Child & Youth Services

ISSN: 0145-935X (Print) 1545-2298 (Online) Journal homepage: www.tandfonline.com/journals/wcys20

Being an Alternative Caregiver: Caring for Children Who Have Experienced Trauma

Erica Ann Conibear, B. Schmidt & C. Mulopo

To cite this article: Erica Ann Conibear, B. Schmidt & C. Mulopo (13 Jun 2025): Being an Alternative Caregiver: Caring for Children Who Have Experienced Trauma, Child & Youth Services, DOI: 10.1080/0145935X.2025.2506043

To link to this article: https://doi.org/10.1080/0145935X.2025.2506043

Published online: 13 Jun 2025.

CHILD & YOUTH SERVICES
https://doi.org/10.1080/0145935X.2025.2506043

Routledge
Taylor & Francis Group

Being an Alternative Caregiver: Caring for Children Who Have Experienced Trauma

Erica Ann Conibear[a,b], B. Schmidt[a,c] and C. Mulopo[a*]

[a]School of Public Health, University of the Western Cape, Cape Town, South Africa; [b]Department of Occupational Therapy, University of the Witwatersrand, Johannesburg, South Africa; [c]Health Systems Research Unit, South African Medical Research Council, Cape Town, South Africa

ABSTRACT

Alternative caregivers play a vital role in South Africa's alternative care system, providing care to maltreated children removed from their primary families. This qualitative descriptive exploratory study explored the experiences of 15 alternative caregivers of children who have experienced interpersonal trauma. Four themes emerged: (1) navigating the pervasive impact of trauma, (2) adopting a unique parenting approach, (3) experiencing secondary trauma, and (4) establishing your own "village" support. Findings highlight the need for caregivers to develop essential skills and access support to meet children's complex needs and manage secondary trauma, particularly within an under-capacitated child welfare system.

KEYWORDS

Alternative caregivers; alternative care; interpersonal trauma; secondary trauma; attachment

Introduction

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 as defined by D'Andrea et al. (2012) encompasses the 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. Children who have experienced interpersonal trauma have complex care needs and require caregivers to adopt a unique parenting approach to manage developmental, behavioral, interpersonal and attachment difficulties (D'Andrea et al., 2012; Kisiel et al., 2014).

A systematic review conducted by Lee and Kim (2023) indicated that childhood maltreatment increased globally during the COVID-19 pandemic

CONTACT Erica Ann Conibear erica.conibear@wits.ac.za School of Public Health, University of the Western Cape, Cape Town, South Africa; Department of Occupational Therapy, University of the Witwatersrand, Khanya Block, Education Campus, 7 York Road, Parktown, Johannesburg 2193, South Africa.
*Centre for Epidemic Response and Innovation, Stellenbosch University, Cape Town, South Africa.

resulting in an estimated prevalence of physical abuse of 18% and psychological abuse of 39%. In South Africa, 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., 2017b; Strydom et al., 2020; Ward et al., 2018). Hall and Sambu (2018) describe South Africa's unique phenomenon of approximately 21% of children not living consistently in the same household as their biological parents. This phenomenon may be due to factors such as historic population control, labor migration, inequitable distribution of housing, limited educational and employment opportunities, high rates of poverty, low marriage and cohabitation rates, and the HIV pandemic. This results in frequent parental absence and increases the risk of child abuse (DSD, 2019; Hall & Sambu, 2018). 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 alternative care placements to keep the child safe from harm.

In South Africa, Chapter 9, section 150, of the Children's Act 38 of 2005 (Children's Act 38 of 2005, 2005) identifies the criteria for children in need of care and protection, as follows:

1. The child has been abandoned or orphaned without visible means of support.
2. The child displays behavior 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 needing care and protection are then removed from these situations and placed within one of the three alternative care placements: temporary safe care, foster care or a child and youth care center (CYCC) (Children's Act 38 of 2005, 2005; Van der Walt, 2018). Foster care is 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 parents. No more than six foster children can be placed within one foster care placement (DSD, 2019). Children, in some situations, may be placed with known relatives by the state in a formal foster care arrangement, alternatively, they will be placed with unknown caregivers in a registered foster placement when

no other suitable caregiver is available (Van der Walt, 2018). Cluster foster care homes are several homes which fall under the umbrella of one registered nonprofit organization (Children's Act 38 of 2005, 2005). The nonprofit organization employs the foster parents and therefore can house several groups of foster children within the cluster (Goemans et al., 2021). A CYCC is a home that provides accommodation and care for more than six children outside of their family environment (Children's Act 38 of 2005, 2005). A temporary safe care home, also known as a place of safety, is 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 38 of 2005, 2005). Within South Africa, temporary safe care placements are often at registered foster homes or Child and Youth Care Centers.

