ORIGINAL ARTICLE

CAREGIVERS' PERSPECTIVE ON BONDING WITH INSTITUTIONALIZED CHILDREN AND ADOLESCENTS

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Highlights: (1) Bonding is crucial for caregivers and those receiving care in institutionalization. (2) There is social invisibility of caregivers in child and youth institutionalization. (3) There is a need to value and train institutional caregivers.

PRE-PROOF

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CAREGIVERS' PERSPECTIVE ON BONDING WITH INSTITUTIONALIZED CHILDREN AND ADOLESCENTS

ABSTRACT

Objective: This study aims at exploring caregivers' perspectives on the bond established in the care of institutionalized children and adolescents. **Methods:** A qualitative study was conducted with ten caregivers from a child and adolescent care institution in southern Brazil. The participants were selected based on two inclusion criteria: direct involvement in child and adolescent care and minimum tenure of three months at the institution. Data collection took place between October and November 2020 through semi-structured interviews. The data underwent directed content analysis guided by Watson's Human Care Theory, which served as grounds for developing the initial coding framework. **Results:** Two categories were obtained: The bond as a form of transpersonal care, which allowed understanding the transpersonal relationships proposed by Jean Watson as a form of care established through the bond between the caregiver and the person cared for; and Care work in bond formation and disruption, which provided insights into how attachment influences the establishment and dissolution of caregiver-child relationships. **Conclusion:** It is essential to foster bonds and attachment in transpersonal relationships, particularly in the care of children and adolescents, where the caregiver's role is indispensable. Within institutional care settings, providing emotional support and recognition is crucial for enabling caregivers to establish attachment-based relationships, which are fundamental to children's and adolescents' development, especially in the deinstitutionalization context.

Keywords: caregivers; institutionalized children; institutionalized adolescents; interpersonal relationships; nursing theory.

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INTRODUCTION

The Statute of the Child and Adolescent (*Estatuto da Criança e do Adolescente*, ECA) establishes protective measures and the rights of children and adolescents, ensuring their safety when threatened or violated, whether due to omission or actions that pose risks[1]. One of these protective measures involves referring children and adolescents to institutional care, which should only be a temporary and exceptional solution when they cannot remain with their parents or legal guardians[2].

Institutional care must be conducted with diligence, considering the needs and relationships between each child or adolescent and their family, aiming to mitigate the issue that led to institutionalization[3]. In this context, institutionalization (removal of a child from their family environment and placement in a care facility as a temporary measure until reunion with their biological or extended family or adoption) is an essential protective strategy. However, it should be implemented responsibly, involving the family through effective public policies[4] rather than as a primary solution to ensure rights[3], particularly in cases where economic conditions are insufficient to meet basic needs.

Within the institutional setting, caregivers are responsible for providing direct care to children and adolescents, ensuring compliance with their rights[1]. However, even though institutionalization is a protective measure, it can cause fear and anxiety in minors due to environmental changes and separation from familiar individuals[5]. Thus, care institutions must address both the physical and emotional needs of their residents.

According to Jean Watson, proponent of the Theory of Human Care (THC) in Nursing, caregiving must foster human beigns' biological, social and spiritual development[6]. Applying this theory to the study subject matter, institutional caregivers become central figures for institutionalized children and adolescents, establishing emotional bonds through expressions of affection and attachment to meet basic needs, provide education and ensure healthy development[7].

This theory posits that care arises from a humanistic perspective, incorporating values, fundamental human needs and scientific knowledge. It conceptualizes caregiving as a mutual relationship of trust and support, fostering an environment marked by acceptance, protection and correction while promoting learning and development across physical, mental, social and

spiritual domains[6]. Establishing trust between children and caregivers is essential for creating a transpersonal connection that enables effective caregiving.

Therefore, caregiving serves as grounds for bonding between caregivers and minors. These bonding is vital to foster a nurturing environment conducive to healthy development, thus reinforcing a sense of support, self-expression, comfort and security while strengthening interpersonal relationships[7-8].

