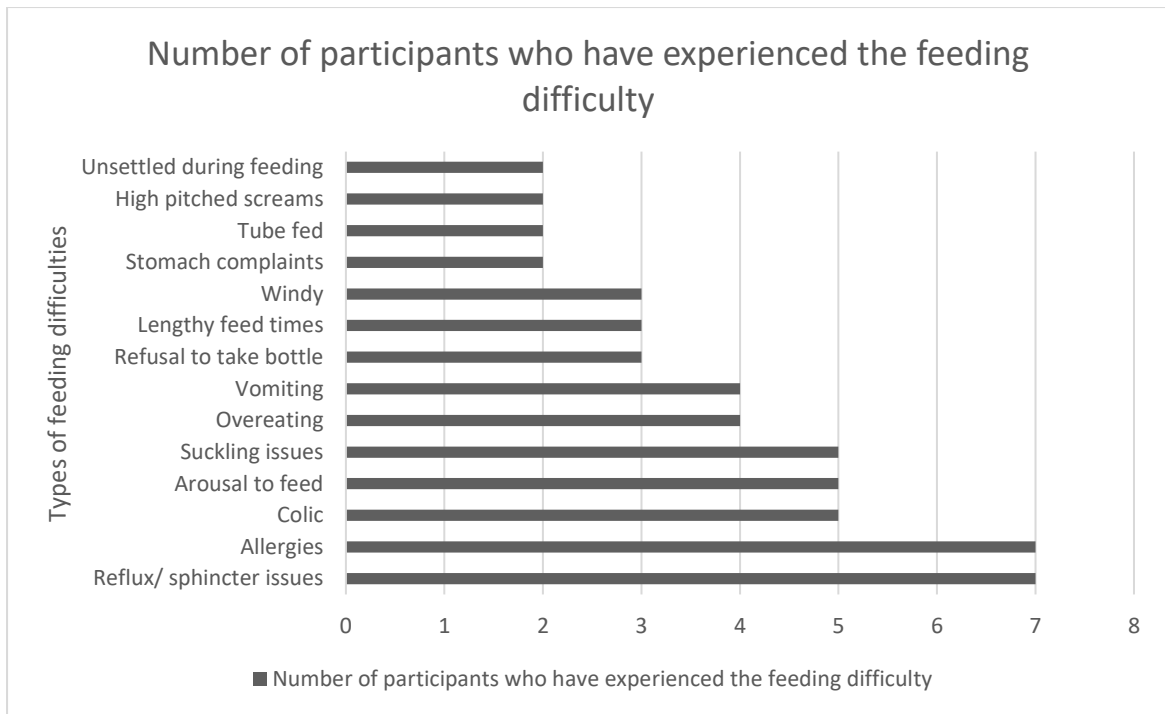


Figure 2: Types of Feeding Difficulties and Number of Participants

Many of the caregivers in this study reported that some of the newborns were generally unsettled when feeding, for example fussing, screaming, moving uncontrollably, and fidgeting to avoid feeding.

Sue: He was breast fed before he came to us so we had to try and get him onto the bottle, he wasn't used to it and would arch his back and turn his head away while screaming at you.

Jen: She didn't want to feed, she would arch her back.

Penny: They are often unsettled while feeding, fussing and fidgeting.

The newborn being "windy" during feeding was commonly discussed by participants as a primary feeding difficulty, which often created other difficulties during feeding. Penny said:

I have had the really unsettled ones during feeding, like the screamers because they get really windy.

Some babies experienced colic and reflux. Reflux was also referred to as the valve not closing and participants discussed these difficulties.

Sue: I have her on hospital formula because she gets colic. She came with the formula so I just kept using it.

Gill: He would scream from burning colic.

Penny: She was crying and screaming with colic.

Nell: You have to be very careful winding him, or else it would all come back out again...So, it was, you know some people do it this way or that, but you can't do any of that, it was always very upright and patting, and just rubbing, nothing that could bring up more.

Nell: The valve doesn't close, so he had reflux.

Jen: He has a valve in his throat that hasn't developed so was windy and needed a special feeding tube.

Vomiting was also identified as a common feeding difficulty for many of the newborns. Participants advised that vomiting was usually linked to instances where the sphincter in the baby's throat did not close properly (reflux).

Nell: It was always just after she would take formula that the food didn't stay down because of the valve that doesn't close.

Allergies to the type of formula used was common, with many of the newborns on special formula. Difficulties with formula led many caregivers to try different formulas to help settle and nurture babies.

Jen: I had to try lots of different formulas.

Kath: I worked out that he was intolerant to the formula, and then I tried goats and that was worse. He was lactose intolerant, so then I put him on lactose-free formula.

The quantity of formula that babies took also varied. Several caregivers talked about overeating being a problem, and suggested that feeding was the only thing that soothed the babies and therefore they always wanted to feed, or that others had not had regular feeds and were therefore starving.

Penny: All our kids are overeaters, so um food is just huge...It's an anxiety producing thing because you want them to be settled and you want them to look like they are replete and you don't want to overfeed them, but they are starving...they keep going and going.

Gill: They drink a lot, they take a lot of milk because it calms them down. It's their only source of being calm...they become little Buddhas because they drink heaps.

However, this need for feeding often led to the babies being over-full and screaming, and vomiting was common.

Penny: He would scream during feeding time due to overeating.

Penny: All the kids' kind of vomit, feeding is a big thing for them because they just keep on eating.

Gill: A lot of them would eat so much they would end up just throwing up.

While some babies craved feeding, others were difficult to arouse to feed. Participants suggested that that it was common for newborns to be drowsy, which resulted in long feeding times as babies would need to be constantly roused.

Gill: So, he slept a lot and you would have to wake him to feed, my daughter would sit and watch TV while feeding him because it took so long.

Kath: It takes a long time to feed, it can be difficult to rouse a baby, it is difficult to rouse the...the time it takes for a feed is doubled or tripled, you know the actual time to get enough milk in is long.

Taking a long time to feed was talked about in conjunction with many of the other feeding difficulties. For example, babies who refused to take a bottle may have taken a long time to feed and were often unsettled.

Jen: She didn't want to feed, she would arch her back. It would take me a long time to feed her.

Problems with sucking were also presented as a common problem for many newborns. Difficulties with sucking on the teat and getting enough milk was one difficulty, and never learning to suckle properly was the other most commonly discussed difficulty.

Lisa: Because he was prem he never learnt to suckle.

Kath: Poor sucking is one of the most common difficulties I have experienced.

Jen: When they can't get enough milk out of the teat and they get tired of sucking.

More serious feeding issues were discussed, and two participants talked about newborns who had required tube feeding. One participant had cared for two newborns who were tube fed, one in hospital and one at her home. Respiratory issues were further identified as common for babies who were tube fed, and one of the infants experienced further feeding difficulties due to long-term tube feeding.

Sue: He had to go through withdrawal in the hospital and I was allowed to stay with him 24/7. His respiration was really rapid and he would get cold, he was on a CPAP

machine, which I learnt about. We stayed in hospital for six days and we tube fed him for about three of those days.

Lisa: He was so prem he was tube fed for like two months. He had a tube down his nose and he had never developed those muscles in his throat for suckling, which also affected his ability to separate air and fluids into his lungs.

Feeding difficulties are a common problem faced by 25 per cent of all children and 80 per cent of children with developmental delays. Statistics and research regarding the commonality of feeding difficulties with babies in foster care is relatively non-existent. However, anecdotal information from paediatric hospitals and foster care agencies suggest that feeding difficulties are a common problem faced by many children in care (Children's Hospital of Philadelphia, 2018; Perpetual Fostering, 2018; Satter, 2018). Newborns who experience difficulties during feeding often experience a plethora of problems, and determining which one is the primary issue can be problematic and create serious difficulty for the newborn, feeding time, and the caregiver (Manikam and Perman, 2000). Reflux, allergies, colic, arousal to feed, and problems with suckling were most frequently cited by participants and consistent with the major types of feeding difficulties identified in the literature. Overeating and refusal to feed were also discussed by participants, as well as tube feeding, time to feed, and vomiting (William, 2000: Yang, 2017).

Reflux was one of the most prevalent difficulties experienced by newborns under the age of six months in foster care (Meadows, 2015), and was implicated by participants as a primary difficulty that often results in secondary feeding difficulties. The interaction between primary and secondary difficulties has been described as the foundation of why feeding difficulties are so complex in nature (Meadows, 2015). In accordance with literature describing the way in which feeding difficulties manifest, the current study identified some common

associations between primary and secondary difficulties. For example, sphincter problems, vomiting, refusal to eat, and screaming during feeding were related. Tube feeding was often connected to secondary difficulties such as suckling, respiratory issues during feeding, longer feeding timeframes, and choking. Likewise, colic was commonly linked to screaming and crying behaviours during feeding, and overeating was often associated with vomiting. Difficulty in rousing during feeding was connected most frequently to lengthy feed times.

Differentiating between the primary and secondary difficulty was sometimes problematic and often unachievable for participants given the intensity and escalation of unsettled behaviours during feeding time, and the participants' focus on providing the newborn with nourishment and attachment opportunities. Primary difficulties are thought to have underlying organic causes, whereas secondary difficulties are often described as behavioural in nature (Manikam & Perman, 2000). Because the impact of the primary difficulty is so great, the newborn develops maladjusted behaviours to cope with the pain (Burklow et al, 1998). This study found that difficulties like reflux cause secondary difficulties such as refusal to eat, which help minimise the pain, resulting in feeding times that involve complex management of difficulties and exacerbation of stress and demand placed upon the caregiver. Differentiating between the primary and secondary difficulty is critical because it informs effective intervention pathways and minimises the impact on the child's neuro and psychosocial development (Hardy et al., 2018).

The commonality of allergies as a feeding difficulty was also significant and was often discussed by participants in relation to colic. Emerging research shows that allergies are experienced by one in ten children under the age of one year and can manifest as reflux, colic or breathing issues (Crooks et al., 2010). It is hypothesised by some researchers that there is an association between the high proportion of newborns with allergies in the foster care system, formula feeding, breastfeeding, and the socioeconomic issues faced by the biological parents

(Luccioli et al., 2014). When children are uplifted they are formula-fed by caregivers rather than breastfed by their biological mothers. Formula made from cow's milk is the most common allergen seen in young babies (Luccioli et al., 2014). The association between allergies and newborns in care who are formula-fed further supports the ongoing debate regarding the benefits of breastfeeding compared with bottle feeding (Britton et al., 2006).

In New Zealand, 38 per cent of Māori children experience allergies before the age of six months (Crooks et al., 2010; Ministry of Health, 2009). The prevalence of allergies experienced by Māori is significant compared to other ethnicities in New Zealand, and is thought to be closely connected to morbidity in Māori children (Luccioli et al., 2014). This disproportionate number may be related to why allergies were among the most common feeding difficulty identified by caregivers, given the over-representation of Māori in the foster care system. Although little is known about the aetiology of allergies for Māori, possible theories suggest a connection between allergies, the high proportion of Māori babies in care, and the poor health outcomes, lower rates of education, and poor lifestyle choices of their biological parents (Luccioli et al., 2014). Given this potential association between Māori, formula feeding, and allergies, breastfeeding Māori babies may be critical to improving health outcomes for Māori children in care. Therefore, weighing up the impact of early cessation of breastfeeding on health outcomes and the risk involved if breastfeeding is continued is critical, because breastfeeding is a basic right of any child, and should consequently be encouraged and continued wherever and whenever possible, regardless of living circumstances (Gribble & Gallagher, 2014).

