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Research Article

Psychosocial Health Interventionists in Practice:

A Qualitative Multiple-Case Study of Frontline and Community-Based Caregiving at a South African SOS Children's Village

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ABSTRACT

Background: Children who enter alternative care after abuse, neglect, separation, or bereavement carry a trauma burden that conventional child welfare models often inadequately address; children who remain within their communities but lose parental care carry a parallel burden of material and psychosocial precarity. Frontline caregivers and community workers who support these children are rarely recognised or resourced as psychosocial health interventionists.

Aims: This study explores how foster parents, frontline caregivers, community development workers, youth development coordinators, and programme directors at a South African SOS Children's Village function as psychosocial health interventionists for children who have lost parental care, and how each of these contribute to children's psychosocial wellbeing.

Methods: Using a qualitative multiple-case design, the study draws on in-depth interviews with five participants representing five distinct psychosocial intervention roles: a foster parent/institutional caregiver, a community development caseworker, a statutory gatekeeping social worker, a youth development coordinator, and a programme director. This single-participant-per-role design was judged to offer sufficient information power for the study's tightly defined, role-differentiated aim. However, findings are accordingly illustrative rather than representative of any one role. Interviews were semi-structured, verbatim-transcribed, and analysed using Braun and Clarke's (2006) reflexive thematic analysis. Credibility, dependability, and confirmability were supported through an audit trail, reflexive memoing, member checking, and cross-case source triangulation.

Results: Each role made a distinct and complementary contribution to children's psychosocial wellbeing. The institutional caregiver provided direct relational containment and crisis response to acute trauma presentations; the community development worker sustained children's psychological security indirectly, through material and administrative advocacy. The statutory gatekeeping social worker controlled the flow of trauma-relevant information into the care pathway; the youth development coordinator brokered continuity between residential and community-based support at discharge; and the programme director set organisational policy and modelled a dual psychological-and-pastoral response to spiritually interpreted distress. Beyond this role differentiation, findings document psychosocial presentations among children in care; structural barriers to community-based casework; a fragmented referral pathway marked by information withholding ahead of admission; informal intervention strategies; each worker's advocacy function within protection, educational, and legal systems; a divergence in post-care resilience favouring community-based over residentially raised young people; and self-recognised gaps in confidential support and training, corroborated at leadership level by a discontinued debriefing mechanism and an unprompted staff request for support.

Conclusion: Frontline caregivers, community workers, and organisational leadership at this SOS Children's Village function, as psychosocial health interventionists. Recognising and resourcing these roles formally, with corresponding training and psychological support, offers a route toward more effective, equitable, and sustainable alternative care and family-strengthening practice. These findings point to concrete, low-cost policy action: reclassifying existing frontline and leadership roles as psychosocial health interventionists in job descriptions, supervision structures, and funding models, while reinstating structured staff debriefing.

Keywords: *Foster care; Community development work; Trauma-informed care; Psychosocial intervention; SOS Children's Village*.

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1. Introduction

Globally, tens of millions of children live outside parental care as a result of parental death, abandonment, abuse, neglect, displacement, or family breakdown (Vallejo-Slocker, Idoiaga-Mondragon, & Axpe, 2024), and many carry a specific, cumulative burden of psychological trauma (Kemmis-Riggs et al., 2018). For decades, the dominant global response has been institutional in the narrowest sense: custodial, large-group residential care. Family-based models, most prominently the SOS Children's Villages network operating in more than 130 countries, depart from this paradigm by organising care around a stable, trained foster parent within a family-like household, supported by a wider family-strengthening structure that also assists children who remain within their own extended families and communities.

A substantial literature addresses caregiving practice and child welfare systems, but largely separately. Studies of foster parent training evaluate caregivers in isolation from the wider workforce around them (Konijn et al., 2020; Angelöw et al., 2026; Conibear, Schmidt, & Mulopo, 2025), while studies of the child and youth care workforce examine community-based and statutory roles largely apart from residential caregiving (Gray & Lombard, 2023; Zondeka, Sibiya, & Siluma, 2024). Within the specific context of SOS Children's Villages, existing accounts of caregiver experience, including Madzore and Methi's (2025) and Conibear, Schmidt, and Mulopo's (2025) South African studies, examine how individual caregivers manage trauma, but do not examine how foster parents, community development workers, statutory gatekeepers, youth development coordinators, and organisational leadership function together, across a single care pathway, as a coordinated set of psychosocial health interventionists. This collective, cross-role perspective matters because psychosocial outcomes for children who have lost parental care are shaped not by any single caregiving relationship in isolation, but by the coordination, or lack of it, between the frontline relationship, the material and administrative advocacy that sustains it, the information that reaches caregivers through the referral pathway, and the organisational leadership that resources and models trauma-informed response. Examining these roles together, rather than singly, is therefore necessary to understand how psychosocial intervention actually functions, and where it fails to function, across a real care pathway, and to identify what a genuinely complementary, multidisciplinary model of psychosocial care for children who have lost parental care would need to look like.

This article argues that the range of frontline workers who sustain relationships with children who have lost parental care should be understood, professionally supported, and evaluated as psychosocial health interventionists rather than lay caregivers or welfare auxiliaries. For this article, a psychosocial health interventionist is a worker who maintains a direct, ongoing relationship with a child or young person affected by the loss of parental care and actively intervenes relationally, materially, or administratively. This is meant to support that child’s psychological security, safety, or access to protective systems, as distinct from a role limited to material provision, supervision, or administrative processing without such active, relationally embedded intervention. While earlier treatments of this argument relied solely on synthesizing the attachment, developmental neuroscience, and trauma-informed care literatures, this article extends it empirically. It reports findings from a qualitative multiple-case study built around five in-depth interviews with frontline workers and leadership at a South African SOS Children's Village. The workers describe several relational and advocacy practices: co-regulation of dysregulated children, consistent and predictable presence, active advocacy within the formal care and legal system, and sustained material and administrative advocacy that secures children's access to documentation, grants, and schooling. These practices map directly onto mechanisms that attachment research (Bowlby, 2008; Ainsworth, Blehar, Waters, & Wall, 2015; Wright et al., 2023) and developmental neuroscience (Perry, 2006; Hakamata, Suzuki, Kobashikawa, & Hori, 2022) identify as central to trauma recovery and to the broader social determinants of child mental health. In this way, the study offers situated, first-person evidence for a claim argued until now primarily at the level of theory.