However, when children and adolescents develop attachment to institutional caregivers, a reciprocal bond is formed. Crucial for effective caregiving, this attachment emerges through daily activities, physical care and emotional expressions[7]. Caregivers recognize that attachment and bonding are fundamental for proper development, as these connections ensure comprehensive and good quality care[7,9].

The bond established between a primary caregiver and a child during early years significantly influences future emotional and cognitive development, shaping exploratory behaviors and affecting linguistic and motor skills. Consequently, attachment relationships and experiences play a critical role in development, making it essential to foster secure bonds[10] that encourage children and adolescents to engage with their environment, interact with others and integrate into society.

Given these considerations, it is imperative to expand knowledge about the bonds formed within institutional care settings. Thus, this study aims at exploring caregivers' perspectives on the relational bonds established in the care of institutionalized children and adolescents. The research question guiding this study is as follows: Which are the caregivers' perspectives regarding the relational bonds formed in the care of institutionalized children and adolescents?

METHOD

This qualitative study was conducted between October and November 2020 following the Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist, a validation standard for qualitative studies[11]. The research *locus* was a child and adolescent care institution in a municipality from southern Rio Grande do Sul, which houses minors aged 0 to 18 who have been separated from their families due to violations of their rights as defined by the ECA[1].

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A total of ten caregivers working the in morning, afternoon and night shifts took part in the study. The inclusion criteria required the caregivers to provide direct care to institutionalized children and adolescents and to have been employed at the institution for at least three months. The exclusion criteria encompassed caregivers on leave, absent due to medical conditions, on vacation, or otherwise unavailable during data collection. Out of 12 eligible caregivers, two were excluded for having worked at the institution for less than three months.

The data were collected through semi-structured interviews conducted by the lead researcher, who had prior experience in qualitative research and was familiar with the institution from previous studies. The interviews were conducted individually at prearranged times and lasted a mean of 30 minutes. The questionnaire included sociodemographic questions and open-ended ones about the caregivers' perspectives on caregiving, strategies applied, challenges and benefits perceived and associated emotions. Initial contact was established via WhatsApp messages sent to numbers provided by the institution's coordinator.

Due to the COVID-19 pandemic, two interviews were conducted via WhatsApp voice calls, while the remaining eight took place in person, adhering to social distancing and preventive measures. All interviews were recorded, transcribed manually in their entirety to a Word document and verified for accuracy.

The data were organized through directed content analysis, wherein codes were defined both prior to and during analysis, based on relevant theoretical frameworks[12]. Therefore, the THC principles guided initial coding and interpretation of the emerging themes.

Watson's ten core principles were applied to structure data analysis, namely: Practicing kindness and equanimity in caregiving; Fostering belief systems through presence; Supporting personal and shared spiritual practices; Building authentic trust relationships; Encouraging expression of positive and negative emotions; Creatively integrating knowledge into caregiving; Engaging in holistic learning experiences; Creating an environment that promotes dignity and peace; Aligning body, mind and spirit through essential care; and Acknowledging the existential dimensions of caregivers and recipients alike[13]. These principles shaped the interpretation of the results.

The following is an example of how the findings (interviewees' statements) were reviewed and validated through double-check by experienced researchers, ensuring accuracy and coherence in categorization.

Interviewees' statements	Initial codes based on the THC	Categories
"[...] you see the child crying, sometimes they arrive here dirty and hungry, then you bathe them, talk to them, put them to bed – that alone comforts you [...] the child starts responding to you differently because we're strangers to them [...]." (C5)	Creating a restorative environment that fosters comfort, dignity and peace.	The bond as a form of transpersonal care
[...] you work directly with them [...] you're there every day, experiencing their suffering, their joy, in various situations. So, I believe the professionals should adopt a broader perspective, considering both financial and human aspects, as we're still far from where we should be. [...] We work with people, we work with lives, and we invest ourselves in it. (C3)	Welcoming the existential dimensions of being cared for and of oneself	Care work in bond formation and disruption

Figure 1: Chart explaining how the categories were created. Pelotas, RS, Brazil, 2021
Source: Reserch data, 2021.