Formal alternative care placements need to be registered with the Department of Social Development (DSD) and need to comply with regulations outlined in Chapters 11 to 13 of the Children's Act No. 41 of 2007 (Children's Amendment Act No. 41 of 2007, 2007). Several reviews on South Africa's child protection system conclude that the alternative care system is overburdened, under-capacitated, and failing a large number of vulnerable children in need of care and protection within South Africa (Jamieson et al., 2017b; Strydom et al., 2020; Van der Walt, 2018). 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).

Within alternative care placements, caregivers are responsible for caring for children who have experienced interpersonal trauma (D'Andrea et al., 2012). Caregivers are responsible for providing care as defined by the Children's Act 38 of 2005 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 behavior in a manner that is appropriate to their developmental stage and overall ensuring the best interests of the child are upheld within their care (Children's Act 38 of 2005, 2005).

An attentive caregiver is the most important protective factor against the negative effects of traumatic experiences (Dobson & Perry, 2010). The importance of alternative caregivers building attachment with the children in their care, alongside the challenges related to this, is emphasized frequently within the literature (Humphreys et al., 2017; Miranda et al., 2019;

Naeem et al., 2022; Tang et al., 2021). 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 that gives the child a sense of feeling safe, secure, and protected (Grady et al., 2017). A secure attachment has been found to protect against the effects of social and environmental stress. However, when a child experiences neglect, inconsistent care, or abuse at the hands of a caregiver, an insecure or disorganized attachment is formed (Purvis et al., 2014). For this reason, attachment-based trauma caused nonviolently (such as through neglect and emotional abuse) or violently (such as through 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 homes 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 is 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 to enable children to heal from interpersonal trauma (Dann, 2021; Dobson & Perry, 2010).

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. However, 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). This identified gap impacts the caregiver's skills and capabilities in providing care to children who have experienced interpersonal trauma. 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) (Rienks, 2020). Globally, research has found high rates of secondary trauma among foster caregivers and child welfare workers and highlights the importance of self-care strategies for these caregivers (Bridger et al., 2020; Rienks, 2020). This raises concerns regarding caregivers' abilities to continue in childcare work and the impact on the quality of care they can provide to the children placed within their care (Hannah & Woolgar, 2018).

Several qualitative studies in South Africa considered the experiences of alternative care from the child's perspective (Dube & Ross, 2012; Malatji & Dube, 2017) or from the social workers' perspective (Lesch

et al., 2013; Phaswana & Erlank, 2023). One study considered caregivers' challenges specifically within institutional care caring for infants and toddlers and found a lack of support and resources hindered their ability to provide care (Oosthuizen-Erasmus & Adlem, 2022). Another study 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, behavioral problems, bonding, discipline, and self-care for caregivers (Dubery et al., 2020). However, little research exists concerning caregivers' experiences across the various alternative care placements within the South African context.

Children who have suffered severe forms of interpersonal trauma are removed from their primary family and placed in the care of a caregiver within an alternative care placement (DSD, 2019). For children to heal from trauma, they need a caregiver who is attuned and attentive to their needs (Dobson & Perry, 2010; DSD, 2019). In South Africa, the child protection system is overburdened and underfunded, therefore there are limited structures in place to support caregivers within the alternative care system (Jamieson et al., 2017b; Van der Walt, 2018). Little is known of these caregivers' experiences within alternative care regarding the challenges they face and what skills and support they require in their caregiving roles. Therefore, this study sought to answer the research question 'what are the experiences of caregivers who care for children who have experienced interpersonal trauma within alternative care placements in South Africa?

Material and methods

Research design

The research method for this study is based on the interpretivist paradigm (Ryan, 2018). A qualitative descriptive exploratory study design was used as this design allows for an in-depth exploration of alternative caregivers' experiences (Doyle et al., 2020).

Participants and recruitment

Fifteen alternative 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 (including cluster foster care).
- *Cluster 2:* CYCC caregivers.
- *Cluster 3:* Temporary safe care caregivers.

Purposive sampling was used to ensure adequate representation of each of the three types of formal alternative care placements within the participant sample. Participants were recruited primarily through a WhatsApp network of alternative caregivers who share information and provide support. Initial recruitment involved advertising participation in the study on a WhatsApp group of caregivers in alternative care. Once initial participants were recruited, snowball sampling was used. All the placements were registered with the DSD. Five CYCCs and six foster care homes were represented in the sample. Three homes were baby homes that operated primarily as temporary safe care placements. Many of the foster care and CYCC placements were also registered as 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.