Given the variety of primary and secondary difficulties identified by participants in this study and how they manifested, it is evident that each individual experience of feeding difficulties is unique, promoting the need for careful consideration and assessment. A thorough assessment and an individualised care plan, developed and monitored by a multi-discipline

team, is recognised as best practice (Rommel et al., 2003; Yang, 2017). This comprehensive assessment framework will help caregivers to achieve a settled, calmer feeding time, optimising quality attachment opportunities, which are critical to child development (Bache et al, 2014; Meadows, 2015). Undertaking an assessment process should include obtaining a detailed account of historical and background information about the newborn and their biological parents, a thorough physical examination, and observations of the newborn during feeding. Such an assessment is imperative in order to understand the difficulty and manage intervention (Bache et al., 2003, Rudolph, 1994). According to caregivers in this research, obtaining background information and care plans is generally not possible, placing the onus on the caregiver to undertake their own ad hoc assessment and independent management of the difficulty.

The issue of information retrieval from the biological parents is often debated in the literature regarding the baby's rights versus the parents' rights. The Privacy Act 1993 details New Zealand's current privacy laws, which are a fundamental reason why background information is difficult to obtain. The Privacy Act 1993 restricts agencies from obtaining information about the biological parents unless the biological parents are aware of and have given permission for the information to be collected and passed on to key stakeholders. This is a contentious issue for many of the participants in the study, as the rights of the baby never seem to be prioritised over the rights of the parents. Although this type of information is in the best interests of the baby and its wellbeing, the biological parents are often not willing to pass it on given the potential risk of disclosing illegal behaviours and not wanting to cooperate with any agency that is taking away their child (Jaques et al., 2014). Changing outcomes for these babies may be significantly resolved if the baby's rights were recognised as paramount.

In conclusion, the common difficulties identified by participants include reflux, allergies, colic, arousal to feed, and issues with suckling. Māori experience a disproportionate

level of allergies, suggesting an association between the over-representation of Māori babies being uplifted and formula fed on cow's milk rather than breast milk, as well as the social factors that may influence the prenatal care of the baby. Feeding difficulties are complex and manifest in unique ways, often causing other types of feeding problems, which only serves to complicate the distinction between primary and secondary difficulties. Differentiating between primary and secondary difficulties assists caregivers to identify the most effective intervention pathways, minimise the impact of the feeding difficulty, and maximise attachment opportunities. A comprehensive assessment framework and ongoing management of the feeding difficulty by a multi-disciplinary team would support caregivers with effective interventions, and reduce caregiver isolation. Additionally, engaging in a broad management plan would alleviate many of the barriers caregivers face when they do not receive background histories due to privacy laws safeguarding the parents' rights to non-disclosure.

Subordinate Theme Two: Causes of Feeding Difficulties

Participants talked at length about the different causes of feeding difficulties. Identifying causality allowed caregivers to better understand the feeding problem and inform appropriate interventions. Causality was a contentious topic for caregivers and was usually discussed with heightened emotions and disregard for the biological family. The newborns themselves were never implicated or blamed for the feeding difficulty, rather the behaviour and actions of the biological mother. Frequent references were made to prenatal exposure to drugs such as methamphetamine, alcohol, and nicotine, as well as parental mental health, abuse, trauma, and neglect (see Table 4).

Table 4: *Common Feeding Difficulties and their Perceived Causation*

Methamphetamine/ Drugs	Nicotine and Alcohol	Abuse, Trauma, Neglect
Bad respiration	Fussy feeders	Crying and fussing during feeding
Very sickly, reflux		Not feeding
Floppy during feeding		
Poor suckling		
Crying and fussing a lot during feeding at the start, high pitched screaming		
Difficult to arouse to feed		
Very long time to feed		
Like to be fed and cuddled more for comfort		

A lack of background information provided by agencies about the newborn meant that participants were making assessments based on their own experience of caring for other babies with similar feeding characteristics, or research they conducted about feeding difficulties. The most frequent causality of feeding difficulties was attributed to maternal substance use during pregnancy. Substances such as methamphetamine, alcohol, and nicotine were all implicated.

Penny: They have all been damaged by drugs I would say, lots of them are premature.

Kath: Mothers who take, take a mixture of things, so you don't know what is causing what, but you know it's related to what the mother has taken.

Caregivers talked about drug use and the relationship to feeding difficulties quite specifically.

Penny: We got him when he was nine weeks old, there was nothing behind his eyes, he was skinny, undernourished...he had been damaged by drugs I would say, he was premature and had reflux and vomited a lot.

Gill: Newborns who have been exposed [to drugs] drink a lot, they are fussy feeders and are very sleepy and grizzly.

Jen: Meth babies have problems with their throats and swallowing, they vomit a lot.

Being sleepy and not feeding as much, or needing to be roused to feed was cited most commonly with methamphetamine and other drug use during pregnancy.

Jen: Meth babies sleep a lot, and they don't feed because they are always sleeping. When they are awake they need low stimulants, very soft lights. They also have louder than usual screams.

Kath: Affected babies are difficult to rouse to feed, the high-pitched scream is like nothing you have heard before.

Some babies were considered by caregivers to have gone through withdrawal periods. It was suggested that withdrawal periods usually lasted six to eight weeks. Several participants spoke about what happens during withdrawal.

Sue: When they go through withdrawal they tremor, their eyes roll back, they can be very floppy...

Sue: Drugs are out of their system after six weeks.

Kath: Withdrawal takes about eight weeks, some effects like the screaming and constant sleeping stop, but other effects are long-term.

Nicotine and alcohol were described by one participant as causing greater damage than drugs to a newborn's ability to feed.

Gill: It's worse for nicotine exposed babies and foetal alcohol babies, they are fussy feeders.

Participants were often critical of the biological parents' behaviour.

Jen: Mum probably drank throughout pregnancy and had a concoction of drugs, she said she didn't, or couldn't remember. I think she was foetal alcohol herself. The baby has no say. The rights of the baby need to be protected.

Kath: A baby is a baby, it's not the baby's fault that the mother has taken stuff.

Gill: The family often cause so many problems, which results in multiple placements and transitions for the baby...

Penny: I disrespect the parents, they haven't cared for them, the family hasn't proven themselves to look after this child.

Gill: The mother had anorexia or bulimia, one of the two, and she didn't like feeding him because she didn't want him to get fat. He never learnt to feed, I got him feeding again and then they sent him back to her and she stopped feeding him again.

Participants also felt strongly that the causes of feeding difficulties were brought about and exacerbated by a lack of information from agencies. This information was crucial to enable effective care for newborns, and reduce the temporal impact of caregivers having to figure out by trial and error what the issues were.

Jen: The agency never gave me the information about the cause of the difficulty, it is important to know and care for the baby in the right way. To promote the rights of the baby we should get this information, it is in the best interest of the baby...

Kath: The social worker passes on info but they don't ask the right questions and I get watered down information...knowledge is powerful and helps with overcoming problematic feeding sessions. Until you have knowledge or the sharing of information, you can do your job better. When you don't have that information, the baby doesn't have the best experience.

Jen: Mostly I receive nothing from my agency, we must figure it out ourselves. I would like to know more medically about a baby and whānau history, it is in the best interest for the baby for information to be passed on.

Kath: I had to do my own research to overcome issues or learn about things.

Jen: The agency never gave me the information I needed, we must figure it out ourselves. I did lots of research myself.

The consensus among the participants was that the information exchange was poor between agencies and medical staff. In addition, successfully detecting the substances taken by

the mother, when they were taken, and in what quantity, was problematic due to legal constraints, the polydrug issue, and lack of honesty on the mother's part.

Penny: Sometimes they'll come with an eating plan, but they don't say how to implement it and other times it gets emailed to you after the placement has started. It's a tough one because the family are not going to divulge that information under traumatic circumstances when the baby has been removed.

Kath: Mothers who take, take a mixture of things, so it is difficult to distinguish what is causing what.

Sue: Nobody likes to say much because it (meth) is such a new thing. I saw on the discharge report from the hospital that says in a very roundabout way that mum was on methamphetamine. They are not allowed to say that unless there has been a test...they used the Finnegan's with this baby, which tells me that they were thinking that it must have been drug withdrawal. The doctors would not say when I asked them, and I asked them several times.

Common known causal factors of feeding difficulties include behaviours related to maternal prenatal health, maternal mental health during and after pregnancy, and criminal or antisocial acts, and are classified as either organic or non-organic in nature (Rommel et al., 2003; Meadows, 2015). Organically caused feeding difficulties are a result of underlying medical conditions, or biological or development problems (Meadows, 2015). Participants cited prematurity as the most common causation for feeding difficulties. Developmental issues caused by prematurity are associated with the aetiology of feeding difficulties due to critical development in utero being interrupted when a baby is born pre-full-term gestation (Schinitz et al., 2005). The preterm impact on the development of a newborn's cognitive and digestive system functioning results in issues that affect successful feeding (Jadcherla et al., 2017).

Suckling, sphincter issues, and breathing difficulties were most frequently implicated as a result of prematurity, and were closely linked to secondary difficulties such as tube feeding, reflux, and choking.

Non-organic causal factors are often social and behavioural issues that can cause both primary and secondary difficulties (Meadows, 2015). For example, an association has been shown between poverty as a social determinant and mothers who experience poor prenatal nutrition and health, increasing their likelihood of engaging in prenatal substance abuse, which results in prematurity (Burklow et al., 1998). Primary difficulties can also materialise into non-organic secondary difficulties. For example, reflux causes the newborn pain, so to overcome the pain, the baby adopts coping behaviours such as refusal to eat to minimise the pain. The current study found a non-organic aetiology involved in difficulties such as overeating. Participants purported that overeating was the result of maltreatment, when the newborn is neglected and not fed regularly. Refusal to eat was another non-organic example given by participants, which can be caused by the newborn being uplifted so often and therefore being extremely unsettled when feeding. Consistent with the organic–non-organic dichotomy of causal factors described in the literature (Meadows, 2015; Yang, 2017), this study found that feeding difficulties seemed to occur on a continuum of organic and non-organic factors, which were difficult to untangle due to the complexity of how the difficulties manifest and the unknown nature of the social determinants faced by the biological mothers.

Prenatal exposure to substances, particularly methamphetamine, is a social issue that was cited by participants as the most common reason for causality of both organic and non-organic types of feeding difficulties. It is unknown in New Zealand how many newborns in care have been prenatally exposed, however anecdotal information suggests that maternal meth use in New Zealand is on the rise, and has affected many newborns who enter the foster care system (Miller, 2016). The extent of the problem has been described by frontline drug and

alcohol services as an epidemic. However, due to the nature of drug abuse and antiquated illicit drug categorisations used by government agencies, it is difficult for services to statistically capture the right information (SocialLink, 2017). Consequently, reliance on subjective experiences of frontline staff, such as foster caregivers, has become fundamental to understanding the extent of the problem.