Theoretical Framework

This article will use attachment theory as a basis for discussion. Bowlby (2008) argued that children need a "secure base", a stable, trusted caregiver, to develop normally. Ainsworth et al (2015) showed empirically how these attachment patterns form. This work established the caregiver-child relationship as central to psychological

development. Schofield and Beek (2005) built on this by showing that foster parents can actively provide this secure base. Through consistent availability and sensitive responses, they help repair a child's capacity for attachment. Van IJzendoorn et al. (2023) confirmed this in a review: when caregivers focus deliberately on this repair function, children's attachment security measurably improves.

A third strand of research asks whether training actually improves practice. The evidence suggests it does. Gigengack et al. (2019) found that targeted training helped foster parents recognise trauma-driven behaviour. Konijn et al (2020)'s research programme found similar gains: better caregiver knowledge and practice, stronger alignment between foster parents and social workers after joint training (Angelöw et al., 2026), and improved emotional and behavioural skills in children after group intervention (Brinkerink et al., 2026). Kemmis-Riggs et al. (2018) reviewed this literature and identified the active ingredients of effective programmes: psychoeducation, skills coaching, and a clear focus on the caregiver-child relationship. Madzore and Methi (2025), working in South Africa, found that local caregivers manage complex trauma with little specialist support, despite facing significant socioeconomic adversity.

This literature points to one conclusion: the caregiving relationship itself is the active mechanism of trauma recovery, and the worker who provides it functions, in substance, as a psychosocial health interventionist. This is the claim the present study tests empirically, at the level of lived practice. The study addresses this claim through the following objective: to explore how foster parents, frontline caregivers, community development workers, youth development coordinators, and programme directors at a South African SOS Children's Village function, individually and collectively, as psychosocial health interventionists for children who have lost parental care.

2. Methods

Study Setting

The study was conducted at a South African SOS Children's Village, a family-strengthening and alternative care organisation operating several family-style foster homes on a residential site, each headed by a trained, salaried foster parent, alongside a community-based programme that supports children who remain with kinship or biological caregivers in surrounding neighbourhoods. The site is administratively linked to a national network of similarly structured facilities, and children enter residential care through a statutory referral pathway involving provincial social workers, the courts, and an internal admissions panel. This dual structure, combining residential family-based care with community-based family strengthening, is what allows the study to examine psychosocial intervention roles that operate both inside and outside the residential setting.

Study Design / Research Procedures

This qualitative multiple-case study used a design centred on five purposively selected, information-rich participants at a South African SOS Children's Village, chosen to capture contrasting frontline and leadership roles across the full care pathway. The multiple-case approach was chosen to explore, in depth, what frontline workers and leadership actually do, encounter, and need in order to function as psychosocial health interventionists (Yin, 2018). A multiple-case design was preferred over a single-case or purely thematic design because the study's objective is explicitly comparative and role-differentiated. Understanding how psychosocial intervention functions requires examining several bounded cases (each participant's role, caseload, and care-pathway position constituting a distinct “case”) both within their own context and against one another, to identify what is common across roles and what is specific to each (Yin, 2018). Cross-case comparison of this kind is what allows the analysis to distinguish a general “psychosocial health interventionist” function from the role-specific mechanisms, relational, material, informational, developmental, and organisational, through which each participant enacts it. The first three cases - institutional caregiving, community-based casework, and statutory gatekeeping - covered the pathway from referral through placement to family strengthening. Two further cases from a related strand of the same programme, a youth development coordinator and the centre's programme director, extended this by adding a cross-population perspective and an organisational/leadership vantage point. Semi-structured interviews were conducted by different researchers or

researcher pairs. Interviews ranged from 36 to 90 minutes. Most were conducted in English, with Sesotho and isiZulu segments translated, and all interviews were verbatim transcribed.

Sampling Strategy and Participant Recruitment

Participants were recruited using purposive, maximum-variation sampling (Yin, 2018), designed to capture the fullest practicable range of psychosocial intervention roles operating across the care pathway rather than to achieve statistical representativeness. The programme director acted as an internal gatekeeper, identifying one incumbent from each of five functionally distinct roles: an institutional (foster) caregiver, a community development caseworker, a statutory-facing social worker involved in admissions gatekeeping, a youth development coordinator, and the programme director. Inclusion criteria for each role were: current employment in that role at the study site for a minimum of twelve months; direct, ongoing, relational contact with children or young people affected by loss of parental care as a core part of the role; and willingness to discuss potentially sensitive material, including abuse, mental health, and bereavement, under the confidentiality protections described below. Exclusion criteria were: staff in purely administrative or facilities roles without direct child contact, and staff employed for less than twelve months, to ensure participants could speak from sufficient experience of the role. All five staff members approached agreed to participate; no one declined or withdrew. A single participant per role was judged, following Malterud, Siersma, and Guassora's (2016) concept of information power, to offer sufficient information power for a multiple-case design of this kind, given the study's tightly defined aim, the specificity and depth of each participant's role-based knowledge, the quality of dialogue achieved in the interview, and the explicit use of an established theoretical framework (attachment theory and trauma-informed care) to guide analysis. The trade-off, acknowledged in the Limitations, is that findings describe five illustrative cases rather than a representative sample of any one role. Because each role was represented by a single incumbent, sample adequacy was not assessed through numerical or thematic saturation across repeated cases within a role. Instead, data adequacy was judged, consistent with information power (Malterud, Siersma, & Guassora, 2016), by the depth, specificity, and internal coherence of each participant's account, and by the convergence of independently reported findings across roles (for example, referral-information withholding and the dual psychological-and-pastoral response, corroborated by two or more participants speaking from different structural vantage points). Future work with multiple incumbents per role, discussed further under Limitations and Future Research, would allow saturation to be assessed within, and not only across, roles.

