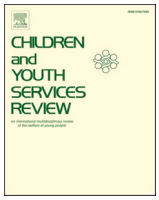
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Intra- and interpersonal influences on child adjustment and resilience in welfare care: A qualitative study with former caregivers in Switzerland

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ABSTRACT

Despite the growing research on child maltreatment within welfare care, few studies have included the caregivers who were involved in care provision and can provide insights on an intra- and interpersonal level. Therefore, this study aimed to examine intra- and interpersonal factors that promoted or hindered the adaptive adjustment and resilience of children in welfare care, from the previously neglected perspective of former caregivers. Qualitative semi-structured interviews were conducted with $N = 12$ Swiss former caregivers. Participants were 10 females and 2 males, aged between 58–91 years (mean age = 74.5 years). Interviews were audio-recorded, transcribed, and analyzed using framework analysis. Two themes emerged from the data on both the intrapersonal level (i.e., *Core Characteristics*, *Coping*), and interpersonal level (i.e., *Caregiving Attitudes and Actions*, *Relationships and Attachment*). Resilience hindering factors included emotion regulation difficulties, issues within the child-caregiver relationship (e.g., differential treatment, abuse and punitive measures, lack of affection and attachment), and placement disruptions. Resilience promoting factors included coping via creativity and imagination, and social and emotional support beyond the caregiver (e.g., siblings, animals). Results highlight key areas for action at the intra- and interpersonal levels, including psychotherapeutic interventions for children in care (e.g., addressing insecure attachment), and psychoeducation and mentoring programs to enhance caregiver reflective practices and improve care provision. Future research and practice should incorporate the caregiver perspective to develop the training and support for care staff and ensure the safeguarding of (current and future) children in welfare care.

1. Introduction

Very little research has examined the caregiver perspective (i.e., foster families, institution staff) to understand the impact of welfare placements. It is essential to include the caregivers who were actively involved in the care provision and play a major role in shaping the development of the individuals in their care (Legault et al., 2006; Thomas & Reifel, 2010). The few existing studies with child welfare staff and social workers suggest that caregivers can offer additional insights into the development of the children in their care, particularly on an intra- and interpersonal level (e.g., Bell & Romano, 2015; McMurray et al., 2008). Exploring the previously neglected perspective of caregivers could not only help to corroborate the self-report data of survivors, but could also provide potentially unique observations on resilience promoting and hindering factors that may not have been apparent to those in welfare care. This paper begins to fill these gaps in the literature using qualitative methodology, which is optimally suited to extend the current knowledge on the (intra- and interpersonal) factors linked to adjustment and resilience of those affected by welfare placements in Switzerland.

Children in out-of-home, foster, or residential (welfare) care settings are exposed to a higher risk for child maltreatment (i.e., physical, sexual, and psychological or emotional abuse, as well as the physical and emotional neglect of minors; Daly, 2014; Hamber & Lundy, 2020; World Health Organization (WHO), 2014). Reasons for this include structural issues, such as poor infrastructure, organizational conditions, and severe staff shortages (Galle, 2018; Ziegler et al., 2018); as well as the prevailing moral and social norms and childcare ideologies of the last

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century (e.g., disciplinary measures and violence against minors) (Ellett & Leighninger, 2006; Rohner et al., 2023). Child maltreatment, both generally and within a welfare context (i.e., institutional child abuse), has been empirically linked to a broad range of negative physical and mental health sequelae (Carr et al., 2020; Weber et al., 2016). Furthermore, the particular dynamics of institutional child abuse, such as the inappropriate use of power and authority by caregivers, can have additional consequences for affected individuals. This can include a lack of trust in authorities and social institutions (e.g., health or justice systems), as well as feelings of betrayal, fear, or disrespect for authority (Freyd et al., 2005; Gabriel et al., 2021). As such, the experience of child maltreatment constitutes a major source of threat to the health and well-being of survivors.

However, despite the potentially high-risk environment and adverse experiences, a non-negligible proportion of institutional child abuse survivors report non-detrimental and even adaptive (i.e., resilient) outcomes and trajectories in later life. For instance, in an Irish investigation with survivors of institutional child abuse, 18.21% of the sample did not meet the full diagnostic criteria for the assessed mental health disorders (Flanagan et al., 2009). Similarly, in an Austrian study with adult survivors of institutional child abuse experienced within the Catholic Church, around 15% of survivors showed no clinically significant psychopathological symptoms (Lueger-Schuster et al., 2014). A recent study in Switzerland with older adult survivors of child welfare placements found that approximately 30% of survivors did not fulfill the criteria for a current or lifetime DSM-5 mental health disorder (Thoma et al., 2022). As studies demonstrate this potential for resilience, there is a growing need to identify factors that promote or hinder resilience in survivors of child maltreatment.