Understanding which factor holds greater significance in causality for prenatally exposed newborns who have feeding difficulties can be problematic, given the secretive nature of drug use and poor maternal prenatal care (Mahony & Murphy, 1999). However, through their subjective experiences of caring for newborns in foster care, participants have identified a pattern of feeding and sleeping behaviours that they attribute to having been exposed to methamphetamine. In accordance with emerging literature (Schmidt, 2018), babies who have been prenatally exposed are often premature, resulting in a high occurrence of suckling, breathing, and sphincter issues, which affect feeding. The connection caregivers made between prematurity, organic issues, and secondary feeding problems included reflux, tube feeding, high pitched crying and screaming during feeding, difficult to rouse to feed, and lengthy feed times. Although the relationship between meth exposure, prematurity, sphincter issues, and reflux has been generally under-researched, participants suggested a possible connection.

Exposure to alcohol and nicotine are social factors also implicated by participants in the causality of feeding difficulties, which is consistent with the polydrug nature of many substance abusers (Jacques et al., 2014). While methamphetamine is fast becoming the drug of choice, the extent of the problem is under-researched, so alcohol and nicotine are still regarded as the substances most widely abused by expectant mothers (Edens, 2016). Participants suggested that newborns who exhibit fussy and unsettled behaviours during feeding have been exposed to alcohol and nicotine. Alcohol and nicotine are the substances most widely abused by expectant mothers in New Zealand, and 30 to 50 per cent of children in care are thought to

suffer the effects of FASD (Edens, 2016; Oranga Tamariki, 2017a; Shannon et al., 2016; Smith & Santos, 2016).

As a consequence of substance use during pregnancy, newborns may experience neonatal abstinence syndrome, which is a six- to eight-week withdrawal period (American Academy of Pediatrics, 2002; Kronstadt, 1991). This is evidenced through the exacerbation of withdrawal symptoms, which may manifest during feeding throughout the newborn's first six to eight weeks of life. Consistent with NAS literature (Smith & Santos, 2016), participants found that babies who experience withdrawal from methamphetamine are sleepy and difficult to rouse to feed, can be floppy, vomit frequently, and when awake are unsettled and engage in high-pitched screaming and crying, which can make feeding difficult. Participants found that these types of feeding difficulties often diminish after a six- to eight-week period. When babies are going through NAS they are unsettled and require a high level of postnatal care (American Academy of Pediatrics, 2002).

The complexity involved in caring for newborns while they are withdrawing can be extremely difficult for even the most responsive caregiver (Kronstadt, 1991). The participants in this study found that although possible NAS made greater demands of them and often required specific feeding strategies, potentially making quality attachment interactions difficult at times, they were always motivated to settle the baby so nourishment and bonding were achieved. Without the appropriate level of responsiveness from caregivers, newborns who experience NAS are at greater risk of further health complications, due to the potential risk of malnutrition, resulting in stress for the newborn and failure to thrive (Smith & Santos, 2016). The stress experienced by the newborn at such a young age has shown to be associated with altered neurodevelopment, increasing the likelihood of adverse outcomes later in life (LaGasse et al., 2003; Sanders-Phillips, 1998; Smith & Santos, 2016; Twomey et al., 2013).

Determining the cause of a feeding difficulty involves consideration of social, biological, neurological, and behavioural factors (Burklow et al., 1998). Differentiating between these factors is complicated, but there are certain conditions that are commonly related to feeding difficulties (Meadows, 2015; Rommel et al., 2003; Sanders-Phillips, 1998). Social influences, such as poverty, are thought to influence an individual's access to quality healthcare and their educational status, which can impact their ability to care for themselves and their baby (Jadcherla et al., 2017; Mahony & Murphy, 1999). The influence of poverty on adverse outcomes for individuals corresponds to data in New Zealand that demonstrates the prevalence of Māori children in care, given the socioeconomic disparities experienced by Māori (Barth et al., 2006). Social determinants such as poverty and marginalisation were often overlooked by participants, with blame instead being solely attributed to prenatal behaviours such as drug use or mental illness. This interpretation creates a punitive cycle whereby the biological parents are always implicated as the problem with little consideration given to the social influences that underlie many of the lifestyle and parenting choices these individuals make (Jadcherla et al., 2017).

Understanding the aetiology of feeding difficulties is a critical factor in a thorough assessment process (Meadows, 2015; Yang, 2017). Identifying the cause of the difficulty can help determine the primary and secondary difficulties, best inform the most effective interventions, and provide the caregiver with a comprehensive awareness of what is happening for the baby (Rommel et al., 2003; Rudolph, 1994). As part of a comprehensive assessment process, obtaining a detailed history of parental health, including maternal prenatal health, is imperative (Jadcherla et al., 2017). However, due to the polydrug nature of substance use during pregnancy and the mothers' fear of recrimination regarding their prenatal and postnatal actions, historical health information is often difficult to access (Jacques et al., 2014; Shannon et al., 2016). This point was often acknowledged by participants. In addition to the polydrug

issue, and consistent with current research (Rommel et al., 2003), this study found that biological parents do not volunteer information readily, and if they do cooperate with welfare agencies, providing the type of detailed information required is often too difficult due to the nature of substance use. The punitive neo-liberal nature of child welfare in New Zealand has shaped a system where inequalities exist for many, particularly Māori (Somerville, 2003). The disparities that exist in the New Zealand welfare system for Māori compared with non-Māori intensify this issue by failing to acknowledge the role social determinants play and the Māori worldview, in which a holistic approach to wellbeing is fundamental (Marsden & Henare, 1992; Mead, 2016).

In conclusion, feeding difficulties are caused by organic or non-organic factors. Organic factors are a result of underlying medical conditions, or biological or developmental problems. Non-organic factors are often social and behavioural in nature. Feeding difficulties do occur on a continuum of organic and non-organic factors, which can be difficult to untangle due to the complexity of how the difficulties manifest, and the unknown nature of the social determinants faced by the biological mother. Prenatal exposure to methamphetamine was seen by participants as being the most common reason for causality of feeding difficulties in newborns in care. Prenatal meth exposure is thought to be both organic and non-organic in nature. Exposure to meth in utero is associated with prematurity, which is thought to be closely linked to developmental feeding issues such as sucking and the sphincter not closing. Furthermore, social factors such as the experience of poverty can impact a mother's prenatal health and access to prenatal care, increasing the likelihood of engagement in substance abusing behaviours during pregnancy. Social determinants, however, are often not considered due to the punitive neo-liberal nature of the New Zealand welfare system, creating further disparities between Māori and non-Māori. Babies who have been prenatally exposed frequently

experience reflux and sucking issues requiring tube feeding, and withdrawal symptoms such as sleepiness, which exacerbate the time it takes to feed.

Subordinate Theme Three: The Impact of Feeding Difficulties and the Strategies Used to Minimise Them

The impact of feeding difficulties on the newborn, feeding time, and the caregiver

Participants identified that feeding difficulties impacted the newborn’s ability to feed, the nature of feeding time, and the caregiver’s role and responsibility. How each feeding difficulty impacted the newborn, feeding time, and the caregiver is summarised in Table 5.

Table 5: *The Impact of Feeding Difficulties*

Feeding Difficulty	Impact of Feeding Difficulty
Unsettled during feeding	<ul style="list-style-type: none"> • Increased feeding time
Screaming during feeding	<ul style="list-style-type: none"> • Increased feeding time • Difficulty with getting enough milk in
Windy	<ul style="list-style-type: none"> • Spilling, unsettled after feed • Difficult to resettle
Taking a long time to feed	<ul style="list-style-type: none"> • Impact routines for both caregiver and newborn
Refuse bottle	<ul style="list-style-type: none"> • Difficulty with getting enough milk in • Increased feeding time • Need for different methods to feed
Vomiting	<ul style="list-style-type: none"> • Going through lots of clothes for both baby and caregiver • Undernourished because not keeping milk down
Overeating	<ul style="list-style-type: none"> • Vomiting • Difficult to know how much has been kept in
Problems with suckling	<ul style="list-style-type: none"> • Undeveloped muscles in throat impacted suckling from teat • Required to be taught how to suckle • Increased feeding time • Inability to separate fluid from air, would cause baby to stop breathing • Requirement to do infant CPR training and how to feed him (provided by hospital)
Rousing to feed	<ul style="list-style-type: none"> • Increased feeding time • Undernourished because difficult to get enough milk in
Baby colic	<ul style="list-style-type: none"> • Difficult to resettle
Allergies	<ul style="list-style-type: none"> • Special formulas that were costly • Increased vomiting and spilling
Reflux/valve in throat not developed	<ul style="list-style-type: none"> • Unsure of how much milk kept down • Increased spilling • Difficult to settle • Increased washing

Participants discussed the direct impact on the babies due to feeding difficulties in learning how to feed properly, the time taken to feed, and the impact on the role of caregiver.

Lisa: He never learnt to suckle because he was tube fed for like two months, he had a tube down his nose and never developed those muscles in his throat for sucking. This affected his ability to separate air and fluids when swallowing, so he was aspirating fluid into his lungs and stopped breathing. When the tubes came out we were trying to teach him to suckle.

Kath: Feeding time is doubled, sometimes tripled...

Jen: Feeding time might take over an hour.

Sue: You go through multiple clothing and have lots of washing from the spilling and vomiting, housework and running a household still has to happen but feeding is lengthy.

Nell: You go through lots of clothes because you get spewed on.

To help overcome the impact of problematic feeding sessions, participants used a variety of products. These included varying formulas, teats, or feeding vessels. Participants had a collection of feeding products they had purchased themselves.

Sue: ...you know, I have a box of different shaped teats, that's my thing, the agency has given me some bottles once, but usually they don't help with costs like that.

Nell: Funding doesn't cover the extra things, we have to apply for extra funding. I think paying for expensive formula or having gripe water is worth it, it makes them more settled, which makes my life easier.

Caregivers would utilise their feeding resources in different ways. Sometimes they would drill holes in teats so it was easier for the newborn to suckle, and modify bottles and sippy cups when teaching newborns to suckle.

The practical strategies caregivers applied during feeding time aligned with the trial-and-error approach they all took. Depending on how the baby would respond, caregivers would either rock or not rock, swaddle or not swaddle, dim the lights or brighten the lights, play music or make it quiet, walk or sit, rub or not rub, pat or not pat. Some patterns did emerge in the strategies caregivers used for certain difficulties. Reference to the “drug affected babies” was made by Jen, Gill, and Kath:

Gill: Milk calms them down, it is their only source of being calm so I feed them for comfort.

Jen: P babies need to feed in a low stimulate place with very soft lights.

Kath: Drug affected babies like to be swaddled when unsettled, and a dark room.

Gill described using the dream feed as an ideal strategy to get babies who won't feed to feed.

Gill: Dream feeding works for babies who don't like to feed or have been tube fed and don't feed. I wait until they are sound asleep and then put a bottle to his mouth and he sucked, I did that for three feeds. Also, when they don't feed you play with the end of their bottle, like you tap it, we used to put a finger under their chin and kind of massage their chin to get them to suck, but the easiest thing is to get them half-asleep to feed them.

Caregivers did not receive training about what strategies were best used for feeding difficulties. Participants discussed the extra burden on caregiving that came with the time they had to take to research and make enquiries regarding the feeding difficulty experienced by the newborn. There appeared to be little information or training provided by agencies and it was the caregivers' responsibility to find out how best to feed the newborn.