Thus, the results were organized within a pre-established framework, namely, Jean Watson's Theory of Human Care (THC), which guided initial coding and the relationships between the codes. Based on the theoretical framework, it was possible to reflect on the caregiving act by analyzing and categorizing the information, leading to the emergence of two main categories. It is noteworthy that a double-check process was conducted by experienced researchers, who confirmed the structure developed.

Figure 2 illustrates how the categories emerged based on THC and the findings:

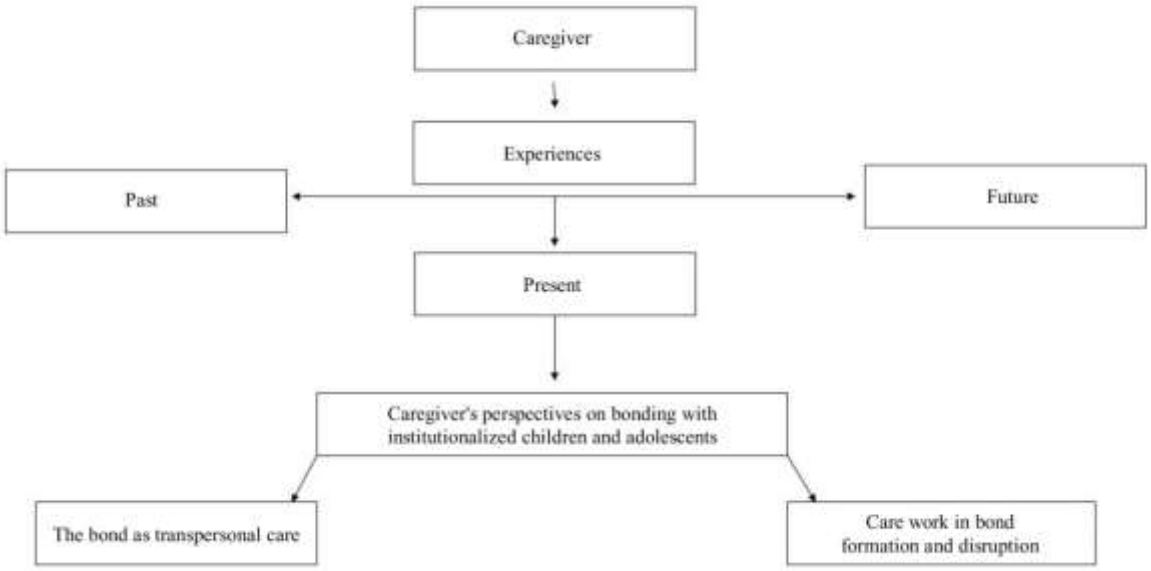

Figure 2 - Data analysis thematic map. Pelotas, RS, Brazil, 2021
Source: Research data, 2021.

From Figure 2, it is evident that the caregivers' perspective on care is shaped by personal experiences, with caregivers drawing upon past experiences to organize the present and envision the future. Thus, informed by life experiences and the changes encountered in interactions with institutionalized children and adolescents, caregivers fulfill their role, with the care provided influenced by formation and disruption of the bonds experienced.

The THC served as grounds for interpretating the results, with the theory's proposed reinterpretation guiding the analysis. At the caregiving moment, an encounter takes place between the caregiver and the person cared for, as seen in the child and adolescent institutionalization context. Care can only be demonstrated and practiced in a meaningful interpersonal relationship, one that involves respect, affection, acceptance and a genuine caregiving relationship[8]. Interpretation of the transpersonal care process enabled identifying how caregiving relationships are established during institutional care, easing interaction between caregivers and children or adolescents.