Theoretically, resilience may be best described as a dynamic, multidimensional construct (Southwick et al., 2014). An influential conceptualization of resilience is provided by the Multi-System Model of Resilience (MSMR; Liu et al., 2017; Liu et al., 2020). Within the MSMR, resilience is described as a dynamic model with three different levels: core, internal, and external resilience. The first level (i.e., core resilience) is composed of intrapersonal characteristics and traits, such as sex, gender, health behaviors (e.g., exercise, diet), and physiological markers, such as stress-reactive systems (Liu et al., 2017). The second level (i.e., internal resilience) refers to interpersonal indicators, such as interpersonal relationships and support (e.g., by family, friends), personal experiences, and social relatedness (Liu et al., 2017). The third level (i.e., external resilience) refers to the specific context of an individual, such as socio-economic status, income, access to services, and cultural ideologies (Liu et al., 2017). According to the MSMR, resilience involves complex interactions between intra- and interpersonal factors, as well as context-specific factors, which influences how individuals adapt to and cope with adversity (Liu et al., 2020).

Systematic investigations around the world are documenting the various phenomena, policies, and impact of child welfare practices and (the often related) institutional child abuse of the last century (see for instance Carr et al., 2010; Carr et al., 2019; Hauss et al., 2018; Lueger-Schuster et al., 2018; Maercker et al., 2014; Thoma, Bernays, Eising, Pfluger et al., 2021). A few of these studies have investigated resilience promoting or hindering factors in survivors of institutional child abuse. For instance, with respect to intrapersonal resilience, identified factors include demographic aspects, such as (older) age and gender (Attar-Schwartz, 2008; Flanagan et al., 2009); personality characteristics or traits, such as persistence, optimism, and better socioemotional functioning (Baptista et al., 2013; Lueger-Schuster et al., 2014; Mc Gee et al., 2020); as well as higher levels of self-efficacy and self-esteem (Thoma et al., 2020; Thoma, Bernays, Eising, Maercker et al., 2021). Regarding interpersonal resilience, identified factors include secure adult attachment style (Flanagan et al., 2009), support systems, and perceived social support (Maercker et al., 2016; Rohner et al., 2022). For context-specific resilience, key factors include socio-economic status, financial situation, education (Flanagan et al., 2009; Thoma, Bernays, Eising, Pfluger et al., 2021), societal acknowledgement, and access to services (Maercker et al., 2016; Mc Gee et al., 2020). Further support comes from recent research comparing the resilience profiles of Swiss survivors and non-affected control individuals (Thoma et al., 2022). Results suggest that certain resilience promoting and hindering factors may vary as a function of the experienced adversity, emphasizing the impact of child maltreatment within welfare care. However, despite this growing body of research on institutional child abuse, the vast number of studies have only been conducted with survivors themselves.

This study therefore aimed to examine intra- and interpersonal factors that promoted or hindered the adaptive adjustment and resilience of children affected by compulsory social measures and placements (CSMP) in Switzerland, from the perspective of former caregivers. In Switzerland, from the middle of the 19th century until 1981, administrative authorities had the power to take children from their parents and place them into welfare care, with the primary aim being the provision of protection and care for minors (Bühler et al., 2019). However, these placements were often carried out arbitrarily and in response to apparent non-conformity to the Swiss social norms of those times, such as single motherhood, being of gypsy origin, or living in extreme poverty (Federal Office of Justice, 2022). Although studies have been conducted with Swiss survivors (e.g., Hauss et al., 2018; Höltge et al., 2018; Thoma et al., 2022), or with their offspring (e.g., Küffer et al., 2016), no studies have been conducted with the caregivers of this historically unique sample. Therefore, this study will explore the following research question: What intra- and interpersonal factors may have promoted or hindered the resilience of minors affected by CSMP, from the perspective of former caregivers? The analysis will be informed by the consideration of relevant theory and conceptual models, including the MSMR (Liu et al., 2017; Liu et al., 2020).

2. Methods

2.1. Study design

The study was part of the project '*Differential aging trajectories in high-risk individuals with past experiences of early adversity*', within the *National Research Program 76* "*Welfare and Coercion – Past, Present and Future.*" This study is a qualitative exploration of the experiences of former caregivers involved in CSMP in Switzerland up to 1981. It was organized and conducted by a research team from the Psychological Institute at the University of Zurich, with the study protocol approved by the Ethics Committee of the Faculty of Arts and Social Sciences at the University of Zurich, Switzerland (ID 20.12.16). In accordance with the Declaration of Helsinki, the study was conducted with the informed consent of all participants.