Sue: You need to do your own research on different difficulties, you need to figure things out yourself. The social worker or agency do not help with this information.

Penny: They will sometimes come with an eating plan, but there is no information about how to implement it. I have never received any advice from my agency. I seek advice from other people.

Lisa: There was no information.

Jen: You don't get enough information about the difficulty to properly care for the child.

Learning about feeding difficulties was also done through ad hoc contexts like from their own parenting experiences, other caregivers, or professionals they trusted. Participants found that contact with people who have experienced or worked with newborns with feeding difficulties were more helpful than agency training sessions and agency social workers.

Sue: I learnt so much from my own parenting history and the people I know in caregiving who can tell me more. I am connected with the foster caregiving network in Tauranga, they are really helpful.

Penny: Contact with other people who have been through it is actually more helpful than professionals sometimes. Speech and language therapists are really good.

Nell: I ask friends for advice and other caregivers. The fostering kids network in Auckland is great.

Spending time either researching feeding difficulties or obtaining information from other networks impacted greatly on the caregiving relationship, especially at the beginning of the placement. Participants said that instead of providing high-quality care to the newborn, their time was spent trying different methods and figuring out what was happening for the

newborn during feeding time. The participants found that instead of maximising attachment opportunities, they were consumed with experimentation and information retrieval.

Kath: I had to do my own research to overcome issues or learn about things. Feeding info is going on a lot of past experience and trial and error. Rather than having calm quiet feeding times where you can bond with the baby, you are busy trying to figure out what's going on for them.

Retrieving the right information was approached in different ways by the participants. All caregivers had their own collective of professional services and a personal support network of other caregivers that they would engage regularly for advice on feeding difficulties. The most important source identified was other caregivers who had cared for newborns with feeding difficulties:

Jen: I get good advice from another caregiver and a doctor who I take all my babies to.

Nell: The natural health shop lady is who I go to first and if she couldn't figure it out I would go to my GP. The first thing we look at is their formula.

Sue: I have a good Plunket nurse. I have developed a good relationship, so they are supportive.

Penny: I ask medical and nursing people before I ask the agency, I probably have more experience now than the agency anyway.

Lisa: SKABOO taught me lots, they were the ones that helped me organise everything, not my agency.

The complexity of caring for this cohort placed also extra demand on the caregivers' day-to-day responsibilities. Extra duties that the participants identified included extra washing, longer feeding times, and extra training.

Sue: You go through multiple clothing, have lots of washing, spilling, and vomiting.

Jen: Feeding would take over an hour, it would take a really, really long time.

Nell: You would try everything you could to keep the food down, and of course that meant we had lots more demand on clothing, including ourselves because you can't avoid getting puked over all the time, and it stinks so you have to change them a lot...so the amount of washing...

Penny: I spent time in the hospital learning infant CPR and how to tube feed him.

Due to the intensity of working with newborns with feeding difficulties, the caregivers' ability to perform other tasks during their day could also be problematic. Foster caregiving for newborns with feeding difficulties was described as a fulltime job, and achieving other tasks outside of the caregiving role was difficult without a support network.

Sue: Housework and running a household still happens, some days it is just more difficult...It's a fulltime job, you need to give 24-hour attention, other caregivers work and have kids, but these kids need 1:1 time.

Kath: Caregiving impacts your whole life, and the higher needs are more unpredictable than babies that aren't high need. Your support network will help with the day-to-day things of the household, it's the day-to-day things which are impacted the most.

Lisa: I had to quit my job and just focus on being a caregiver.

Gill: It's a fulltime job.

To minimise the impact of the intensity of caregiving for newborns with feeding difficulties, caregivers would rely on their personal support network. The support network was imperative to caregivers for three reasons: to allow sole focus to be on the newborn and provide

them with a stable and settled environment that optimised attachment opportunities, to allow caregivers to achieve the household responsibilities, and to promote emotional wellbeing.

Sue: My husband is a good support so I can stay at home, I couldn't do this job without him. Other caregivers work and have kids but the baby needs 1:1 time, I don't believe in daycare.

Penny: I am a nurse so I have to work, it makes it difficult, my husband is my only support in Auckland...you need a break because it is tiring.

For many of the participants, establishing a routine also aided in minimising the extra demand the feeding difficulties would create, ensuring the caregiver could achieve their household obligations, and providing better opportunities for attachment. Penny and Jen talked about how important establishing a routine was so they could manage caregiving and their own households.

Jen: I put all the babies I have into a routine, otherwise it is too difficult when managing other family commitments.

Penny: I really try and get them into a routine early...it is difficult because you don't know their routine when they arrive or when they are taken away from you. Routine helps to cope with their complexities.

Sue: When they sleep in the morning I tend to get all my jobs done, do my washing, do everything, because the afternoon is generally gonna go to custard, and in the afternoon, I will try and sleep if the baby sleeps. Very few of us caregivers, apart from a couple of us, don't actually work or have their own kids at home with them still. These kids need 1:1 time, especially during feeding and settling.

Although routines were preferred, some of the participants found it difficult to establish them initially due to the feeding difficulties. Feeding time in the first few weeks of a placement was described as constantly changing and unpredictable.

Lisa: He was put into a bad routine because he needed to take medication all the time. It interrupted his sleep time and put more pressure on the feeding time.

Kath: Keeping them awake during feeding and resettling them after feeding makes it difficult to establish a routine.

Jen: One baby I couldn't put into a routine and I was so tired, he had been at four homes before me and this poor wee soul was just being shunted around.

Routines were considered an important factor to promote good feeding. Participants found that if they could establish a routine, they would be more prepared during feeding time and therefore cope with the complex demands more effectively, resulting in greater opportunities for attachment to occur.

Nell: In a typical feeding session I would organise myself earlier so I was ready for whatever was going to happen, that's why the routine is so important. I get the cushions so I can sit nice and comfortable, I would pick up baby and have different scenarios around that, then I would have a cloth and things next to me so you can have everything in your reach, because you don't want to get up, it is important bonding time. There is a lot happening and you watch them drink, you make sure everything is okay, the body contact, they hear your heartbeat, that kind of stuff.

Woven throughout the discourse were a plethora of emotions that the participants would experience during feeding. Common terms used to describe how the participant was feeling during feeding are shown in Figure 3.



Figure 3: Common Emotions Caregivers Experience when Caregiving

When the participants described the feeding difficulty, often it evoked how they felt when feeding times were particularly intense. Although their emotions were powerful at times, all participants explained how these emotions never impacted their ability or motivation to care for the newborn.

Lisa: I would teach him to suckle by sticking the nipple of the bottle in his mouth and squeezing, basically drip feeding. He could have died very easily, he would stop breathing all the time, I would have to sit and try and take 40mls out of a bottle...It was really scary and stressful, but I had no choice, he was so tiny and vulnerable.

Kath: It's stressful initially having to work out what's going to work for this baby and what's going on, but you have to just keep going, they deserve it.

Penny: It's anxiety producing because you want them to look replete...you probably show signs of stress, like this is hard work today, but it's not their fault, I'm sure they can feel my stress but you keep going.

Participants always saw the babies as innocent and completely deserving of any extra help and time required to ensure successful feeding. The newborn was never held responsible.

Nell: The frustration of the extra washing because they were always puking on yourself, but it has nothing to do with the child, they can't help it.

Kath: I find it much easier to stay calm and care for a kiddie in care because they can't help what they are doing.

Sue: Making baby comfortable at any cost is the most important thing.

Gill: I tried to make feeding and bonding a nice experience but because I had to get food into him without him coughing and spluttering and nearly dying it was hard, but I would hold him close and you just can't help but bond with this needy child that does not deserve what he was going through.

A distressing factor for caregivers when feeding newborns with difficulties, however, was minimising the impact on their household. Unsettled feeding behaviours during the night would at times wake the household, and unsettled feeding and settling behaviours during the day would impact the caregiver's other household obligations. Caregivers would go to great lengths to minimise the impact of the feeding difficulty on the household, which would be emotionally draining.

Penny: When the baby is screaming during late night feeds I can feel myself getting stressed because you can imagine the young adults in our household when they get woken up all the time. I have to only take newborns with feeding difficulties when my kids haven't got exams, then we won't have a baby in the house.

Kath: If they have got reflux, one little girl I carried for eight weeks so she would be upright, baby carriers are not safe so I carried her in my arms for eight weeks. I had a very sore back, and I tried to fold washing and do all of those sorts of things, but yeah it was the only thing that would stop her from screaming.

Jen: I was so worried about him waking B all the time during night feeds, he would never settle longer than half an hour at a time, so I would sit with my hand in the cot trying to settle him.

The importance of professional and personal support networks was identified as essential to the success of being a foster caregiver and in promoting emotional wellbeing. Professional support networks such as Plunket provided advice and support with managing the feeding difficulty, and personal networks were beneficial for hands-on support and debriefing opportunities. Within the personal support networks were the family support systems, which were described as the most crucial type of support. Families provided hands-on practical support with the baby during feeding time, with many participants suggesting that foster caregiving newborns with feeding difficulties would be unachievable without a family support network.

Jen: B helped with feeding, she would become the mum. Having a second pair of hands is so important, otherwise it is difficult.

Kath: I have a really supportive family, which helps me stay calm and do the job I need to do...my mum helps with the day-to-day household things, which leaves me time to be with the baby during the lengthy feeding sessions.

Sue: My husband helps when he's home. I have developed my own support network, this allows caregivers to be in it for the long haul. It is good to talk, debrief, and moan.

Feeding time is an important ritual for any newborn, of which the primary goal is nourishment for normal growth and development (Chatoor et al., 1998). When a newborn experiences feeding difficulties, the impact of the difficulty can hinder the newborn's ability to obtain the right intake of food for effective functioning. When a newborn is unable to take in enough food, the baby can fail to thrive, and is at greater risk of being under nourished,

experiencing feeding issues later in life, and greater adversities throughout their lifespan (Chatoor et al., 1998). A point of contention for participants was knowing how much formula the newborn required, and if they had taken enough for normal growth and development. The impact feeding difficulties had on how much the newborn consumed caused a considerable amount of stress for the participants. Understanding the amount the newborn had consumed and if they were replete was problematic when feeding times consisted of vomiting, screaming like they were in pain, overeating like they were still hungry, and sleeping like they had had enough. The stress a caregiver may experience during feeding can cause further feeding maladaptations and secondary problems, perpetuating further stress (Hardy et al., 2018). Overeating was one example provided by a participant. The caregiver kept feeding the newborn, even though they had ingested the recommended dosage. The newborn was then overfull and vomited, resulting in further distress for the caregiver because the amount of milk ingested was then unknown.