Figure 3 presents a time segmentation (past, present and future) that respectively delineates the moment prior to the interaction between child/adolescent and caregiver, during the interaction and after interaction. The first diagram represents the caregiver, the second the

child/adolescent, and the third illustrates transpersonal care. It is observed that the interpersonal relationship begins at the present moment, when both individuals interact and caregiving takes place. In turn, this creates a delicate boundary between care and bond formation, altering perspectives of both the caregiver and institutionalized child/adolescent.

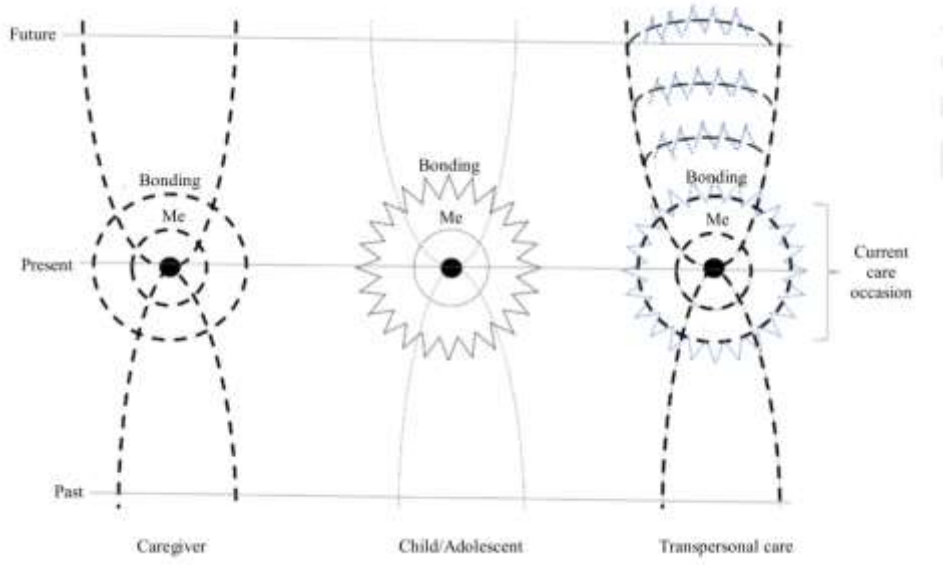

Figure 3 - Interpreting the dynamics of the transpersonal care process in the institutional foster care context based on the proposal described by Watson[6]. Pelotas, RS, Brazil, 2021
Source: Research data, 2021.

The study adhered to the ethical principles outlined in Resolution No. 466 by the National Health Council[14] and was approved by the Research Ethics Committee (*Comitê de Ética em Pesquisa,* CEP) under opinion number 4,239,361 and CAAE 13592519.8.0000.5316. The participants' consent was obtained through Free and Informed Consent Forms (FICFs), which they read and signed. The participants' identities were kept confidential, with identification assigned using the letter "C" (for caregiver) followed by a sequential numeral, in accordance with interview order (C1, C2, C3...).

RESULTS AND DISCUSSION

All participants were women aged between 27 and 64 years old. Their tenure within the institution ranged from six months to 20 years, with a mean of 8.46 years. In relation to marital status, three participants were married, three were divorced and four were single, living in households with one to five people. Concerning number of children, whose ages varied from five to 31 years, two participants had three children, three had two, four had one, and one had no children. Family income ranged from R$ 1,045.00 to R$ 2,500.00. The participants' academic backgrounds was varied, encompassing fields such as Social Assistance, Social Communication, Accounting, Geography, Languages, Education, Pedagogy, Psychopedagogy and Nursing.

The results illustrate the way attachment relationships are formed in the caregiving work for institutionalized children and adolescents from the caregivers' perspectives. These findings were organized into two categories: The bond as transpersonal care and Care work in bond formation and disruption.

The bond as transpersonal care

This category highlights how several specific factors influence interactions between children and adolescents and their institutional caregivers within institutionalization, such as feelings of estrangement and unfamiliar environments, which require attention to individual needs.