2.2. Participants

Participants were recruited during a 6-month period (May to October 2021) using purposive sampling and multiple recruitment channels. A study flyer was posted in public areas (e.g., community centers, universities, libraries, supermarkets), as well as channels specifically targeting older adults, such as online groups for seniors and retirement homes. Additionally, study details were distributed using social media, radio advertisements, and the contacting of key individuals on the history of CSMP in Switzerland (e.g., historians, journalists). Interested persons contacted the research team and a telephone screening was carried out, which could also be conducted via e-mail for those with hearing difficulties. The inclusion criteria were having been a caregiver of children (up to age 18 years) affected by CSMP in Switzerland up until 1981, native Swiss German speaker, and no diagnosis of dementia. Those who met the inclusion criteria were invited for an in-person interview, with two individuals not meeting the criteria. Sample size was determined based on empirical evidence on data saturation in qualitative research, in which 97% of the codes were identified within

the first 12 interviews (Guest et al., 2006; Hennink & Kaiser, 2022).

2.3. Data collection

Semi-structured interviews were conducted between June and October 2021 at the university or at participant's homes and involved four researchers, including the first and fourth authors. The interview guide was first pilot tested to best formulate and structure the interview questions, with three topic areas: (1) information on the care setting and caregiver's position (e.g., care setting type, number and age of children in care, reason for placement, roles); (2) experiences and observations during care related to the children's development (e.g., caregiving style and strategies, influences on development and resilience); and (3) the public debate on CSMP in Switzerland and its influence on former caregivers, individuals formerly affected by CSMP, and society. Prior to the interview, participants were sent the study information sheet and informed consent form to read. These documents were discussed on the day of the interview and the informed consent form was then signed. Participants first answered the sociodemographic questions and then completed the audio-recorded interview, which lasted between 60–90 min. Interviews were conducted by two interviewers, with one main interviewer and one co-interviewer who was responsible for taking field notes and asking any follow-up questions. To create an open and empathetic atmosphere for participants, interviewers received interview training from the last author, who is an experienced qualitative researcher. Participants' emotional state was monitored throughout and at the end of the interview participants were debriefed and given a list of psychological support options. A (previously disclosed) financial compensation of 120 Swiss Francs (approximately 120 US dollars) was provided upon completion of the interview. The Covid-19 hygiene regulations of the Federal Office of Public Health (Bundesamt für Gesundheit) and the University of Zurich were adhered to during all interviews.

2.4. Data analysis: framework analysis

Interviews were transcribed by Swiss German speakers using the f4 audio transcription software (Audiotranskription, 2021). Interviews were translated to High German and English, then reviewed by at least two transcribers, and were subsequently anonymized. Data analysis was conducted using MAXQDA version 2020.4.2 (VERBI Software, 2020) on the anonymized High German transcripts. The Framework Analysis method was applied, involving a systematic process in which the data is coded and structured in a matrix to facilitate interpretation of the data and identification of key themes (Ritchie & Spencer, 1994). Specifically, the analysis comprises 5 interdependent stages: (1) familiarization with the data; (2) identification of the thematic coding framework; (3) indexing the transcripts using the coding framework; (4) charting the data into a summary matrix; and (5) mapping and interpretation with respect to the research questions (Gale et al., 2013).

Regarding validity and reliability, triangulation was conducted to ensure rigor, quality, and trustworthiness in the findings (Archibald, 2016). All transcripts were independently coded by the two interviewers (first and fourth authors), followed by discussions and refinements of the codes with an experienced third researcher (third author), and final discussions and agreements with the study lead (last author). This resulted in high intercoder agreement with a Kappa value of $\kappa = .88$ (Hallgren, 2012). Cross-validation was also employed to increase rigor, with a sub-set of transcripts independently indexed by an additional two external researchers, resulting in high overall agreement (Golafshani, 2003). To avoid researcher bias and to increase accuracy, respondent validation was then conducted with selected participants to discuss, corroborate, and refine the themes (Torrance, 2012).

3. Results

The results are illustrated by participant quotes, labelled with the participant ID, gender, and age. See the Supplementary Material for the corresponding Swiss German and High German quotes.

