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CAREGIVERS' EXPERIENCES OF PROVIDING ALTERNATIVE CARE TO CHILDREN WHO HAVE EXPERIENCED INTERPERSONAL TRAUMA IN GAUTENG, SOUTH AFRICA

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ABSTRACT

Background: In South Africa, there are high rates of children who experience interpersonal trauma as a result of physical, sexual or emotional abuse; neglect; or abandonment. If a child is maltreated and is identified to need care and protection, they may be removed from the harmful environment and placed in an alternative care placement. This may be a temporary safe care placement, a foster care home, or a Child and Youth Care Centre. There is a paucity of research into caregivers' experiences within these alternative care placements.

Aim: To explore and describe the experiences of caregivers of children who have experienced interpersonal trauma within alternative care in Gauteng, South Africa.

Methods: A qualitative descriptive exploratory study design was used. A sample of fifteen caregivers across the three types of formal alternative care placements (foster care, Child and Youth Care Centres and temporary safe care placements) was recruited from placements in Gauteng, South Africa. Data were collected using semi-structured interviews, which were audio recorded with permission from participants and transcribed verbatim. The data were analysed using thematic content analysis.

Ethical considerations: Ethical approval was obtained from the University of the Western Cape's Biomedical Research Ethics Committee and permission to conduct research was obtained from the Gauteng Department of Social Development. Participants were provided with an information letter detailing the research risks and benefits of the study, how their information would be protected and stored, and their right to withdraw from the study at any point. Participants were then asked to sign a consent form if they agreed to participant in the study. Participants were asked to refrain from using any specific identifying information about the children within their care during the interviews. Pseudonyms have been used to keep participants' identities and the identification of the home confidential.

Findings: The findings are presented in four themes with two to three sub-themes each. The themes are as follows: (1) THE CHILD: The pervasive impact of trauma on children from hard places; (2) THE HOMES: Structuring placements towards family and permanence (3) THE CAREGIVER: Caregiving that demands steadfast love and a relinquishing of control; (4) THE SYSTEM: Navigating a child protection system that can perpetuate trauma.

Discussion: Bronfenbrenner's Ecology of Human Development was used to discuss the findings. This model frames the multiple contextual layers of the challenges caregivers face, as well as the

factors that aid in their ability to provide care to children who have experienced interpersonal trauma. The discussion illustrates how caregivers aim to provide care in response to the trauma the child has experienced and how this is done with little training and support from the child protection system that at times perpetuated trauma, resulted in caregivers often experiencing secondary trauma.

Conclusion: This research highlighted the systemic shortcomings of child protection services in supporting caregivers within alternative care caring for children who have experienced interpersonal trauma. The support from the surrounding community was identified to be the greatest facilitator that capacitated the caregivers' work. There is a need for ongoing trauma-related training and mentoring in order to reduce the impact of secondary trauma experienced by caregivers.

Keywords

Caregivers

Alternative care

Foster care

Child and Youth Care Centres

Temporary safe care

Interpersonal trauma in childhood

Secondary trauma

Attachment

Bronfenbrenner's Ecology of Human Development

Trauma-informed

Declaration

I declare that *Caregivers' experiences of providing alternative care to children who have experienced interpersonal trauma in Gauteng, South Africa* is my own work, that it has not been submitted for any degree or examination in any other university, and that all the sources I have used or quoted have been indicated and acknowledged by complete references.

Name: Erica Ann Bourn **Date: 8 November 2023**

Signed: 

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Tables and Figures

List of acronyms

DSD – Department of Social Development

NPO – Non-profit organisation

CPO – Child protection organisation

RSA – Republic of South Africa

CYCC – Child and Youth Care Centre

POS – Place of safety

UN – United Nations

ACE – Adverse childhood experiences

Definitions

Formal alternative care: The Children's Court may rule that a child is to be removed from their biological family environment and placed within alternative care: either a foster care placement, a Child and Youth Care Centre, or temporary safe care according to Chapter 11 of the Children's Act (Children's Act, 2005).

Foster care: A form of care within the context of a family setting for a child who is unable to be cared for in the short, medium, or long term by his/her biological or adoptive parents. In line with international trends, the Children's Act (Children's Act, 2005) prefers foster care placement over a Child and Youth Care Centre. No more than six foster children can be placed within one foster care placement (DSD, 2019).

Cluster foster care scheme: A group of foster care homes which fall under the umbrella of one registered non-profit organisation (Children's Act, 2005). The non-profit organisation employs the foster parents and therefore can house several groups of foster children within the cluster (Goemans et al., 2021). The foster homes within the cluster need to comply with the same parameters as stand-alone foster care placements and the managing organisation must comply with the Nonprofit Organisations Act (Act 71 or 1997) (Gallinetti & Sloth-Nielsen, 2010; Children's Act, 2005).

Child and Youth Care Centre: A Child and Youth Care Centre is a home that provides accommodation and care for more than six children outside of their family environment (Children's Act, 2005). According to the National Childcare and Protection Policy, placement of a child in a Child and Youth Care Centre is a last resort-option when no other suitable option is available (DSD, 2019).

Temporary safe care / place of safety: A placement in an approved home where the child can be safely accommodated in a temporary capacity, while a longer-term placement is pending a decision or court order (Children's Act, 2005). Within South Africa, temporary safe care placements are often at registered foster homes or Child and Youth Care Centres. The Children's Act uses the term 'temporary safe care'; it is more commonly referred to in practice as a 'place of safety'.

Care: The Children's Act (Children's Act, 2005) defines care as providing the child with a suitable place to live, living conditions conducive to the child's health, promoting the well-being and development of the child, and providing the necessary financial support. Furthermore, care involves protecting the child from harm, directing and securing their education and upbringing, guiding their

decisions and behaviour in a manner that is appropriate to their developmental stage and overall ensuring the best interests of the child are upheld within their care.

Caregiver: Any person other than the child's parent or guardian who is providing care. A caregiver may be a foster parent, a person who cares for a child with consent from the child's parent or guardian, the person at the head of a Child and Youth Care Centre where a child has been placed, or a child and youth care worker who cares for a child who is without appropriate family care (Children's Act, 2005).

Interpersonal trauma in childhood: The range of maltreatment and interpersonal violence experienced by children and adolescents, which includes, but is not limited to; sexual, physical or emotional abuse, severe bullying, severe neglect, witnessing domestic violence, serious disruptions in caregiving as a result of caregiver mental illness, substance abuse or criminal involvement (D'Andrea et al., 2012).

Secondary trauma: The experience of symptoms similar to post-traumatic stress as a result of exposure to the suffering of others when working within trauma-related contexts (Hannah & Woolgar, 2018). Often also referred to as vicarious trauma, compassion fatigue, or burnout (Salloum et al., 2015). Symptoms may include intrusive thoughts, hyperarousal and avoidance behaviours (Rienks, 2020).

Child protection organisations: Designated non-profit organisations subsidised by the Department of Social Development who collaborate with the government to provide statutory services (Strydom et al., 2020), which may include the removal of children in need of care and protection, arranging placements for children within alternative care, and adoption services, among others (Children's Act, 2005).

Gauteng: One of the nine provinces within South Africa. It is the smallest province in terms of geographical area; however, it is the most densely populated and mostly highly urbanised with two major cities, namely Johannesburg and Pretoria (Gauteng-info, n.d.)

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Chapter 1: Introduction

1.1. Background

Globally, there are high rates of childhood exposure to interpersonal traumatic stressors, to the extent that this has been described as a silent epidemic (D'Andrea et al., 2012; Kaffman, 2009). A systematic review conducted by Lee and Kim (2023) indicated that childhood maltreatment increased globally during the COVID-19 pandemic with an estimated prevalence of 18% of physical abuse and up to 39% of psychological abuse. Interpersonal trauma in childhood is described as an 'epidemic' due to the frequency of child maltreatment increasing over the last three decades, and it is described as 'silent' because public health services have neither responded with appropriate screening or treatment interventions nor put effort into preventive measures (Kaffman, 2009). In 1998, Felitti et al. published the Adverse Childhood Experiences (ACE) study, which demonstrated that exposure to abuse or household dysfunction in childhood has a strong graded relationship with multiple risk factors for ill health in adulthood (Felitti et al., 1998). Since this landmark epidemiological study, there is a growing body of evidence to suggest that exposure to adverse events within childhood has a long-term detrimental effect on health outcomes across the board, which warrants a reorienting of public health services toward combating this silent epidemic (Hambrick et al., 2019; Zarse et al., 2019).

Trauma is caused by an event or series of events that are experienced by an individual in such a way as to be perceived as life-threatening and to influence the individual's well-being and functioning negatively (Thompson-lastad et al., 2017). Children are a vulnerable population as they are dependent upon their caregivers to meet their basic needs; therefore, when these basic needs are not met or when they are hurt by the adults entrusted with their care, they may experience interpersonal trauma. Interpersonal trauma is defined by D'Andrea et al. (2012) as the range of maltreatment or physical violence caused interpersonally, which may include familial physical, emotional or sexual abuse; neglect; community assault or bullying; witnessing domestic violence; or serious disruptions in caregiving.

In South Africa, statistics show that up to one in four children experience some form of physical abuse, sexual abuse or neglect (Artz et al., 2018; Strydom et al., 2020). Alarmingly, an estimated 53% of child abuse occurs within a child's home at the hands of a known perpetrator, resulting in the primary home becoming a place of interpersonal trauma (Jamieson et al., 2017a). This may require the removal of the child from their primary home, where they are susceptible to abuse, into an alternative care placement in order to keep the child safe from harm. Chapter 9 of the Children's

Act (Children's Act, 2005) identifies the following criteria for children in need of care and protection:

1. The child has been abandoned or orphaned without visible means of support.
2. The child displays behaviour which cannot be controlled by the parent.
3. The child lives or works on the street or begs for a living.
4. The child has a substance addiction without support to obtain treatment.
5. The child is exposed to exploitation.
6. The child lives in circumstances which may seriously harm their well-being.
7. The child is in a state of physical or mental neglect.
8. The child is maltreated, abused or degraded by a parent, caregiver or the person under whose control the child is.

Children identified as being in need of care and protection are then removed from these situations and placed within one of the following formal alternative care placements (Children's Act, 2005; Van der Walt, 2018):

- Temporary safe care (commonly referred to as places of safety)
- Foster care (including cluster foster homes)
- Child and Youth Care Centres (CYCCs)

Formal alternative care placements need to be registered with the Department of Social Development (DSD) and need to comply with regulations outlined in the Children's Act (Children's Act, 2005; Children's Ammendment Act, 2007). Therefore, within these alternative care placements, caregivers are at the forefront of the 'silent epidemic' of caring for children who have experienced interpersonal trauma (D'Andrea et al., 2012).

Caregivers within these contexts are not required to have any formal qualification, and social workers overseeing placements are often overburdened and are therefore unable to provide the necessary support or training to caregivers (Centre for Child Law, 2012). Many of the children within the alternative care system are not provided with any form of therapeutic services (DSD, 2019; Jamieson et al., 2017a; Van der Walt, 2018). Literature highlights that caregivers within alternative care often experience burnout, compassion fatigue and/or secondary trauma (Hannah & Woolgar, 2018).

The lack of formal training, the lack of support from social workers, the lack of therapeutic services provided and the prevalence of burnout experienced by caregivers (Hannah & Woolgar, 2018)

demonstrates a need for research into caregivers' experiences of providing care to children who have experienced trauma; this will enable an understanding of what support is needed for caregivers within the alternative care system.

1.2. Research setting

This research was conducted within the Gauteng province of South Africa. South Africa held its first democratic election in 1994, and embarked on a journey of righting the injustices caused by the Apartheid regime, including implementing policies in line with international standards on the care and protection of all children (Singh & Singh, 2014). South Africa's child welfare services are governed by the Department of Social Development (DSD). However, a large proportion of child protection work is done by non-profit organisations often subsidised by DSD funding (September, 2006).

Gauteng is the most densely populated province in South Africa and is highly urbanised with two major cities, namely Johannesburg and Pretoria, housed in a small geographical area (Gauteng-info, n.d.). According to Hall and Sambu (2018), it is home to 29% of the country's households and 21% of the country's children. Of these children, 10.7% do not live with either biological parent, indicating high numbers of children within either informal kinship care or the formal alternative care system. Due to a lack of a central reporting system, recent statistics regarding the number of children in temporary safe care and CYCCs are not readily available (Van der Walt, 2018). However, in 2023, there is an estimate number of 35 804 children receiving foster care grants in Gauteng, indicating the number of children who are orphaned, abandoned, at risk, abused, or neglected and placed by the courts in foster care (Hall, 2023).

1.3. Problem statement

In South Africa, there is a high prevalence of children who are orphaned, neglected or abandoned, or who have experienced sexual, physical, or emotional abuse, resulting in high rates of interpersonal trauma and many children being placed in alternative care (DSD, 2019; Hall & Sambu, 2018; Jamieson et al., 2017a). Research has shown that children who have experienced interpersonal trauma have complex care needs (D'Andrea et al., 2012; Kisiel et al., 2014) and that an attentive caregiver is the most important protective factor against the negative effect of traumatic experiences (Dobson & Perry, 2010; DSD, 2019).

There is a higher availability of research relating to alternative care and trauma from higher-income countries compared to lower- to middle-income countries (Beyerlein & Bloch, 2014; Leve et al.,

2012). The research available from South Africa focuses on evaluating the functioning of the alternative care system (Community Agency for Social Enquiry, 2010; Van der Walt, 2018), critiquing child protection services (Jamieson et al., 2017a; Strydom et al., 2020) or the child's perspective of alternative care placements (Dube & Ross, 2012; Malatji & Dube, 2015; Schiller, 2015).

There is available literature related to caregivers' experiences with alternative care specifically in relation to challenges with attachment (West et al., 2020) and the experience of vicarious trauma or compassion fatigue (Lynch et al., 2018). However, little is known about caregivers' overall experience of caring for children who have experienced interpersonal trauma within South Africa's alternative care system. Gaining insight into caregiver's experiences would improve how social, healthcare and education services can better position themselves to support caregivers, aid identifying the gaps of training required for caregivers within alternative care, and highlight the shortcomings of policy implementation.

1.4. Research question

What are the experiences of caregivers who care for children who have experienced interpersonal trauma within alternative care placements in Gauteng, South Africa?

1.5. Aim

This study aims to explore and describe the experiences of caregivers of children who have experienced interpersonal trauma within alternative care in Gauteng, South Africa.

1.6. Objectives

1. To describe the challenges faced by caregivers in providing care to children who have experienced interpersonal trauma
2. To describe the factors which have helped caregivers in providing care to children who have experienced interpersonal trauma
3. To describe the skills and support required by caregivers to provide care to children who have experienced interpersonal trauma

1.7. Significance of the study

Gaining insight into what factors help and hinder caregivers' abilities to provide care will enable policymakers, healthcare professionals, and child welfare workers to better support caregivers

within the alternative care system and, by extension, will improve the care given to children who have experienced interpersonal trauma. Insights from the study can be used to make recommendations to child protection services regarding the gaps within the training and support given to caregivers.

1.8. Overview of chapters

Chapter 1 introduces the research study, including the background to the study; the research setting; the problem statement; the research question, aims, and objectives; and the significance of the study.

Chapter 2 provides an overview of the theoretical framework of Bronfenbrenner's Ecology of Human Development which will be applied to the research findings in the Discussion section.

Chapter 3 is the literature review which provides an overview of the available literature, relevant to child protection policy, alternative care in South Africa, interpersonal trauma in childhood, and the experience of caregivers.

Chapter 4 outlines the methodology that was used in the research study, including a mention of trustworthiness and ethical considerations.

Chapter 5 documents the research findings in the format of four themes with two to three sub-themes each.

Chapter 6 is the discussion of the research findings which draw on Bronfenbrenner's model as outlined in Chapter 2.

Chapter 7 is the conclusion, including a mention of the limitations and recommendations of the research.

Following Chapter 7, the reference list and appendices can be found.

Chapter 2: Theoretical framework

Within qualitative research, a framework can be used to provide a theoretical lens through which the data can be viewed. The framework proposes a set of assumptions which form the worldview or understanding of reality (Green, 2014). Bronfenbrenner's work in studying human development has been adopted as the theoretic framework underpinning this research.

2.1. Bronfenbrenner's Ecology of Human Development

Urie Bronfenbrenner studied human development and critiqued other developmental theorists for studying the individual within a controlled research environment (Bronfenbrenner, 1977; Darling, 2007). He proposed that the individual's development can only be understood when seen as being embedded within their environments - not only the immediate environments but the broader social contexts (Bronfenbrenner, 1977). Bronfenbrenner defined these broader social contexts as ecosystemic levels and described that the individual is situated within the micro-, meso-, exo-, macro and chronosystems. These ecosystems are defined in relation to **Figure 1** below. He highlighted how there are continuous interactions between these changing environments throughout the lifespan which impact development.