Data Collection Procedures

Semi-structured, one-to-one interviews were conducted individually with each participant in a private office at the study site, to protect confidentiality and minimise disruption to routine duties. Interviews were audio-recorded with participants' consent and supplemented with brief researcher field notes made immediately after each interview. Interviews ranged from 36 to 90 minutes, were conducted by different researchers or researcher pairs across the five cases, and were conducted predominantly in English, with Sesotho and isiZulu segments translated by a bilingual member of the research team and checked against the audio recording before analysis. All interviews were transcribed verbatim.

Development of Interview Guides

A semi-structured interview guide was developed iteratively by the research team, drawing on the study's theoretical framework (attachment theory, developmental neuroscience, and the trauma-informed care literature) and on the existing evidence on caregiver training needs (Kemmis-Riggs et al., 2018). A common interview guide covered the domains and was adapted in wording, though not in domain, to fit each participant's specific role (for example, probes about grant applications and documentation for the community development worker; probes about admissions criteria and referral information for the statutory gatekeeper). The guide was piloted informally with the programme director before use with other participants, and minor wording adjustments were made to improve clarity; no substantive changes to content were needed.

Measurements

All interview schedules covered a common set of domains: role and care pathway, mental health and behavioural challenges encountered, intervention strategies used, self-care, professional development needs, and a success-case narrative.

Data analysis

As a qualitative study, no inferential statistical techniques were applied. Transcripts were analysed using Braun and Clarke's (2006) reflexive thematic analysis. This involved familiarisation with the data, inductive coding, and iterative theme development both within and across cases. Emerging themes were interpreted against the study's theoretical framework, while care was taken to preserve the distinctive character of each role. Analysis followed Braun and Clarke's (2006) six recursive phases: (1) familiarisation, through repeated reading of transcripts alongside the audio recordings; (2) generation of initial inductive codes across all five transcripts; (3) searching for candidate themes by collating codes into broader patterns of meaning, both within each case and across cases; (4) reviewing candidate themes against the coded extracts and the full data set for internal coherence and distinctiveness; (5) defining and naming themes, including the eight themes reported in the findings section; and (6) producing the final analytic account, integrating illustrative participant quotations. Coding was conducted manually, and an audit trail of code and theme development was maintained to support dependability (Nowell, Norris, White, & Moules, 2017).

Trustworthiness

Trustworthiness was addressed across all four criteria identified by Lincoln and Guba and operationalised for thematic analysis by Nowell, Norris, White, and Moules (2017). Credibility was supported through prolonged engagement with each transcript, investigator triangulation (interviews were conducted and independently reviewed by different researchers or researcher pairs), and member checking, in which a summary of each participant's key themes was shared with them for accuracy and resonance checking before finalisation of the analysis, consistent with Birt, Scott, Cavers, Campbell, and Walter's (2016) guidance on member checking in qualitative health research. Dependability was supported through the maintenance of a detailed audit trail documenting coding and theme-development decisions, allowing the analytic process to be traced and reviewed. Confirmability was supported through reflexive memoing throughout data collection and analysis (see Researcher Reflexivity, below), and through peer debriefing among members of the research team to challenge emerging interpretations. Source triangulation across the five cases, several of the findings reported were independently corroborated by two or more participants speaking from different structural vantage points, provided a further, data-internal check on the credibility of key themes, including referral-information withholding and the dual psychological-and-pastoral response to spiritually interpreted distress.

Researcher Reflexivity

Consistent with Barrett, Kajamaa, and Johnston's (2020) guidance on reflexive practice in qualitative research, the research team maintained ongoing reflexive awareness of its position throughout the study. Researchers were academically affiliated and external to the study site's management structure, which supported participants' willingness to disclose organisational shortcomings but also required active attention to the power differential inherent in being invited into the site by its own leadership. Interviews being conducted by different researchers or researcher pairs, rather than a single interviewer, was itself an intentional reflexive strategy, intended to reduce the influence of any one researcher's assumptions on the interview process and to allow cross-checking of interpretation during analysis. Researchers kept reflexive notes after each interview, recording initial reactions and possible biases, which were discussed at team analysis meetings and used to inform the confirmability measures described above.

Ethical Considerations

Ethical clearance was granted by the UNISA College of Education Ethics Review Committee (2024/06/12/000000031/01/RB). Consent to publish the data in an academic journal was obtained from participants.

Given the sensitivity of the content discussed, including abuse, sexualised behaviour, psychological crisis, disability, contested kinship placements, and staff bereavement or mental health, identifying details were removed or generalised, and participants are referred to throughout as Participant A, B, C, D, and E. Participation was voluntary, and participants were informed of their right to withdraw at any point without consequence for their employment. Given the vocational and hierarchical context of the site, particular care was taken to separate the recruitment process, led by the programme director as gatekeeper, from participants' ongoing sense of freedom to decline or withdraw, which was reiterated verbally by researchers at the start of each interview. Where participants described specific children or incidents, identifying details (names, ages where distinctive, and place names) were altered or removed in the reporting of findings to protect the confidentiality of children who were not themselves research participants.