3.1. Sample characteristics

A total of $N = 12$ interviews were conducted with 10 females and 2 males, with an age range of 58–91 years (mean age = 74.5 years; $SD = 9.69$). Vocational training was the highest education level for most participants (10/12), with medium to high ratings of socio-economic status. Half (6/12) were married or in a relationship. Regarding their work in the welfare system, a few participants (2/12) were involved as foster families, with the majority (11/12) being institutional staff (i.e., in children's homes, psychiatric units). Two participants had also experienced CSMP themselves. See Table 1 for the sample characteristics.

3.2. Intrapersonal factors

On an intrapersonal level, the analysis assessed individual factors relating to the children and their self-regulation, which may have promoted or hindered their resilience. Two main themes emerged from the data: *Core Characteristics* and *Coping*. See Table 2 for an overview of the themes, descriptions, and examples.

3.2.1. Core characteristics

The theme *Core Characteristics* refers to the observed characteristics or traits of the children in care, and the associated treatment by the caregivers, which may have influenced development and well-being. For instance, several caregivers (7/12) described differences depending on age, with younger children perceived as more vulnerable: "They were really the smallest ones there, too. They couldn't defend themselves at all."[1] (P02, female, 58). In contrast, older children were often seen to be more defiant: "It [resistance] just comes at a certain age (…) at a certain age, you question everything at home."[2] (P03, female, 81). Some caregivers (4/12) also reported differential treatment by gender, with girls being perceived as more "patient and compliant"[3] (P01, female, 67) and boys being viewed in a more negative light: "It's just that at that time, the girls were much more adapted (…) the girls were the easy ones in the classes and the boys were the less easy ones (…) very often the boys actually were very difficult kids later on in school, the ones who acted out. Either they took over the role of the class clown or probably went stealing in the stores, that certainly. Everything in a criminal direction."[4] (P01, female, 67).

In addition to demographic aspects, half of the caregivers (6/12) reported the emotional state of the children to be an influencing factor for well-being and development: "An insecurity was always present with these kids, though. You can't forget that. Once you've been ripped out [from the family] like that."[5] (P03, female, 81). Caregivers observed difficulties with emotion regulation, such as "children who had little self-confidence"[6] (P05, female, 82), or children who "just processed through frustration"[7] (P04, female, 70). Such emotional difficulties were often connected to the lack of emotional security and instability of such welfare placements: "That she is pathologically jealous or she steals, these are all consequences of her first childhood years. She could never develop emotionally at all. You can't do that if you're pushed from one place to another."[8] (P03, female, 81).

3.2.2. Coping

The theme *Coping* refers to the observed strategies and behaviors of the children that were described as mechanisms of coping or processing. Several caregivers (6/12) reported that the children were resourceful and creative, using specific individualized strategies to make the best of their situation. For instance, some children were observed using discarded scraps to create toys for themselves: "They were also very creative. So they built their own toys to some extent. (…) I had to buy the red cheese, the Edam cheese with that wax layer around it. Now they made

Table 1
Sample characteristics.

ID	Gender	Age	Type of care worked in	Affected by CSMP in own childhood / Type	Highest level of education	Longest occupation	Relationship status	SES
P01	Female	67	Children's home	No	University	Remedial teacher	Single	6
P02	Female	58	Children's home	Yes / unknown	Vocational job training	Commercial clerk	Married	8
P03	Female	81	Foster family	No	Higher vocational training	Social worker	Married	8
P04	Female	70	Children's home, Foster family	No	Vocational job training	Farmer	Married	6
P05	Female	82	Children's home (private)	No	Higher vocational training	Nursery teacher	Single	5
P06	Male	71	Psychiatry	No	Higher vocational training	Social worker	In a relationship	6
P07	Female	69	Children's home	No	Higher vocational training	Remedial teacher	Divorced	6
P08	Female	73	Children's home	Yes / children's home	Higher vocational training	Home director	Single	8
P09	Female	76	Children's home	No	University	Remedial teacher / principal	Single	5
P10	Female	91	Children's home	No	Higher vocational training	Caregiver	Single	5
P11	Female	67	Children's home (private)	No	Higher vocational training	Nurse	Married	5
P12	Male	89	Children's home, Psychiatry	No	Higher vocational training	Social worker	In a relationship	3

Note. CSMP = Compulsory social measures and placements; ID = Participant identifier; SES = Subjective evaluation of socio-economic status: From 1 (lowest) to 10 (highest).

balls out of this wax layer, they were cannon balls, and then they put their little men on the castles and shot at each other."[9] (P05, female, 82). Similarly, the children often used imagination as a coping tool to escape from their harsh reality: "It [imagination] is a protection. Maybe also the defense mechanism that one has. (…) Some of them [took refuge] in their fantasy world, so they got themselves a kind of life raft."[10] (P01, female, 67). The caregivers observed that by applying such strategies the children "somehow became stronger"[11] (P05, female, 82) and showed adaptability or resilience to their circumstances: "I think everyone had their strategies to some extent, how it works best. Because it's an unnatural situation, so it's actually quite good that the children still had so much in them, that they tried 'what do I do so that it goes well for me?'"[12] (P07, female, 69).