This theory was later adapted to the 'bioecological theory', which sought to highlight how the human at the centre of these embedded environments is not a passive recipient of the impact of the environment but is rather an active participant (Rosa & Tudge, 2013). The individual is active in shaping their environments through reacting to them and drawing out responses to them (Darling, 2007). Furthermore, it is insightful to note that Bronfenbrenner was intensively interested in the family as an institution and contributed to the literature on class influences of the family, family policies and what is needed for healthy families. The family forms part of the individual's microsystem and therefore plays an immediate and profound role in shaping development (Rosa & Tudge, 2013).

This framework is applicable to this research as Bronfenbrenner's work stressed the "person-context interrelatedness" (Tudge et al., 2009, p. 199) and demonstrated that studying a dyadic relationship between a caregiver and child within a sterile clinical environment, devoid of the complex interactions that occur within the layers of the environment is unable to tell the full story of human development (Bronfenbrenner, 1977; Darling, 2007). In the same way, the findings from this research will demonstrate that considering the relationship between the caregiver and the child who has experienced interpersonal trauma isolated from the surrounding community, service

provision constraints, child protection system and the South African context, will yield an incomplete story.

The diagram below has been adapted to include the relevant factors when considering a child who has experienced interpersonal trauma and has been placed within alternative care. The diagram will be unpacked in relation to its relevance to this research study below.

Figure 1: Bronfenbrenner's Ecology of Human Development

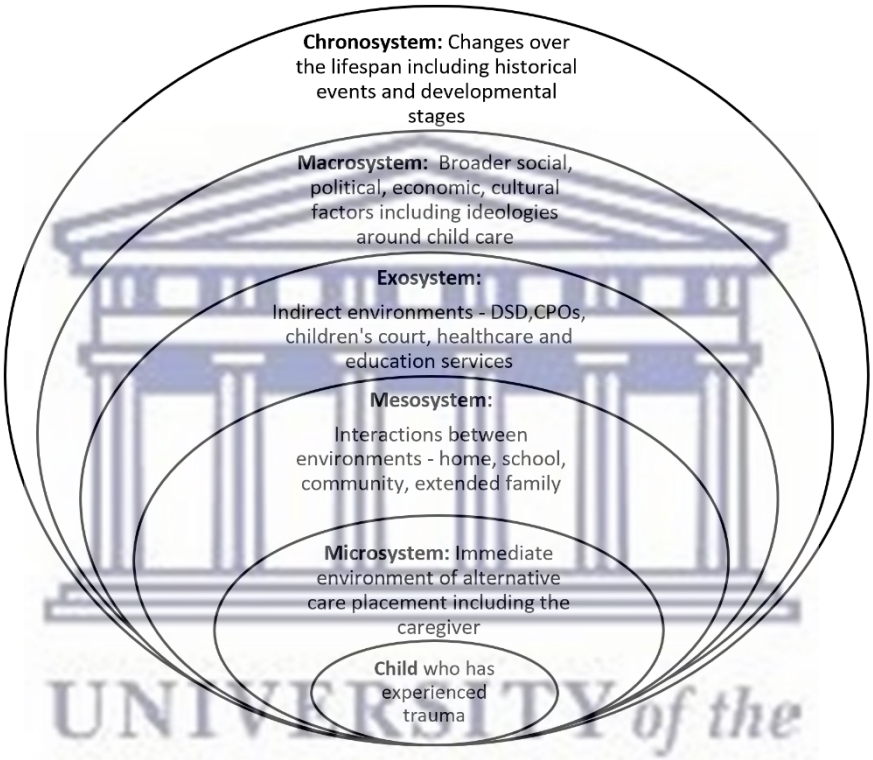

Figure adapted from Paquette and Ryan (2007).

The **child,** within the context of this research refers to a child who has experienced interpersonal trauma and has been placed within alternative care.

The **microsystem** constitutes the complex relations between the developing individual and their immediate environment, which comprises of the home, school, and workplace (Bronfenbrenner, 1977). At a microsystem level, a child who has been removed from their biological family and placed within an alternative care placement has experienced a complete change in their microsystem. The home (a foster home, CYCC, or a temporary safe care placement) is now part of their microsystem, as well as the caregivers within this home. This research will be looking at the complex interactions between the caregiver and the child, as well as the broader context.

The **mesosystem** refers to the interactions between microsystems, or can be understood as a "system of microsystems" (Bronfenbrenner, 1977, p. 515), for example between a caregiver and school or between the family and a religious institution or other relatives. These interactions occur as the child moves outside of the home environment, and they may be positive and have a healthy effect on the immediate microsystem environment, or, if conflict exists between the microsystems, this may have a detrimental effect (Ettekal & Mahoney, 2017).

The **exosystem** refers to the indirect environments, which the child is not immediately a part of but that still impact on the micro- and mesosystem interactions. The exosystem influences, limits, or determines what happens within the more immediate environments (Bronfenbrenner, 1977). Within alternative care, Children's Court is a noteworthy component of the exosystem as the decisions made regarding the child's placement are made in court. Other institutions such as healthcare and education services, the Department of Social Development and other child protection services feature prominently at this level.

The **macrosystem** refers to "the overarching institutional patterns of the culture or subculture, such as the economic, social, educational, legal, and political systems, of which micro-, meso-, and exosystems are the concrete manifestations" (Bronfenbrenner, 1977, p. 515). At this level, we consider the ideologies around childcare and adoption, accepted cultural practices of parenting, and the current economic and political climates which impact family life.

These systems are all embedded within the **chronosystem**, which highlights how these environments change over time and with each life stage (Bronfenbrenner, 1977). It takes into consideration historical events and the individual's life stage - for example, the environments in which an infant interacts are vastly different to those of a teenager.

Conclusion

Bronfenbrenner's model is helpful in considering the complex interactions between the various eco-systemic environments that influence one another throughout the lifespan of the child or caregiver. This framework will be used to discuss the research findings in Chapter 6.

Chapter 3: Literature review

3.1. Introduction

This literature review will begin with a brief overview of the relevant policies for protecting children and will then look at how these policies are being implemented in practice within the child protection system in South Africa. It will then provide an overview of alternative care and the relevant literature related to foster care, CYCCs and temporary safe care placements. The current landscape of interpersonal trauma in childhood in South Africa will be outlined, including the current movements within trauma theory and interventions. Finally, the literature related to the experience of caregivers, their role in promoting attachment, and the common experience of secondary trauma will be considered.

3.2. Policies to protect children in South Africa

South Africa has successfully formulated policies outlining children's rights and procedures for their protection against maltreatment in line with the United Nations Convention on the Rights of the Child (September, 2006; United Nations, 1989). For example, in the Constitution, Chapter 2, Section 28 states that "every child has the right to family care, parental care, or to appropriate alternative care when removed from the family environment" (*Bill of Rights*, 1996, p. 11). Chapter 9 of the Children's Act 38 of 2005 and it's subsequent amendments (Children's Act, 2005; Children's Ammendment Act, 2007) outlines the protocol for children in need of care and protection, including the procedure to be followed for removing a child from their home environment and placing them within temporary safe care. Furthermore, the National Childcare and Protection Policy (DSD, 2019, p. 9) outlines the commitment of the state to children's rights to "survival, protection, development and participation" and documents a comprehensive intersectoral framework to implement measures to achieve the vision of all children living in safe, nurturing families, protected from maltreatment and able to develop to their full potential.

3.3. State of the child protection system in South Africa

Despite these progressive policies, research demonstrates that there are significant gaps between policy and practice. September (2006) highlights the problem of no central reporting system, which results in many children and families not receiving the necessary services or the follow-up that they require. Furthermore, since the majority of child protection organisations (CPOs) are non-profit organisations (NPOs), there is a lack of financial resources and poor staff retention, which compromise the quality of care these organisations are able to provide (September, 2006). This

issue was further exacerbated this year (2023) in April when the DSD Gauteng cut NPO funding by up to 60% in order to shift to other priority areas (SA Federation for Mental Health, 2023). A report by Jamieson et al. (2017a) paints a discouraging picture of child protection services in South Africa through a series of case examples of poor reporting of abuse, poor response by police members, poor case management by social workers, and a profound lack of therapeutic services available to victims of abuse. These policy- and system-level factors impact the child's experience of trauma, as well as caregivers' abilities to provide care within the alternative care system (Beyerlein & Bloch, 2014; Choudhury, 2020).

3.4. Alternative care placements

The United Nations (UN) has provided countries with guidelines on the alternative care of children (United Nations, 2010) and recommends that all individuals involved in the care of children be provided with sufficient training and resources. The UN recommends that long-term family-based care should be prioritised, and residential care (such as within a CYCC) should only be a temporary measure until family-based care can be developed (United Nations, 2010). The following paragraphs outline the literature related to the three forms of formal alternative care in South Africa.

There are various role players within the alternative care system. Firstly, the DSD is responsible for providing overall governance of the child protection system; therefore, all placements need to be registered with the DSD and should comply with their regulations and standards of care (September, 2006). The DSD is also responsible for service delivery. However, a large portion of service delivery is done by NPOs or CPOs with the aid of some government funding. These services are conducted by statutory social workers who may be employed by the DSD or a CPO and include the removal of children in need of care and protection, placement in a suitable home, conduction of adoptions, and facilitating reunifications (September, 2006). The Children's Court is responsible for providing court orders which are needed to place children in alternative care placements; these court orders need to be renewed every 2 years unless otherwise ruled by the court (DSD, 2019).

An article written by Van der Walt (2018) describes the overall state of the alternative care system in South Africa. She concludes that the system is overburdened, under-capacitated, and failing the large number of vulnerable children in need of care and protection within South Africa. Choudhury (2020, p. 72) aptly concludes that "trauma lies at the core of children's experiences in the alternative care system – it underlies the reason for children being placed into the system". This highlights the need for a trauma-informed approach within the alternative care system (Beyerlein & Bloch, 2014).

Foster care placement

Several research studies document carers' and children's experiences of foster care placements (Ntshongwana & Tanga, 2018; Schiller, 2015), with a particular focus on foster care placement breakdown (Gilbertson & Barber, 2003; Strijker et al., 2011; Valentine et al., 2019). Reasons for placement breakdown include a lack of system-level support (Gilbertson & Barber, 2003) and foster children displaying unmanageable problem behaviour (Strijker et al., 2011). Studies often highlight the challenges of problem behaviour without considering the behaviour through a trauma lens (K. J. Perry & Price, 2017; Valentine et al., 2019). Broadly, there is acknowledgement within research that children within the foster care system are a vulnerable population at risk of poorer developmental outcomes (Bruskas, 2008; Leve et al., 2012).

CYCC placement

A Child and Youth Care Centre is a form of institutional care as it provides a home for more than six children and does not have the family structure that exists within a foster care placement. Children's homes, reformatories, and shelters for street children all fall under the umbrella of CYCC placement (Van der Walt, 2018). In recent years, there has been a significant move away from institutional care for children due to the multiple adverse effects of institutional care on a child's development, attachment, mental health and future prospects (De Silva & Punchihewa, 2011; Lumos, 2015). Therefore, policy describes placement with children's homes to be a 'last resort' (Children's Act, 2005; United Nations, 1989). However, there is an acknowledgement that CYCC placements are a necessary and needed feature within child welfare systems (Huynh, 2014). In South Africa, historically, many CYCCs were started by philanthropists to provide care to many children orphaned through the AIDS pandemic out of a humane concern for their welfare (Malatji & Dube, 2015). Several studies have provided insights into the positive and negative experiences of growing up within CCYCs in Johannesburg, South Africa (Dube & Ross, 2012; Malatji & Dube, 2015).

Temporary safe care

A temporary safe care placement's purpose is to provide a child with care in a registered home, while a decision on the longer-term placement by the Children's Court is pending (Children's Act, 2005; Children's Ammendment Act, 2007). A temporary safe care placement may become a long term foster care or CYCC placement if that is the outcome ruled by the Children's Court as the most suitable option for the child in need of care and protection (Children's Act, 2005). Many CYCCs and foster care homes are also registered as temporary safe care placements. Very little

research is available about temporary safe care placements in South Africa, likely because of their short-term nature. One study conducted in South Africa looked at developing an empowerment program to equip caregivers with the necessary skills to care for children within a temporary safe care placement (Dubery et al., 2020). This program consisted of nine sessions that covered topics such as medical care, trauma, behavioural problems, bonding, discipline, and self-care for caregivers (Dubery et al., 2020). Similarly, a study conducted by Hope and van Wyk (2018) aimed to develop a practice model for emergency child protection intervention for social workers. This included a recommended process to be followed when removing a child from a harmful situation and placing them at a CYCC registered as a temporary safe care placement. This study problematized social workers' tendency to "remove first, think later" and removals done poorly often caused more harm to the child in an already vulnerable position (Hope & Van Wyk, 2018, p. 48). Both studies highlight gaps that exists in policy and practice for the care of children being placed with temporary safe care.

3.5. Interpersonal trauma in childhood

Globally, there is a high prevalence of childhood exposure to maltreatment, with an estimate of one in four children being exposed to physical violence and one in five children being exposed to sexual victimization prior to the age of 18 (D'Andrea et al., 2012; UNICEF, 2017; World Health Organisation, 2020). In South Africa, these statistics are even more staggering: one in three children experience some form of sexual abuse and one in four experience abuse or neglect (Artz et al., 2018; Jamieson et al., 2017a; Strydom et al., 2020; Ward et al., 2018). Research has shown that trauma experienced within childhood has serious health consequences which often persist into adulthood (Ward et al., 2018; Zarse et al., 2019).

Hall and Sambu (2018) document South Africa's unique phenomenon of many children not living consistently in the same household as their biological parents, which results in frequent parental absence and increases the risk of child abuse occurring (DSD, 2019). Factors such as historic population control, labour migration, inequitable distribution of housing, limited educational and employment opportunities, high rates of poverty, low marriage and cohabitation rates, and the HIV pandemic have resulted in 21% of all South African children not living with either of their biological parents. This rate is significantly higher within poorer households and lower in wealthier households (Hall & Sambu, 2018). The high rates of child maltreatment, in combination with the low rates of consistent nurturing parental care, have resulted in many children being in need of alternative care placements in South Africa (Van der Walt, 2018).

Movements within the trauma field

A systematic review by Zarse et al. (2019) considered findings from 134 articles in the English language which contained the phrase "adverse childhood experiences" demonstrated that over the past 25 years, there has been a growing interest in research into exposure to adverse events in childhood since Felitti et al.'s (1998) epidemiological study. However, within the field of mental health, when it comes to the diagnosis and treatment of complex trauma which occurred within childhood, the area of research is still relatively new and mostly limited to higher-income countries (B. D. Perry, 2009; Purvis et al., 2014; B. Van der Kolk, 2014). Even then, the internationally used *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) (American Psychiatric Association, 2013), which is used internationally by mental health professionals, is limited in its diagnostic criteria of the impact of trauma in childhood (B. Van der Kolk, 2014). The current 'trauma- and stressor-related disorders' within the DSM-5 do not adequately capture the range of symptoms often experienced by children and adolescents who have experienced sometimes multiple and repeated traumatic events within the critical years of development (Cook et al., 2005; Spinazzola et al., 2021; Streeck-Fischer & van der Kolk, 2000). Therefore, many trauma theorists have advocated for a new diagnosis, and have proposed 'developmental trauma disorder' (Spinazzola et al., 2018, 2021). This diagnosis would better represent the impact of "multiple or chronic exposure to one or more forms of developmentally adverse interpersonal trauma" (Atchison & Morkut, 2005, p. 405).

Despite the limitations of the DSM-5 diagnostic criteria, there is some literature available which provides guidelines on and recommendations for the care of children who have experienced trauma (Beyerlein & Bloch, 2014; Choudhury, 2020; Parry et al., 2021; Sullivan et al., 2016). Key theorist van der Kolk (2005) outlines the three core pillars which are required for the treatment of trauma: firstly, the development of safety; secondly, promotion of healing relationships; and thirdly, the teaching of self-management and coping skills. These are the pillars on which trust based relational intervention (TBRI) is based (Purvis et al., 2013). TBRI is a caregiving model rather than a clinical model; therefore, the principles can be implemented by caregivers in a variety of contexts. The three principles are as follows (1) empowerment - providing attention to physical needs; (2) connection - providing attention to attachment needs; and (3) correction - providing attention to behavioural needs (Purvis et al., 2014). Lastly, Perry's (2009) 'Neurosequential Model of Therapeutics' is worth noting; however, it is more of a clinical model, therefore more difficult for caregivers to apply in practice.

Trauma-informed care

The need for trauma-informed care within the child welfare system is highly documented in literature (Choudhury, 2020; Parry et al., 2021; Sullivan et al., 2016). Choudhury (2020, p. 67) defines a trauma-informed approach as one that "understands and considers the pervasive nature of trauma and promotes environments of healing and recovery rather than practices and services that may inadvertently re-traumatize". Beyerlein and Bloch (2014) propose that a trauma-informed service should include the following elements: (1) routine screening for exposure and related symptoms, (2) evidence-based and culturally appropriate assessment and treatment methods, (3) an address of the impact of trauma on the family unit, (4) assurance of the continuity of care across the various treatment providers, and (5) implementation of mechanisms to minimise the experience of secondary trauma and to strengthen resilience.