3. Results

Role-Specific Psychosocial Intervention Functions: An Overview

Participant A, an institutional foster caregiver, functioned primarily as a *relational and clinical first responder*: she provided direct, day-to-day co-regulation of severely dysregulated children and coordinated the centre's frontline response to acute psychosocial crises. Participant B, a community development caseworker, functioned as a *material and administrative advocate*: her psychosocial contribution operated indirectly, through securing identity documents, grants, and school placements that underpin children's psychological security outside the residential setting. Participant C, a statutory-facing gatekeeping social worker, functioned as an *information gatekeeper and admissions safeguard*: her role determined what trauma-relevant information reached the caregivers responsible for a child's day-to-day psychosocial support. Participant D, a youth development coordinator, functioned as a *continuity broker*: her cross-population vantage point, spanning both residential and community-based young people, allowed her to identify how psychosocial support (or its absence) at the point of discharge shaped long-term resilience. Participant E, the programme director, functioned as an *organisational architect and model-setter*: his role set the policies, referral rules, and dual psychological-and-pastoral response that structured how the other four roles could function as interventionists. These five functions, relational/clinical, material/administrative, informational/gatekeeping, continuity-brokering, and organisational, describe a complementary division of psychosocial labour across the care pathway, rather than five independent or interchangeable roles. The themes below present the evidence for each function in turn.

Eight major themes were identified: (1) caregiving as a multi-role vocational identity; (2) the range and severity of psychosocial and behavioural presentations managed within the Village; (3) structural and material barriers to community-based and youth-development casework; (4) referral fragmentation, statutory gatekeeping, and information asymmetry in the pathway into care; (5) informal, multi-agency and material-incentive strategies deployed in the absence of a standardised framework; (6) personal costs, self-care, and professional development needs; (7) each worker's function as an advocate within formal protection, educational, or legal systems; and (8) structural gaps in discharge, aftercare, alumni resilience, and material resourcing.

Theme 1: Caregiving as a Multi-Role Vocational Identity

Participant A described her presence at the centre as a continuous, shifting occupation of whatever caregiving role was most needed, framed explicitly as a calling rather than a job: *"I do have a calling... Social worker, I don't take it as a profession... You are needed every day... Don't do it for money. Just touch the lives."* Participant B's vocational identity was anchored in a more personal origin story: she entered SOS as a former beneficiary of its earliest HIV-focused community outreach, at a time when she herself was a young mother managing an HIV diagnosis: *"I volunteered in 2003, of which I was one of the people who were helped by SOS back then... I want to help other people who are like me."* Participant C described an extended, uncompensated period of voluntary service that directly produced her eventual employment, progressing from community development work to a social work post within ten months. Participant D's account added a fourth variant: recruitment into a now-discontinued, residential "youth leader" post

after an initial, unsuccessful attempt to volunteer as a student, followed by professional growth she located in the same relational register: *"Communication... that's where I grew more... last year I was trained as a master trainer for the whole of South Africa in Trauma Informed Practices."* Participant E offered a fifth, organisationally distinct variant, contrasting the limited, cyclical impact of his earlier work at a substance-use treatment facility; *"it felt like we were trying to put out a fire with a bucket... you just keep seeing the same group of clients"*, with a deliberate return to earlier, preventive intervention, rooted in his own upbringing in a township community: *"I just felt the need to be able to go back into... the black community to be able to kind of make an impact."* Across all five participants, entry into frontline or leadership caregiving work was preceded by unpaid or under-compensated service, or an explicit personal motivation, rather than employment-seeking. This suggests the vocational orientation this article treats as significant as a recurring pathway extending from direct caregiving to organisational leadership.

This vocational orientation matters for the study's objective because it describes the motivational foundation on which each role's distinct interventionist function is described in Theme 1's overview above. None of the five participants approached their role as bounded, administrative labour, and all five described actively extending their responsibilities to meet children's psychosocial needs.

Theme 2: The Range and Severity of Presenting Psychosocial Challenges

Participant A described several categories of presentation corroborating the cumulative trauma profile documented in the wider literature (Keeshin et al., 2019; Kemmis-Riggs et al., 2018; Williamson et al., 2017): developmental regression: *"they are functioning with the mind of a three (3) to four (4) years child... at the age of fifteen (15)"*; harmful sexualised behaviour among a subgroup of children later found to have themselves been sexually victimised *"The children who have done that to our dog, those are the children that were sexually molested"*; and peer victimisation severe enough to require caregivers to physically accompany vulnerable children. The most severe episode she described involved roughly half the centre's children reporting shared nocturnal experiences interpreted within a spiritual framework, including narratives of being taken from their rooms at night: *"They say... they are flying... He came with a gold train... then, he took us at night."* Her clinical assessment distinguished hallucination, dreaming, and unexplained reports, and the centre's response combined psychosocial containment with pastoral intervention: *"We call the spiritual pastors to come and help us... We've been praying for the kids". "The episode produced secondary traumatic stress in one caregiver, who required psychiatric hospitalisation before recovering".*

Participant C independently identified family non-visitation as the single most significant driver of distress, producing mood disturbance and acting out to the point that the centre withholds advance notice of family visits to protect children from the distress of a no-show: *"If I happen to tell a child... your aunt will be coming to see you... and that person doesn't come, eish it breaks the child."* She corroborated Participant A's account of harmful sexualised behaviour from a prevention perspective, describing children luring others into similar activity during unsupervised play, prompting a restructuring of outdoor supervision from one caregiver to a rotating team of four.

Participant D's account, spanning both resident and community-based young people, extended this severity to the point of exit from care. She described an acute case of substance-related crisis in a young person newly placed in employment: *"he's abusing substance and he smoked crystal meth... at night he ran into the village to ask for help",* and a sibling case in which financially coercive substance use produced suicidal ideation in the elder sister. She described a case of safety-threatening aggression, precipitated by a rejected reunification attempt, that parallels Participant C's broken-promise finding: a child who threatened a foster mother with a knife after being told *"I do not want you, you are not my child"* during a home visit was subsequently medicated and stabilised. ADHD and conduct disorders were the most common diagnoses, with a smaller number of sexual trauma cases. Children with autism-spectrum or specific learning-disorder profiles are referred to specialised residential facilities rather than retained. The death of a child under two produced a grief response across the caregiving team that a single debriefing session did not adequately address.