In addition, the majority of the caregivers (10/12) also described instances of children acting out and resisting as a form of coping with the welfare placement: "I once asked him 'Why do you always run away everywhere? You told me you liked it there. Then why did you run away?' [He said] 'I had to, I couldn't help it.' He just had this urge."[13] (P03, female, 81). However, such coping strategies reinforced a negative perception of these children, leading to harsher treatment or punishment: "Yes they just were a little difficult because they didn't adhere to the norms so much, or respectively, they had their own norms. So from that point of view, they weren't popular [with the caregivers] right, because they were, in everyday life they were demanding."[14] (P06, male, 71).

3.3. Interpersonal factors

On an interpersonal level, the analysis assessed inter-individual factors relating to social and emotional interactions within the welfare environment, which may have promoted or hindered resilience. Two main themes emerged from the data: *Caregiving Attitudes and Actions* and *Relationships and Attachment*. See Table 2 for an overview of the themes.

3.3.1. Caregiving attitudes and actions

The theme *Caregiving Attitudes and Actions* refers to the caregiving and child rearing approach, encompassing the (often negative) caregiving attitudes and concrete actions, which had a direct impact on the treatment and well-being of the children. Caregivers suggested that the attitude towards caregiving had a major influence on care provision and that some caregivers "did not treat the children with much respect"[15] (P02, female, 58). One participant described a commonly held belief that the children were expected to earn the care they were given: "We said you do your contribution to our community. For example, mopping, let's get back to mopping, they weren't rewarded for that, that was a given. Looking at rewards, I said 'Who is rewarding me for taking care of you?' That's what it's like."[16] (P03, female, 81).

Many caregivers (8/12) stated that these harsh attitudes reflected the caregiving approach at that time, which was often reliant on punitive measures and disciplinary actions, including physical and emotional abuse: "They were beaten. They were mentally abused with really nasty words."[17] (P02, female, 58). Accounts of other abusive and neglectful practices were also reported, such as the force-feeding of spoiled food, caregivers who "just gave medicine so that they [the children] were calmer and whatnot"[18] (P06, male, 71), as well as detrimental hygiene practices: "The poor child must have been sitting on the toilet for two hours. She [caregiver] tied it to the toilet. (…) That was the one [child] who was between maybe 8 months and 1 year old."[19] (P11, female, 67).

However, many caregivers (10/12) also reported taking measures to "save them [the children] from worse"[20] (P03, female, 81), with attempts to protect the children from some of the harsh treatment: "I also didn't, or also tried to see that they [the children] didn't provoke a confrontation with the madame [caregiver in charge] (…) that you just tried to limit damage before it was big or before blame was heaped on them."[21] (P11, female, 67). A few caregivers reported efforts to shift away from punitive measures in their caregiving approach: "So the strategy was that I accepted them and worked with them and was nice to them and didn't punish them. (…) And then the children have respect for you and you don't have to punish them."[22] (P12, male, 89). These beneficial interactions were linked to more positive attitudes and beliefs: "I think you have an obligation to these children (…) to the people you have to take care of. Giving them a voice when they can't defend themselves."[23] (P02, female, 58).

3.3.2. Relationships and attachment

The theme *Relationships and Attachment* refers to interpersonal relationships between the children and their caregivers, peers, and family of origin; focusing on the provision of emotional and social support and the opportunities for attachment and emotional development. Regarding the connection with caregivers, most (9/12) reported a lack

Table 2
Overview of themes – Intrapersonal and interpersonal factors that promoted or hindered resilience.