See Table 1 for a description of the study participants: pseudonyms were allocated based on the most prominent placement type. The placement description provides an indication of which clusters were represented by each participant. Data saturation was reached with a sample size of 15, which aligns with the convention within qualitative research (Young & Casey, 2019).

Semi-structured interviews

Semi-structured interviews were conducted in person and online using an interview guide. Interviews were conducted with individual caregivers and were 60 to 120 minutes in duration. The interview guide was developed by the researcher using the research objectives, which were informed by literature, to formulate the interview questions. The interview guide included demographic information and questions aligned with the research objectives as follows:

a. What challenges have you experienced in providing care to children who have experienced interpersonal trauma?
b. What factors have helped you or aided in your ability to provide care for children who have experienced interpersonal trauma?
c. Describe the skills that you think a caregiver needs to provide care for a child who has experienced interpersonal trauma.

The interview guide also contained several prompts for each question which guided the researcher to prompt for further details and expand on something of interest that may have been mentioned by the participant during the interview. The interviews were audio recorded with consent from participants and then transcribed verbatim.

Table 1. Summary of participants (Details as captured during data collection March–August 2023).

Pseudonym	Years experience	Role	Placement description	Number of children in the home	The age group of children
F1A & F1B	10	Mother & father	Foster care & POS	1 biological, 1 adopted, 4 fostered	4–18 years old
F2	4	Mother	Foster care & POS	3 fostered	7–18 years old
F3	11	Mother	Foster care within a cluster home	2 adopted, 6 fostered	0–18 years old
F4	15	Mother, cluster foster care manager	POS & cluster foster manager	2 adopted	0–18 years old
F5	13	Mother	Long-term foster placement	2 children (twins) relatives	15 years old
F6	12	Father	Foster care within a cluster home	2 biological, 3 fostered	10–18 years
POS1	13	Baby home manager	POS – baby home	Up to 16 babies	0–3 years old
POS2	10	Baby home manager	POS – baby home	6 babies	0–3 years old
POS3	12	Baby home manager	POS – baby home	14 POS placements, 3 adopted, 2 fostered	0–5 years old
CYCC1	21	Managing director, adoptive parent, social worker	CYCC & POS	2 homes – 10 girls, 10 boys	0–18 years
CYCC2	3	Social worker and project coordinator	CYCC & POS	30 children	0–5 years old
CYCC3A	24	Child and Youth Care worker – special needs	CYCC & POS	50 children across 3 cluster homes	0–4 years old
CYCC3B	8	Development & stimulation coordinator, adoptive mother	CYCC & POS	50 children across 3 cluster homes	0–4 years old
CYCC4	13	Foster father, owner of CYCC	Foster care, CYCC, and POS	3 fostered children, CYCC has 32 children	0–18 years
CYCC5	12	Previous house mother, now residential social worker	CYCC & POS	22 children	0–18 years old

Data analysis

The interview transcripts were analyzed using reflexive thematic analysis as outlined by Byrne (2022). The following steps are involved in 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. Codes were then grouped 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, and codes and themes were revised and reworked several times. Finally, the themes are reported in the findings and discussion sections using selected extracts relating to the study objectives and literature.

Trustworthiness

To ensure trustworthiness, the strategies outlined in Lincoln and Guba's (1985) seminal work were applied as follows: 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 second and third authors to limit the amount of researcher bias imposed on the data. To ensure credibility, three participants (one from each cluster) reviewed the primary findings from the interviews as a form of member checking. Furthermore, the codes and themes were reviewed several times by the second and third authors. Data triangulation was used by collecting data from three participant groups. A reflexive journal was kept recording reflections after each meeting with the participants (Creswell & Miller, 2000; Morse, 2015). 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 utilized bracketing by outlining preconceptions around the research topic with a reflexive journal throughout the data collection phase (Tufford & Newman, 2012).

Ethical considerations

Ethical approval was obtained from the University of the Western Cape's Biomedical Research Ethics Committee (BMREC reference number: BM22/10/8) and permission to conduct research was obtained from the Gauteng Department of Social Development (File number 02/02/23). 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 participate 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.

Table 2. Summary of themes.

Theme 1	Theme 2	Theme 3	Theme 4
Navigating the pervasive impact of trauma	Adopting a unique parenting approach	Experiencing secondary trauma	Establishing your own "village" support

Results

Theme 1: Navigating the pervasive impact of trauma

The first theme, 'navigating the pervasive impact of trauma' describes some of the challenges the caregivers faced due to the impact of trauma on the children who have been placed within their care. Children had been removed from circumstances of neglect, abuse, abandonment, serious disruptions in caregiving, and child trafficking. Each situation involves, at the least, a separation from the biological mother, which in itself is an experience of interpersonal trauma, as noted 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)

Caregivers noted that the neglect or abuse had to be very severe to warrant 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)

Many caregivers experienced difficulties with children who displayed extreme behavioral challenges. These behaviors included lying, stealing, throwing temper tantrums, running away from the home, breaking things, and sometimes extremely violent behavior which involved hurting other children, hurting the caregivers, or hurting themselves. One caregiver provided the following helpful insight into understanding these extreme behaviors:

> Some of the behavioral challenges have been absolutely huge and it's why these kids often get labeled 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)

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)

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. Some children within their care 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)

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 attachments with children who had come from multiple previous placements.