3.6. The experiences of caregivers

Despite the United Nations' (2010) recommendation that all individuals involved in the care of children be provided with sufficient training and resources, it is apparent that this is not the reality within South Africa's alternative care system. A report released by Parliament on foster care states that prospective foster parents "often go through an assessment process and *may* have to participate in a structured orientation programme" and then goes on to state that insufficient resources have been allocated to implement what is required by legislation (Gudula-Koyana & Khanye, 2019, p. 1). There is a formal NQF level 4 qualification available within South Africa called 'Child and Youth Care Work', which several caregivers working in CYCCs have; however, this qualification is not a requirement for employment, nor does the qualification cover trauma-related content (Community Agency for Social Enquiry, 2010; Mhizha & Nhedzi, 2023).

This identified gap impacts on the caregiver's skills and capabilities in providing care to children who have experienced interpersonal trauma. Within the literature, there are two key concepts presented most frequently in relation to caregivers' experiences within alternative care: firstly, the importance of attachment (West et al., 2020) and, secondly, the experience of secondary trauma (Hannah & Woolgar, 2018).

Attachment

Attachment theory (Bowlby, 1988) explains that when a caregiver provides a safe and nurturing environment, the child forms a secure attachment. Attachment is defined as the part of the relationship between the infant and the caregiver which gives the child a sense of feeling safe,

secure, and protected (Grady et al., 2017). The attachment cycle describes four phases: (1) infant has a need; (2) infant cries; (3) needs are met by the caregiver; (4) trust develops (Zeanah et al., 2011). This cycle is repeated over and over in order to form secure attachments. A secure attachment has been found to protect against the effect of social and environmental stress. However, when a child experiences neglect, inconsistent care, or abuse at the hands of a caregiver, an insecure or disorganised attachment is formed (Purvis et al., 2014). For this reason, attachment-based trauma caused non-violently (such as through neglect and emotional abuse) or violently (such as though sexual and physical abuse) has a severe detrimental effect on a child's development (Kisiel et al., 2014). Furthermore, the removal of children from their home to ensure their safety, resulting in separation from their primary caregivers, puts a child at risk of further trauma and loss even if the caregiver was not providing adequate care (Sullivan et al., 2016). Therefore, the importance of the role of caregivers in providing children with a safe and nurturing environment within the alternative care system is paramount, as these relationships hold the power enable children to heal from interpersonal trauma (Dann, 2021; Dobson & Perry, 2010).

Attachment within alternative care

There is a plethora of literature on attachment within alternative care. Research indicates that the age at which a child is placed into alternative care has an impact on the likelihood of developing a secure attachment, with children younger than 2 years old being more likely to develop new bonds in comparison to older children (Kelly, 2017). A literature review done by West et al. (2020) found that the characteristics of the foster parent, such as responsiveness and sensitivity to the child's emotional state, were more important than the characteristics of the foster child in developing secure attachments. Another study indicated that the placement of children (after the age of 1 year) into foster care homes after severe institutional deprivation resulted in significant recovery with regards to attachments and feelings of security in comparison to the children who remained in institutional care (Smyke et al., 2010), again highlighting that placements within foster families should be favoured above CYCCs. Another study conducted in South Africa, found that social workers working with foster parents had a limited understanding of attachment theory and interventions and perceived biological families as being unmotivated to improve their relationships with their children resulting in low rates of successful reunifications (Lesch et al., 2013).

Secondary trauma

Another common concept within the literature on caregivers and alternative care is that of secondary trauma, also termed compassion fatigue, vicarious trauma, or burnout (Rienks, 2020).

Research found high rates of secondary traumatic stress among foster caregivers and child welfare workers and highlight the importance of self-care strategies (Bridger et al., 2020; Rienks, 2020). As a result of ongoing exposure to the traumatic experiences of children (the primary traumas), caregivers experience symptoms similar to those of post-traumatic stress disorder (secondary trauma), which include heightened arousal, avoidance, emotional numbness, depression, and intrusive thoughts of the traumatic experiences of others (Rienks, 2020). This raises concerns regarding caregivers' abilities to continue in childcare work and the impact on the quality of care they are able to provide to the children placed within their care (Hannah & Woolgar, 2018).

3.7. Conclusion

Despite excellent polices being in place, South Africa has a long way to go in implementing an effective and capacitated child protection system (Jamieson et al., 2017b; September, 2006; Van der Walt, 2018). The overarching issues of human resources and funding constraints impact the effectiveness of alternative care placements and place strain on caregivers within these settings. This is concerning considering the high numbers of children who are in need of care and protection within South Africa as a result of several contextual factors that lead to family breakdown (Jamieson et al., 2017a). The importance of caregivers building secure attachments with children who have experienced interpersonal trauma within alternative care and the high risk of secondary trauma has been highlighted (Dobson & Perry, 2010; Hannah & Woolgar, 2018).

Chapter 4: Methodology

4.1. Research design

A qualitative descriptive exploratory study design was used. This study design allows for an in-depth exploration of caregivers' experiences. A qualitative research design is most suited to answering the research question as it seeks to understand a specific topic from the perspective of the local population it involves (Mack et al., 2005).

4.2. Research setting

The study was conducted in Gauteng, South Africa. Within South Africa, an estimate of 20 – 34% of children experience some form of contact violence before the age of 18 (Jamieson et al., 2017a); therefore, this setting is appropriate as there are high rates of children who are maltreated and need to enter alternative care placements. Gauteng is the most densely populated province, with many foster care homes, CYCCs, and temporary safe care placements within a small geographic area; therefore, the researcher did not need to travel long distances to reach participants. Data collection took place from March to August 2023. During this period, the DSD Gauteng withdrew large amounts of funding from CPOs, placing additional strain on the services being provided to caregivers across these placements (SA Federation for Mental Health, 2023).

4.3. Sampling method

Purposive cluster sampling was used to select participants from the three clusters, namely foster care homes, Child and Youth Care Centres (CYCCs), and temporary safe care (POS) placements which constitute the three formal alternative care placements. The sampling was purposive in order to ensure adequate representation of each of the three types of formal alternative care placements within the participant sample. All the placements were registered with the DSD. Out of the 12 foster care and CYCC placements, 9 were also registered temporary safe care placements. The reason for this is that a child can be placed in the home temporarily while a longer-term placement is pending with the court. Often the temporary safe care placement would become a longer-term placement within the foster home or CYCC.

Recruitment of participants from each cluster was done with assistance from a key informant who was well informed about the study. The key informant is an experienced caregiver who is a registered foster care and temporary safe care placement. She is part of a network of foster parents in Gauteng and has worked closely with several CYCCs in Gauteng. The network is located on

WhatsApp and consists of caregivers working within alternative care with the purpose of sharing information and providing support. This network was utilized for convivence sampling in order to gain contacts of potential participants without assistance from DSD. Initial recruitment was done by advertising participation in the study on a WhatsApp group of caregivers in alternative care. Thereafter, snowballing sampling was used once initial participants were recruited. Participants were asked preliminary questions to ensure they met the inclusion criteria of the study. Permission was first obtained from CYCC managers prior to requesting CYCC caregivers to participate in the study. A letter of support for the study from the key informant can be found in **Appendix D**.

4.4. Study sample

Fifteen caregivers who provide care for children who have experienced interpersonal trauma were selected from the three types of alternative care settings as noted below.

- *Cluster 1:* Foster care caregivers
- *Cluster 2:* CYCC caregivers
- *Cluster 3:* Temporary safe care caregivers

Several of the participants straddled more than one type of placement within their role and experience, therefore allocation to each cluster to ensure equal representation of each cluster was difficult to achieve. See **Table 1** below for a description of the study participants: pseudonyms were allocated based on the type of placement that was most prominent. See the placement description (sixth column in **Table 1**) for an indication of which clusters were represented by the participant. Data saturation was reached with a sample size of 15, which aligns with the convention within qualitative research (Young & Casey, 2019).

Selection criteria:

Inclusion criteria

- The caregiver must have or have had a child or several children in their care who has/have experienced interpersonal trauma.
- The placement must be registered with the Department of Social Development and must comply with the regulations stipulated within the Children's Act (Children's Act, 2005; Children's Ammendment Act, 2007).
- The caregiver must be directly involved in the care of the child/children, must have a minimum of 2 years of experience, and must be willing and able to share their experiences.
- The caregiver must be located in Gauteng, South Africa.

Table 1: Summary of Participants

(Details as captured during data collection in the period March – August 2023)

Pseudonym	Age & Gender	Demographic	Years experience	Role	Placement description	Number of children in home	Age group of children
F1A & F1B	38 y/o female, 41 male	White South African, married	10	Mother & father	Foster care & POS	1 biological, 1 adopted, 4 fostered	4-18 years old
F2	49 y/o female	White South Africa	4	Mother	Foster care & POS	3 fostered	7-18 years old
F3	50 y/o female	White American	11	Mother	Foster care within a cluster home	2 adopted, 6 fostered	0-18 years old
F4	37 y/o female	White American	15	Mother, cluster foster care manager	POS & cluster foster manager	Now 2 adopted	0-18 years old
F5	47 y/o female	White South African	13	Mother	Long-term foster placement	2 children (twins) relatives	Now both 15 years old
F6	47 y/o male	Black, Congolese	12	Father	Foster care within a cluster home	2 biological, 3 fostered	10-18 years
POS1	44 y/o female	White American	13	Baby home manger	POS – baby home	Up to 16 babies	0-3 years old
POS2	34 y/o female	White South African	10	Baby home manger	POS – baby home	6 babies	0-3 years old
POS3	48 y/o female	White South African	12	Baby home manger	POS – baby home	14 POS placements, 3 adopted, 2 fostered	0-5 years old
CYCC1	53 y/o female	White South African	21	Managing director, adoptive parent, social worker	CYCC & POS	2 homes – 10 girls, 10 boys	0-18 years
CYCC2	29 y/o female	White South African	3	Social worker and project coordinator	CYCC & POS	30 children	0-5 years old
CYCC3A	55 y/o female	Black, Malawian	24	Child and Youth Care worker – special needs	CYCC & POS	50 children across 3 cluster homes	0-4 years old
CYCC3B	30 y/o female	White American	8	Development & stimulation coordinator, adoptive mother	CYCC & POS	50 children across 3 cluster homes	0-4 years old
CYCC4	35 y/o male	White South African	13	Foster father, owner of CYCC	Foster care, CYCC and POS	3 fostered children, CYCC has 32 children	0-18 years
CYCC5	47 y/o female	Black South African	12	Previous house mother, now residential social worker	CYCC & POS	22 children	0-18 years old

Exclusion criteria

- Unregistered placements or if the home is non-compliant with the DSD regulations
- Caregivers who have less than 2 years' of experience in caregiving
- Unable to communicate confidently in English
- Caregivers outside of Gauteng

4.5. Data collection

Introducing the study

Participants were contacted and introduced to the study content, the rationale for the study and what would be expected of them should they agree to participate. The participant information sheet and consent form, as documented in **Appendix A and B,** were then explained. Due to the sensitive nature of the area of study, it was paramount for the researcher to ensure that informed consent was obtained and understood by the participant.

Semi-structured interviews

Interviews are a commonly used data collection technique within qualitative research. It is a purposeful discussion between two people with the goal of building an understanding of the participant's world by deeply exploring their point of view, feelings, and perspectives (Robson & McCartan, 2016). This data collection method is most suited to answering the study's objectives as it allowed the researcher to ask specific questions about the experience of caring for children who have experienced interpersonal trauma. Once signed consent was obtained from the participants, a semi-structured interview was scheduled.

Most interviews were conducted in person, and two interviews were conducted online on an audio-recorded Zoom call, as a virtual meeting was more practical for the participants. The researcher and the study participant kept their video cameras on for the duration of the virtual interview which minimised the differences between the interviews conducted in-person and virtually. The in-person interview locations were chosen to ensure that the researcher did not meet the children in the home during the interview.

See **Appendix C** for the interview guide of the semi-structured interviews. Preliminary questions about the caregiver's demographic information and placement background were asked to position the caregiver's experiences within context. Thereafter, the interview questions were guided by the

study objectives to build an understanding of caregivers' experiences of caring for children who have experienced interpersonal trauma.

The interviews were semi-structured, which allowed the researcher to have a list of standard questions and prompts for each participant, as well as to expand on something of interest that may have been mentioned by the participant during the interview. With consent from the participant, a voice recorder was used to record the interview, and a notebook was used to write down points raised which would require revisiting or clarification later in the interview. Interviews were conducted in English because the majority of individuals residing in Gauteng have a competent grasp of the English language and it was not feasible for the researcher to utilise translators.

4.6. Data analysis

The audio recordings of the interviews were transcribed verbatim by a transcriber who signed a confidentiality agreement. The interview transcripts were analysed using thematic content analysis as outlined by Braun and Clark (2006). The following steps are involved in the thematic analysis. Firstly, the researcher became familiar with the data collected in the interviews. This was done by reading and re-reading interview transcripts and taking notes regarding initial ideas. Thereafter, the data were coded. This involved capturing the segments of meaning that emerged from the data. Coding was done manually using Microsoft Word. Thereafter, codes were grouped together into potential themes, and the entire data set was reviewed to ensure all the codes could be related to a theme. The themes were then defined and named. This process was iterative; therefore, codes and themes were revised and reworked several times. Finally, the data were presented using selected extracts, relating back to the study objectives and literature (Braun & Clarke, 2006).

4.7. Trustworthiness

Within qualitative research, trustworthiness is assessed using the criteria of credibility, transferability, dependability and confirmability (Lincoln & Guba, 1985). The strategies used to achieve trustworthiness include peer debriefing, triangulation, member checking, keeping an audit trail, and reflexivity (Morse, 2015). For transferability, the researcher provided a detailed description of South Africa's alternative care system and the context of Gauteng in order for readers to evaluate the potential of study findings being transferred to a different context. An audit trail documenting the key decisions made throughout the study, and the reasoning thereof was kept, demonstrating dependability. To ensure confirmability, the researcher made use of peer debriefing with the supervisor and the key informant in order to limit the amount of researcher bias imposed on the data. Furthermore, the researcher's theoretical standpoints are stated up front in the

paragraph below. To ensure credibility, triangulation will be used by collecting data from three participant groups. Six participants (two from each cluster) were asked to review the primary findings from the interviews as a form of member checking. A reflexive journal was kept to record reflections after each meeting with the participants (Morse, 2015). The researcher acknowledges that her positionality and her personal and professional viewpoints may have imposed bias during data collection and analysis; therefore, the reflective journal was used for personal monitoring of thoughts and feelings.

4.8. Reflexivity

Reflexivity was important within this study. Adonis (2020, p. 64) reflects that "when the subject under investigation is related to trauma, listening to or being exposed to personal accounts of participants' traumatic experiences can carry a significant emotional cost for researchers". Therefore, throughout this study, the researcher intentionally debriefed experiences and took breaks during the data collection phase to allow time to process the difficult experiences that the researcher bore witness to in the interviews. In terms of positionality, the researcher is an Occupational Therapist by profession, with an interest in trauma-informed practice. The researcher is not working with any alternative care placements; therefore, there was no overlap between the researcher's work and the research study. The researcher is a white, South African female and holds to the Christian faith. This demographic was similar to that of several participants, which made connecting with these participants easier within the interviews. Several participants recruited for the study were American, which was initially surprising but may be explained by the American Christian worldview which honours a calling to help the vulnerable in lower-resourced places like South Africa. Several of the American participants were volunteers working with financial support from the States. Therefore, it is not surprising that these participants were able to continue being caregivers when many of their South African counterparts needed to close considering the financial challenges many placements experience. After the first 10 interviews, the researcher noted that majority of the participants were white females; therefore, the male participants and participants representing other racial groups were intentionally recruited in order to add diversity to the sample.

4.9. Ethical considerations

The researcher obtained ethical approval from the University of the Western Cape's Biomedical Research Ethics Committee before proceeding with any research activities (reference number BM22/10/8). See **Appendix F** for the ethical clearance letter. The participants that were recruited for the study are caregivers who are registered with the DSD. Therefore, permission was obtained

from the Gauteng DSD to conduct research within the area of alternative care (file number 02/02/23); see **Appendix E** for the letter of approval.

Research participants were issued with an information sheet regarding the nature of the study. The information sheet (**Appendix A**) and consent form (**Appendix B**) are attached. The participants were also informed that their participation in this research study was entirely voluntary. To ensure this, time was granted to the participant prior to scheduling the interview to read though the information sheet and to withdraw if they did not feel comfortable proceeding with the interview. The researcher undertook to protect the identity of the participant as well as the identity of any of the children under their care in the study. Due to the sensitive nature of the information being gathered about the children within their care, participants were asked to not use children's names or any specific identifying details of the children within the accounts they were to provide in the interviews. The researcher ensured not to interact with the children in the home; therefore, minor assent was not required for this study as the focus of the research was on the caregivers' experiences. The researcher ensured that neither the name of the participant nor the name of the care placement was included in the data collected. Participants will be identified by a pseudonym made up of the type of care placement (F for foster care, CYCC or POS for temporary safe care) and a number in all transcripts, analyses, and reporting to conceal the identity of the participants. Only the researcher knows the correlating identity of the participants in relation to the pseudonyms.