> [...] you see the child crying, sometimes they arrive here dirty and hungry, then you bathe them, talk to them, put them to bed – that alone comforts you [...] the child starts responding to you differently because we're strangers to them [...]. (C5)
>
> You always need to be attentive to their movements [...]. (C6)

According to Watson, care involves a humanistic and altruistic approach where an encounter between caregiver and the person cared for takes place, which can only be demonstrated and practiced effectively in an interpersonal relationship[8]. The THC application is evident in the care provided by the interviewees, who aim at creating a reconstitutive environment, enhancing comfort and dignity while addressing the needs of institutionalized children and adolescents. This promotes closeness between both parties:

> [...] care functions here include food, bathing, taking them to school, speaking with their teachers and often having to correct them with their studies [...]. (C8)

Based on the principles of the theory applied, the relationship between caregivers and institutionalized children or adolescents develops in a transpersonal manner, mediated by interpersonal interaction and guided by the observation of existing care needs. This dynamic fosters a holistic perspective grounded in humanistic, ethical and spiritual aspects of care, acknowledging each person's broad characteristics and biopsychosocial and spiritual needs. By addressing these care needs, a comprehensive and care-centered thinking model is shaped[15].

A study conducted in child and adolescent care centers from Uruguay highlights that caregivers perceive their role as addressing both basic needs (such as nutrition, hygiene and sleep) and emotional, educational and health-related requirements[16].

By establishing a bond, professionals ease the attachment process for children and adolescents. Attachment is a fundamental mechanism in human beings, fostering security and strengthening relationships with primary figures, typically the mother. Deficiencies in these interactions may lead to developmental setbacks[10]. Additionally, the participants recognize that turnover of caregivers affects the bonding process, as shifts alternate while children and adolescents remain in the institution without experiencing life beyond its confines:

> [...] sometimes I leave and think, what kind of prospects do they really have? [...] None. You go in, you leave, and they stay there. They see it, they feel it [...] that there's no life beyond these walls. (C3)

> [...] they develop attachment to us in different ways. Some get closer, others remain more distant. (C7)

Within the institutional setting, caregivers strive to build and maintain a relationship of trust, concerned with the future development and life prospects of those under their care[13]. Thus, it was possible to identify that effective care must be established interpersonally through practice and demonstration, addressing human needs to foster both immediate and long-term growth and development[6].

Furthermore, caregiver turnover disrupts bond formation, compromising care continuity, which is identified as one of the main challenges related to human resources in child and adolescent care institutions[16].

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Relationships between caregivers and children develop in different ways, influenced by mutual affinities and similarities. Some children establish stronger connections with specific caregivers, forming a primary attachment figure within the institution. The transformation of mediated behaviors reflects this involvement[17]. Some testimonies highlight the emotional connection between caregivers and children, evidenced through future aspirations and activities designed to promote development and fulfill their needs.

> [...] encouraging them, helping them develop motor and speech skills, learning to play, to share, to eat properly [...] ensuring cleanliness, bathing. [...] When dealing with older children, you realize that love must be combined with boundaries. [...] Bonding means balancing affection with discipline, showing love also involves setting limits. (C8)

The pursuit of closeness with a primary bond figure allows developing behaviors that promote security, protection and bonding[17]. As the actions by a bond figure play a crucial role in shaping a child's bond pattern, responsiveness and sensitivity contribute to secure bonding, which enhances motor, linguistic and cognitive abilities, easing communication and interaction[10].

A Colombian study[18] that involved caregivers in a child and adolescent care institution also found that some children form stronger bonds with certain caregivers. In these cases, children feel comfortable sharing their problems, while caregivers provide support and guidance[18].