Theme 2: Adopting a unique parenting approach

This theme is titled 'Adopting a unique parenting approach' as caregivers needed to adjust how they parented in response to the pervasive impact of trauma resulting in children having complex needs, as described in the quote below:

> These are children who have experienced interpersonal trauma have been extremely hurt, abused or neglected by their primary family. And whether that happens when you are a newborn 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)

Some caregivers shared how the experience of trauma impacts brain development and often results in a sensitized 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)

Caregivers also had to learn how to respond to challenging behavior; most caregivers shared that they would reward positive behavior and take away rewards if the child displayed bad behavior. None of the caregivers utilized any form of physical punishment, particularly acknowledging the background 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 traumatized kids. (F2)

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… We've got a calendar up on the board where we write who's doing what and when. (F2)

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) the infant has a need; (2) the 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 disorganized 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)

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)

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 a proper attachment, the development is so slow. Attachment is foundational to everything. Language, personality, confidence. Kids who don't have attachments end up failing to thrive. They are, I would say, the worst cases. (CYCC2)

Theme 3: The experience of secondary trauma

This theme is titled 'The experience of secondary trauma' as many caregivers described experiencing emotional strain, burnout and high levels of ongoing stress resulting in symptoms of trauma. 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)

The below quote describes POS2's realization that she had neglected her own needs as she always would place the children's needs above her own:

> 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 said, you will not do any more. 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)

Caregivers need to come to terms with their limitations and recognize 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)

Caregivers shared that counseling for caregivers should be mandatory, and every caregiver needs a support system because caregivers also need to be cared for to enable them to do this work, as noted in the quote below:

> You should have a counselor. You need to debrief. You need somebody who's going to say that your mental health actually matters. (POS2)

Theme 4: Establishing your own "village" support

This theme is titled 'Establishing your own "village" support' as in response to the experience of secondary trauma, caregivers had established their own support systems to provide a buffer for the challenges they faced and to share the caregiving load. This was essential as caregivers did not receive adequate support from the state, as described in the quote below:

> Getting any sort, just support generally is non-existent. So you, as the foster parent, have to do all of it and fight for all of it. And if you don't, they will very happily just dump a child with you and come see them every second year when the court order is up for renewal. If they even come then. (F4)

Caregivers demonstrated the ability to build their own support system, in the form of a supportive surrounding 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 worked night shift for us for 3 months just because we were not coping and I did not have the capacity to hire somebody. When we've been in trouble, we can just phone and say, "Hey I need help," and they'll show up. (POS2)

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 requests for donations or practical help with maintenance or would volunteer time to assist with tutoring or specific child-caring tasks. The below quote highlights the various ways in which the surrounding community assisted one of the CYCCs:

> A lot of people want to come and volunteer, which really helps, especially with the homework. We have volunteers that bring activities to do for the kids, it's just something a bit different for them to do and, they love it. For example, the toddlers are now doing swimming and dancing, which has helped them engage so much. The community also helps with financial support. We have people donating food like fresh bread every day for the house mothers. And on Christmas, they would ask, 'Can we bring something for the kids and the staff?' And then they all get a Christmas hamper. (CYCC 2)

Discussion

The first theme considered caregivers' challenges navigating the pervasive impact of trauma, and 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. 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. Subsequently, alternative caregivers experienced many challenges navigating the impact of these traumatic experiences on the child's development, behavior, 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 (Kisiel et al., 2014; Spinazzola et al., 2018). 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 need for more support in caring for children who have experienced trauma is

similarly echoed by a study by Oosthuizen-Erasmus and Adlem (2022) which looked at the caregiver's challenges in managing difficult behavior and poor attachment resulting from early life adversity. These findings highlight the need for alternative caregivers to be equipped with skills to navigate children's complex care needs with regard to development, behavior and attachment. Furthermore, they require access to appropriate therapeutic interventions for the children within their care.