The researcher acknowledges that the chosen area of study is sensitive in nature and involved the participants sharing experiences about the care of children, which is a vulnerable population group. Therefore, there was a risk of participants experiencing psychological stress when sharing experiences which may have been difficult. Therefore, the researcher had available referral details for counselling services if any participant expressed distress during their interview; however, no participants required referral through the data collection process. The researcher believes that the potential value which the research study can add within the field of alternative care outweighed the risk of harm and undertook to minimise the potential risks to the participants who agreed to participate in the study.

4.10. Data management

All the audio recordings and transcripts were stored within password protected folders on the researcher's laptop and were backed up on the UWC Google Drive. Transcription was outsourced and the transcriber was asked to sign a confidentiality agreement prior to being given access to the recordings; this agreement required the transcriber to delete any data related to the study after the

work was completed. After 5 years, all information related to the study will be deleted from the researcher's laptop, and all transcripts and any other hard copies of notes taken during the study will be destroyed.

Chapter 5: Findings

In this chapter, the findings of the research will be described. Using thematic analysis as outlined in Chapter 4, the transcripts of the 15 interviews were coded, and the codes were then grouped together under four main themes, with three sub-themes for themes 1- 3 and two sub-themes for theme 4. Broadly, the themes cover (1) the children who experienced interpersonal trauma, (2) the alternative care home structure, (3) the caregiver within the alternative care placement, and (4) the child protection system. The chapter will conclude with a summary of the main findings in relation to the three research objectives.

These themes and sub-themes are summarised in **Table 2** below:

Table 2: Summary of themes

Theme 1	Theme 2	Theme 3	Theme 4
THE CHILD	THE HOMES	THE CAREGIVER	THE SYSTEM
The pervasive impact of trauma on children from hard places	**Structuring placements towards family and permanence**	**Caregiving that demands steadfast love and a relinquishing of control**	**Navigating a child protection system that can perpetuate trauma**
Subthemes	*Subthemes*	*Subthemes*	*Subthemes*
1. Reasons for placement: neglect, abuse & abandonment	1. Foster care: trying to create 'normal' family life	1. A parenting approach that loves fiercely and builds attachment	1. The shortcomings of child protection services
2. The effect of trauma on development, behaviour & attachment	2. Temporary safe care: short term baby homes	2. Holding loosely to control in caregiving	2. The experience of secondary trauma
3. Caregiver's need for trauma informed services & training	3. CYCCs: longer term institutional care	3. Importance of support & self-care	

Theme 1:

5.1. THE CHILD: The pervasive impact of trauma on children from hard places

The first theme, 'the pervasive impact of trauma on children from hard places', focuses on what the participants shared about the children who have been placed within their care. They described

the ‘hard places’ from which the children were removed. These places included circumstances of neglect, abuse, abandonment, serious disruptions in caregiving and of child trafficking. Each situation involves, at the least, a separation from the biological mother, which in itself is an experience of interpersonal trauma. Often, situations involved more layers of trauma in various forms. These ‘hard places’ were defined by F1A in the extract below:

> *These are children who have experienced, I think you would call it interpersonal trauma. Basically, they have been extremely hurt or abused or neglected by their primary family. And whether that happens when you are a new-born or that happens for the first ten years of your life, there's damage and there's trauma. And because of that you have to parent differently and facilitate healing as much as possible (F1A, 38 y/o female, foster parent)*

This quote also alludes to the damage that is caused by interpersonal trauma which has a pervasive impact on many aspects of life. This warrants a different parenting approach, which will be considered in Theme 3.

The sub-themes explore the following: firstly, the reasons why the children were removed and placed within alternative care; secondly, what effect trauma has had on the development, mental health, behaviour and attachment of the children; and thirdly, the caregiver’s need for trauma-informed services and training in order to provide care for the children coming from these situations with complex needs.

Sub-themes:

5.1.1. Reasons for placement: neglect, abuse and abandonment

Caregivers were asked to share some background information about children who had been placed within their care that would indicate whether they had experienced interpersonal trauma as per the definition given by the researcher. Caregivers shared these stories willingly with emotion. Many expressed that they found it challenging to witness children being maltreated first hand. Several caregivers indicated that all children who have been placed within the alternative care system have experienced interpersonal trauma because they have been separated from their biological mother, this understanding is highlighted in the quote below:

> *All these kids have already experienced trauma because they're not with their biological moms anymore, and they have already suffered a loss like a death. (POS1, 44 y/o female, baby home manager)*

Many caregivers shared stories of children who had been neglected, and some indicated that neglect was the most frequent reason for a child to have been removed. Many children within alternative care placements still had surviving parents. The below quote highlights that within the CYCC placement, many of the children were removed due to neglect or abuse:

> *The main reasons for a removal would be neglect and abuse. 20 years ago, most of them were abandoned. These days most are probably removed. Orphaned is actually a small number. (CYCC1, 53 y/o female, CYCC manager)*

Abandonment and neglect often occurred together. Several caregivers, particularly within the temporary safe care placements, shared stories of infants being abandoned in hospital wards and then neglected without a caregiver to attend to them, often for months as social workers would not react promptly to find a placement for these children, as expressed in the quote below:

> *Children who have been abandoned on hospital wards… I picked up a little person who had actually gone home with his mom first. She surrendered him about 2 weeks later and then he sat in the hospital unattended for 10 weeks. The only reason he came home to me is because typically at the end of November, social workers try to clear their desks. So at the end of year there's an influx of children because they're trying to clear their desks. (POS1, 44 y/o female, baby home manager)*

Some of the stories shared indicated a child had experienced many layers of trauma - often repeated and varied forms of maltreatment within the early years of life. For example, one particularly shocking story was shared of a child who was born into a drug-using household and then sold into a sex-trafficking ring, abused in a prison cell, and neglected within a hospital ward prior to moving into a long-term foster placement. The below quote from the respective caregiver highlights the uncovering of the many layers of trauma within circumstances like this:

> *There was a physical trauma of sexual abuse which you could see medically… As we investigated her background, we started discovering all these elements of abuse as went deeper and deeper into the story, there were recordings of her being sexually violated… the trauma was so apparent. (CYCC4, 35 y/o male, foster parent and CYCC owner)*

Caregivers noted that the neglect or abuse had to be very severe to warrant a removal by child protection services. Several caregivers experienced frustration at children not being removed when

they should have been, therefore the trauma experienced was often prolonged and the damage that was done was more severe than it would have been had there been more responsive services:

> *Because they're not removed when they should be either. They're removed when somebody has complained 8 million times. I mean, ideally, a child should be removed when they're not getting the care that they need. But they're not. (F2, 49 y/o female, foster parent)*

5.1.2. **The effect of trauma on development, behaviour and attachment**

Once these children were removed from the circumstances described above, they were placed within alternative care. When caregivers were asked about what challenges they experience, they shared how these early traumatic experiences impacted the children. Caregivers expressed difficulty navigating various developmental challenges, for example some children had difficulties with sensory integration, while others had several medical challenges resulting in frequent hospital admissions. One caregiver expressed how during the COVID pandemic she was not permitted to stay with the child during these hospital admissions:

> *And so at 3 months old, when my child literally couldn't breathe, he's turning blue. I rushed him to the hospital, and they basically took my child from me. For 3 months I couldn't help him. I couldn't do anything for him. I wasn't even allowed to see him for most of the time. My child was left completely unattended. (POS2, 34 y/o female, baby home manager)*

Many children were diagnosed with attention deficit disorders or hyperactivity. Some children presented with gross motor delays which were physical and therefore apparent in early years, others had learning challenges that only became apparent once the child entered the formal schooling system as described in the quote below:

> *It's hard to see some of the deeper issues, your developmental delays have to be very pronounced to pick them up in a small child. I think there may be an element to which they do also develop through further trauma. There are a few of the kids now with fairly severe learning disabilities or autism or retardation who you wouldn't have thought that when they were 2 years old because they were milestone accurate in terms of the physical milestones. (F4, 37 y/o female, POS & cluster foster care manager)*

Many caregivers experienced difficulties with children who displayed extreme behavioural challenges. These behaviours included lying, stealing, throwing temper tantrums, running away from the home, breaking things, and sometimes extremely violent behaviour which involved

hurting other children, hurting the caregivers, or hurting themselves. One caregiver provided the following helpful insight into understanding these extreme behaviours:

> *Some of the behavioural challenges have been absolutely huge and it's why these kids often get labelled as problem kids and why people don't take in older kids. But they're not problem kids, they're hurting kids. And it's not from a place of "I'm a malicious, horrible, bad kid", but "I'm a hurting, scared, I don't know how else to cope". Kids who have grown up around violence only know violence. So we've had some very violent children in our house… (F1A, 38 y/o female, foster parent)*

Several caregivers experienced food-related difficulties, particularly with children who had been neglected and deprived of food prior to their placement. Caregivers noted that the physical effects of food deprivation include being underweight and developmentally delayed, but there is also an effect on their emotional response to food, as described in the following quote:

> *When they have not had regular access to food, it becomes a dramatic thing for them. They cry when every single bottle is finished. The minute they're hungry, they're dysregulated and panicking. They will eat too much. They will fight for food. They're motivated by food. Their little brain says, you haven't had enough, and you will never have enough (POS1, 44 y/o female, baby home manager)*

Caregivers also shared stories of children who had experienced serious disruptions in caregiving from being moved between several placements and how that impacted the child's ability to form new bonds. The child had learned from experience within their early years not to attach to a caregiver because they couldn't trust the caregiver to respond or to stay, as described in the following quote:

> *We had a little girl, who at the age of 9 months had been in four different placements. Because she had no attachment, whenever she became dysregulated it was difficult to get her to calm down, because every person was a threat. She was placed in foster care and in four days the family brought her back. Cause she couldn't cope with another transition. (CYCC2, 29 y/o female, CYCC social worker)*

This quote illustrates how interpersonal trauma has an impact on a child's ability to form secure attachments, which then increases the likelihood of a placement failing, resulting in further disruptions in caregiving. Caregivers found it difficult to build attachment with children who had come from multiple previous placements.

5.1.1. **The need for trauma-informed services and training**

Several caregivers shared challenges in accessing healthcare services, therapeutic services and schooling that met the trauma-related needs of the children within their care. Caregivers expressed frustration with medical professionals who did not know how to work without having a full background history of the child, which was often not available. Caregivers shared stories of social workers removing or moving children in a way that amplified the trauma of the situation as children were not prepared adequately for a placement transition. Others shared how medical procedures were done in a way that frightened children as no effort was made to create a safe environment for traumatised children. These gaps were more significant for caregivers who had limited options in terms of accessing private services, as expressed in the following quote:

> *Trauma informed care does not exist here. With some of our kids, we've accessed a whole lot of medical care, but it's certainly not trauma informed. I mean, it often traumatises the children more because these people treat them so horrendously in our medical facilities, it ends up adding to their trauma. It is possible to find a trauma informed therapist in private healthcare settings, albeit seldomly, but you can find them. But in government, nothing. I think it's because staff in government facilities are so overwhelmed, everyone is traumatised. (F1A, 38 y/o female, foster parent)*

Another profound gap in service provision is access to options for treatment of children who have extreme behavioural challenges. One caregiver shared about an 8 year old who threw temper tantrums and became so violent that she was a danger to herself and others in the home. The below quote highlights the gaps in accessing services that were able to assist in this situation:

> *In South Africa, we do not have the resources to be able to deal with extreme behavioural challenges. We currently have a child that is experiencing this, she completely loses it. Complete aggression. You cannot restrain her. She becomes so strong. You cannot reason with her. She just swears at you. And I'm talking specifically the one child is, she's just turned eight, so we're not talking teenagers. Your only action eventually is to call an ambulance and go to an emergency room at a government hospital, sometimes by then they've calmed down, then you see a psychiatrist, there's limited medication they can prescribe and when they're on that, and at the maximum dose for their weight, there's pretty much nothing else you can do. (CYCC1, 53 y/o female, CYCC manager)*

The caregiver also noted that there are no placements that would accept a child who displayed this kind of behaviour. The only institution that accepts children with challenging behaviour only

admits children over the age of 12; therefore, caregivers have no choice but to keep the child displaying behavioural problems within their care.

Furthermore, some caregivers also shared experiences of accessing therapeutic services that were not necessarily helpful or effective, as expressed in the quote below:

> *If you don't have that core of attachment, I don't think just talking therapy or just play therapy works. I mean all of the kids who went off the rails had therapy. They were the only ones that had therapy because they were going off the rails. But it didn't change anything in the end. And so you can't just say, we're going to get you to a psychologist and that's going to fix it. (F4, 37 y/o female, POS & cluster foster care manager)*

A couple of the caregivers acknowledged that part of the challenge within South Africa is that not enough research has looked at trauma within our context, meaning that accessible, effective, and evidenced-based interventions are hard to come by. Most of the research available within the field of trauma comes from high income countries and contexts that look very different to ours, and caregivers highlighted the need for research from the South African context, as indicated in the quote below:

> *I think the South African view of trauma, especially childhood trauma, has to be researched more thoroughly. (CYCC4, 35 y/o male, foster parent and CYCC owner)*

Another form of support that caregivers mentioned was the need for training. No qualification is required to be a caregiver within alternative care. Only three caregivers mentioned that they had received formal foster care training. Four of the CYCCs had some staff with a Child and Youth Care Worker qualification. Many of the caregivers had demonstrated resourcefulness in sourcing their own training, which they found to be valuable. Most caregivers expressed that more training would have been helpful, particularly trauma-informed training that could be given on a practical and ongoing basis, as expressed in the following quote:

> *I think one thing that's very important is repeated training. If you send caregivers on a training before they get children, and then you expect them to implement that training for the next 10 years, it doesn't work. I think you almost need at least 6-monthly interactions with the material, preferably in a supportive peer group where you can hear people validating your experience. That would be helpful for parenting generally, not just trauma parenting. (F4, 37 y/o female, POS & cluster foster care manager)*

In conclusion, this theme explored the varied traumatic experiences of the children that led to them being placed within alternative care. Subsequently, caregivers experienced many challenges navigating the impact of these traumatic experiences on the child's development, behaviour, and attachment. The last sub-theme explored caregiver's need for trauma-informed services and training.

Theme 2:

5.1. THE HOMES: Structuring placements towards family and permanence

This theme will describe what caregivers shared related to the structuring of the alternative care homes. 'The home' may be a foster care home within a context of a family, or a temporary safe care baby home that takes in infants for shorter durations in comparison to the other placement types, or a CYCC which has an organisational structure, many more children and staff working in shifts to provide care. The sub-themes will describe each of these three placements and some of the placement specific challenges.

This theme is called 'structuring placements towards family and permanence' as the majority of the caregivers interviewed believed that children should be raised in a family environment that is as permanent as possible. Foster parents were more likely to be able to achieve this in their home, whereas CYCCs and temporary safe care placements recognised the limitations to achieving what was believed to be ideal.