The testimonies further reveal the caregivers' concern for the children's future, demonstrating a sense of responsibility that extends beyond the present:

> Care means [...] guiding them, teaching them how to navigate life challenges. [...] So many unexpected things can happen and, without guidance, they might lose their way. [...] [When asked about bonding] Yes, it's necessary [...] you have to play with them, stimulate them [...]. (C1)
>
> [...] money doesn't matter [...] it helps, but [...] it doesn't reward you. [...] The real reward is being able to help others. [...] They'll become someone in life, [...] they'll have a future, they'll have a family. [...] "This is just a passage, you're here now, but you'll have your own home some day." [...] I always tell them that. (C2).
>
> [...] they'll remember and think: "Wow! She told me this". (C8)

> [...] Girls love to dance, it relaxes them and, from there, we start conversations and other activities they enjoy. [...] Working with children means understanding their backgrounds and experiences. Their stories make you reflect, develop empathy and reassess your own values. (C9)

These accounts reflect the practice of humanistic values and deepening of sensitivity towards oneself and others, fostering personal growth[13]. C8's statement underscores that children will carry their caregivers' words with them into the future. Additionally, the caregivers act with compassion, providing support through their presence and engaging in care practices that promote well-being[13], considering their ability to help others as the ultimate reward.

A study[19] examining the practices of social educators in a child and adolescent care institution using photographic records found that their efforts extend beyond fulfilling basic needs. They ease socialization and knowledge sharing, fostering new learning opportunities. Through creativity and play, caregivers equip children with strategies to cope with the realities of institutional care[19].

The current study also highlights that caregivers perceive themselves as responsible for the children's well-being. Their attention nurtures bonds, and the children's and adolescents' emotional frailty oftentimes compels caregivers to establish deeper connections:

> [...] you're not dealing with machines; you're dealing with people. Avoiding emotional bonds is nearly impossible. Unintentionally, you grow attached to the frailty of these children and adolescents. [...] You devote yourself to doing the best you can for them while you're there. (C3)

> [...] whatever happens to them, you're there, responsible for them. So [...] you must pay them all the attention they deserve. The bond you develop makes you even more committed to them. (C6)

When interactions occur intentionally, bonds emerge through empathy, mutual understanding, affection, kindness, consistency and reciprocity. These elements go beyond addressing basic needs: they shape relationships focused on the growth and development of all involved[20].

Caregivers strive to create a restorative environment for children and adolescents, fully engaging to meet their needs while respecting their personal backgrounds. They aim at

embracing the existential dimensions of both the cared-for and themselves[13]. In this sense, a strong interpersonal relationship enhances effective care and supports childrens' and adolescents' growth and development.

By establishing trust and supportive interactions, effective communication fosters expressions of empathy and affection within caregiving relationships. This interaction provides attention, concern and encouragement, ensuring that a dynamic and meaningful interpersonal connection enhances care quality. Consequently, bonding enables transpersonal caregiving, fostering child and adolescent development through an altruistic and humanistic perspective aligned with theoretical principles.

Care work in bond formation and disruption

This category highlights the caregivers' understanding of their role in forming and disrupting bonds during interactions with children and adolescents, as well as the significance of these bonds in their institutional path. The caregivers acknowledge that bond formation is essential at the institutionalization moment, throughout the institutionalization period and during deinstitutionalization, made possible through continuous coexistence:

> [...] you work directly with them [...] you're there every day, experiencing their suffering, their joy, in various situations. So, I believe the professionals should adopt a broader perspective, considering both financial and human aspects, as we're still far from where we should be. [...] We work with people, we work with lives, and we invest ourselves in it. (C3)
>
> [...] we work every other day, so we're always here (C7)
>
> [...] yes, it definitely makes a difference in how they're welcomed, how they connect with the institution, and how they leave—it truly does. (C10)

These accounts reveal that caregivers strive to provide an environment that fosters reconstruction, enhancing comfort and dignity. They also aim at aligning body, mind and spirit through intentional care[13]. The THC highlights care factors rooted in a humanistic perspective combined with scientific knowledge, beginning with development principles, where parents or primary caregivers share values within a humanistic-altruistic system shaped by life experiences[13]. Through the knowledge acquired, children and adolescents expand their

perspectives by developing beliefs, interactions and experiences with caregivers and peers, influencing their personal growth.