In response to the pervasive impact of trauma, the findings highlighted how caregivers have learned to parent differently, and how they put intentional effort into building attachment as they recognized the foundational role attachment plays in healing from trauma. The theme of attachment appears frequently within the literature on trauma and alternative care. The available literature is congruent with the study findings in emphasizing the importance of attachment in healing from trauma (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), and the foundational role of attachment in development. Alternative caregivers also implemented intentional structure and routine into their homes, had strategies in place to cope with meltdowns and temper tantrums and ensured discipline was done in such a way that reinforced positive behavior rather than punished them. This is in line with the trust-based relational intervention (TBRI) as proposed by Purvis et al. (2013) which is a therapeutic model to train caregivers to care for children with complex developmental trauma. TBRI proposes 3 key principles – (1) empowerment – giving attention to physical needs; (2) connection – giving attention to attachment needs; and (3) correction – giving attention to behavioral needs. Therefore, the findings from this study highlight the potential opportunity of trialing TBRI within alternative care settings in South Africa by making training and support available to caregivers.

The findings highlighted the strain caregivers experienced from being exposed to their children's trauma, needing to put their needs before their own, and the powerlessness of not being able to "fix" the children within their care. Secondary trauma can be defined as 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). This is often also referred to as vicarious trauma, compassion fatigue, or burnout (Salloum et al., 2015). Symptoms may include intrusive thoughts, hyperarousal and avoidance behaviors (Rienks, 2020). These experiences led caregivers to realize that they also needed to take care of themselves. The concept of 'caring for the caregiver' occurs occasionally

in general healthcare literature (Tamayo et al., 2010). The findings from this study highlight the need for caregivers to be cared for as they frequently experience emotional strain when caring for children who have experienced trauma. Similarly, a study by Leake et al. (2019) investigated what factors are required to reduce caregiver strain among foster, kin and adoptive parents. This study found that to mitigate caregiver strain and prevent burnout, caregivers required (1) access to trauma-informed health professionals, (2) counseling 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 would be beneficial to caregivers within the South African context, 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. Therefore, this study highlights the gaps within the state's child protection system in supporting caregivers in their role. A means by which caregivers were able to mitigate some of the strain they faced in their role was by establishing their own support systems. 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). 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 complex needs cannot be understated. An article by Reupert et al. (2022) advocated for a 'village' approach to supporting families experiencing adversity, which involves promoting the caregiver's agency and empowerment, giving children a voice, and celebrating the caregiver's and children's strengths. Reupert et al. (2022, p. 1) conclude 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 and state services.

Concerning 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 first theme 'navigating the pervasive impact of trauma', further highlights how the failing child protection system may compound the trauma which children experience, thereby increasing the complexity of situations caregivers need to navigate. State services need to make efforts to bridge the gap of policy implementation. The Children's Act is the primary policy document that governs the alternative care system (Children's Act 38 of 2005, 2005; Gudula-Koyana & Khanye, 2019), however, this policy does not provide any structure and guidance regarding how caregivers within the system should be supported. Therefore, while South African policies are geared toward promoting the best interests of the child, little exists within policy to guide how caregivers within the alternative care system should be equipped or supported. This policy gap explains the findings related to the vacuum of support provided to caregivers. The findings from this study have provided insight into what kind of support and training caregivers require and should be made overt within child protection policies. These include training related to navigating the complex needs that result from the impact of trauma and psychosocial support to help mitigate the impact of secondary trauma and burnout experienced by alternative caregivers.

Table 3. Implications for practice.

Key findings	Implications for practice
Navigating the pervasive impact of trauma	Children within alternative care have complex needs because of early traumatic experiences, therefore, there is a need for social and therapeutic services to be re-oriented to better support and equip alternative caregivers in navigating these complexities.
Adopting a unique parenting approach	With a recognition of the neurodevelopmental impact of trauma, caregivers demonstrated an ability to respond to children's needs with specific strategies. These strategies included establishing structure and routine, continually completing the attachment cycle, using positive reinforcement instead of punishment and responding with calmness to a meltdown. These strategies provide insight into what is needed for children to heal from trauma and should be incorporated into caregiver training.
The experience of secondary trauma	Caregivers' experiences of secondary trauma highlight the gap in 'caring for the caregiver'. There is a need for measures to be implemented to mitigate caregiver strain and prevent burnout, such as debriefing and counseling to enable alternative caregivers to continue to provide quality care.
Establishing your own village support	Caregivers demonstrated resilience in building their own support systems by drawing on resources from the surrounding community. Strengthening community support has been highlighted as an essential element of supporting alternative caregivers in providing care.

Limitations

One limitation was that there was a lack of diversity concerning race and gender within the sample group, which may be due to several reasons, such as utilizing a WhatsApp group primarily for sampling, where there may have been an existing racial bias on the group. Time and resource constraints prevented further exploration and data triangulation as the study was conceptualized and designed to be completed within a specified timeframe for a degree purpose.