The role of a foster caregiver is to provide a nurturing environment, whereby quality attachment interactions are prioritised (Stukes-Chipungu & Bent-Goodley, 2004). Providing newborns with stability and consistency and optimising opportunities for positive early life experiences and development are key to reversing the effects of previous maltreatment and minimising further adversity throughout their lives (Centre for Social Research and Evaluation, 2012). The development of attachment is a fundamental phenomenon for healthy childhood development (Bowlby, 1982; Mooney, 2010), and feeding time is a critical context both for nourishment and for secure attachments to develop (Ainsworth et al., 1972). However, when feeding time is interrupted by difficulties, participants prioritised nourishment over attachment. Moreover, the impact of diminished attachment opportunities on the caregiver-newborn relationship is thought to increase the risk of placements breaking down (Atwool, 2006; Chicchetti et al., 2006). Contrary to existing research, this study found that although the

primary goal of feeding is nourishment, caregivers engaged in as many strategies as possible to minimise the impact of the feeding difficulty and ensure bonding still occurred. Although extra demand and stress were placed on the caregiver, newborns were not held responsible, and therefore the willingness of the caregiver to provide the best opportunities to the newborn remained constant. The willingness of caregivers to overcome feeding difficulties and optimise attachment interactions suggests there is little correlation between feeding difficulties, poor attachment development, and placement breakdowns.

The willingness of the participants to prioritise both nourishment and attachment opportunities was grounded in the caregivers' commitment and motivation to reverse the negative effects of maltreatment, and minimise the potential for future adversity throughout their lives. It is thought that newborns who have been uplifted in New Zealand have experienced some form of maltreatment (Breslau et al., 2014). The consequences of childhood maltreatment can be extreme and lifelong, and are associated with disruptions in the neurological, psychological, and social development of children (Fisher et al., 2006; Toth et al., 2013). Maltreated children suffer up to seven times more acute and chronic health conditions, suggesting that a large proportion of children in care experience conditions that may hinder positive development and growth (Fischer et al., 2014). Therefore, reversing the adverse outcomes experienced by this cohort is an important goal of any child welfare system (Altenhofen, 2013; Schinitz et al., 2005). The health and behavioural conditions caused by maltreatment complicate the type and level of care these medically fragile newborns require, placing a great deal of responsibility on the foster caregiver (Dozier et al., 2001).

Newborn feeding difficulties is one such condition that impacts the caregiver, by placing greater demand on their roles and responsibilities. Such things as increased washing, longer feed times, and interrupted routines are implicated. However, the commitment and motivation of the caregiver acts as a protective factor that safeguards and prioritises the

caregiver-newborn relationship at all costs. Ensuring the caregiver is aware of the commitment they are making, and has apposite character and credentials, is a fundamental part of the recruitment process, and establishes whether the individual is suitable for the complex role (Dozier et al., 2001; Lang et al., 2016). Caregivers who commit to caring for vulnerable newborns with complex needs make a significant commitment that is both physical and emotional (Dozier & Rutter, 2008). The commitment and characteristics of the caregiver are closely linked to how successful the child in care adjusts and develops (Dubois-Comtois et al., 2015). Likewise, the motivation of the caregiver is linked to how successful and stable a placement is (Cole, 2005). Altruistic caregivers have a great deal of empathy and make decisions based upon what is good for others (Kang, 2007). This altruistic motivation appears to be the driving force behind the participants in this study, suggesting that certain caregiver characteristics support greater placement stability and promote positive development opportunities.

To minimise the impact the feeding difficulty has on the newborn, attachment interactions, and the caregiver, participants engaged in a variety of strategies. In accordance with strategies identified by Yang (2017), caregivers adopted a calm, responsive, and relaxed demeanour during feeding, which settled the baby and promoted attachment interactions. Practical strategies included using a variety of different products such as special teats, bottles, and formulas, and establishing routines whenever possible. Developing professional and personal support networks to provide strategies and advice, debriefing opportunities, and hands-on support also helped. Given the limited background information caregivers received and the non-existent training provided around issues such as feeding difficulties (Lenora, 2010; Marcellus, 2004), participants were responsible for figuring things out themselves and developing their own resources. Both professional and personal support networks were common resources used by participants. Caregivers require a good professional support

network to help them effectively manage the newborns' care requirements and complex needs (Barth, 1991). The professional networks were established by the participants, and were made up of individuals who were trusted and who had prior experience with newborns and feeding difficulties. Personal support networks were also critical to the success of placements, and were associated with caregiver wellbeing, which is fundamental for placement stability. These networks are therefore an important credential for any caregiver (Bates & Dozier, 2002).

Given the complexity and unique nature of how feeding difficulties manifest for different individuals, identifying one strategy to fit all problems is impractical (Manikam & Perman, 2000). Although a trial-and-error approach was always adopted by participants, given the complexity of aetiology, some specific interventions were used for certain difficulties. In accordance with methamphetamine literature (Schmidt, 2018; Smith & Santos, 2016), newborns who had been prenatally exposed preferred minimal stimulation during feeding, very soft lights, and to be cuddled. Reflux and vomiting were also associated with specific strategies that include specific winding techniques and feeding upright.

In conclusion, feeding difficulties can impact the newborn's ability to receive nourishment and thrive, and opportunities for attachment during feeding. Nourishment is always the priority for caregivers, but engaging in intervention strategies by using a trial-and-error approach helps to maximise the opportunities for attachment during feeding. Strategies such as using different products, accessing professional and personal support networks, and identifying patterns in feeding behaviours are all important. However, the most critical factor in minimising the impact of the feeding difficulty and maximising attachment processes is the commitment, responsiveness, and motivation of the caregiver, which overcomes many of the feeding problems that may impact attachment.

Theme Two: Attachment

Attachment was the second major theme that emerged from the results. Attachment is highly relevant because successful bonding is thought to impact the stability of foster care placements. Attachment was discussed by participants in many different contexts related to both relationship and placement stability. The types of attachment interactions participants engage in during feeding, and how feeding difficulties impact successful bonding and placement stability were also deliberated. The length of time placements continued was implicated as a critical factor in successful bonding, as was the caregiver's emotional wellbeing and support networks. Cultural considerations were discussed briefly by participants, but were often not emphasised when issues with bonding or placement stability were raised. These findings are discussed in depth in the following section.

When the relationship between the caregiver and newborn was raised, participants often referred to bonding. Establishing attachment was a priority for the participants during a placement, as they were all aware of how important it was for the newborn and healthy development:

Kath: Once I learnt properly about attachment, the focus became all about the child.

Nell: You want that attachment for them.

Lisa: Every child needs to bond with a caregiver, it is important for their development.

The way in which the caregiver achieves attachment is through the engagement of specific interactions during feeding time. The types of interactions identified by participants are shown in Figure 4.

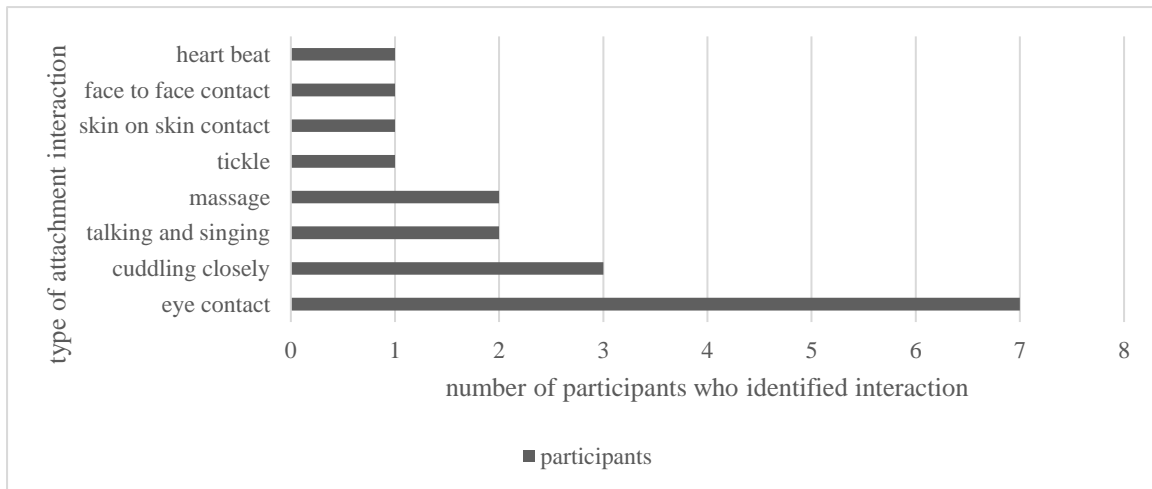


Figure 4: The Types of Interactions Identified by Participants

Eye contact was the most recognised attachment interaction. Although the caregivers used different methods, there was a universal understanding about the importance of touch and interaction. Caregivers used different ways to explain the types of touch and interaction they engaged in. Nell, for example, always held the baby under her heart so it could hear her heartbeat. Nell also discussed the importance of skin-on-skin contact, and how this interaction should not be limited to the biological mother. Kath enjoyed talking and singing to the babies in her care, and found that massage during problematic feeding sessions not only settled the baby to feed, but was also an effective interaction for bonding. Whatever the interaction, caregivers were always motivated to provide the newborn with opportunities to attach.

Attachment took time and was impossible to establish in the first few days. All participants noted that once the baby had settled into its new environment, the process of attachment could begin, and was not limited to just the primary caregiver, but occurred with multiple family members.

Penny: I don't think attachment happens straight away, I think it takes a few days or a bit longer. They need interaction to feel secure first.

Jen: You cannot have attachment in the first 24 hours, it is impossible.

Gill: The baby bonded with my daughter first.

Jen: B would sit and feed him for over an hour, they developed an attachment.

Nell: One little one became very attached to my daughter who would feed him and play with him.

All participants understood that feeding time was not only critical for nourishment but also the development of attachment. Participants discussed this in terms of what a typical feeding session would entail for them. Gill, for example, discussed how she would set herself up first, and make sure she had everything she needed, such as water, a burping cloth, and cushions for support. Making sure the baby was comfortable and settled was the next task, and ensuring the baby was positioned in such a way that attachment interactions could occur. How feeding time would progress from here was largely unknown by Gill and many other caregivers, due to the feeding difficulties experienced by many newborns in their care. Feeding difficulties intensified feeding time and made the process of attachment more complex for participants. During problematic feeding sessions, quality attachment interactions sometimes seemed difficult to achieve. This was articulated by four of the participants:

Penny: It is hard because it isn't a peaceful time when there are feeding difficulties, but you do what you can to give them that interaction. The goal is to try and settle them, then it can be a lovely time, it's quiet and you make eye contact.

Lisa: Holding him very upright, this wasn't soothing, it was just the way it could be done...Often it was difficult to make it a nice experience because I had to try and get this food into him without him coughing and spluttering and nearly dying, but I would always hold him close, you can't not bond with this needy child. It impacts the attachment relationship sometimes because you end up having to position him a bit

further away. The most important thing is to feed him so he doesn't die, so that's what I did.

Jen: Attachment during feeding can be impacted because they sleep so much and don't want to feed and you worry about not getting enough in.

Sue: Drugs slow the development of attachment because the baby just wanted to sleep during feeding, and was so floppy, like he wasn't there for the first six weeks.

Participants identified that caring for newborns with feeding difficulties was much more complex compared with newborns without feeding difficulties. Gill describes this complexity as a result of the unsettled and unpredictable nature of this cohort:

Babies with higher needs require a caregiver with experience or knowledge around their higher needs...it impacts your whole life, it's not like a normal newborn that has settled periods and non-settled periods, you know they are a little bit more predictable. Like non-affected babies are a lot more predictable than an affected baby.