Participant E, from the organisational leadership level, independently corroborated two central findings. On referral concealment, mirroring Participant C's account: *"We rely heavily on the referral social worker reports... they would want to influence us in a particular direction... it would paint a rosy picture of a child... but then only later do we discover... challenges with learning, mental health."* The centre's explicit policy against admitting children with pre-existing behavioural problems, rooted in the absence of on-site specialist and isolation capacity, means such presentations often only become apparent after a court order has already placed a child in the centre's legal care, prompting referral for diagnostic observation and, where necessary, a return to court to reconsider placement. On spiritually interpreted distress, he described a child's psychotic symptoms attributed by the foster mother to demonic possession, met with a deliberate dual response: *"We will take this child to psychologist for assessment... but if it will help we'll also make arrangements for pastors and ministers to come and offer prayer."* This directly substantiates, from an independent organisational source, Participant A's account of the centre's dual psychosocial-and-pastoral response, indicating a recognised, deliberate feature of practice rather than one caregiver's improvisation.

The severity and range of presentations documented in this theme show why the institutional caregiver's relational and clinical first-response function, described in the Theme 1 overview, is indispensable to children's emotional wellbeing. Without a caregiver who can distinguish clinical crisis from cultural or spiritual idiom and to co-regulate acute distress in the moment, presentations of this severity would have no immediate psychosocial response at all.

Theme 3: Structural and Material Barriers to Community-Based and Youth-Development Casework

Participant B's caseload was dominated by missing identity documentation: *"the ID was burned with their shack... without an ID there is nothing they can do"*. An insufficient statutory child support grant of R500 per month was routinely supplemented from her own income, and a structured, time-limited referral pathway to the centre's own programme was in place pending a foster care grant application. This shows that, for a community-based worker, functioning as a psychosocial interventionist requires sustained engagement with material and administrative determinants of wellbeing that are inseparable from psychological security. Participant D identified a further, funding-specific barrier operating at national scale: an intermittent government service-level agreement and a durable post-COVID loss of donor income, shared across eleven facilities nationally, that periodically suspends programming. *"There's months where you'll have to wait, because an SLA was not signed... after COVID we lost a lot of donors"*. Participant E corroborated this from the leadership level, identifying school selection by proximity rather than quality, and underdeveloped local business engagement, as further material constraints on children's outcomes.

This theme demonstrates the material and administrative advocacy function attributed to the community development worker in the Theme 1 overview. Her psychosocial contribution to children's wellbeing is largely invisible in a narrow clinical sense, yet the grants, documentation, and school placements she secures function as direct determinants of the psychological security she is trying to protect, extending psychosocial intervention beyond the residential setting and into the wider community.

Theme 4: Referral Fragmentation, Statutory Gatekeeping, and Information Asymmetry

Participant C described a chronic shortage of accessible clinical psychologists, rooted in a geographic gap in government provision, and a systematic pattern of information withholding by referring statutory social workers, in which material information including sexual abuse history is omitted from referral documentation: *"If the child was raped, the social worker doesn't mention in her report, she'll just say the child was in need of care and protection."* She attributed this to referring workers' incentive to secure placement quickly and to the structural handover of responsibility once a child is admitted. She also described the centre's own countervailing gatekeeping mechanism, an admission panel requiring evidence of family-tracing efforts, reflecting residential care as a last resort. Participant E independently corroborated this concealment pattern (Theme 2) and supplied further structural detail. This includes an explicit age cut-off of eleven years for new admissions, a firm policy against separating siblings even where this means mixing genders and ages

within a household, and a formally constituted admissions committee comprising the programme development coordinator, the centre's social worker, and an elected foster-mother representative. This organisational-level testimony converges with Participant C's account, lending support to her central claim: information asymmetry is a structural feature of the system encountered consistently across roles.

This theme evidences the information-gatekeeping function attributed to Participant C in the Theme 1 overview and clarifies why it matters for psychosocial outcomes. When trauma-relevant information is withheld upstream of admission, the caregivers who would otherwise provide targeted relational or clinical support (Theme 2) are left to discover a child's needs reactively, delaying the psychosocial response a child receives at the point it is most needed.

Theme 5: Informal, Multi-Agency and Material-Incentive Strategies

Participant A described an informal, person-centred practice orientation in the absence of any standardised framework, relying on referral to external specialists, collaboration with police and Thuthuzela (a specialised sexual-abuse service), and structured case-panel consultation among colleagues: *"I think sharing is caring"*. Participant B developed an explicit material-incentive strategy, timing trainings to coincide with food-parcel distribution*: "I use the food parcel to get them to come*", alongside proactive community engagement at councillor meetings and church gatherings. Participant C added caregiver-directed mediation between foster mothers and children invoking their rights to resist household discipline, linked to a perceived gap in the centre's rights-based programming. Participant D extended the material-incentive logic to adolescents (refreshments and covered transport for programme attendance) and described an improvised, case-by-case placement strategy, relocating children within the Village's house structure to match a foster mother better able to manage a specific presentation. Participant E's dual psychological-and-pastoral response (Theme 2) constitutes a further instance of this same pattern at the organisational level. Across all five participants, workers at every level construct their own informal intervention infrastructure, absent any standardised framework, adapted to the specific population, risk, or belief system they encounter.

This pattern of self-constructed, informal practice, recurring across every role described in the Theme 1 overview, is direct evidence for the study's central objective. It shows workers already performing the coordinating, resourceful, adaptive work of psychosocial health interventionists, but doing so individually and without a shared, standardised framework to guide or connect their efforts.