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 in South Africa. The findings highlighted the challenges that arose from the pervasive impact of interpersonal trauma on children's development, behavior, and attachment. Caregivers responded to these challenges by adopting a unique parenting approach which intentionally built attachment. These findings provided valuable insights into what is needed to equip caregivers with the skills to navigate children's complex needs.

Alternative caregivers experienced secondary trauma from having to witness the effect of trauma on the children within their household. They recognized that they often neglected their needs because they always put the children's needs above theirs. Therefore, the importance of acknowledging their limitations and seeking debriefing and counseling when needed was highlighted. Furthermore, caregivers demonstrated the ability to build their own support systems in the absence of state support by drawing on the resources in the surrounding community. This support was identified to be the greatest facilitator that capacitated the caregivers' work and should be considered an essential element within the alternative care system, particularly in the instances when state support is insufficient.

Funding

The work reported herein was made possible through funding by the South African Medical Research Council through its Division of Research Capacity Development under the SAMRC Research Capacity Development Initiative - Postdoctoral Fellowship Programme from funding received from the South African National Treasury. The content hereof is the sole responsibility of the authors and do not necessarily represent the official views of the SAMRC or the funders.

Disclosure statement

This research was conducted in fulfillment of the requirements for the Degree of Master of Public Health at the School of Public Health, Faculty of Community and Health Sciences, University of the Western Cape.

References

Artz, L., Ward, C. L., Leoschut, L., Kassanjee, R., & Burton, P. (2018). The prevalence of child sexual abuse in South Africa: The Optimus Study South Africa. *South African Medical Journal = Suid-Afrikaanse Tydskrif Vir Geneeskunde*, *108*(10), 791–792. https://doi.org/10.7196/SAMJ.2018.v108i10.13533

Beyerlein, B. A., & Bloch, E. (2014). Need for trauma-informed care within the foster care system: A policy issue. *Child Welfare*, *93*(3), 7–21.

Bowlby, J. (1988). *A secure base: Parent-child attachment and healthy human development*. Basic Books.

Bridger, K. M., Binder, J. F., & Kellezi, B. (2020). Secondary traumatic stress in foster carers: Risk factors and implications for intervention. *Journal of Child and Family Studies*, *29*(2), 482–492. https://doi.org/10.1007/s10826-019-01668-2

Byrne, D. (2022). A worked example of Braun and Clarke's approach to reflexive thematic analysis. *Quality & Quantity*, *56*(3), 1391–1412. https://doi.org/10.1007/s11135-021-01182-y

Children's Act 38 of 2005. (2005). https://www.gov.za/sites/default/files/gcis_document/201409/a38-053.pdf

Children's Amendment Act No. 41 of 2007 (2007).

Choudhury, A. (2020). Trauma-informed care in the childcare and family placement process: Miracle Foundation's approach within alternative care in India. *Institutionalised Children Explorations and Beyond*, *7*(1), 65–73. https://doi.org/10.1177/2349300319894446

Creswell, J. W., & Miller, D. L. (2000). Determining validity in qualitative inquiry. *Theory Into Practice*, *39*(3), 124–130. https://doi.org/10.1207/s15430421tip3903_2

D'Andrea, W., Ford, J., Stolbach, B., Spinazzola, J., & van der Kolk, B. A. (2012). Understanding interpersonal trauma in children: Why we need a developmentally appropriate trauma diagnosis. *The American Journal of Orthopsychiatry*, *82*(2), 187–200. https://doi.org/10.1111/j.1939-0025.2012.01154.x

Dann, P. (2021). *Preventing and healing developmental trauma*. 1–10.

De Beer, A. (2015). Ubuntu and the journey of listening to the Rwandan Genocide Story. *Verbum et Ecclesia*, *36*(2), 1–9. https://doi.org/10.4102/ve.v36i2.1436

Dobson, C., & Perry, B. D. (2010). The role of healthy relational interactions in buffering the impact of childhood trauma. In E. Gil (Ed.), *Working with children to heal interpersonal trauma: The power of play* (pp. 26–43). The Guilford Press.