As cited by all participants, the most complex feeding difficulties to manage were the difficulties experienced by newborns who had been prenatally exposed to methamphetamine. When a newborn is constantly sleeping, drowsy, or not lucid during feeding, interacting with them is difficult. Jen and Kath explain their experience of trying to attach to newborns who have been prenatally exposed to meth:

Jen: Babies who are addicted are sleepy and difficult to rouse to feed. It is hard enough getting them to take in enough milk, let alone stay awake long enough to interact.

Kath: The drug babies have nothing behind their eyes. This lasts for six weeks or so, and makes it difficult to make eye contact.

Despite feeding difficulties intensifying feeding times, the caregivers always overcame the feeding difficulty and managed to achieve attachment for the newborn. The caregivers' motivation to attach was constant and never wavered:

Gill: Feeding difficulties don't make a difference, a baby is still a baby. It's not the baby's fault. It doesn't matter how unsettled they are, at the end of the placement you have bonded with them.

Jen: No matter what you are going to bond with the baby, even if the baby is screaming the whole way through feeding, you are still going to end up bonding.

Nell: When you feed them, no matter what the feeding issue is, you hold them close under your heart, it is what happens after the feeding that gets difficult. There is a lot happening during feeding as well, but you are always looking at them, they hear your heartbeat.

Kath: The relationship is affected because initially there is so much trial and error trying to find out what is going on for the baby and get the baby as settled as the baby is going to get...So, it actually adds more stress on top of what's already sitting there...That doesn't affect attaching though, I have never had a problem with attachment, because I am passionate about these particular kiddies. I just think that there is something within me that just thinks, well you may have had that experience but while you are in my care, you know this is going to be your experience, and I think the actual love and care actually overrides the stress.

Nell: The stress has nothing to do with the child, it was about the extra jobs which the difficulties created. They can't help it, but it was more about the extra washing and it was difficult to get stuff dry with no drier, so there was a bit more demand on you as a carer, but you want that attachment for them. I mean you can't, umm, you can't not get

attached, if that makes sense, because, umm, I wouldn't be able to give the same kind of care, it would just be some object rather than someone you feel really close to.

Although feeding difficulties complicated feeding time, the difficulties were never directly implicated in the disruption of attachment. Caregivers identified other factors related to the foster care system itself that would disrupt the attachment process or cause placement breakdowns.

The age of the baby was an important factor many participants considered when thinking about successful attachment, or conversely the damage poor attachment creates.

Sue: When uplift happens at birth it is better than when they are older. The damage is already done, each transition is a setback in terms of attachment.

Penny: When they are older the trauma of separation starts to impact them, sometimes you can tell with the babies who are a bit older and have been passed around a lot.

Gill: Babies are different to bond with compared to toddlers, they have a different memory, they get moved around all the time.

The length of placements was also a critical factor. Participants suggested it impacted placement security and could be detrimental to the baby's ability to attach. To understand this, caregivers would make constant reference to the transitional nature of their job. Six of the participants identified as a transitional caregiver and one as a whānau caregiver. However, the whānau caregiver had originally been a transitional caregiver and only intended to care for the family members for a temporary period. The participants defined their roles as short-term carers until the newborn was placed in a home for life placement, which was either back with their biological parents or in a permanent foster care placement.

Nell: We are transitional or respite carers, we always want to make sure we can see a placement through to the end. It is all about the baby.

Penny: We are not in this to keep any of these children, that is not our role, we provide them with what they need while they are here. Attachment is a big part of what they need. When they are moved around many placements they struggle to attach.

Sue and Jen spoke about how the role of transitional caregiver becomes problematic when placements last longer than anticipated, placing greater demand on the caregiver due to the complex nature of caring for newborns with feeding difficulties:

Sue: A lot of placements break down because we thought it was only for six weeks. We were told it was only for this amount of time, it is a significant issue... You were told this child will be with you for three months, you think that's okay, that's fine, but after five months, then after nine months it becomes difficult to sustain.

Jen: I only had her for 24 hours, her bottle was weird and I couldn't work it out. And as a single mum, not having a second pair of hands to back you up made it too difficult to sustain for a long period. They thought I would have the baby for months, with no sleep. I was out of my depth with this one, she just constantly fussed.

Moreover, when placements got continually extended, the personal commitments of the caregiver were impacted. Personal commitments included pre-booked medical appointments and pre-booked vacations, all of which were commitments not conducive to placements.

Sue: One that we had, I had a back operation booked and K had a knee operation booked, so we had deadlines, and there is a wedding in the family, and there are events that happen in everybody's family. And if you were told that this child will be with you for three months, you think okay that's fine, in five months' time I am going to Europe for six weeks, and there is plenty of time. And I can understand there is plenty of

slippage, but it is still going on after five months, so I had to postpone my back surgery because we still had a duty to him. The social worker said that will be fine, we will have it sorted by then, but they didn't. In the end we had to give him to another caregiver.

Gill: The uncertainty of placements with these babies impacts your life, it is responsible for breakdowns.

Participants talked about the tensions and dilemmas around attaching to foster children who they knew were only in their care for a temporary period. However, although some caregivers struggled with emotional connections, once attached, all participants managed to overcome their reservations to emotionally protect themselves.

Nell: We just wanted to make sure we can see a placement through to the finish, which hasn't always happened. Ummm, we have had a couple of placements in the last six years where I have pulled the plug, where I have said, look there is no plan, there is nothing in place to say what is going to happen in a year's time or in five months' time or, so because there was no end in sight I said, you know, I don't want to hang in there for one or two years because I don't want to give them up again. You want attachment for them...because I wouldn't be able to provide the same kind of care...But you know the babies are not here to keep, you know that, but it doesn't mean you don't attach to them...you need to protect yourself as the caregiver as well, it is hard letting them go after a long time.

Kath: It can be very difficult to transition if you have attached, or if they have attached to you. Some don't like to attach because of the emotional damage when a child is taken. I don't believe in that, you need to reverse the adverse effects.

Gill: I didn't know how long I would have them for, so it was difficult to bond at first, but then in like the space of a week I changed my mind. You never know when they

will be taken away so it is hard. I was afraid of attachment because I thought he would be leaving, but I knew if he was ever going to do well in life he needed to.

Extended placement lengths that can impact the caregiver's personal commitments, or the caregiver's ability to sustain caring for a newborn with complex needs for a longer period, force the caregiver to make a decision about accessing respite or ending the placement. The need to access respite was a key factor in why placements breakdown and was viewed by all participants as an undesirable option. Participants viewed themselves as the newborn's primary, consistent person and therefore were reluctant to hand them over to a stranger (respite caregiver) for an intermittent period. Adding to this decision was the unknown nature of respite placements, the lack of proper transitional processes, and the view that respite was another setback for the already unsettled newborns. The feeding difficulty only complicated the transition process, as caregivers were not able to pass on information about feeding and routine and would find that the newborn often came back unsettled and upset.

Jen: Respite can be a really horrible experience and it can really damage the baby. I need to know all the information about the routine so I can keep the baby as calm and settled as possible, but that never happens. The children I know who have had multiple placements are going to take years to overcome the trauma, it impacts them and takes them years to work through. They relive the separation and then experience different placements all the time.

Gill: When they have been passed around a lot they are really unsettled.

Sue: Every time a baby is moved it is a setback, it impacts them in different ways, they are unsettled for a couple of weeks, and some don't want to make eye contact.

Gill: We had to end the placement...we were so stressed, it was so difficult, the younger placements get moved around all the time...it's not good for them. Respite is another

reason why kids get shipped around a lot, they are unsettled as...The ones who go in and out are very unsettled. I wouldn't want to send them to respite if it was someone I didn't approve of.

Any type of activity like respite, which disrupted the newborn's feeding routine, impacted the development of attachment during feeding. These disruptions impacted the baby's willingness to attach because they became unsettled and confused when they got passed around. Visitation with the biological family was also implicated, but all caregivers understood this was also vital.

Gill: Respite impacts attachment during feeding, it is difficult once they attach to you, they don't understand where they are going and they get passed around a lot. They become really unsettled during feeding times when they have been away and are out of their routine.

Penny: They experience separation anxiety when they are away from us for visitation, respite and other appointments. It is really unsettling for the baby.

Jen: I wouldn't make eye contact with them initially if they did not want to look at me when I was feeding them. I was a stranger to them.

Kath: One child would turn his face away so I would use my hands to make him face me in a nice way until the habit kind of slowly eased away. It happens when they have experienced lots of moving around...Once they are in a stable environment the baby becomes more settled and attachment interactions during feeding are easier.

Participants reported that once babies were in a stable environment and were settled, quality bonding time was optimised. When newborns began attaching, often the participants would see a decline in the intensity of some of the feeding difficulties:

Sue: They are stressed and unsettled at the start of a placement, or quiet and compliant. Once they have overcome their attachment issues and have been given a stable environment they are settled and happy... The baby was never held during feeding so wouldn't take the bottle, didn't like being cuddled and freaked out at eye contact. His shoulders were stiff and he would turn away, he didn't respond for six weeks, then once he started to smile he came good, achieved attachment and started to thrive.

Penny: At the start they are often emotionally devoid of reactions to anything.

Gill: They are less cuddly and are unsettled at the start of the placement, particularly the ones who go in and out.

Providing newborns in their care with attachment opportunities was always a priority for participants, but this attachment knowledge was grounded in a Western paradigm. Issues of attachment were primarily located in the relationship between caregiver (and sometimes family members) and the newborn. The acknowledgement of Māori views of attachment, given the high proportion of Māori babies in care, was marginally acknowledged by some participants. Likewise, the inclusion of Māori cultural norms and practices was minimal within the caregiving role. Caregivers were always open to providing a culturally sensitive placement for the newborn, but their knowledge and access to training was inadequate.

Cultural awareness training offered by agencies was limited, but several participants were motivated to be culturally sensitive and many engaged in their own cultural research.

Sue: There is no cultural training, there is identity training but that is optional.

Lisa: As a whānau caregiver I was offered no training, I am Pākehā and my foster children are Māori. They followed the policy to put the kids with family, but I don't have the links or knowledge to support their cultural connections and things like that.

Nell: I have so many resources which I have researched around me for cultural support, there is a great marae down the road that offers lots of things.

Jen: I try and figure out what the appropriate protocols are for that baby.

Gill: The agency doesn't come and say this is a baby of Māori descent and the whānau would like this to happen.

Lisa: I do everything I can, my partner is Māori so I go to the hui he organises so I can take the kids.

Participants' knowledge of Māori cultural models of attachment was non-existent, and most felt that because of the age of the newborn, cultural considerations were not critical to their care.

Gill: With babies it doesn't matter, with older children it becomes more important.

Kath: There is not really any cultural considerations because they are little babies.

With little discussion around the cultural aspects related to attachment and foster care placements, it is evident that the foster care system is grounded in a Western view of attachment theory and wellbeing. Although the intrinsic phenomenon of attachment is thought to be universal for all (Bowlby, 1982), the Western models of attachment theory focus solely on the dyadic relationship between a caregiver and newborn. Contrary to the Western view, Māori view attachment as an integral part of their identity, which is achieved not only through interpersonal relationships, but through connections to the land, the spiritual realm, and the wider universe (Haenga-Collins & Gibbs, 2015). Attachment literature primarily provides a framework for understanding healthy emotional development in infants, whereby bonding with a primary caregiver enables the newborn to develop a sense of security to allow them to explore the universe, navigate relationships, and regulate behaviours (Bowlby, 1958a; Prior et al., 2006). Without successful attachment to a primary caregiver, newborns are at greater risk of

experiencing social, emotional, and cognitive maladjustment, subsequently resulting in adverse outcomes experienced throughout the lifespan (Prior, 2006; Rees, 2007). Given this knowledge, participants in this study were all aware of the importance of attachment for newborns in care, and prioritised it as one of their major responsibilities.