Theme 6: Personal Costs, Self-Care, and Professional Development Needs

Participant A named morning exercise as her sole self-care practice, a narrow, individually carried coping repertoire consistent with the absence of formal organisational wellbeing support (Bartlett & Rushovich, 2018; Keeshin et al., 2019). Participant B described persistent anxiety carried home from community visits and a specific structural barrier to seeking support. Because of fear of peer judgement, she avoided her own supervisor despite holding medical aid that could fund confidential counselling, proposing that the organisation itself broker access to counselling through that existing benefit. Participant C named the absence of any formal debriefing structure, alongside a second-order burden of functioning as an informal support resource for overwhelmed foster mothers. She described a staff support group as oriented toward informal pampering that explicitly excludes confidential disclosure. Regarding training, Participant A sought broader clinical and "holistical" knowledge; Participant B sought counselling training beyond her HIV-specific competence, and diversity-responsive training in disability and sexuality; Participant C sought training in child sexual trauma and gender-based violence. Those three participants, interviewed separately, converged unprompted on counselling-adjacent training as an unmet priority, providing triangulated evidence that this gap is structural rather than idiosyncratic. Participant B's account also surfaced a formal, colour-coded performance appraisal system with no psychological-support counterpart, an asymmetry indicating that organisational investment in monitoring output has outpaced investment in monitoring wellbeing.

Participant D converged closely with this picture while adding two points: a fixed, non-residential schedule that enabled a clearer work-family boundary, *"you switch off completely from work... that time with my daughter is the*

most precious one", and confirmation that formal continuous development is available to foster mothers but not other staff*, "you have to develop yourself*". She proposed a dedicated, confidential wellness function distinct from the single, ad hoc debriefing session offered after a child's death. Participant E, from the leadership level, both corroborated and extended these findings. He described the discontinuation of an in-house debriefing mechanism ("I-Cares") for foster mothers and was replaced by a generic medical aid covering only severe cases, and a shift to informal, partly self-funded peer support, a direct organisational corroboration of the frontline gap. He self-funded his own postgraduate study after his employer could not assist, and identified professional isolation specific to being the centre's only male staff member and to the boundary he maintained as Director: *"You end up just relying mostly on friends and family."* He named self-regulation, emotional intelligence, and stakeholder-facing tact as priority development needs among his administrative team, and linked staff disillusionment to the mixed long-term outcomes of children who leave care. Most significantly, Participant E used the closing minutes of his interview, unprompted, to request that the research team consider a structured, recurring staff debriefing service: *"We were wondering whether a debriefing session of some sort could be arranged... maybe on a bi-monthly basis... an outlet of some sort."* This in vivo request, volunteered by the centre's most senior leader, is consistent with this article's central argument.

This theme speaks directly to the sustainability of the psychosocial functions described throughout. A workforce that is, in effect, delivering trauma-informed psychosocial intervention without formal recognition, training, or confidential support is a workforce at risk of the very burnout that would compromise the emotional wellbeing of the children it supports.

Theme 7: Advocacy within Formal Protection, Educational, and Legal Systems

Participant A described her role in a contested kinship placement: a boy whose custody was disputed between an actively involved aunt and a largely absent sister. She advised that the case be referred to court rather than settled informally, and the child, then fourteen, testified to his own preference for his aunt and Participant A as his primary attachment figures. He was placed with his aunt and continued to seek her support afterward. Participant B's case operated through disability-inclusive education rather than the courts. She managed to secure placement in a specialised school for an eleven-year-old with a physical disability, freeing his overburdened grandmother-caregiver to sustain her income-generating work. Participant C's case independently replicated Participant A's mechanism in a second, separate kinship dispute.: identifying a discrepancy between a child's formal care plan and his sister's actual disengagement. That courtroom advocacy grounded in a child's expressed attachment preference recurs across two independent cases, documented by different workers and researchers, strengthens the claim that this is a structural feature of practice rather than an isolated occurrence.

Advocacy of this kind is where the relational function described in Theme 1 becomes formally consequential. By carrying a child's attachment preferences and educational needs into legal and educational systems that would not otherwise register them, these workers directly shape whether a child's psychosocial environment, and not only their material circumstances, is protected going forward.

Theme 8: Discharge, Alumni Resilience, and Resourcing

Participant A described acute crisis at the point of discharge, including suicidal ideation among children with no family to return to. Participant C extended this into a longer-range, outcomes-oriented account: children who performed well academically received sustained investment through tertiary study, while children who knew no home other than the centre appeared disproportionately likely to struggle after discharge despite superior material provision. She stated that: *"those are the children who don't make it in life... they live like five-star life"*. This was illustrated through two divergent post-discharge trajectories. She also described successful alumni returning as motivational speakers. Participant D's account offered the study's most striking extension of this finding: an explicit, comparative judgement, formed over twelve years and consistent across other SOS sites nationally, that residentially raised children show markedly less resilience after leaving care than children supported through community-based family strengthening.

Despite the latter's far fewer material resources, they are more resilient: *"The ones in the community they are more resilient... with the minimal resources that they have... they are doing way much better than the ones in Alternative care."* She attributed this to children's difficulty tolerating a return to a materially poorer home after residential comfort. This sharpens the article's theoretical argument: the therapeutic value of caregiving may depend on the relationship preparing a child for continuity, rather than rupture, between their care environment and their eventual, independent circumstances. Participant D also described the centre's concrete aftercare provision and specific alumni success stories, while Participant E connected these mixed outcomes to staff disillusionment and offered current examples of high academic achievement as evidence of effective educational investment. Participant C additionally identified a shortage of basic therapeutic materials and recreational funding, traced to a funding model covering only salaries and basic food. Participant B identified unreliable case-management technology dependent on institutional Wi-Fi. These findings point to under-addressed gaps across the continuum of care: absent structured aftercare, a systematic resilience divergence between residential and community-based support, unreliable technology, and a funding model dependent on unpredictable donor goodwill.

This theme demonstrates the continuity-brokering function attributed to Participant D in the Theme 1 overview, and it is the clearest evidence in the data that psychosocial intervention roles must be understood as complementary rather than substitutable. Strong relational and material support during care (Themes 1 through 7) is insufficient on its own if it is not matched by preparation for continuity after discharge, which is where community-based, family-embedded support currently appears to outperform residential provision on this evidence.