Doyle, L., McCabe, C., Keogh, B., Brady, A., & McCann, M. (2020). An overview of the qualitative descriptive design within nursing research. *Journal of Research in Nursing*, *25*(5), 443–455. https://doi.org/10.1177/1744987119880234

DSD. (2019). *National child care and protection policy: Working together to advance the rights of all children to care and protection* (p. 132). https://www.gov.za/sites/default/files/gcis_document/202102/national-child-care-and-protection-policy.pdf

Dube, N., & Ross, E. (2012). Sanctuary or double-edged sword? Challenges confronting adolescents living at Nkosi's Haven in Johannesburg, South Africa. *SAHARA-J: Journal of Social Aspects of HIV/AIDS*, *9*(4), 200–209. https://doi.org/10.1080/17290376.2012.745297

Dubery, M., Strydom, C., & Strydom, H. (2020). The development of an empowerment programme for child-carers in private places of temporary safe-care. *Social Work*, *56*(3), 296–309. https://doi.org/10.15270/56-4-859

Goemans, M., van Breda, A. D., & Kessi, S. (2021). Experiences of young people preparing to transition out of cluster Foster Care in South Africa. *Child and Adolescent Social Work Journal*, *38*(2), 227–237. https://doi.org/10.1007/s10560-020-00704-1

Grady, M. D., Levenson, J. S., & Bolder, T. (2017). Linking adverse childhood effects and attachment: A theory of etiology for sexual offending. *Trauma, Violence & Abuse*, *18*(4), 433–444. https://doi.org/10.1177/1524838015627147

Gudula-Koyana, S., & Khanye, Y. (2019). Overview of the Foster Care System in South Africa. *Parliment of the Republic of South Africa Research Unit*, 1–12.

Hall, K., & Sambu, W. (2018). Demography of South Africa's Children. *South African Child Gauge 2018*, 90–93. www.childrencount.ci.org.za

Hannah, B., & Woolgar, M. (2018). Secondary trauma and compassion fatigue in foster carers. *Clinical Child Psychology and Psychiatry*, *23*(4), 629–643. https://doi.org/10.1177/1359104518778327

Humphreys, K. L., Nelson, C. A., Fox, N. A., & Zeanah, C. H. (2017). Signs of reactive attachment disorder and disinhibited social engagement disorder at age 12 years: Effects of institutional care history and high-quality foster care. *Development and Psychopathology*, *29*(2), 675–684. https://doi.org/10.1017/S0954579417000256

Jamieson, L., Sambu, W., & Mathews, S. (2017a). Out of Harm's way? Tracking child abuse cases through the child protection system at five selected Sites in South Africa. In *Children's Institute*. University of Cape Town.

Jamieson, L., Sambu, W., & Mathews, S. (2017b). *Policy Brief: Strengthening the Child Protection System in South Africa*. https://doi.org/10.1186/s13033-016-0060-z

Kisiel, C. L., Fehrenbach, T., Torgersen, E., Stolbach, B., McClelland, G., Griffin, G., & Burkman, K. (2014). Constellations of interpersonal trauma and symptoms in child welfare: Implications for a developmental trauma framework. *Journal of Family Violence*, *29*(1), 1–14. https://doi.org/10.1007/s10896-013-9559-0

Leake, R., Wood, V. F., Bussey, M., & Strolin-Goltzman, J. (2019). Factors influencing caregiver strain among foster, kin, and adoptive parents. *Journal of Public Child Welfare*, *13*(3), 285–306. https://doi.org/10.1080/15548732.2019.1603131

Lee, H., & Kim, E. K. (2023). Global prevalence of physical and psychological child abuse during COVID-19: A systematic review and meta-analysis. *Child Abuse & Neglect*, *135*, 105984. https://doi.org/10.1016/j.chiabu.2022.105984

Lesch, E., Deist, M., Booysen, L., & Edwards, E. (2013). South African social workers' knowledge of attachment theory and their perceptions of attachment relationships in foster care supervision. *Children and Youth Services Review*, *35*(7), 1101–1109. https://doi.org/10.1016/j.childyouth.2013.04.025

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. SAGE Publications, Inc.

Malatji, H., & Dube, N. (2017). Experiences and challenges related to residential care and the expression of cultural identity of adolescent boys at a child and youth care centre (CYCC) in Johannesburg. *Social Work (South Africa)*, *53*(1), 109–126. https://doi.org/10.15270/52-2-549

Miranda, M., Molla, E., & Tadros, E. (2019). Implications of foster care on attachment: A literature review. *The Family Journal*, *27*(4), 394–403. https://doi.org/10.1177/1066480719833407

Morse, J. M. (2015). Critical analysis of strategies for determining rigor in qualitative inquiry. *Qualitative Health Research*, *25*(9), 1212–1222. https://doi.org/10.1177/1049732315588501

Naeem, N., Zanca, R. M., Weinstein, S., Urquieta, A., Sosa, A., Yu, B., & Sullivan, R. M. (2022). The neurobiology of infant attachment-trauma and disruption of parent–infant interactions. *Frontiers in Behavioral Neuroscience*, *16*, 882464. https://doi.org/10.3389/fnbeh.2022.882464