As a result of the responsibility all participants felt regarding attachment for newborns in their care, ensuring bonding could occur during critical periods of a newborn's day was fundamental. Participants recognised the binary function of feeding time, i.e. that it was primarily for nourishment, but also a primary context for bonding. The quality of attachment interactions during feeding is an important factor in the development of secure attachments (Ainsworth et al., 1972). Intimate interactions during feeding were once described as exclusive communications between a biological mother and newborn (Smith & Ellwood, 2011). However, the modern-day diversity of the maternal figure shows that these interactions are still achievable with a substitute and non-kin caregiver. Participants engaged in a range of attachment-promoting interactions during feeding, such as eye contact, cuddling, talking, singing, massage, tickling, skin-on-skin and face-to-face contact, strengthening the debate regarding successful attachment with substitute caregivers. Achieving quality attachment interactions with newborns who experience feeding difficulties can complicate this process, particularly for those newborns who have been prenatally exposed to methamphetamine, given their propensity to sleep during feeding time (Schmidt, 2018). However, the commitment and motivation of the caregivers (Dozier et al., 2001), helped to overcome many of the barriers this cohort faced and to optimise attachment interactions.

Although feeding difficulties make attachment more complex, according to participants neither feeding difficulties nor attachment directly contribute to placement breakdowns. Alternative factors such as age, multiple placements, and the transitional nature and length of placements hold greater negative consequences for the stability of the placement. In accordance

with attachment literature (Van den Dries et al., 2009), participants felt that age was an important factor when establishing secure attachments. The critical period for attachment is reported to be in the first six to nine months of a baby's life (Shaffer & Emerson, 1964). Participants found that the older the infant was, the more difficult it was to establish attachment. This age-related difficulty was thought to be connected to the trauma of separation from their biological families and previous caregivers, as well as the multiple placements they experienced as they aged.

Multiple placements are another factor thought to significantly interrupt attachment (Atwool, 2006; Newton et al., 2000). Multiple placements include any type of disruption in the newborn's known environment and routine, and can include respite with other caregivers and visitation with the biological parents. Participants found that multiple placements disrupted attachment by unsettling the newborn, often causing separation anxiety, and disrupting its feeding routine. Separation anxiety emerges when a newborn attaches, compounding the difficulty newborns in care experience when they are uplifted from their familiar caregivers and surroundings (Shaffer & Emerson, 1964). When a newborn is moved around it becomes unsettled during feeding, perpetuating maladaptive behaviours that are purported to place greater demand on the caregiver and contribute to placement breakdowns (Brown & Bednar, 2006; Newton et al., 2000)

Despite the escalation of behaviours when newborns have been moved around many different placements, participants in this study found no association between intensified feeding difficulties and placement breakdowns. The non-wavering commitment and motivation to be responsive and patient to the newborn outweigh the detrimental effects of multiple placements, and are fundamental in protecting the fostering relationship. Furthermore, multiple placements, rather than the placement stability, are detrimental to the newborn's willingness to attach. The trauma of losing its primary caregiver over and over eventually affects the baby's

motivation to attach (Oosterman et al., 2007). This unwillingness is overcome through time, stability, and consistency of placement, three things that all the participants were prepared to provide. The visible impact of multiple placements on the attachment behaviour of a newborn strengthened the participants' determination to provide a stable home, rather than ending the placement.

Given that foster caregivers are not the biological mothers, many argue that substitute carers are unable to perform tasks of which only a biological mother is capable (Grace, 1989). Researchers argue that hormones are released after birth that prompt the mother and baby to feel a connection with each other (Klaus & Kennell, 1976; Smith & Ellwood, 2011). Contrary to this finding and in accordance with Dozier et al. (2001), the caregiver's commitment and motivation to attach to the newborn supersedes any other barriers. This is evidenced by the caregivers' willingness to attach, regardless of the emotional impact on them when the placement ends. Non-biological caregivers may not experience the intrinsic connection to attach to the newborn, but their extrinsically based motivation to provide for and nurture can be just as advantageous (Bick et al., 2013). Furthermore, studies suggest that the association between bonding and the release of oxytocin is not exclusively experienced by a biological mother (Laurent, 2014), further supporting the capability of the substitute caregiver to attach.

An often-unacknowledged factor thought to be relevant to the success of attachment and placement stability involves the incorporation of cultural sensitivity and models of attachment within the foster care framework, given the disproportionate number of Māori children in state care (Somerville, 2003). There are three times the number of Māori children compared to non-Māori children in the New Zealand foster care system (Ministry of Social Development, 2017), which was evident in the current study, in which all the newborns discussed were of Māori descent. This disproportionate number is grounded in the effects of colonisation on Māori, resulting in the over-representation of adult Māori in all aspects of the

health and welfare sectors in New Zealand, placing individuals at greater risk of involvement with child welfare services (Bart et al., 2006; Conn et al., 2013; Franz & Woodward, 2006). Given the high number of Māori in the welfare system, it is disconcerting that the cultural awareness, sensitivity, and practices of participants were limited to very basic understandings of Te Ao Māori. The adverse outcomes children in care face throughout their lifespan (Atwool, 2010; Bart et al., 2006) may have a closer association with poor cultural practices within the foster care framework than other implicated phenomena (Somerville, 2003).

Acknowledging the Māori worldview of attachment is a fundamental aspect of holistic wellbeing prioritised by Māori (Marsden & Henare, 1992; Mead, 2016). The Western view of attachment suggests that attachment begins to develop around six months of age (Van den Dries et al., 2009). This age-related view is what many participants also suggested, by stating that babies are too young for cultural practices to be relevant. However, for Māori, attachment is a holistic phenomenon whereby connections are made with more than one person, also supporting the finding that newborns in care can attach to more than one person. Connections are also made with extra-personal phenomena such as whakapapa and whenua (Mead, 2016). These connections begin at birth and are achieved using Māori myths and legends, te reo, pepeha, and waiata (Royal, 2005). When a child is in a non-Māori placement, it is difficult for caregivers to achieve these goals. Connections with the wider whānau and Kaumātua are traditional ways in which identity is developed and tikanga are passed on to future generations (Marsden & Henare, 1992). The priority of the New Zealand welfare system to place Māori children with whānau is not always possible, but visitation and connection with wider whānau and Kaumātua should always be prioritised (Keane, 2011)

Training and support is often centred around the paramountcy principle and physical wellbeing, with little regard being given to promoting emotional, spiritual, and cultural wellbeing (Jacobsen et al., 2014). Transitional caregivers receive basic cultural training around

identity, but there is no ongoing cultural supervision or support for caregivers, or cultural training that encompasses Māori views on attachment and practical ways the system and the caregiver can support the newborn to connect with their wider universe (Taonui, 2011). Caregivers were motivated to provide a culturally sensitive and appropriate environment for newborns in their care, but they were responsible for finding out what they needed to know. This type of research is a difficult task when their worldview is not grounded in Te Ao Māori (Pryor, 2005).

In conclusion, the theme of attachment yielded some interesting results that related to how feeding difficulties impact the attachment relationship between a caregiver and newborn. Although feeding difficulties complicate feeding times and place greater demand on the caregiver role, there is no association between feeding difficulties and the development of attachment, regardless of the non-existent cultural attachment models for Māori babies within the foster care framework. Although caregivers identified other factors that may impact the caregiver's opportunity to engage in attachment interactions during feeding, the motivation, willingness, and commitment of the caregiver acted as a protective factor, always prioritising attachment opportunities and safeguarding against placement breakdowns. The fortitude of the caregivers' temperament also worked to strengthen the stability of the placement, therefore minimising the frequency of placements breaking down. Placement breakdowns were more frequently associated with extended placement lengths. When placements went on longer than anticipated, caregivers found they needed to either access respite or end the placement. Ending the placement was always favoured over respite due to the nature of the respite system.

Conclusion

It became evident from the outset of this project how little is known about specific phenomena that impact newborns in foster care, such as newborn feeding difficulties and the attachment relationship between a foster caregiver and newborn. Given the abundant evidence regarding the importance of attachment, and the association between insecure attachment patterns and adverse outcomes faced by children in care, identifying which phenomena are most detrimental to the attachment relationship is fundamental to improving outcomes for this cohort. Additionally, investigating how and if the attachment relationship is connected to placement breakdowns, given the overwhelming evidence suggesting the negative impact multiple placements have on childhood development, seems relevant. This is a highly contemporary issue in New Zealand today given the high number of children, particularly Māori, in the foster care system, and the adverse outcomes they are faced with.

Specifically focusing on newborns with feeding difficulties was largely embarking on the unknown. Much is known about how feeding difficulties manifest, however little is known about how a feeding difficulty may impact a substitute caregiver's motivation, willingness, and opportunities to attach, given the complexity of care required by this cohort during feeding. Exploring this phenomenon could only be achieved through understanding the caregivers' perspective, as it prioritises their experience as the front-line service deliverers.

To answer the research question of how the relationship is impacted between a foster caregiver and newborn who experiences feeding difficulties, two objectives were prioritised. Understanding the caregiver's experience of caring for newborns with feeding difficulties, and how that may impact the attachment relationship and contribute to placement breakdowns, was the first objective and arguably the most important feature of this study. Understanding how feeding difficulties are minimised by caregivers and attachment optimised during feeding time

was the second objective. The objectives were achieved and the study found that newborn feeding difficulties do complicate feeding time and make attachment interactions more difficult to achieve, but due to the fortitude of the caregivers temperament to provide the best opportunities for newborns in their care, attachment interactions are always accomplished, even in the most problematic feeding circumstances.

Understanding the caregivers' experience of caring for newborns with feeding difficulties and how caregivers manage problematic feeding times entailed the identification of the different types of difficulties, how they manifest, their aetiology, and how they impact feeding time, the newborn, and the caregiver. The most common types of feeding difficulties experienced include reflux, allergies, colic, arousal to feed, and problems sucking. Feeding difficulties are complex in nature, and often a newborn will experience a multitude of feeding problems. Given the complexity of differentiating between the primary and secondary difficulties and the organic or non-organic aetiology is problematic, but imperative for best management.

The most frequently cited causal factor for feeding difficulties was exposure to methamphetamine. Feeding difficulties related to prenatal exposure to methamphetamine include organic difficulties caused by prematurity, such as sucking issues, and non-organic difficulties caused by neonatal abstinence syndrome. Exposure to methamphetamine in utero can cause a plethora of issues during feeding, and can be the most problematic when caregivers are trying to engage in attachment interactions. Feeding difficulties include sleepiness, which makes it difficult for caregivers to rouse the newborn to feed and bond with. Given the prevalence of methamphetamine use in New Zealand, further and more targeted research in this area would be highly beneficial.