During the care process, caregivers establish bonds with children and adolescents, and these bonds are reciprocated. Additionally, bonds also develop among the children and adolescents themselves. However, within this interaction, bonds are constantly formed and broken due to caregiver turnover, institutionalization and deinstitutionalization.

Institutionalization frequently leads to separations and disruptions of bonds, prompting caregivers to adopt defensive strategies as self-protection in their role. Furthermore, there is a need for a clear perception of the caregiving practice, which still stems from personal demands, where defensive strategies and a focus on basic care serve as protective mechanisms against future bond disruptions[21]. These disruptions pose various challenges for caregivers, affecting their daily work and causing feelings of anxiety, anguish and sadness. One defense mechanism used to cope with these difficulties is forming more superficial bonds to mitigate the suffering caused by future separations[2].

Although bond formation is indispensable, it also presents challenges. Caregiver C4 mentions the difficulty inherent to dealing with the absence left by children and adolescents after having developed a strong bond:

> [...] yes, certainly, because some of them become very attached to us. We must be very careful, as they eventually leave, and we feel their absence. However, we must still show affection and provide care. (C4)

To protect themselves from the pain of bond disruptions, caregivers sometimes adopt a more detached stance, engaging less from the emotional point of view. Nevertheless, along with attachment, closeness and bond formation are crucial for the development of these children and adolescents, creating a paradox between the attachment necessity and the fear of suffering from eventual separations. The relationship between care and bonding is evident in the testimonies, as caregivers' proximity to children and adolescents strengthens the bond:

> [...] this thing about bonding, I don't know, we have this bond. In the end, we must care for them. (C6)
>
> I believe it's a big change for them, and for us too. We also learn to manage attachment because we get attached many times, and so do they. But we must

> understand that this is just a temporary phase. While they're here, we do everything for them. [...] In our space, we're the ones who take care of them [...]. (C8)

Caregivers are reluctant to form bonds with institutionalized children and adolescents, recognizing that the institution is "just a temporary phase". Nevertheless, they acknowledge the attachment necessity for effective caregiving. Their approach focuses on providing genuine support, guiding children and adolescents through learning experiences and fostering a developmental environment where they assume full responsibility for their care[13].

Additionally, caregivers observe that children also develop strong attachments to them. A study[22] conducted with institutionalized children and adolescents found that forming an emotional bond with the closest caregiver serves as an essential adaptive coping strategy, evidenced by their search for support, contact, comfort and connection with caregivers.

The caregivers' accounts also reflect concerns about the challenges resulting from institutionalization and the disruption of family bonds, leading them to seek strategies to alleviate these difficulties in their caregiving work:

> [...] in caring for a child, you try to divert their thoughts, to lessen the sense of absence and longing. You engage them in activities, talk to them, play games, [...] ask them to draw, and they will often draw their family. Then you work on their emotional side and try to momentarily shift their thoughts away from missing their family. (C3)
>
> Caring for a child in a shelter [...] at first, you don't understand what's happening. Each one reacts differently. [...] One of them may sit quietly in a corner and cry, another may have an outburst and break things, but it's always due to missing their family, their siblings, father, mother [...]. (C6)

The caregivers' statements point to the childrens' and adolescents' experiences in institutionalization, stating that they "don't know what to do, each one reacts differently", referring to their experience of the unknown and how much they miss their families. In response, the caregivers acknowledge the importance of providing emotional support and resort to games as a key strategy. Similar findings emerged in another study[23], which used therapeutic play with institutionalized children and identified themes such as institutional routines, longing for family, insecurity in an unfamiliar environment and fear of violence.