Oosthuizen-Erasmus, L., & Adlem, A. G. (2022). Challenges experienced by caregivers caring for abandoned infants and toddlers in institutional care. *Social Work/Maatskaplike Werk*, *58*(3), 309–331. https://doi.org/10.15270/58-3-1059

Phaswana, K., & Erlank, E. C. (2023). Rendering services in child and youth care centres: Experiences and challenges of social workers. *Social Work*, *59*(2), 43–63. https://doi.org/10.15270/59-2-1034

Purvis, K. B., Cross, D. R., Dansereau, D. F., & Parris, S. R. (2013). Trust-Based Relational Intervention (TBRI): A systemic approach to complex developmental trauma. *Child & Youth Services*, *34*(4), 360–386. https://doi.org/10.1080/0145935X.2013.859906

Purvis, K. B., McKenzie, L. B., Becker Razuri, E., Cross, D. R., & Buckwalter, K. (2014). A Trust-based intervention for complex developmental trauma: A case study from a residential treatment center. *Child and Adolescent Social Work Journal*, *31*(4), 355–368. https://doi.org/10.1007/s10560-014-0328-6

Reupert, A., Straussner, S. L., Weimand, B., & Maybery, D. (2022). It Takes a Village to Raise a Child: Understanding and Expanding the Concept of the "Village." *Frontiers in Public Health*, *10*, 1–7. https://doi.org/10.3389/fpubh.2022.756066

Rienks, S. L. (2020). An exploration of child welfare caseworkers' experience of secondary trauma and strategies for coping. *Child Abuse & Neglect*, *110*(Pt 3), 104355. https://doi.org/10.1016/j.chiabu.2020.104355

Ryan, G. (2018). Introduction to positivism, interpretivism and critical theory. In *Nurse researcher.* (Vol. *25*, Issue 4, pp.14–20). RCN Publishing Company Ltd. https://doi.org/10.7748/nr.2018.e1466

Salloum, A., Kondrat, D. C., Johnco, C., & Olson, K. R. (2015). The role of self-care on compassion satisfaction, burnout and secondary trauma among child welfare workers. *Children and Youth Services Review*, *49*, 54–61. https://doi.org/10.1016/j.childyouth.2014.12.023

Spinazzola, J., van der Kolk, B., & Ford, J. D. (2018). When nowhere is safe: Interpersonal trauma and attachment adversity as antecedents of posttraumatic stress disorder and developmental trauma disorder. *Journal of Traumatic Stress*, *31*(5), 631–642. https://doi.org/10.1002/jts

Spinazzola, J., van der Kolk, B., & Ford, J. D. (2021). Developmental trauma disorder: A legacy of attachment trauma in victimized children. *Journal of Traumatic Stress*, *34*(4), 711–720. https://doi.org/10.1002/jts.22697

Strydom, M., Schiller, U., & Orme, J. (2020). The current landscape of child protection services in South Africa: A systematic review. *Social Work*, *56*(4), 0–2. https://doi.org/10.15270/56-4-881

Sullivan, K. M., Murray, K. J., & Ake, G. S. (2016). Trauma-informed care for children in the child welfare system: An initial evaluation of a trauma-informed parenting workshop. *Child Maltreatment*, *21*(2), 147–155. https://doi.org/10.1177/1077559515615961

Tamayo, G. J., Broxson, A., Munsell, M., & Cohen, M. Z. (2010). Caring for the caregiver. *Oncology Nursing Forum*, *37*(1), E50–57. https://doi.org/10.1188/10.ONF.E50-E57

Tang, A., Almas, A., Zeytinoglu, S., Zeanah, C. H., Nelson, C. A., & Fox, N. A. (2021). Long-term effects of institutional care and enhanced attachment relationships on close adolescent friendships. *Child Development*, *92*(6), 2431–2446. https://doi.org/10.1111/cdev.13592

Tufford, L., & Newman, P. (2012). Bracketing in qualitative research. *Qualitative Social Work*, *11*(1), 80–96. https://doi.org/10.1177/1473325010368316

United Nations. (2010). Guidelines for the alternative care of children.

Van der Walt, G. (2018). Alternative Care in South Africa. *Obiter*, *39*(3), 615–651.

Ward, C. L., Artz, L., Leoschut, L., Kassanjee, R., & Burton, P. (2018). Sexual violence against children in South Africa: A nationally representative cross-sectional study of prevalence and correlates. *The Lancet. Global Health*, *6*(4), e460–e468. https://doi.org/10.1016/S2214-109X(18)30060-3

Young, D. S., & Casey, E. A. (2019). An examination of the sufficiency of small qualitative samples. *Social Work Research*, *43*(1), 53–58. https://doi.org/10.1093/swr/svy026