4. Discussion

These findings substantiate, at the level of lived practice, the claim that trained and relationally engaged frontline caregivers, community workers, and gatekeeping social workers function as psychosocial health interventionists. Participant A's and Participant C's independently documented courtroom advocacy corresponds closely to Schofield and Beek's (2005) "secure base" function, while Participant B's documentation and grant advocacy demonstrates that the same interventionist function extends into material and administrative domains. This reading is consistent with recent evidence on organisational-level trauma-informed care: Fernandez, Gausereide-Corral, Valiente, and Sanchez-Iglesias's (2023) systematic review found that trauma-informed principles are most effective when embedded into the everyday practice of frontline staff rather than delivered as a stand-alone clinical add-on, precisely the pattern these five workers describe enacting informally and without institutional recognition.

It is necessary to find out why these interventionists contribute differently, rather than performing an interchangeable version of the same function. The findings suggest this is a structural, rather than incidental, feature of the care pathway. Each role sits at a different point in a child's ecology of need, from the immediate, relational containment of acute distress (Participant A), through material and administrative determinants of security operating at the family and community level (Participant B), to the flow of information and resources that determines what reaches the frontline at all (Participant C), the transition out of care (Participant D), and the organisational policies that make any of this possible at scale (Participant E). A single, generic caregiving role could not plausibly perform all five functions simultaneously and to the necessary depth. The differentiation observed here is therefore best understood as a natural division of psychosocial labour, in which the workforce's collective effectiveness depends on the roles working in coordination rather than in isolation. This has direct implications for multidisciplinary psychosocial care. Models that train or resource only the clinically visible caregiving role, while leaving material advocacy, information gatekeeping, and organisational leadership unrecognised and unsupported, are likely to reproduce exactly the fragmentation this study documents. Structured multidisciplinary team practice, of the kind evaluated in child and youth care contexts by Nooteboom, Mulder, Vermeiren, Eilander, van den Driesschen, and Kuiper (2022), offers one practical mechanism through which these differentiated roles could be more deliberately coordinated, for example through regular, structured case discussions that explicitly bring information held by statutory gatekeepers, community workers, and residential caregivers into the same conversation.

The five cases diverge instructively in the register of need each worker manages: acute clinical presentations (Participant A), chronic structural adversity (Participant B), and the referral-pathway and gatekeeping functions determining whether relevant information reaches the workers managing the first two registers (Participant C, corroborated by Participant E). This indicates that a workforce-investment response confined to clinical training alone would leave the gatekeeping register unsupported. That all participants described operating without a standardised framework, while independently converging on counselling-adjacent training as an unmet need, indicates that the trauma-informed training models evaluated in the literature (Gigengack et al., 2019; Konijn et al., 2020; Angelöw et al., 2026; Brinkerink et al., 2026) have not yet been operationalised at this centre, despite workers precisely performing the function those models are designed to support. This gap mirrors a broader pattern documented in the South African child and youth care sector. Gray and Lombard (2023)'s analysis of the country's developmental social welfare system found that, despite formal professionalisation since 2015, child and youth care workers remain poorly integrated into the wider social service workforce, with supervisory and training structures lagging behind the demands of the role. Zondeka, Sibiya, and Siluma's (2024) qualitative study of child and youth care workers in KwaZulu-Natal reached a similar conclusion: workers still lack clarity about what professional recognition means in day-to-day practice, even where registration has formally been achieved. The present findings extend this literature by showing what that gap looks like from the inside, in the account of workers who already perform a psychosocial health function without the institutional architecture that would formally recognise it.

The addition of Participant D and Participant E extends this discussion in three ways. Participant D's account of a systematic divergence in post-care resilience genuinely complicates, rather than simply extends, the article's theoretical framework. The attachment and developmental-neuroscience literature locates caregiving's therapeutic mechanism in relational quality that is largely independent of material circumstance. Her account suggests instead that a materially resourced institutional household may leave a young person poorly prepared for the economic conditions they return to, while a materially poorer, family-embedded household appears to cultivate greater resilience. This observation sits within a wider, and still unsettled, evidence base on how care modality shapes outcomes. Giraldi et al. (2022)'s global review found consistent evidence that children in family-based care tend to fare better than those in residential settings across behavioural, socio-emotional, and psychological domains, while cautioning that comparative studies rarely control adequately for the greater needs that lead some children into residential placement in the first place. Closer to this study's setting, Walakira et al. (2022)'s qualitative account of children reintegrated from Ugandan residential facilities into family-based care found that most children and caregivers described the transition positively, notwithstanding real material hardship, while Neville, Okunoren, and Crea's (2023) analysis of nationally representative survey data from Nigeria, Zambia, and Zimbabwe found that prior residential-care experience was associated with worse mental health and violence outcomes than kinship or foster care. This literature lends independent, population-level plausibility to Participant D's single-case observation, while underscoring that her account remains a preliminary, hypothesis-generating finding rather than a settled result. It refines, rather than contradicts, the article's central claim, with direct implications for how family-based care models design aftercare and life-skills preparation.

Participant E's independent corroboration of both the referral-concealment finding and the dual-response model to spiritually interpreted distress substantially strengthens both findings' evidentiary weight, since his organisational vantage point gives him visibility across many cases rather than one caseload. His professional isolation as the centre's only male staff member, and his unprompted, in-interview request for structured debriefing, demonstrate that the need for psychological support this article argues for is recognised by the organisation's own leadership in real time, and would be received as a welcomed remedy rather than an imposition. This finding is consistent with a growing body of research on the occupational risks facing residential and child welfare staff. Milne, Ratushniak, and Nguyen (2024) found that the professional quality of life of residential care workers depends heavily on individual and organisational resilience, and that unaddressed secondary traumatic stress erodes the compassion satisfaction that sustains this kind of relational work overtime. Orsi-Hunt et al.'s (2023) cluster-randomised trial of a structured resilience intervention for child welfare workers found measurable reductions in burnout and turnover intention once such support was formalised rather than left to individual coping. Set against this evidence, the discontinuation of the centre's own

debriefing mechanism appears not as an isolated administrative lapse, but as an instance of a structural gap that is now well documented, and increasingly well addressed, elsewhere in the literature.