Contrary to existing knowledge, feeding difficulties are not associated with placement breakdowns. Although feeding difficulties place extra demand on the caregiver role, the commitment and altruistic motivation of caregivers, and the intervention strategies they use to reduce the impact, promote bonding and stabilise placements. To achieve quality bonding time caregivers engaged in a variety of intervention strategies, most important of which included engagement with professional and personal support networks, and using specialised products. Given the importance of the caregiver role in the healthy development of newborns in care, supporting the caregiver in any way is critical to improving outcomes and stabilising placements. Improving communication and information sharing between key stakeholders, developing specialised training modules, and providing every newborn with a comprehensive assessment and ongoing feeding management plan, overseen by a multidisciplinary team, would be beneficial in reducing the demand on and the isolation of the caregiver. Likewise, reforming the respite system so newborns have a consistent respite caregiver, and developing an effective transition process, will encourage caregivers to utilise the respite system, thus stabilising placements.

Extended placement timeframes are the primary reason for placement breakdowns. When placement lengths are extended, the complex needs of newborns with feeding difficulties can become too great for the caregiver to sustain for longer periods, forcing the caregiver to end the placement. Additionally, when placements interfere with pre-planned personal commitments, and if the commitments cannot be changed, the caregiver must either access respite or finish the placement. This is an extremely distressing decision for caregivers, and due to the nature of the respite system, ending the placement often seems like the best option for the newborn's wellbeing.

Māori are disproportionately represented in the foster care system. All the babies in this study were of Māori descent. Therefore, prioritising a culturally sensitive, holistic model of

care should be paramount for improving outcomes for this cohort. Māori experience the highest rates of allergies compared with non-Māori babies, suggesting a potential association between breastfeeding, formula feeding, and the allergies these babies experience. Prioritising their rights to be breastfed, even when they have been uplifted, may help to reduce the number of Māori babies in care with allergies and the adverse outcomes they face. Working from a holistic model of wellbeing is thought to also change the outcomes for Māori newborns, by acknowledging the impact of social factors on wellbeing. Understanding the effect of social factors on maternal and newborn wellbeing will also help to reduce the punitive nature of the current child welfare system in New Zealand. Furthermore, developing a culturally comprehensive foster care framework that provides ongoing cultural training and supervision to caregivers is another fundamental way of contributing to better outcomes for Māori babies in care.

Limitations

It would have been worthwhile to have had access to a broader range of caregivers across different regions in New Zealand. Understanding the experience of caregivers in other regions besides Tauranga and Auckland would have given wider understandings. This group were all highly experienced, and it would have been useful to have interviewed caregivers with less experience as well as caregivers with more extensive experience of placement breakdowns. Likewise, interviewing more caregivers with whānau placement might have added further and more valuable information around coping with feeding difficulties and attachment processes. This study focused on the primary caregiver, but it would have been worthwhile to interview men and other family members about their experiences of caregiving for this cohort, to offer a more holistic understanding. Additionally, it would have been beneficial to interview Māori caregivers, to understand their cultural perspective and experience and investigate if they offer a more culturally sensitive way of caring for newborns with feeding difficulties.

Future research

This study has highlighted a possible association between children in care and feeding difficulties, so further research in this area would be advantageous in helping to promote secure attachment opportunities. Further investigation into systemic processes that place greater demand on the caregiver role and impact attachment would also be beneficial. Processes such as the success and relevancy of caregiver training packages, the respite system, and placement timeframes and their impact on placement stability could be possible pathways for further investigation.

At a societal level, further research regarding substance use during pregnancy and the effects on the baby would be beneficial. Although alcohol, nicotine, and cannabis are most commonly used during pregnancy, further research into prenatal exposure to methamphetamine and the effects of methamphetamine on a newborn baby is critical given the contemporary issue methamphetamine has become in New Zealand. Investigating the impact and the prevalence of methamphetamine abuse in New Zealand will contribute to knowledge that may help identify pregnant users early and minimise prenatal exposure, raise awareness about an anecdotally identified significant issue, and provide useful information for individuals who work with or care for people affected by methamphetamine.

Further investigation regarding the needs of Māori children in care and how to best meet those needs is imperative given the disproportionate number of Māori in this cohort. Understanding how to incorporate Te Ao Māori within the foster care framework may help to minimise some of the negative outcomes faced by Māori children in care.

In conclusion, the fortitude of caregiver temperament is a powerful and protective factor that overcomes many of the barriers caregivers and newborns with feeding difficulties experience, and ensures achievement of essential attachment opportunities for healthy

development and growth. Given this knowledge, prioritising the wellbeing and knowledge base of the caregiver should be an essential role of any foster care organisation. Therefore, providing caregivers with appropriate and effective resources, which minimise the demand placed on their role, is critical to improving outcomes for children in care.

He Whakataukī

Take care of our children.

Take care of what they hear,

Take care of what they feel.

For how the children grow, so will the shape of Aotearoa.

Dame Whina Cooper

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Appendices

Appendix A: Information Sheet



School of Psychology
Massey University Auckland
Private Bag 102904
North Shore
Auckland 0745
New Zealand

Foster caregiving with infants who experience feeding difficulties

INFORMATION SHEET

Researcher Information:

Tena koe,

**Ko Putauaki toku maunga
Ko Rangataiki toku awa
Ko Ngati Awa toku iwi
Ko Nga Maihi toku hapū
Ko Nari ahau**

My Name is Nari Hann. I am currently studying towards a Masters in Psychology at Massey University. This research project is the final component of my degree and will take me a year to complete.

Project Description

This research project will look at the caregiving relationship with infants who have difficulties feeding. Caregiving can be an extremely difficult and taxing role. This project aims to understand what it is like to be a caregiver. This is an important area of research because of the number of children in foster care and supporting caregivers is an important factor in minimizing the potential for placement breakdowns and providing a stable environment for the infant.

If you are a foster caregiver who has cared for a baby with feeding difficulties I would like to hear about your caregiving experience. Feeding difficulties are defined as reflux, vomiting, crying when feeding, tube feeding, peg feeding, unsettled when feeding, allergies to certain formulas, difficulties sucking or with teats etc.

Participant Identification and Recruitment

- Caregivers have been identified through agencies in the community or by other caregivers.
- Caregivers will be contacted by the agency or caregiver first and asked if they would like to participate.

- The criteria to be selected for this project are;
 - The caregiver must be a foster caregiver
 - The caregiver must have cared for an infant who experiences feeding difficulties.
- There will be six to eight caregivers participating in this study.
- The project should not pose any risk at all to participants.

Project Procedures

- The project involves one interview with the researcher (Nari). There are no right or wrong answers; it is your experience we are wanting to find out about.
- The interview conversation will be sound recorded only, so the researcher can write up the conversation after the interview and identify common themes.
- The interview should take no longer than one hour and will be done at a location where you feel comfortable.
- If you feel stressed and overwhelmed the interview time can be postponed and the researcher can offer support services to help.
- If you are unable to meet in person, the interview can be conducted via other mediums.

Data Management

- The information that you give will be used to understand your personal experience of feeding the infant with feeding difficulties.
- The information will be analysed by the researcher and the researcher's supervisor.
- The information will be written in a report discussing what the study found. There will be no personal information such as the caregiver/ infant's names, ages, or addresses included.
- Sometimes the reports may get published. If this does occur there will be no personal information included about the caregiver and the infant.
- The information will be stored in a locked cupboard in the researcher's home office. It will only be accessible to the researcher
- The information will be kept throughout the course of the thesis and will be disposed of once the study is completed in accordance with Massey University guidelines. When the information is disposed of it will be shredded.
- The information will not be used for any other purpose except for this study.
- The caregiver will be given a summary of the projects findings upon completion of the study.

Participant's Rights

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 at any time until the analysis section of the study is complete. This will be approximately two months after the time of the interview.
- ask any questions about the study at any time during participation;
- provide information on the understanding that your name will not be used unless you give permission to the researcher;
- 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.

Project Contacts

Nari Hann
 Researcher
 Mobile: [REDACTED]
 Email: Nari.Hann.1@uni.massey.ac.nz

Veronica Hopner
 Supervisor
 Senior Lecturer
 Massey University
 Phone: (09) 414 0800 ext. 43101
 Email: V.Hopner@massey.ac.nz

Caregivers are welcome to contact either Nari or Veronica at any time during the project to discuss any queries or concerns regarding the project.

2. **MUHEC APPLICATIONS**

Committee Approval Statement

This project has been reviewed and approved by the Massey University Human Ethics Committee: Northern, Application NOR 17/45. If you have any concerns about the conduct of this research, please contact Dr Ralph Bathurst, Acting Chair, Massey University Human Ethics Committee: Northern, email humanethicsnorth@massey.ac.nz

Appendix B: Interview Schedule



School of Psychology
Massey University Auckland
Private Bag 102904
North Shore
Auckland 0745
New Zealand

Interview Schedule

1. How is the relationship affected between a caregiver and infant who experiences difficulties feeding?
 - a. What happens in a typical feeding session?
 - b. What are the feeding difficulties experienced by the infant?
 - c. What types of interactions are occurring between the caregiver and child when the child is feeding well or when they are not feeding well? e.g. eye contact, cuddling.
 - d. Are there unsettled behaviours which impact the feeding process? How do these impact interactions during feeding?
 - e. How do problematic feeding sessions impact the caregiver and their motivation to attach with the infant?
2. What strategies do foster caregivers use to help settle an infant with feeding difficulties and promote quality caregiver-child interactions during feeding?
 - a. What strategies are used by the caregiver to overcome the feeding difficulty?
 - b. What strategies are used by the caregiver to settle an unsettled baby?
 - c. What products are used to aid the feeding process and minimise feeding difficulties?
 - d. What strategies does the caregiver use to stay calm during problematic feeding sessions?
 - e. What information and support are you provided with from your organisation to help this process.
3. Are there any other important factors to consider about the caregiver and the infant?
 - a. Are there cultural considerations which are pertinent to the caregiver or infant or their relationship?
 - b. Is the infant's biological parents and extended family still involved, if so in what capacity?
 - c. What resources are available to support the caregiver in respect to problematic feeding?
 - d. Can the caregiver identify other strategies or resources which might support them with minimising problematic feeding sessions?

Appendix C: Participant Consent Form



School of Psychology
Massey University Auckland
Private Bag 102904
North Shore
Auckland 0745
New Zealand

Foster Caregiving with newborns who experience feeding difficulties

PARTICIPANT CONSENT FORM - INDIVIDUAL

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/do** not agree to the interview being sound recorded.

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

Signature: **Date:**

Full Name - printed

If you would like to receive a summary of the finding when the project is finished, please provide your email address below

Email Address:

Appendix D: Glossary of Māori terms

Hapū	Sub-tribe
Hui	Meeting
Iwi	Tribe
Kaumātua	Elder/ Grandparent
Mokopuna	Grandchild
Pākehā	European New Zealander
Papatūānuku	Earth mother
Pepeha	Introduction that establishes identity
Pēpi	Baby
Rangi-nui	god of the sky
Tamariki	Children
Te Ao Māori	The Māori world
Te Reo	The language
Tikanga	Cultural customs and protocols
Tūrangawaewae	A place to stand
Waiata	Song
Wairua	spirit
Wairuatanga	spirituality

Whakapapa	Genealogy
Whakataukī	Māori proverb
Whakawhanaunagatanga	process of establishing relationships
Whānau	Family
Whanaungatanga	relationship, kinship, sense of connection
Whāngai	Māori adoptive process
Whenua	Land