Theme	Description	Example
Intrapersonal Factors		
Core Characteristics	Observed characteristics or traits of the children, and associated treatment by caregivers, which may have influenced development and well-being.	- Age (younger children more vulnerable, older children more resistant) - Gender (e.g., girls more compliant, boys more deviant) - Difficulties with emotion regulation/development
Coping	Observed strategies and behaviors of the children that were described as mechanisms of coping or processing, which may have been beneficial for the well-being of the children.	- Resourcefulness and creativity (e.g., using wood scraps as toys) - Imagination as a means of escape (e.g., fantasy world) - Acting out (e.g., resisting caregivers/rules, running away), further punishments
Interpersonal Factors		
Caregiving Attitudes and Actions	Caregiving and child rearing approach, encompassing (negative) caregiving attitudes and concrete actions, which influenced the treatment and well-being of the children.	- Harsh caregiving attitudes (e.g., children should work to earn their care) - Punitive, abusive, or neglectful actions (e.g., beatings, medicating, psychological abuse) - Protective measures (e.g., avoid confrontation, reduce punitive measures, strict but fair approach)
Relationships and Attachment	Interpersonal relationships between the children and their caregivers, peers, and family of origin, focusing on the provision of emotional and social support and opportunities for attachment and emotional development.	- Lack of caregiver attachment and affection - Inadequate peer support (e.g., little external social support, animals as emotional support) - Limited family of origin contact (emotional instability, benefit of joint placement of siblings)

of love and affection, so that the children "were in a constant deficit in terms of emotional development and love."[24] (P01, female, 67). Some caregivers suggested that this was due to their training, in which they were instructed not to have "too much proximity, don't build strong relationships to the children"[25] (P07, female, 69). Others intentionally tried to limit attachment, as the children would eventually leave: "You can't replace parents. And I also, we also knew when a child came, it would leave again. And even if you had a lot of trouble with it, at some point you just had to let it go again."[26] (P05, female, 82). Nevertheless, almost all caregivers (11/12) reported some attempts to fulfil the children's need for emotional support, such as giving "every child a goodnight kiss"[27] (P08, female, 73), or trying to make the children feel at home: "I didn't really do anything special except make them feel like you're welcome here. You have a home with us now."[28] (P03, female, 81). Many caregivers stated that the children "were looking for security"[29] (P09, female, 76) and were in such need of emotional support that they "soaked it up if you were nice to them"[30] (P02, female, 58) and even small actions had a big impact: "You got so much gratitude with nothing, with nothing! Doing just a little bit of listening, it's incredible!"[31] (P01, female, 67).

Regarding children's peer relationships, most caregivers (8/12) reported that the children "rarely had visitors"[32] (P10, female, 91) and that "there was practically no outside contact with children"[33] (P08, female, 73). However, some caregivers (5/12) noted that within the care settings the children "had a lot of nice relationships with each other"[34] (P10, female, 91) and often acted as a source of support for one another: "And usually the children who had been [there] for a while passed it on when a new one came. You could sometimes see that they said 'You know, it works like this'."[35] (P05, female, 82). Half of the caregivers (6/12) also observed children forming a connection to animals as a source of emotional support: "There were rabbits. Especially the girls spent a lot of time with the rabbits. Of course, that was something soft to cuddle and mother a little bit."[36] (P02, female, 58).

Concerning the family of origin, most caregivers (9/12) reported limited contact, and when there was contact, it was often perceived as disruptive for the child: "The head of the home, he then said 'That's typical, the [child] has been home again, now she's completely… now you have to train her again'."[37] (P01, female, 67). Some caregivers (6/12) felt that contact with the family of origin could reinforce feelings of instability associated with the welfare placement: "I realized this boy was taking damage between the mother, the father, and us. (…) They brought in a psychologist. That was a big hassle. Then they found that the boy is no longer the same. This is no longer the same boy! This back and forth is wearing him down."[38] (P03, female, 81). Despite this, many caregivers stated that the joint placement of siblings (when possible) was a protective factor for the children's emotional and social development: "By having multiple sets of siblings, it wasn't as… well, it certainly wasn't an easy situation for those siblings. But they had somebody in the family. I thought there was a difference between kids who had another sibling there and those who were there by themselves."[39] (P02, female, 58).

4. Discussion

The current study examined intra- and interpersonal factors that promoted or hindered the adaptive adjustment and resilience of children affected by CSMP in Switzerland, from the previously neglected perspective of former caregivers. Two main themes emerged on both the intrapersonal level (i.e., *core characteristics*, *coping*), and the interpersonal level (i.e., *caregiving attitudes and actions*, *relationships and attachment*). Potential resilience hindering factors included emotion regulation difficulties, issues within the child-caregiver relationship (e.g., differential treatment, abuse and punitive measures, attitudes that devalue children, lack of affection and attachment), and placement disruptions. Potential resilience promoting factors included the coping mechanisms of creativity and imagination as mental escape, and social and emotional support beyond the caregiver (e.g., siblings, animals).