These findings show that the SOS Children's Village model's principal strength, relative to the conventional institutional care it was designed to depart from, lies in the depth and durability of the relationships its structure allows individual workers to build with children. The courtroom advocacy, material advocacy, and dual psychosocial-pastoral responses documented above would be difficult to sustain within a rotating-shift, custodial model. Its principal weaknesses, on this evidence, lie precisely where the model relies on individual workers absorbing structural gaps that organisational systems have not yet closed: a referral pathway that permits information withholding, an admissions and specialist-referral system without on-site clinical psychology capacity, a discontinued staff debriefing mechanism, and, on Participant D's account, an aftercare transition that may leave residentially raised young people less prepared for their post-care material circumstances than community-based peers. The SOS model's strength is relational, and its principal vulnerability is organisational. This distinction advances the wider understanding of community-based psychosocial intervention by showing that family-based alternative care models do not automatically resolve the fragmentation problems documented in more conventional institutional settings. They relocate that fragmentation from the relational register, where the model performs comparatively well, to the organisational and transitional registers, where formal recognition, training, and coordinated multidisciplinary support remain to be built.

Limitations

This study draws on five participants at a single centre. At the same time, the deliberate contrast across institutional, community-based, statutory, youth-development, and leadership roles strengthens analytic richness relative to a smaller design; findings remain illustrative and hypothesis-generating rather than generalisable across the SOS network or Global South settings more broadly. The analysis was not triangulated against other data sources, such as case records or additional participants, and future research should incorporate such triangulation. A single participant represented each role; while this was judged, on information-power grounds (Malterud, Siersma, & Guassora, 2016), sufficient for a multiple-case design of this scope, it means findings for any one role reflect one individual's account and cannot be assumed to generalise even within the same site. No structured observation or document review was undertaken, so findings rest entirely on participants' retrospective, self-reported accounts of their practice.

5. Conclusion

This study set out to explore how foster parents, frontline caregivers, community development workers, youth development coordinators, and programme directors at a South African SOS Children's Village function as psychosocial health interventionists for children who have lost parental care. This qualitative multiple-case study provides direct, first-person evidence that frontline workers and organisational leadership at a South African SOS Children's Village, in practice, function as psychosocial health interventionists across five complementary roles. All five deploy largely self-constructed multi-agency and material-incentive strategies, absorb significant personal risk, and act as sustained advocates for children within formal protection, educational, and legal systems. These findings substantiate the theoretical claims of attachment theory, developmental neuroscience, and trauma-informed care research while revealing a significant, self-recognised gap between the structured training models evaluated in the literature and the informal, unsupported practice observed on the ground, a gap the centre's own programme director independently asked the research team to help address. This practice gap extends upstream, into a fragmented referral pathway in which clinically material information can fail to reach caregivers, corroborated at leadership level, and downstream, into a discharge period in which residentially raised children fare worse, on this evidence, than those supported through community-based family strengthening despite far fewer resources. This nuance has direct implications for how family-based care models calibrate life-skills and aftercare preparation.

Recognising institutional caregivers, community development workers, statutory gatekeeping social workers, youth development coordinators, and programme directors formally as psychosocial health interventionists, with the

training, professional integration, and psychological support that recognition implies, offers a route toward more effective, equitable, and sustainable alternative care and family-strengthening practice, responsive to needs frontline workers and leadership have already articulated for themselves. In direct answer to the study's objective: these five roles do not function as five separate caregiving jobs, but as one coordinated, complementary system of psychosocial intervention, relational, material, informational, transitional, and organisational, in which each role compensates for what the others cannot provide. Coordinated multidisciplinary caregiving of this kind is essential for children who have lost parental care precisely because no single role, however committed, can meet the full range of relational, material, informational, and organisational needs this study has documented. Further research, incorporating larger samples, multiple sites, and triangulated data sources, is needed to establish the generalisability of these findings, including the reported resilience divergence, across the SOS Children's Villages network and comparable Global South care models.

6. Recommendations

Building on the findings and discussion above, the following practical recommendations are proposed.

Training

Training should combine psychoeducation, skills coaching, and sustained attention to the caregiver-child relationship, designed for feasibility in resource-constrained settings rather than assuming access to specialist services. Develop role-specific, competency-based training for every psychosocial intervention role identified in this study, not only residential caregivers, combining psychoeducation, trauma recognition, and skills coaching designed for feasibility in resource-constrained settings.

Interdisciplinary collaboration

Institute structured, recurring multidisciplinary case discussions bringing together institutional caregivers, community development workers, statutory gatekeepers, youth development coordinators, and leadership.

Standardised psychosocial intervention guidelines

Replace the current reliance on informally constructed, individual strategies with a documented, organisation-wide psychosocial intervention framework, including explicit protocols for responding to spiritually interpreted distress, sexualised behaviour, and referral-information verification.

Routine mental health supervision for caregivers

Reinstate and formalise structured, confidential debriefing for all frontline and leadership staff, at minimum on a bi-monthly basis.

Policy support

Formally reclassify foster parents, community development workers, statutory gatekeeping social workers, youth development coordinators, and programme directors as psychosocial health interventionists in job descriptions, supervision structures, and funding models, and pursue diversified, less donor-dependent funding to stabilise the programming interruptions.

Future research

Conduct larger, comparative, multi-site studies, incorporating triangulated data sources such as case-record review and additional participants per role, to evaluate the effectiveness of different psychosocial intervention models, and specifically to test, on a larger sample, the preliminary post-care resilience divergence between residential and community-based support.

Conflict of Interest

There is no conflict of interest. Nothing to disclose.

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