Sub-themes:

5.1.1. **Foster care: trying to create 'normal' family life**

A foster home can take up to six foster children and can also have additional biological or adopted children. Four of the foster parents interviewed were married, and two foster parents were part of a cluster foster home model. Most of the children within these placements were long term foster care placements, therefore there was little movement of children in and out of the homes. This sub-theme has been titled 'trying to create "normal" family life' because all the foster parents interviewed desired for the children within their care to feel like this was their family, the caregivers were often referred to as "mom and dad" by the foster children, and several of the children moved from a foster placement towards adoption. The desire for children to have a long-term family is expressed in the quote below:

We aim to give children who don't really have any other options, family and permanence. So the goal is that children realise that they're not a problem but a gift. That's kind of our heart, that they're not just a problem to be solved, but rather that they are wanted and loved and accepted and that they're forever safe with us. We're very pro-reunification, so if reunification is possible, we would fight for that like we did with our first foster kid. But the nature of the children that we take in, often that's very unlikely. (F1A, 38 y/o female, foster parent)

Furthermore, caregivers expressed the belief that creating a healthy long term family environment is essential for healing from interpersonal trauma:

We really believe that that trauma that is caused in a family can actually only be healed in a family. It's very difficult for that to be healed in a children's home or in a temporary place, because it's more difficult to achieve permanence and attachment in those settings (F1A, 38 y/o female, foster parent)

Several foster parents acknowledged that even though they aimed to create a "normal" family life, there were elements of their lives that were quite different from families that only had biological children. For example, managing very challenging behaviour, regular court visits, adopting a very different approach to discipline, and having a large family with children from very different backgrounds. Some of these elements will be expanded on in theme 3 under 'parenting approach'. The challenge of having a larger than normal family is expressed in the quote below:

Having a really big family just limits you in lots of ways. You can't really do all of things that you would normally do as a family. We don't often visit people because you can't impose a family of eight on people. Because we're also just a family, we're not like an organization where there are multiple volunteers or people who come in or anything. It's just us. So we never ever get a break. (F1A, 38 y/o female, foster parent)

Foster parents also shared that even though they desired permanency for the children within their care, sometimes that was difficult to achieve. Several caregivers shared that in some cases they faced resistance in trying to adopt particularly older children, as expressed in the quote below:

We would have adopted if we'd been given a chance, but Joburg child welfare just didn't do anything. When he was 17 years old, the magistrate said, take his file straight to DSD. I give him permission to overrule, to go past Joburg child welfare and just go straight to DSD with his file, get it pushed through before he's 18. But DSD said they can't do that. They're taking

a long time to do adoptions and they're not interested in a 17 year old who's about to age out. (F2, 49 y/o female, foster parent)

Caregivers experienced this as a challenge as there are still several limitations of only being a foster parent, which would fall away if the placement moved to adoption. For example, it is much easier to put a child onto a caregiver's medical aid if they are adopted, as expressed in the quote below:

I am finalizing adoption now of one of my children, and to get an adoption agency that was willing to do it was so difficult. It took almost a year, because they were like, "why would you adopt a child like this?" She's a 15-year-old, now. And I'm saying, but she's going to need medical care, and I need to have her on medical aid. It's practical. If she has a seizure and she goes to the hospital, I cannot do anything about it. (CYCC4, 35 y/o male, foster parent and CYCC owner)

5.1.2. **Temporary Safe Care: short term baby homes**

As mentioned in Chapter 4, many of the caregivers interviewed across all three placements were also registered temporary safe care placements. However, three of the caregivers interviewed had structured their homes to predominantly take in children needing care for shorter periods. All three of these homes were baby homes that only accepted infants under the age of 2 years old, with the aim of moving these infants into more longer-term family placements, either through adoption, reunification or to a long-term foster care placement. These intake decisions are explained in the quotes below:

As far as intake goes, we're looking to intake typically children six months and under just because it often takes two to three years to walk the road to permanency, either adoption or put into permanent reunification with their family. (POS1, 44 y/o female, baby home manager)

The below quote explains the process of the child leaving the baby home:

For a child to leave, they either need to be adopted or reunified with their families. Depending on the situation, most of my kids will end up in foster care pending adoption. It's better that the child goes and lives with that family as early as possible. And the social workers just need to get their stuff organized. Normally within six months of them going to their families, they are adopted officially. (POS2, 34 y/o female, baby home manager)

Caregivers within these placements recognised that a short-term placement within a baby home is not ideal, however these placements are needed because of the time it takes for the administrative processes required to find a suitable longer-term placement for children in need of care and protection. The limitations of the baby home structure are expressed in the quote below:

> *I don't think that it's in the child's best interest to have them in this holding ground for 3 years or 4 years. It would be much better for them to be in a family where they were going to preschool, hanging out with friends and they had an older sibling, and they had a pet etc. In a baby home we have some really weird things that don't exist in a typical family, such as having rotating caregivers. Their lives are very small. They don't go to preschool. We do all of our educational stuff in the house. Like 99% of their days look exactly the same. (POS1, 44 y/o female, baby home manager)*

Caregivers within these placements all shared that the biggest challenge was the emotional strain of new children coming in regularly and having to say many difficult goodbyes to children whom they had bonded with. This will be explored further in theme 3.

5.1.3. **CYCCs: longer term institutional care**

Within legislation, a CYCC placement is a last resort option, as globally there is a move away from institutional care. These placements can accommodate more than 6 children and require a team of staff and organisational structure to operate. Within South Africa, caregivers noted that due to the overwhelming need for placements for children requiring care and protection, CYCC placements are needed as they are able to accommodate larger numbers of children in comparison to foster care placements. Several placements tried to structure the CYCC as close to a family structure as possible in order to limit the negative effects of institutional care, as expressed below:

> *We operate on what we call a family homes model. The thinking behind that is to give these children as close to a normal family life as possible. So as un-institutionalised as possible is our goal. So that's why we're limited to ten children per house. You'll have noticed there's not any signs up, that kind of thing. We really try to keep them out of the business side of things, so it's really just to try and be family to them for as long as they need us. (CYCC1, 53 y/o female, CYCC manager)*

Therefore, many CYCC also aimed to move children into adoptive places or pushed for reunification with their families. However, if the biological family did not consent for the child to be adopted, the chances of moving to an adoptive placement decrease as the child gets older,

resulting in many children living in the CYCC long term until they age out. The below quote expresses the reasons why this situation is not ideal for the child:

> *So even though I feel like we're a pretty well-run children's home, children shouldn't be growing up in a children's home. So ultimately you want to see them going back into their families. Not only because we feel like we can't meet all their needs in a children's home, but also because of what happens once they age out. So you age out without having any family? Who is there for you when you don't have a job, when you're getting married, when you have a baby, on Christmas Day? Who's there if you don't have family and you grew up in a children's home and now you've had to leave? (CYCC1, 53 y/o female, CYCC manager)*

The caregivers within CYCC placements expressed difficulty navigating the transition of children out of the placement when they become adults. If children are not adopted out or reunified with family, then they are only 'wards of the state' until the age of 18; thereafter, the DSD removes any financial support or social service involvement. If the now-adult was residing in a CYCC, they would often need to find alternative accommodation and employment if they had completed schooling. The following quote expresses the pitfalls of this arrangement and an overall failure of the alternative care system to set children up for success in later life:

> *Lasted out till 18, and then what? And the developmental ages of many foster children are behind… And suddenly you need to find a place, find something. It's really, really tough. Therefore, many children leaving the alternative care system at age 18 end up in informal settlements doing drugs and resorting to crime. I think there's no aftercare. We see it all ending at 18, but so much more is needed. (CYCC4, 35 y/o male, foster parent and CYCC owner)*

In conclusion, this theme unpacked how caregivers structured their homes around the children within their care by aiming for as much of a family environment as possible. It highlighted the challenges of institutional care expressed by CYCC and temporary safe care caregivers and commented on the challenge CYCC caregivers faced in navigating the transition of the child into adulthood and the unfeasible expectation of the state for them to now stand on their own feet as independent adults.

Theme 3:

5.2. THE CAREGIVER: Caregiving that demands steadfast love and a relinquishing of control

This theme focuses on the caregiver: what drives them, what their beliefs and values are, how they approach the work of caregiving, and how they navigate the hardship that comes with caring for children who have experienced interpersonal trauma. This theme has been titled 'caregiving that demands steadfast love and a relinquishing of control'. The first sub-theme, 'a parenting approach that loves fiercely and builds attachment' expands on the steadfast nature of the love that caregivers show to the children who are placed in their care. They love the children 'fiercely' by intentionally building attachment and adopting a parenting approach that demonstrates sensitivity to the hard places they have come from. The second sub-theme, 'holding loosely to control in caregiving' expands on the complexities that caregivers navigate because of the temporary nature of placements, needing to navigate relationships with biological families, and coming to terms with their own limitations. Navigating these complexities demand that caregivers relinquish the need to be in control of every situation. Balancing the tension of 'loving fiercely' and 'holding loosely to control' is demanding, therefore caregivers often experienced emotional strain. The need for support and the importance of self-care are expanded on in the last sub-theme.

The following quote captures some of this complexity that comes with caring for children within alternative care placements and that was echoed by many other participants:

> *What we learned from our foster care course was that nobody ever belongs to anybody. Children come into a family, whether they're born into it or come into it for a period of time. It's up to us as caregivers to love them, teach them, give them boundaries, but be flexible enough for them to grow into the person they meant to be; they need to be their own person. You have to love fiercely and hold loosely. (F2, 49 y/o female, foster parent)*

Sub-themes:

5.2.1. A parenting approach that loves fiercely and builds attachment

This sub-theme is titled 'a parenting approach that loves fiercely and builds attachment' as caregivers adopted a unique parenting approach to meet the complex needs of children who have experienced interpersonal trauma, which included putting effort into building attachment. The motivation that fuelled these efforts was a fierce love for the children within their care. Many caregivers viewed their work as a calling. They spoke about how their faith in God motivates them

to love children who are vulnerable and sometimes difficult to love. Many expressed that it was impossible to do this work without love; CYCC caregivers noted that staff who did not love the children they cared for did not last very long in the job. The below quote is the response of a caregiver when asked about her role in the home:

> *By just basically caring for their needs. And that's, I think, my heart, is to bring a child that's hurt and broken into a place where they can join society as a functioning human, you know, with attachment, with love. They know what that is because I gave it to them. No matter what happens after they leave my house, because I have no control over it. That they can go back and say, "Somebody wanted me, somebody loved me," and that's me. (POS2, 34 y/o female, baby home manager)*

Parenting approach

Caregivers spoke about how children who have experienced trauma have unique challenges and needs. Some caregivers shared how the experience of trauma impacts brain development and often results in a sensitised autonomic nervous system response with a tendency to overreact as if they are responding to danger, as highlighted in the quote below:

> *With children who've experienced trauma there is a difference in brain development and the way they perceive the world you know. And that fight flight, freeze response is very, very strong. So it can often be frustrating for a caregiver when dealing with a child, and you think you're just asking, "Tell me why you did that". And they're standing there, not physically able to even get words out. And you're like, "What's wrong with you? Speak to me." Because it shouldn't be such a big thing. But in that child's mind, we often see, like, a very exaggerated experience for them. (CYCC1, 53 y/o female, CYCC manager)*

Due to this understanding, caregivers have learned to parent differently and shared experiences of responding to children's unique developmental, behavioural, and emotional needs. The below quote illustrates a sensitivity to the child's emotional need and history of rejection:

> *You just need to go another extra mile for their emotions. You need to let them talk about their past. You know, my one child was saying, "I miss my tummy mommy". And I said, "I bet she is such a beautiful, sweet lady and I'm sure you look a lot like her". And like there's no reason to say anything negative about their biological family because we don't know the story. Most of the parenting is going to be just like biological, but there will be an extra element of emotion. Because they were rejected. (F3, 50 y/o female, foster parent)*

Caregivers also had to learn how to respond to challenging behaviour; most caregivers shared that they would reward positive behaviour and take away rewards if the child displayed bad behaviour. None of the caregivers utilised any form of physical punishment, particularly acknowledging the backgrounds of abuse. Caregivers also learned how to respond to emotional outbursts, meltdowns, or temper tantrums by trying to respond with calmness and giving the child chances to 're-do', as described in the quote below:

> *When she's having a meltdown and she's got too much in her brain, she's shouting and screaming… you've got to get down to their level and you've got to just be their calm… I've also learned that instead of getting cross with them when they say the most outlandish thing or lie. Instead, I say, "Let's say that again. Let's re-do". It's better to underreact when you have traumatised kids. (F2, 49 y/o female, foster parent)*

Many caregivers spoke about the importance of structure and routine for the children. Therefore, several caregivers had strict meal and sleep times and visual schedules on the walls. They also ensured to prepare children in advance if there was going to be a change in the normal weekly routine. This helped children to know what was expected of them as described in the quote below:

> *The kids are the most secure when they know what it is that's expected of them. In the past, they have not known what is required of them and they've been shouted or screamed at, or like in my son's case, beaten. So they need to know what is required of them. I'm going to wake up in the morning, I'm going to clean teeth, I'm going to wee. And when I come home from school, I do this and then I do that. I found it's very important. We've got a calendar up on the board where we write who's doing what and when. (F2, 49 y/o female, foster parent)*

Caregivers, particularly in the temporary safe care baby homes, recognised the importance of building a sense of self for the child and had strategies in place to ensure that after the child moved into a more permanent placement, they had items that would tell a story of where they came from, as described in the quote below:

> *One of the things that we're trying to do for our kids is, is to really give them a sense of history and a sense of story. So from the very beginning we try help them have a sense of autonomy in such a shared living space… And when they leave, I make a scrapbook for each child, every picture and video we've ever taken, any gift or card or whatever. What we're trying to do is tell the story of that child's life. Anything that has been theirs or has been significant to their story goes with them when they go for adoption. (POS1, 44 y/o female, baby home manager)*

Another way in which caregivers enabled children to build a sense of self is by utilising activities such as swimming, gymnastics, art, sport, etc. Many caregivers noted how beneficial these kinds of activities were for the children's development, sense of confidence, and overall healing from trauma, as expressed in the quote below:

> *With swimming, you won't believe what an enormous difference it makes. Our kids started talking, they were previously only comfortable speaking among their peers and very shy to speak with their house mothers. Now after a few swimming outings, they're chatting to everyone, climbing out of their shell and that's been significant… we've seen so much progress (CYCC2, 29 y/o female, CYCC social worker)*

This quote also highlights that although the work of caring for children who have experienced interpersonal trauma was noted to be challenging, caregivers often made mention of being able to witness children making progress and the joy of being a part of helping them heal and overcome adversity. Several caregivers shared how their work came with needing to make sacrifices, but seeing the children make progress was always worth the sacrifice. Another caregiver described caregiving in the following way:

> *It's the best, hardest thing you've ever done. But I think that's what parenting is. It's the best, hardest thing… Choosing to do what's best rather than what's easiest… And, you know, the grief that comes with this calling is part of the cost… These children are definitely worth the cost. Yeah, it's costly, but it's worth it. (POS1, 44 y/o female, baby home manager)*

Building attachment

Attachment is the bond between the caregiver and the child which makes them feel safe, secure, and protected. Many caregivers spoke of the importance of building attachment with the children within their care, with the understanding that interpersonal trauma disrupts attachment with biological family; therefore, attachment is necessary to heal from trauma. Therefore, many caregivers spoke about strategies and efforts to intentionally work on building secure attachments with the children in their care; this was done by repeating the attachment cycle over and over. The attachment cycle has four phases - (1) infant has a need; (2) infant cries; (3) needs are met by the caregiver; (4) trust develops. Interestingly, one foster parent noted that this applies to older children just as much as it applies to infants as described in the quote below:

> *Every time the attachment cycle happens, it builds wiring into the child's brain that "my voice matters, I'm heard, the world is a safe place, I can trust my caregivers". When you haven't*

had that or even when there has been a disorganised or badly formed set of that, and a child moves into your home for the first time, it doesn't matter the age of the child, you still have to build the attachment cycle, but it just looks slightly different with older children. So one of our older children, for example, who joined us as a preteen… for the first couple of weeks I would get "mom, mommy, mom, mom, mom", just 20 million times a day. Often not even necessarily needing anything. But we learnt you just constantly respond because, again, it just forms that attachment with them. (F1A, 38 y/o female, foster parent)

Two of the caregivers within the temporary safe care baby homes spoke about how they use kangaroo mother care to build attachment with new infants coming into the home. They also highlighted they never left babies to 'cry it out' when they were distressed:

We reduce the effects of trauma in a child's brain by completing that attachment cycle a million times. I don't want babies crying in this house. If someone is crying, then someone needs to be with them. We have a very regimented sleep schedule, but we just don't plop the kids into bed and say, "Cry it out". (POS1, 44 y/o female, baby home manager)

For this reason, the baby homes aimed to have a high staff to child ratio, one home managed to achieve a 1:1 staff to child ratio, and the homes that had a lower staff to child ratios expressed that it was difficult to meet each child's emotional needs adequately.