The right to family life (or its absence) is not only influenced by family circumstances but also by broader social factors. Oftentimes detached from social realities, these factors can

lead to reinstitutionalization through moralizing approaches. Therefore, reintegration into the family environment requires strategies that address the root causes of institutionalization, necessitating well-planned care actions[24]. In this context, the formation of secure bonds is essential for emotional development and the future ability of these children and adolescents to reconnect with their families.

From the testimonies of C6 and C3, it is evident that the caregivers encourage positive emotional expression among the children, engaging them in activities that shift their focus away from missing their families. Through these strategies, they support creative problem-solving, combining knowledge with intuition in caregiving[13].

Given their caregiving experience, in which they manage the emotional impact of institutionalization on children and adolescents, who miss their families and oftentimes struggle to understand why they were placed in an institution, caregivers find themselves experiencing a dynamic similar to motherhood, feeling like part of the children's families:

> [...] I feel like a mother, a sister, I feel [...] deeply emotionally involved. (C3)
>
> [...] we're not supposed to form bonds, but how can you not bond with a child? One who stays with you for four, five, six years, or even one, two, three years. [...] We become their second family, you see? So, it's impossible not to form a bond [...]. (C5)
>
> [...] many times, you see a child you cared for, who spent two or three years in the shelter, and later on you see them with a family on the street, and they remember you [...]. (C8)

These statements reveal concern with the care provided in a humanized and altruistic way, which not only includes observation but extends to interaction, and shows the involvement between the caregiver and the person cared for, the bond and accountability. In addition, the caregivers sought to embrace the existential dimensions of those under their care[13]. And in this process, they experience the formation of a bond similar to the one developed in their own family.

Care takes place within the relationship between caregiver and recipient, inherently tied to humanity. The connection between the THC and caregiving in child and adolescent institutionalization highlights the effectiveness of empathy, active listening, affection and a focus on biological and humanistic aspects[8]. Moreover, caregivers face stress and emotional

strain that require support structures. Thus, it is crucial to create reflective and supportive spaces to strengthen caregiving teams and their social and self-care skills[16].

Finally, child and adolescent institutional care remains socially undervalued, evident in lack of training and in low remuneration. The invisibility surrounding political and social discussions on institutionalized care further complicates the situation[25], discouraging societal engagement in addressing the challenges faced by caregivers and the children they support.

FINAL CONSIDERATIONS

The caregivers' perspective on the bonds established in the care of institutionalized children and adolescents is broad, encompassing hygiene and education demands as well as emotional support. However, in this context, although bonding and fostering affection are essential for child and adolescent development, caregivers must cope with the distress caused by disruption of these bonds at the deinstitutionalization moment.

Additionally, the data highlight the social invisibility of the role performed by caregivers, as they earn low wages and lack emotional support to handle the hardships inherent to caring for institutionalized children and adolescents. Continuous training and psychological support might better prepare them to manage the consequences imposed by institutionalization on children and adolescents.

Integrating a Nursing professional into the institutional environment might also provide valuable support for caregivers in addressing both the physical and emotional needs of those under their care. Furthermore, this professional could work within a network, coordinating services and ensuring follow-up with the families of institutionalized children and adolescents. This approach may help mitigate or solve the issues that led to institutionalization, easing childrens' and adolescents' reintegration into their original families. It is essential to work towards preserving family and community bonds, as institutionalization oftentimes results from family vulnerabilities that could be addressed, reducing the physical and emotional consequences faced by children and adolescents due to disrupted family ties.

Applying the THC framework helped interpret the findings, revealing that its core elements are present in the caregiving relationship. Caregivers strive to provide the attention and affection necessary for the full development of children and adolescents. In addition, they

focus on education, preparing those under their care for future integration into family and society.

Although this study is limited by the fact that data collection took place during a social distancing period, it contributes by offering insights to develop support strategies for caregivers. These strategies would enable them to cope with the distress caused by bond disruptions during deinstitutionalization, ensuring that care is based on strong emotional bonds and meaningful connections.

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