In the first intrapersonal theme (i.e., core characteristics), caregivers reported differences in adjustment according to the children's demographic characteristics. Older age and female gender were linked to better adaptability during their time in care. The age-related observations may be explained by developmental improvements in coping capacity and deployment of effective coping strategies (e.g., Zimmer-Gembeck & Skinner, 2011), which have previously been shown for children in foster care (Tahkola et al., 2021). Regarding the observed gender differences in adaptability, girls were viewed to be more adapted, compliant, and manageable, whereas boys were reported to have more behavioral problems. These findings may reflect known gender differences in emotion and behavior expression (e.g., Chaplin & Aldao, 2013). However, this distinction is also consistent with a qualitative document analysis on case files of children affected by CSMP in Switzerland (Businger et al., 2018). Results showed that boys' behavior was evaluated negatively twice as often as girls, with girls more often described as vulnerable or at risk, while boys were reported as being work-shy and having behavioral problems (Businger et al., 2018). Given that caregivers in the current study reported differential treatment according to gender, such gendered perceptions could influence the quality of care provision and potentially reinforce maladaptive behavior and coping. While further research is needed to investigate such perceptions, the integration of more reflective practices into the caregiving approach may help to reduce gendered expectations or biases (e.g.,

Domon-Archambault et al., 2020).

Caregivers also observed emotion regulation difficulties in many children, which some perceived as being related to the separation from the family of origin at a young age. This is supported by research on the transition to out-of-home placements, which is associated with the loss of attachment relationships, emotional insecurity, and uncertainty about caregiving arrangements (Mitchell & Kuczynski, 2010). Furthermore, caregivers in the current study reported poorer adjustment in those with emotion regulation difficulties. This is consistent with a recent study that showed an association between emotion dysregulation and internalizing mental health disorders in older adults with a history of complex trauma exposure, including those affected by CSMP (Pfluger et al., 2022). These findings highlight the displacement and transition into welfare care as a crucial period for caregiver intervention to support socioemotional functioning and adjustment.

The last intrapersonal theme (i.e., coping) identified the observed coping strategies and behaviors of the children. Several caregivers noted the children using creative coping strategies to make the best of their situation, such as making toys from discarded food scraps. This corroborates similarly creative solutions reported in a study of Swiss survivors of indentured child labor, in which the children pieced together the shreds of newspaper that served as toilet paper in order to read and educate themselves (Höltge et al., 2018). A specific coping strategy mentioned by many caregivers in the current study was the use of imagination to escape their harsh reality and envision a better future. This may be seen as beneficial for resilience, as future-oriented thinking has previously been shown to have positive effects on mental health among youth in foster care (Cabrera et al., 2009). However, the mental escape from reality can also be understood as a sign of dissociation, a common reaction to child maltreatment (e.g., Hulette et al., 2011). While such dissociative reactions to trauma can be viewed as a protective mechanism in the short term (Alayarian, 2019), research suggests that it is positively related to higher levels of psychopathology in the long term, such as an increased likelihood for the development of posttraumatic stress disorder (PTSD) (Vang et al., 2018).

With regard to the first interpersonal theme (i.e., caregiving attitudes and actions), most caregivers described a child-rearing approach in which extreme disciplinary measures, abuse, and neglect were common occurrences. This corroborates reports from Swiss survivors (e.g., Hauss et al., 2018; Leuenberger & Seglias, 2015; Thoma, Bernays, Eising, Maercker et al., 2021), and is consistent with a large body of international research on institutional abuse (e.g., Carr et al., 2019; Carr et al., 2020; Lueger-Schuster et al., 2018). Previous studies have identified external influences on these abusive welfare practices, such as poor working conditions for caregivers, or different childcare ideologies regarding violence against minors (Ellett & Leighninger, 2006; Galle, 2018; Rohner et al., 2023). Building on this, the current study adds a novel interpersonal perspective on the influence of the personal attitudes and beliefs of caregivers. For example, some caregivers linked the punitive measures or negligence to a lack of respect towards children in care and the belief that the children should earn their care (e.g., by working). This substantiates survivor reports of stigma, discrimination, and maltreatment by caregivers due to their status as an institutional child; as well as the use of (physical) manual labor inappropriate for children (Carr, 2009; Höltge et al., 2018; Mc Gee et al., 2020). The results are also similar to early research with parents, which found that parents with attitudes that devalued children were more likely to physically discipline their children (Jackson et al., 1999). Future studies should further examine the influence of these devaluing attitudes in professional caregivers. This may be particularly important for stigmatized children in welfare care, as negative social perceptions can further influence personal attitudes and perpetuate violence against children (Lilleston et al., 2017).