Many caregivers also noted how attachment is foundational for development as well as learning the ability to form bonds later in life. The children who had difficulties with attachment also had developmental challenges that were very difficult to address:

If a child doesn't have proper attachment, the development is so slow. Attachment is foundational to everything. Language, personality, confidence. Kids that don't have attachment end up failing to thrive. They are, I would say, the worst cases. (CYCC2, 29 y/o female, CYCC social worker)

Some caregivers noted that the interventions, such as psychological counselling or play therapy, proposed by professionals were sometimes ineffective unless they considered this foundational role of attachment. The following quote highlights this and speaks to the difficulty of building secure attachments in CYCCs where there are rotating caregivers:

And I think our children, its trauma, but it's also attachment. And you've got to be looking at it from both. Psychologists work with our children, they often miss the components of

understanding the attachments and how important that is to everything. It is difficult to facilitating healing from trauma when the child doesn't have a secure attachment to their parents and within this context, they have had multiple caregivers, because even if you've been in the same children's home your whole life, your caregivers have changed. (CYCC1, 53 y/o female, CYCC manager)

5.2.2. Holding loosely to control in caregiving:

This sub theme has been titled 'holding loosely to control in caregiving' because caregivers shared many stories of situations in which they had little control over. This will be explained in three short sub-headings which will cover caregivers needing to hold loosely - (1) Due to the temporary and transient nature of placements, (2) In dealing with biological families, (3) In recognising an inability to 'fix' every difficult situation.

a. Holding loosely to control in the temporary nature of placements

This sub-heading speaks to the temporary nature of alternative care placement. Unless the placement moves to an adoption, the court needs to review and renew placements every 2 years. Even if the court decides to rule that the caregiver can have custody until the age of 18, there is sometimes a possibility of the child being reunified with biological family. After the child turns 18 years old, there is no legal tie of the child to the caregiver. Furthermore, since the child is still a 'ward of the state' the court may decide to move the child to a different placement. One placement went through a painful experience of having all the babies within the placement removed from the home during a period that the home was struggling to renew their registration with DSD:

There had been a lot of legislation changes, therefore several homes were struggling to actually renew their certificate. Leading up to our certificate expiring, we had been in contact with DSD and we were told that we don't need to worry. Children won't be removed. You know, that's not in their best interest. Unfortunately, that did not turn out to be true for us. So our certificate expired in February that year and DSD demanded that we remove all twelve children from our home... So that was really unfortunate and horrible for everybody. (POS1, 44 y/o female, baby home manager)

The feeling of 'holding loosely' was more pronounced within the temporary safe care baby homes as, within these placements, children would typically stay for periods of less than 2 years until they could be adopted or reunified; therefore, these caregivers had to 'hold loosely' as they would love them knowing that they would have to say goodbye. Caregivers within these homes expressed that

every time a child left the home, it would take an emotional toll on them, and they had to develop strategies to cope with grief that accompanied saying goodbye, as expressed in the quote below:

> *And, you know, to open ourselves to that and to give these children the power to hurt us by loving them, you know, that's the call. It's a challenge to love these children wholeheartedly, knowing that you will have to release them, and that there are parts of their stories that you cannot control. And it's devastating. So learning tools and having structures in place so that you can emotionally withstand all of the hellos and goodbyes. (POS1, 44 y/o female, baby home manager)*

b. Holding loosely to control when dealing with biological families

Until adoption, there is always a possibility of a child being reunified with their biological family. If the biological parents have not consented for the child to be adopted, they often are given preference of custody if they have rectified the situation that led to the child's removal. Therefore, caregivers often have to interact with the biological families who caused the harm that led the child to being removed. Several caregivers expressed challenges related to having to deal with biological families who were still involved in the child's life, as expressed in the following quote:

> *The children are the easy part. Dealing with the families is very, very, very difficult, especially because they all believe their children were removed in error and you are bringing them up wrong. I think that's, that is one of the biggest challenges, how to deal with that and to be positive with the children and to try to love their family despite what they've done. That is my hardest thing. (F2, 49 y/o female, foster parent)*

c. Holding loosely in recognising an inability to 'fix'

Furthermore, 'holding loosely' also speaks to caregivers needing to come to terms with their limitations and recognise that it is not in their power to fix every broken situation. Caregivers reflected on needing to reframe their expectations, let go of situations that were out of their control, and find peace when a situation was not resolved in the way they hoped it would. Several caregivers shared how parenting children who have experienced trauma was more challenging than they anticipated at the beginning, and they often felt they were ill equipped for many situations, as expressed by F5 below:

> *I'm the one who's got to fix everything. And it's very difficult because I haven't been able to fix these kids and I never will be able to… but if I had known, when I did the foster care course, we weren't warned about that. Because you don't think about it, you think, "Oh, this*

poor little child, I'm going to fix them with love", and you can't fix them with love... And I mean, just that feeling of hopelessness where, this child is hurting and needs to be fixed, and I can't fix them, and I don't even understand what is hurting them. (F5, 47 y/o female, foster parent)

Many caregivers shared difficulties with coming to that realisation, and spoke about situations which led to burnout before they sought counselling or help for themselves.

5.2.3. **Importance of support & self-care**

A reoccurring mention was made regarding the need for more support in many different forms by the majority of caregivers. Many of the caregivers highlighted the void of support from social welfare services (noted in Theme 4). Some expressed a loneliness in their work and expressed the need for counselling services and debriefing after difficult experiences. Those who accessed counselling and debriefing shared how valuable they found it. One male foster parent described the need for more support with the following insights:

Because parents think they can do it all, but you can't. You've got a child now that needs your full attention, support team would be important. And I'd make counselling mandatory for everyone post fostership… In a normal environment, you would have the 9 months of pregnancy, right? In that time, your mom, your grannies, your neighbours, everybody's giving you a lot of input. And then the baby's born and mom stays over and granny stays over. You have support post pregnancy. It's very different when it's a foster child because you've skipped that whole section of building those skills. You now have the child because you don't have clean slate child. You have a child with baggage. Your mom's advice, your granny's advice, limited at best. (CYCC4, 35 y/o male, foster parent and CYCC owner)

Several caregivers mention the importance of seeing a counsellor or having opportunities to debrief. The below quote was shared by a caregiver who reached burn out before she sought help, and now advocates for the need for counselling and spaces to debrief the situations that are beyond her ability to fix:

You should have a counsellor. You need to debrief. You need somebody who's going to say that your mental health actually matters. Because in our field, we are carers. And so we are constantly putting our children's needs before our own, even the need to eat or sleep. I had burnout, because my brain literally said, you will not do anymore. And I couldn't, I could not

do basic things. We worry about our kids all the time and we stop worrying about ourselves. (POS2, 34 y/o female, baby home manager)

Several caregivers spoke about the emotional strain from needing to process multiple hard stories of the children placed within their care, as described in the quote below:

One of the things that surprised me was living with constant trauma. You can't shut your eyes to that level of pain, you are bombarded with it all the time. You are faced with your own children's trauma, which crops up all over the place… and faced with some of the horrendous things that are done to children. I never considered the impact that kind of facing that on a day-to-day basis would have… And so you learn kind of strategies to cope and I think we get better and better at it. But I have moments that are really dark… (F1A, 38 y/o female, foster parent)

Therefore, several caregivers commented on the importance of self-care, this is as basic as trying to get enough sleep, remain hydrated and eat regular meals, as described in the quote below:

Self-care needs to be practical because people told me, "You need to look after yourself". That is not helpful. I have a kid in hospital. I have a kid that passed away. What does this actually look like? Then somebody said to me, "You need to drink five glasses of water a day, and you need to eat three meals a day", and that was helpful, because it's practical. (POS2, 34 y/o female, baby home manager)

The value of support from the community

"It takes a village to raise a child" is an African proverb which speaks to the role of the surrounding community in the life of a child. A couple of the caregivers mentioned this phrase, and many spoke of the practical, emotional, and financial help that they have received from their surrounding 'village'. They spoke about how it is impossible to do this work on their own and they shared many stories of how their families, workplaces, and communities come around them and support them, as illustrated in the quote below:

And my family has been unbelievably supportive for us personally. My mom, bless her, she worked night shift for us for 3 months just because we were not coping and I did not have capacity to hire somebody. And so my mom stepped in and worked, literally worked night shift for us for 3 months. When we've been in trouble, we can just phone and say, "Hey I need help," and they'll show up. (POS2, 34 y/o female, baby home manager)

Caregivers within institutional care settings spoke about the value of having staff who support one another and work as a team. Some caregivers spoke about how the surrounding community would respond to request for donations or practical help with maintenance or would volunteer time to assist with tutoring or specific child caring tasks. One temporary safe care baby home was based in a house owned by the church on the neighbouring property. The below quote highlights the various ways in which the church supported the work of the home:

> *We pay nothing pretty much for rent. So that's their main contribution to the house. That's how our church directly supports us. They also have bailed us out, they did renovations on the house for us. Yeah. So, the money between the church and the baby house kind of flows to the baby house. We're allowed to use the property; we can use the sandpits. Children love the sandpits. So, yeah, it does give us a much larger place to play. (POS2, 34 y/o female, baby home manager)*

One critical way in which the 'village' provided support was in the form of financial contributions. Caregivers shared the many expenses required to provide adequate care to children within alternative care. These expenses included expensive formula milk, transport expenses, medical expenses, private schooling which accommodated for special needs (or was the only option as the government schools were full), the cost of therapy where needed, extra-curricular activities, the cost of nappies and food with adequate nutritional value, the cost of employing staff or sourcing training, among others. Many caregivers made mention of how the lack of finances has limited them in their ability to provide care and how having access to finances enabled them in providing care. The below quote highlights the cost of accessing private healthcare services and how caregivers are often restricted in trying interventions which may be helpful due to the lack of finances:

> *Even my own kids' journey, we have tried probably 8 to 10 different kinds of therapists. I would say of those, I've been happy with 3 of them. But now by the time you figure out you're unhappy, especially with a psychological therapist, you've probably had six sessions that have cost you a grand each. What foster parents have that money? Very few. It's not a lot of rich people that do this. So that's very difficult. It's quite risky to try anything new because you don't know how it's going to go. And then that's your budget for that finished. (F4, 37 y/o female, POS & cluster foster care manager)*

In conclusion, this theme covered the role of the caregiver, how they are motivated by love, how they have learned to parent differently, how they put intentional effort into building attachment,

and how they have learned to recognise their limitations and navigate relationships with biological families. This theme also looked at the need for more support and the importance of self-care. Lastly, caregivers are not able to do this work alone; the value of the support from the surrounding community was noted, including that of financial provision.

Theme 4:

5.3. THE SYSTEM: Navigating the child protection system that can perpetuate trauma

This theme will explore the broader child protection system which caregivers within alternative care need to navigate. The theme is named 'navigating a child protection system that can perpetuate trauma' as caregivers experienced that the child protection system at times fails to act in the best interests of the child, and in doing so can perpetuate trauma in both the child as well as the caregivers by disempowering the people and organisations at the forefront of providing care to vulnerable children.

The sub-themes will expand on the shortcoming of child protection services, how caregivers felt powerless when facing bureaucratic decisions which lead to caregivers experiencing secondary trauma.

Sub themes:

5.3.1. The shortcomings of child protection services

There was an overall disappointment expressed by caregivers in the child protection system, along with a distrust of the people who held the power to make important decisions with regards to the care of children placed in alternative care. Despite the Children's Act mandate to act in the 'best interests of the child', caregivers shared many examples of child protection services failing to do so, as expressed in the quote below:

> *There are a lot of personal agendas and ideologies about care for orphan and vulnerable children that are deciding bureaucratic, and legislative changes and drives that are actually not in the best interests of children. (POS1, 44 y/o female, baby home manager)*

Caregivers shared many challenges with the DSD and trying to navigate the child protection system. These challenges included trying to work with social workers who are overburdened and therefore ineffective, distressing Children's Court experiences, barriers to adopting children, challenges with administrative delays, a profound lack of training, and little attention being put into

reunification efforts. Furthermore, in the new financial year (April 2023), the DSD announced that their priority areas have changed which resulted in a shift of funds away from many NPOs doing child protection work. The following caregiver reflected on the impact this will have in the quote below:

> *So now with now the CPOs that's funding is being cut off, there will be fewer social workers trying to manage an already overloaded case load. So kids are not going to be removed when they should be, and the abuse, the neglect all those things are going to increase, like skyrocket, and there are not going to be enough hands to handle these caseloads… Kids are going to die. I'm sorry, but I can't see how this is a win. (CYCC2, 29 y/o female, CYCC social worker)*

This quote highlights how a decision made at government level has a knock-on effect from de-capacitating the CPOs to impacting services on the ground trying to combat violence against children. Delays in removing children from abusive situations or not having enough alternative care placements for children to go to are examples of how the trauma experienced by children is perpetuated.

Several caregivers experienced a clash of ideologies with social workers or judges that would hinder the possibilities of children getting adopted. Most of the caregivers believed that adoption would achieve long-term family and permanence and is therefore the best outcome for a child placed within alternative care. Therefore, felt frustrated when they faced resistance towards adoption within the child protection system. Furthermore, none of the caregivers interviewed had seen much effort put into reunification work, as expressed in the quote below:

> *Social workers in their own personal capacity not being pro adoption, so they're happy to just renew court orders. You know you go to court every two years, renew the order. And there are no real programs that really work for reunification. It isn't a big focus. DSD and the Children's Act say children should be reunified with families, and rightly so, they should, but if we're not putting the effort into fixing what went wrong in the first place, it's not going to change. (CYCC1, 53 y/o female, CYCC manager)*

Caregivers shared a frustration that important decisions which impacted their work were being made at a level that was disconnected from the reality of what was happening at the level of the child. For example, the CYCC caregivers shared how the DSD kept changing the requirements that the CYCCs needed to comply with to keep their registration. Caregivers noted that it is often costly to meet requirements, and they would lose out on funding until their registration was renewed. This

has resulted in many CYCCs being closed in recent years. Some caregivers held the assumption that these strict regulations were implemented in an effort to close CYCCs as policies preferred foster placements over institutional care. In the below quote, the caregiver reflects on the difficulties they had in renewing the centre's DSD registration the previous year:

> *The people that are making the big decisions in the government, have no idea what's happening actually on the ground. We were cut off from our funding because we weren't registered, but we kept submitting everything and they kept coming with new things that we didn't have. Because they want to shut down CYCC's and I understand, in a perfect world we wouldn't have CYCCs. We wouldn't have foster families. We would just have families. But we don't live in a perfect world. And they already have kids waiting for foster families and there's no one. So where would these kids go if they close us down? (CYCC3B, 30 y/o female, CYCC development & stimulation coordinator)*

Caregivers within the alternative care system are governed by legislation, court rulings and procedures and protocols, all of which they have little say in or control over. Several caregivers felt disempowered within the child protection system, as they had no authority to make the important decisions, yet had to bear all the responsibility of them, as described in the quote below:

> *I think that it can often feel as though you have all the responsibility and no authority. The statutory social worker, DSD, the children's courts are all telling you how to do things. They are the role players who have authority, but they don't even necessarily know the children. Because the way it works is we've got custody, but they're still wards of the court, so we can make decisions around their day to day, but the big decisions of this child must be adopted, this child must be reunified, we've got no say in it. (CYCC1, 53 y/o female, CYCC manager)*

5.3.2. **The experience of secondary trauma**

This feeling of disempowerment within the system often results in the experience of secondary trauma. For example, one caregiver, who took custody of her brother's children when they were removed from the household due to severe neglect and both parents being drug addicts, shared her experience of the system in following quote:

> *I have to say that the trauma that I went through myself just to get custody of them was, was not cool… So I think that the, the thing that was really difficult was that I was trying to help these kids, but I was perceived as the bad person. (F5, 47 y/o female, foster parent)*

One caregiver defined trauma in the below quote:

> *Trauma is when something that you perceive as life or self or identity threatening is happening, and you don't have the ability to fight against it (F4, 37 y/o female, POS & cluster foster care manager).*

She then went onto explain that within this work, there are many situations that caregivers experience that they did not have the ability to fight against, such as working within a disempowering child protection system with little support. These situations included incidents of the court ruling for the child to be reunified or moved to another placement, not having the authority to make important medical decisions for children within their care, or what state the child is in when they are placed in the home, among others. The below quote by POS1 which describes her reflection on the situation mentioned previously of having all the children removed by DSD:

> *We did the best that we could do with what were given. There were so many things that were outside of our circle of control, and we did what we could and made ourselves available to sit with our children through the trauma of those transitions to the best of our ability and then had to release them. So, yeah, it was pretty rough. (POS1, 44 y/o female, baby home manager)*

This theme highlights the many system level challenges as well as the many gaps in service provision which caregivers experienced as barriers to providing care to children who have experienced interpersonal trauma. Furthermore, it highlighted that the powerlessness that caregivers felt in the big decisions that lead to experiencing secondary trauma.

5.4. Research objectives

To conclude this chapter, a summary of the findings related to the research objectives is presented below:

Caregiver's challenges

Caregivers faced several challenges within their homes related to providing care to children who have experienced interpersonal trauma. These challenges included difficulties navigating the effects of trauma on development, behaviour, and attachment as described in the first theme. Furthermore, caregivers faced several challenges due to the lack of support from various external structures. These challenges included a lack of availability of trauma-informed services and a lack of training and support provided by social welfare. Caregivers faced numerous challenges with

DSD, including barriers to adoption, changes in regulations resulting in children being removed, and many financial constraints which were exacerbated by a withdrawal of funding by DSD this year as noted in the third theme. Several caregivers expressed experiencing secondary trauma because of needing to process many difficult situations from which their children came from, as well as from working within a disempowering child welfare system.

Factors which have aided caregivers

As described in the second theme, majority of caregivers noted that the support of their surrounding communities to be the greatest facilitator that supported their work in caring for children who have experienced interpersonal trauma. Their communities helped to provide practical, financial, and emotional support. Several caregivers accessed counselling, debriefing, and psychosocial support services which they found very beneficial. Within the larger homes, having a high staff to child ratio was beneficial and teams who supported one another were also noted to be valuable. Furthermore, several caregivers found that the training they had sourced was beneficial, which aided in helping them to better understand attachment and trauma, and how to use structure and routine within their parenting approach.

Skills and support required by caregivers

In terms of skills, many caregivers viewed their work as a calling; therefore, a strong sense of purpose and ability to love children who were sometimes difficult to love was often noted as an essential skill. The ability to communicate well with their children or when dealing with biological families was noted. The ability with withstand the emotional strain of children coming and going in the shorter-term placements was important. In terms of support, caregivers noted that more training, which was practical and repeated, would have been helpful. Psychosocial support in the form of debriefing or counselling was noted to be essential. More financial support was always needed to adequately meet the children's complex care needs.

5.5. **Summary of the chapter**

The findings were presented in 4 themes. In theme 1, the child's experience of interpersonal trauma and its pervasive impact on development, behaviour and attachment was explored. In theme 2 the way in which foster homes, temporary safe care baby homes, and CYCCs were structured towards long-term family was presented Additionally, the need for trauma-informed services and training was noted. In theme 3, the caregivers' ability to 'love fiercely' and to 'hold loosely' was demonstrated, as well as the need for support was highlighted. In theme 4, the overarching child

protection system (and its failings) was presented, including the challenges that caregivers face in navigating this with little authority, which lead to caregivers experiencing secondary trauma.

Chapter 6: Discussion

In this chapter, the findings presented in Chapter 5 are discussed in relation to the conceptual framework and the relevant literature. In Chapter 2, Bronfenbrenner's (1977) Ecology of Human Development model was introduced in relation to the study area and each ecosystem was defined. The ecosystems are used to structure this chapter.

6.1. The individual

THE CHILD: The pervasive impact of trauma on children from hard places

The first theme considered caregivers' experiences in relation to the child who is placed within alternative care. In relation to the diagram in Chapter 2, this refers to the child who experiences a primary trauma and is embedded within the concentric rings representing the multiple layers of environments.

The varied traumatic experiences of children which led them to be placed within alternative care were explored, these included neglect, abuse, abandonment and often a multi-layered experience of interpersonal trauma. These traumatic situations have been termed 'hard places' in the theme tile. The term 'children from hard places' was originally coined by Dr Purvis (2014) to describe children who have had a difficult upbringing, which often results in these children being difficult to parent. The findings noted that this trauma was often compounded by a slow response of child protection services which delays the removal or placement of children in need of care and protection. Similarly, a report by The Children's Institute tracked child abuse in South Africa and found a high prevalence of abuse and many of these cases were poorly responded to by child protection services. This report concluded that "violence against children is a pervasive problem that affects many children in South Africa" (Jamieson et al., 2017a, p. 7). Furthermore, a systematic review of 10 years of literature sought to describe the current landscape of child protection services. This review highlighted that the system inadequately responds to the daily reality of violence perpetuated against children due to being poorly resourced (Strydom et al., 2020).

Caregivers explained that every child placed within alternative care has experienced the trauma of being separated from their biological mother. Spinazzola et al. (2018) term this trauma as an 'attachment disruption' within the primary caregiver relationship. A review of current literature by Naeem et al. (2022) supports this from a neurobiological perspective. Several studies have shown that early-life adversity, particularly separation of an infant and their biological mother, causes an

influx of stress hormones which can disrupt brain development leading to pathology and maladaptive behaviours later in life (Naeem et al., 2022).

Subsequently, caregivers experienced many challenges navigating the impact of these traumatic experiences on the child's health, development, behaviour, and attachment. The pervasive impact of trauma is consistent with findings from other studies that looked at the detrimental long-term effects of childhood adversity (Anda et al., 2006; Kisiel et al., 2014; Spinazzola et al., 2018). A discussion on the DSM-5 diagnostic criteria of trauma- and stressor-related disorders and concluded that "children exposed to trauma exhibit a wide variety of symptoms and domains of impairment" (Virginia Commission on Youth, 2017, p. 3). Spinazzola et al., (2018) reported that the combination of interpersonal trauma and separation from a caregiver has been shown to impact children's ability to master age-appropriate skills, emotional regulation, functioning in relationships and other psychosocial skills.

The findings on the pervasive impact of trauma further emphasize the need for a suitable diagnosis that adequately describes the impact of complex trauma within the foundation years of development as described in several studies (Atchison & Morkut, 2005; Ford et al., 2022; Spinazzola et al., 2021). A comprehensive diagnostic criterion will better equip caregivers and health professionals in understanding the needs of children who have experienced interpersonal trauma and enable more suitable treatment interventions to be developed.

The last sub-theme explored caregiver's need for the trauma-informed services as many caregivers had difficulty accessing services that adequately met the complex needs of the children with their care. This links to the exosystem in Bronfenbrenner's model as the lack of appropriate services available has an impact at the individual level. Beyerlein and Bloch (2014) envision trauma-informed service delivery to be a practice where all staff develop an understanding and maintain awareness of the impact of traumatic experiences. This understanding will lead to appropriate responses, screening practices, training, treatment and policies. The findings highlighted that within the South African context, many of these services are overburdened and under-resourced and practitioners and staff are likely to have experienced trauma or secondary trauma themselves (Strydom et al., 2020).

Finally, the need for caregivers to be better capacitated and equipped with training was noted in the findings. This is mentioned within other studies, for instance Van der Walt (2018) explains that the children who are placed within alternative care are more likely to have behavioural and emotional challenges as they come from broken and dysfunctional families. Therefore, it is of

utmost importance that caregivers are supported with training to equip them with the skills to look after these children. Van der Walt's (2018) study similarly found that very few caregivers have received any formal training rendering them incapacitated to deal with potential crises that may arise. Trust based relational intervention (TBRI) is a relevant intervention strategy designed to provide caregivers with evidenced-based approaches for parenting children from hard places (Purvis et al., 2013). Several studies have demonstrated its effectiveness in decreasing trauma-symptoms and difficult behaviours in children who have experienced complex interpersonal trauma within childhood (McKenzie et al., 2014; Purvis et al., 2014, 2015).

6.2. The microsystem

The child is embedded within the microsystem, which is made up of the child's immediate home environment which includes the primary caregiver. Within the microsystem, the findings from Theme 2 which described the alternative care placements, and Theme 3 which focused on the caregivers' role and approach are discussed below.

THE HOME: Structuring placements towards family and permanence

The findings within this theme outlined how caregivers responded to trauma with the intention of creating a microsystem environment that was safe, loving, and sought to provide the child with a long-term family environment where possible. This approach is in line with an international move away from institutionalized care for children (De Silva & Punchihewa, 2011; United Nations, 2010). The findings from this study contrast the opinion of Perumal and Kasiram (2008) who argue that children's homes have greater infrastructural support and therapeutic interventions in contrast to foster care families who are often constrained by poverty.

This theme explored the challenges of institutional care expressed by CYCC and temporary safe care caregivers. The detrimental effects of institutional care for children have been well documented (Berens & Nelson, 2015; De Silva & Punchihewa, 2011; UNICEF, 2003). However, within the South African context, caregivers expressed the view that larger CYCCs homes are needed to accommodate the large numbers of children in need of care and protection, as there are not enough foster parents to accommodate children within foster care alone. This sentiment is similarly expressed by Huynh (2014, p. 3) who raised a concern that "policymakers may be shutting down some of the most important care structures for children in under resourced countries". The findings highlighted that caregivers often faced barriers to adopt children, that very little effort is being put into reunification efforts and that CYCCs are systematically being shut down by continuous changes in registration requirements. Therefore, this highlights the need for DSD to

give more careful consideration into efforts that move children towards long term family placements and capacitating existing placements to provide quality care.

One avenue available for a child to move into a long-term permanent placement is adoption. The findings showed that adopting a child, particularly older children, can at times be difficult to achieve as they faced resistance from some of the key role players within the child protection system. A study done by Luyt and Swartz (2022) explored the implementation of adoption policies and highlighted that adoption is a practice fraught with conflicting beliefs and many role players (Luyt & Swartz, 2022). Similarly, a review of adoption trends in South Africa concluded that adoption rates are low in comparison to other countries, considering the high numbers of children within the alternative care system. This was likely due to socio-cultural preference for kinship care, social worker attitudes, and the heavily bureaucratic process involved in adopting a child (Mokomane & Rochat, 2012). These conflicting beliefs and bureaucratic barriers are examples of an interaction between the caregiver within the microsystem and role players within the exosystem that impact on the child at an individual level.

THE CAREGIVER: Caregiving that demands steadfast love and a relinquishing of control

This theme covered the role of the caregiver and the parenting approach they adopted. The caregiver is the most essential element of a child's microsystem, and the importance of the child-caregiver interactions are highlighted often throughout Bronfenbrenner's work (Rosa & Tudge, 2013). Despite their essential role, caregivers' experiences, motivation, and rationale behind their parenting approach within the context of alternative care is seldomly documented in literature.

The findings highlighted how caregivers love the children within their care 'fiercely', how they have learned to parent differently, how they put intentional effort into building attachment as they recognised the foundational role attachment plays in healing from trauma. The theme of attachment appears frequently within literature on trauma and alternative care. The available literature is congruent with the study findings in emphasising the importance of attachment (Dobson & Perry, 2010) and describing the effect of disrupted attachment leading to interpersonal trauma (Grady et al., 2017; Kisiel et al., 2014; Spinazzola et al., 2021). The findings from this study add the caregiver's voice to the literature on attachment by describing their efforts in consistently building attachment (even with older children), the foundational role of attachment in development, and the shortcoming of therapeutic interventions that do not consider the role of attachment in promoting healing.

Furthermore, the concept of 'holding loosely to control' was explored in how caregivers have needed to navigate the temporary nature of placements, communication with the biological families of children who have been removed and coming to terms with their limitations or inability to rectify situations that caused harm to themselves or the children. Other than a couple of quantitative studies which considered caregivers perspectives on placement breakdown (Gilbertson & Barber, 2003) and factors influencing caregiver strain (Leake et al., 2019), there is little documented in literature about caregivers' experiences of handling these complexities within alternative care. Navigating these challenges tended to cause caregivers to take emotional strain.

The experience of emotional strain and the importance of self-care were frequently mentioned concepts in the findings. The concept of 'caring for the caregiver' occurs occasionally in general healthcare literature (Tamayo et al., 2010). The findings from this study also highlighted the need for caregivers to be cared for as they frequently experience emotional strain caring for children who have experienced trauma. Similarly, a study by Leake et al. (2019) looked into what factors are required to reduce caregiver strain among foster, kin and adoptive parents. This study found that in order to mitigate caregiver strain and prevent burnout, caregivers required (1) access to trauma-informed health professionals, (2) counselling services for themselves as well as their children, (3) formal training to increase trauma-related competencies, (4) tangible resources such as housing, food and financial assistance, (5) social support from friends, family and other caregivers doing similar work, and (6) access to respite care. All of these factors were also noted by the caregivers within this study, however Leake et al.'s (2019) study was conducted in the United States where some of these factors may be provided through state services, in contrast to South Africa where these need to be self-sourced by caregivers and are virtually absent within the state child protection system.

6.3. The mesosystem

Within Bronfenbrenner's model, the mesosystem is the interactions between the various microsystems in which the individual interacts. The findings demonstrated the value of support given by the surrounding community, and a shared sentiment among caregivers that they are not able to do this work alone and that 'it takes a village to raise a child'. This proverb is rooted within the African ethic of *Ubuntu* and captures the interdependence and interconnectedness of humans which stands in contrast to the individualistic and independent culture of the West (De Beer, 2015).

Caregivers found the absence of state support and poor fragmentated services challenging. Therefore the need for a robust, intentionally created, surrounding community to support caregivers

in the work of providing care for children who have histories of complex trauma and have complex needs cannot be understated. An article by Reupert et al. (2022) advocated for a 'village' approach to supporting families experiencing adversity. This article also draws on Bronfenbrenner's model in defining the village and drawing out helpful principles to define what support for families can look like when the surrounding community is connected to both the caregivers and the children. These principles include promoting caregiver's agency and empowerment, giving children a voice, and celebrating caregiver's and children's strengths. Reupert et al. (2022, p. 1) concludes that there is a "need to move past a siloed, professional centric approach when working with families".

The need for more support for caregivers was a prominent theme in this study. Applying Reupert et al.'s (2022) 'village approach' may enable us to consider what this support can look like if the resources from the surrounding community are strengthened, and we begin to move away from a reliance on fragmented professional services. Furthermore, the findings highlight the need for trauma-interventions to be developed within the South African context, as there are strengths that exist in communities that can be utilized and may contrast Western developed individualistic approaches.

6.4. The exosystem

THE SYSTEM: Navigating a child protection system that can perpetuate trauma

Theme 4 considered the shortcomings of the child protection services. Caregivers highlighted system-level challenges and the many gaps in service provision which caregivers experienced as barriers to providing adequate care to children who have experienced interpersonal trauma. At an exosystem level, the various role players and institutions that are disconnected from the individual's immediate environment but still impact significantly on the development and well-being of the individual are considered (Bronfenbrenner, 1977).

Caregivers described the shortcomings of DSD, social workers, children's court and the child protection system in general. These shortcomings have been documented across other literature (Jamieson et al., 2017a; September, 2006; Van der Walt, 2018). September (2006, p. 67) describes South Africa's child protection system as a "system in disarray" resulting in the occurrence of traumatized children being exposure to further abuse. The article concludes that systematic attention needs to be given "to societal structures and systems that predispose children to abuse, neglect and exploitation" (September, 2006, p. 71). Van der Walt (2018) states that the child protection system is overburdened and is therefore failing the neglected and abused children who are in desperate need of the services of overwhelmed social workers and Children's Court.

Furthermore, this theme highlighted caregivers' experience of feeling powerlessness in being unable to influence decisions that were made by the various bureaucratic role players about the children within their care. This sense of powerlessness often led to the experience of secondary trauma. The experience of secondary trauma from bearing witness to many difficult stories and from repetitive exposure to others' experiences of trauma has been documented in other studies (Bridger et al., 2020; Hannah & Woolgar, 2018; Rienks, 2020), and are consistent with the findings from this study. Additionally, this study found that caregivers also experienced secondary trauma from efforts navigating a child protection system in "disarray" (September, 2006), with limited training or support and with, at times, conflicting ideologies and has been shown throughout the findings of this study. This demonstrates the urgent need for support and capacitating of caregivers at the forefront of child protection work, as well as urgent attention to be given in capacitating the various role players within the child protection system, including DSD, Children's Court and CPOs.

6.5. The macrosystem

At a macrosystem level, the broader South African context, relevant policies, and ideologies around childcare are considered. Moodley et al. (2020) highlights that South Africa's complex sociopolitical needs to be considered as a backdrop in alternative care system. Apartheid law contributed towards the incidence of labour migration, poverty, unequitable healthcare delivery, education and work opportunities, and low marriage and cohabitation rates. These macrosystem factors impact on the modern family structure, child care approaches, prevalence of neglect, abuse and abandonment, and access to services (Hall & Sambu, 2018; Sooryamoorthy & Makhoba, 2016).

In terms of ideologies around childcare, the findings highlighted challenges related to adoption and incidences of CYCCs being closed. Luyt and Swartz (2022) explain that kinship care is much preferred culturally within South Africa, but when the capacity of these traditional, informal networks become depleted, the number of children requiring formal alternative care placements increases. Therefore, the many cultural ideologies around childcare and the perceptions of different role players of what is actually 'in the best interests of the child' also factor into these macrosystem influences.

In relation to South African policy, studies conducted by the Children's Institute conclude that despite comprehensive law and policy, poor implementation has led to the child protection system failing to protect children (Jamieson et al., 2017b). The Children's Act is the primary

policy document that governs the alternative care system (Gudula-Koyana & Khanye, 2019; Children's Act, 2005), however this policy does not provide any structure and guidance regarding how caregivers within the system should be supported. The National Policy Framework for Families makes mention of strengthening support given to biological families as well as foster caregivers in order to promote reunification efforts, however these efforts were noted to a pilot intervention and evidence of their implementation cannot be found in literature (National Policy Framework for Families, 2001). Therefore, while South African policies are geared towards promoting the best interests of the child, little exists within policy to provide guidance on how caregivers within the alternative care system should be equipped or supported. This policy gap provides an explanation for the findings related to the vacuum of support and training provided by social welfare services to caregivers.

6.6. The chronosystem

The chronosystem considers how these ecosystems change over the individual's lifespan. The findings highlighted the challenge of caregivers trying to navigate the critical developmental transition from childhood to adulthood. The second theme highlighted caregiver's concern for children when they age out of the system within the context of a CYCC. These concerns included the withdrawal of state financial support, and the expectation that children with developmental challenges are now expected to forge their own path into adulthood. A review of literature on care-leaving from residential CYCCs in South Africa highlighted that there is very little policy available on care-leaving, that many care-leavers felt inadequately prepared for independent living, experience a loss of the social structure they previously had, many ended up living in informal dwellings, and even fewer succeeded in living independently (Van Breda, 2018). Similarly, a study by Goemans, et al, (2021) considered both the perspectives of caregivers and of teenage youth in the foster care system and found there was a tension between the youth's desire for independence and the need for interdependence. From both caregivers and care-leaver's perspective, more attention needs to be given at a policy level to provide guidance and structure to caregivers and youth to navigate the transition from childhood to adulthood and thus out of the child protection system (Goemans et al., 2021; Van Breda, 2018).

6.7. The need for an ecosystemic approach in supporting caregivers

In conclusion, Bronfenbrenner's model (1977) has illustrated the complex interactions between the various ecosystems in which the caregiver navigates in their role of providing care to children who have experienced interpersonal trauma. The discussion argues that caregivers within alternative

care aim to provide care in such a way that children are able to heal from trauma. However, doing so with limited support and poor service delivery within a child protection system that at times perpetuates trauma and as a result caregivers tend to experience secondary trauma. Therefore, when considering what is required to support caregivers within alternative care, an ecosystemic approach needs to be taken in order to ensure structures and strategies exist at a micro-, meso-, exo-, macro, and chronosystem level.

Chapter 7: Conclusion

7.1. Limitations

There are a few limitations to this study. Firstly, there was a lack of diversity within the sample group which may be due to several reasons. It is likely that due to the nature of the work, a majority of white females tended to fill the caregiver role within the alternative care homes. Alternatively, due to utilizing the WhatsApp group primarily for sampling, there may have been an existing racial bias on the group. Alternative sampling methods could have been explored. Therefore, the sample group lacked more demographic diversity of race and gender. The researcher used snowballing to identify further participants which meant that several participants knew each other, and sometimes held similar perspectives as they likely had conversations about their experiences with each other.

Secondly, this study only covered the experiences of caregivers within registered, formal alternative care placements. Therefore, the findings may not be generalised to include informal alternative care placements such as kinship care or child-headed households, which occur frequently within the South African context. Thirdly, this study only considered the caregivers' experiences; there would be value in further research that explores the child's experience or the experiences of statutory social workers involved in finding placements for children.

Lastly, the context of this study was within an urban, high-density context; therefore, transferability of findings may not be extended to alternative care homes based within more rural settings which may not have access to the same services or infrastructure as Gauteng.

7.2. Recommendations for practice

This study highlighted the need for trauma-related training and capacitating of caregivers within alternative care as noted in the first theme, under the sub-theme 'caregiver's need for trauma-informed services and training'. Training which involves ongoing mentoring and support should be considered by the DSD and CPOs involved in child protection work.

Furthermore, it highlights the need for emotional, financial, and practical support for caregivers as noted within the third theme within the sub-theme 'importance of support and self-care'. Respite care options, counselling, and debriefing services would aid in buffering the emotional strain faced by caregivers.

The fourth theme highlighted the shortcomings of the child protection services delivered particularly by the DSD; therefore, several recommendations with regards to policy implementation and the need for reform of social services can be made.

7.3. Recommendations for future research

There is a need for more research on the topic of interpersonal trauma in childhood within the South African context. Research which explores the underlying reasons for the high prevalence of neglect, abuse, and abandonment would be beneficial. Furthermore, research into contextually appropriate methods of facilitating healing from the effects of trauma in childhood would add value in this field.

There is a need for quantitative studies to provide updated statistics on the number of children needing placements, the number of children within the alternative care system, and the number of placements that have closed in recent years as compared to the number of new placements. This information would aid in providing an indication of how overburdened the system is in order to advocate for more resources.

There is a need for further research into what can trauma-informed care could look like within the South Africa context. The use of action research could be beneficial in developing, implementing, and monitoring a programme that would meet the training and support needs of caregivers working within alternative care.

7.4. Conclusion

This study has explored the experiences of caregivers who are providing care to children who have experienced interpersonal trauma within an under-resourced and under-capacitated child protection system. The findings highlighted the challenges that arose from the pervasive impact of interpersonal trauma on children's development, behaviour, and attachment and how caregivers responded to these challenges. The challenge of navigating the child protection system with little support, as well as of accessing trauma-informed services was also explored. The practical, emotional, and financial support from the surrounding community was identified to be the greatest facilitator that capacitated the caregivers' work. Ongoing trauma-related training and mentoring would aid in reducing the impact of secondary trauma experienced by caregivers.

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APPENDIX A: Information letter

UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa
Tel: +27 21 959 2809 Fax: 27 21 959 2872
E-mail: soph-comm@uwc.ac.za

Project Title: Caregivers' experiences of providing alternative care to children who have experienced interpersonal trauma in Gauteng, South Africa

What is this study about?
This is a research project being conducted by Erica Ann Bourn at the University of the Western Cape. We are inviting you to participate in this research project because you are a caregiver who is currently caring for children who have experienced interpersonal trauma within one of the following registered alternative care placements: Foster Care, Child and Youth Care Centre or temporary safe care placement. The purpose of this research project is to explore caregivers' experiences of providing alternative care for children who have experienced interpersonal trauma in relation to their physical, attachment and behaviour needs.

What will I be asked to do if I agree to participate?
You will be asked to share your experiences within a semi-structured interview which will be approximately 1 hour in duration. The interview will only be conducted in English and the location of the interview will be decided upon between you and the researcher: it can either be in-person at a location chosen for your convenience or over a Zoom call if preferred. The interview will be audio recorded with your consent. In the interview, you will be asked preliminary questions about the kind of care placement in which you provide care for children, and from what kind of circumstances the children you care for have come from, in order to provide insight into the nature of interpersonal trauma experienced. In these questions, you will be asked to refrain from using any of the children's names or specific identifying information such as their birth location or unique personal characteristics to protect their identities in the research. Thereafter, questions about factors which help or hinder your ability to provide for the children's physical needs such as nutrition and safety, attachment or relational needs, and behavioural needs will be asked.

Would my participation in this study be kept confidential?
The researchers undertake to protect your identity and the nature of your contribution. To ensure your anonymity, neither your name nor the name of the care placement will be included in the data collected. A pseudonym made up by the kind of placement (foster care, CYCC or temporary safe care) and a number will replace your name on all transcribed data, and only the researcher will have knowledge of the correlating names.
To ensure confidentiality, all audio recorded data will be stored on the researcher's laptop in a password protected folder and will be named according to the above-described pseudonyms. If any transcription is outsourced, the transcriber will be asked to sign a confidentiality agreement. Your name, the placement name, and any specific identifying information will not appear within

the research write up or any publications. If we write a report or article about this research project, your identity will be protected.
In accordance with legal requirements and/or professional standards, we will disclose to the appropriate individuals and/or authorities' information that comes to our attention concerning child abuse or neglect of children within your care or potential harm to you or others. In this event, we will inform you that we must break confidentiality to fulfil our legal responsibility to report to the designated authorities.

What are the risks of this research?
There may be some risks from participating in this research study. In sharing experiences of caring for children which may have been difficult during the interview, you may experience some psychological or emotional stress.
All human interactions and talking about self or others carry some number of risks. We will nevertheless minimise such risks and act promptly to assist you if you experience any discomfort, psychological or otherwise during the process of your participation in this study. Where necessary, an appropriate referral will be made to a suitable professional for further assistance or intervention.

What are the benefits of this research?
This research is not designed to help you personally, but the results may help the investigator learn more about what skills and capabilities are required for caregivers of children who have experienced interpersonal trauma. We hope that, in the future, other people might benefit from this study through improved understanding of factors which help or hinder in caring for children who have experienced interpersonal trauma within alternative care placements. This knowledge may be used in aiding health professionals, policy makers, or welfare organisations to better support caregivers within alternative care.

Do I have to be in this research, and may I stop participating at any time?
Your participation in this research is completely voluntary. You may choose not to take part at all. If you decide to participate in this research, you may stop participating at any time. If you decide not to participate in this study or if you stop participating at any time, you will not be penalized or lose any benefits to which you otherwise qualify.

In terms of the requirements of the Protection of Personal Information Act (Act 4 of 2013), personal information will be collected and processed:

What type of personal information will be collected?
Narrative information regarding your personal experiences of caring for children who have experienced interpersonal trauma will be collected during an interview which will be audio recorded.

Who at UWC is responsible for collecting and storing my personal information?
All information will be collected and stored by the principal researcher, Erica Bourn, who's contact information is available below.

Who will have access to my personal information outside of UWC?
Transcription of audio recorded interviews may be outsourced outside of UWC. In this case, the transcriber will be asked to sign a confidentiality agreement.

How long will my personal information be stored?
After 5 years all information related to the study will be deleted from the researcher's laptop and all transcripts and any other hard copies of notes taken during the study will be destroyed.

How will my personal information be processed?
Audio recordings of the interview will be transcribed verbatim and then analysed using a thematic analysis approach.

What if I have questions?
This research is being conducted by Erica Ann Bourn, a master's student within the School of Public Health at the University of the Western Cape. If you have any questions about the research study itself, please contact Erica Bourn at: 072 877 3145 or 4104219@myuwc.ac.za.
Should you have any questions regarding this study and your rights as a research participant or if you wish to report any problems you have experienced related to the study, please contact:

Prof Uta Lehmann
Head of Department: School of Public Health
University of the Western Cape
Private Bag X17
Bellville 7535
ulehmann@uwc.ac.za

Prof Anthea Rhoda
Dean: Faculty of Community and Health Sciences
University of the Western Cape
Private Bag X17
Bellville 7535
chs-deansoffice@uwc.ac.za

This research has been approved by the University of the Western Cape's Biomedical Research Ethics Committee.

Biomedical Research Ethics Committee
University of the Western Cape
Private Bag X17
Bellville
7535
Tel: 021 959 4111
e-mail: research-ethics@uwc.ac.za

APPENDIX B: Consent form

UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa
Tel: +27 21 959 2809 Fax: 27 21 959 2872
E-mail: soph-comm@uwc.ac.za

Title of Research Project: Caregivers' experiences of providing alternative care to children who have experienced interpersonal trauma in Gauteng, South Africa

The study has been described to me in language that I understand. My questions about the study have been answered. I understand what my participation will involve, and I agree to participate of my own choice and free will. I understand that my identity will not be disclosed to anyone. I understand that I may withdraw from the study at any time without giving a reason and without fear of negative consequences or loss of benefits.

☐ I agree to be audiotaped during my participation in this study.
☐ I do not agree to be audiotaped during my participation in this study.

In terms of the requirements of the Protection of Personal Information Act (Act 4 of 2013), personal information will be collected and processed:

☐ I hereby give consent for my personal information to be collected, stored, processed, and shared as described in the information sheet.
☐ I do not give consent for my personal information to be collected, stored, processed, and shared as described in the information sheet.

Participant's name: _____

Participant's signature: _____

Date: _____

APPENDIX C: Interview guide

Title: Caregivers' experiences of providing alternative care to children who have experienced interpersonal trauma in Gauteng, South Africa

Interviewer: Erica Ann Bourn, School of Public Health, UWC

Length of interview: Approximately 1 hour

Introduction

Good day, thank you for being willing to participate in this research study and for making time for this interview. As explained in the information sheet, this research study is being conducted as a Master's study in Public Health at the University of the Western Cape. The purpose of this interview is to explore your experiences of providing care to children who have experienced interpersonal trauma. For confidentiality reasons, please avoid using any names of your children during the interview so that it is not disclosed in the recording.

- Do you have any questions before we start?

Caregiver demographic information

- Age: _____ Gender: _____ Race: _____
- Job title / role within the home:_____
- How many years of experience do you have in being a caregiver? _____

Background of alternative care placement

- Foster / temporary safe care / CYCC
- Can you provide me with a brief background on the home?
    - How/why the home was started
    - Set up / structure
    - How many children you currently have
    - Number of children it can accommodate

My research study aims to understand your experiences as a caregiver in providing care to a child/ children who have experienced interpersonal trauma, so I just want to take a moment to define what I mean when I say 'interpersonal trauma' as well as what I mean by 'providing care':

Interpersonal trauma: *Refers to the range of maltreatment and interpersonal violence experienced by children and adolescents, which includes, but is not limited to; sexual, physical or emotional abuse, severe bullying, severe neglect, witnessing domestic violence, serious disruptions in caregiving as a result of caregiver mental illness, substance abuse or criminal involvement (D'Andrea et al., 2012).*

Care: *as defined by the Children's Act care is providing the child with a suitable place to live, living conditions conducive to the child's health, promoting well-being and development of the child and providing the necessary financial support. Furthermore, care involves protecting the child from harm, directing, and securing their education and upbringing, providing guidance for their decisions and behaviour appropriate to their developmental stage and overall ensuring the best interests of the child are upheld within their care.*

- Without using children's names or too specific identifying information, can you share some of the children's backgrounds in relation to why they have been placed with alternative care? And whether the child/children in your care have experienced interpersonal trauma?
- Have you received any formal or informal training in caregiving and/or trauma competent caregiving?

Challenges

- Describe the challenges you have experienced in providing care to children who have experienced interpersonal trauma
    - Prompts: Difficult behaviour? Relational difficulties? System level difficulties (social workers, DSD, birth certificates, court difficulties)? Lack of permanence? Administrative delays?

Helpful factors

- Describe factors that have helped you / aided in your ability to provide care for children who have experienced interpersonal trauma
    - Prompts: Nutrition? Routine? Support? Training? Structure?

Skills and support

- Describe the skills and support you think a caregiver needs to provide care for a child who has experience interpersonal trauma

- Prompts: What skills have you learned? What do you wish you knew before you started? What would make this job easier? Who has provided you with support? What does support look like?

Conclusion

Thank you for taking the time today to share your experiences with me for the purpose of this research study, your contribution is valued and appreciated. You will be asked to read this interview transcript and preliminary findings as part of member checking, please notify me of any errors in what was transcribed or in my understanding of our discussion. A reminder that you maintain the right to withdraw from the study at any point.

APPENDIX D: Key informant letter of support

Omphile House
Cell: 083 282 6372
Email: jacquelinejean@gmail.com
Facebook page: @Omphile House
PBO number: 930053024

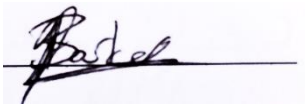
Letter of support

Research title: Caregivers' experiences of providing alternative care to children who have experienced interpersonal trauma in Gauteng, South Africa

I, Jacqueline Barker, from Omphile House (PBO number: 930053024) hereby support the above proposed research study, conducted by Erica Ann Bourn, Master's degree student in the School of Public Health at the University of the Western Cape. Omphile House is registered with the Department of Social Development as a foster care placement and temporary safe care placement.

Once permission is obtained from Department of Social Development, I will provide the researcher with assistance in accessing a network of potential participants working in the area of alternative care in Gauteng. I ensure that permission to be contacted is obtained from known contacts prior to sharing any contact details with the researcher in order ensure the POPI Act is not infringed upon in the recruitment phase of the study.

Signed at _____Roodepoort, JHB_____ *on the* ___22 September 2022_____ *(date)*

Signature: 

APPENDIX E: DSD letter of permission

GAUTENG PROVINCE
SOCIAL DEVELOPMENT
REPUBLIC OF SOUTH AFRICA

Enquiries: Dr. Sello Mokoena
Tel: 082 331 0786
File no.: 02/02/23

Dear E Bourn

RE: APPLICATION TO CONDUCT RESEARCH IN THE GAUTENG DEPARTMENT OF SOCIAL DEVELOPMENT

Thank you for your application to conduct research within the Gauteng Department of Social Development.

Your application on the research on ***"Caregivers' experiences of providing alternative care to children who have experienced interpersonal trauma in Gauteng, South Africa"*** as approved by *University of the Western Cape* has been considered and approved for support by the Department as it was found to be beneficial to the Department's vision and mission. The approval is subject to the Department's terms and conditions as endorsed on the 13th November 2019.

You have permission to interview departmental officials and beneficiaries, conduct observations and access relevant documents where necessary.

May I take this opportunity to wish you well on the journey you are about to embark on.

We look forward to a value adding research and a fruitful co-operation.

With thanks

Dr Sello Mokoena
Director: Research and Policy Coordination
Date: 27/02/2023

APPENDIX F: Ethical clearance

UNIVERSITY of the WESTERN CAPE

60 YEARS of hope, action & knowledge

9 December 2022

Mrs EA Bourn
School of Public Health
Faculty of Community and Health Sciences

BMREC Reference Number: BM22/10/8

Project Title: Caregivers' experiences of providing alternative care to children who have experienced interpersonal trauma in Gauteng, South Africa

Approval Period: **9 December 2022 – 8 December 2025**

I hereby certify that the Biomedical Science Research Ethics Committee of the University of the Western Cape approved the scientific methodology and ethics of the above mentioned research project and the requested amendment to the project.

Any further amendments, extension or other modifications to the protocol must be submitted to the Ethics Committee for approval.

Please remember to submit a progress report annually by 30 November for the duration of the project.

For permission to conduct research using student and/or staff data or to distribute research surveys/questionnaires please apply via: https://sites.google.com/uwc.ac.za/permissionresearch/home

The permission letter must then be submitted to BMREC for record keeping purposes.

The Committee must be informed of any serious adverse event and/or termination of the study.

Ms Patricia Josias
Research Ethics Committee Officer
University of the Western Cape

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NHREC Registration Number: BMREC-130416-050

FROM HOPE TO ACTION THROUGH KNOWLEDGE.