In the final interpersonal theme (i.e., relationships and attachment), caregivers described their relationships with the children to be characterized by a constant lack of love or affection. While this is consistent with survivor reports (e.g., Leuenberger & Seglias, 2015; Thoma, Bernays, Eising, Maercker et al., 2021), the current study identified caregivers' rationales for this emotional neglect, such as being instructed during training not to form relationships with the children in care. During this period of CSMP in Switzerland, the children were considered to come from norm-violating families and therefore strictness and extreme discipline were deemed necessary to 're-educate' the children (e.g., IEC, 2019). Some caregivers also intentionally limited their attachment to the children, with the rationale that the children would eventually leave their care. Previous research has demonstrated similar findings among foster parents, with attachment difficulties being linked to the emotional toll of children leaving care and the associated sense of loss (Geiger et al., 2013).

Regarding the relationships with the family of origin, the joint placement of siblings was considered beneficial, with these children perceived as more resilient and adaptive. Consistent with research on sibling relationships in familial and institutional settings (e.g., Mota et al., 2017), caregiver reports suggest that siblings draw support from each other to facilitate their socioemotional development. However, sibling placements was stated to be the exception rather than the norm during Swiss CSMP, with further research required for an in-depth examination of potential risks and benefits associated with sibling placements. In addition, caregivers reported limited contact with biological parents, which was perceived to be disruptive. This contradicts previous research in which continued contact with biological parents was found to be beneficial for the mental health of children in foster care (McWey et al., 2010). However, in contrast to a foster family, which may retain some semblance of a familial structure; institutional placements are characterized by an organizational care structure with varied caregivers. This may represent greater care instability, which may be worsened by inconsistent contact with families of origin. Combined with the reported lack of affection from caregivers, the absence of a primary attachment figure may have had a potentially detrimental impact on child development. This is supported by research showing that disrupted attachment in childhood can result in long-term social, emotional, and cognitive difficulties (e.g., Carr et al., 2020; Schuengel et al., 2009). It is therefore crucial to establish a positive and stable caregiving environment that facilitates meaningful attachment experiences with caregivers to promote the socioemotional development of children in care.

The exploratory nature of the current study gives rise to several implications and opportunities for research and practice. The lack of information on the dynamics of perpetration in welfare settings inhibits a meaningful influence on risk reduction for abuse and neglect in welfare care (Flood & Dembele, 2021). However, the current study demonstrates that the caregiver perspective can not only complement survivor reports, but can also offer unique insights into the characteristics, motivations, and facilitators of abuse and neglect. To expand on this initial evidence, future caregiver studies are needed to examine additional risk and protective factors (and their interactions) at individual, interpersonal, welfare, and societal levels. Regarding policy considerations, caregivers reported difficulties in handling the emotional and behavioral problems of children in care, issues with attachment and bonding, and complications arising from contact with families of origin. One solution would be to allocate funding for psychoeducation and training programs for caregivers on dealing with trauma responses and behavioral problems in children (Konijn et al., 2020), bonding and attachment (Dozier et al., 2009), and children's loyalty conflicts with biological parents (Mehta et al., 2013). This could help produce more favorable results for caregivers (e.g., strengthened knowledge base, stress-management techniques), as well as children in care (e.g., developing trusting relationships with caregivers). Concerning practice, caregivers emphasized prominent issues for children in welfare care that may benefit from psychotherapeutic support, such as emotion regulation difficulties and insecure attachment. Caregivers also identified potential strengths that could be fostered, such as coping through creativity and imagination. As the use of imagination for mental

escape can also indicate dissociative reactions to trauma (e.g., Alayarian, 2019), therapeutic mentoring may help to monitor and support the safe development of such coping skills (Johnson & Pryce, 2013). Caregivers may also benefit from the implementation of support services, such as work-related counselling or peer-mentoring programs to train and integrate conscious, reflective practices into care provision (e.g., Domon-Archambault et al., 2020). This may address issues that impact the quality of care, such as stress management or attitudes that devalue children.

Some study limitations must also be considered. For instance, given the retrospective study design and the opt-in recruitment method, the sample may be prone to self-selection, social desirability, or recall biases. Future studies are needed to build on the current findings with prospective, longitudinal assessments, including qualitative observational (e.g., ethnographic) research (Leverton et al., 2019). Furthermore, the results may reflect a gender-bias, as only two of the twelve participants were male. However, historic reports of CSMP in Switzerland suggest that this may be an accurate representation of the gender ratio for professional caregivers involved in CSMP at that time (Czáka & Droux, 2018). Despite these limitations, achieving the intended sample size ($N = 12$) for saturation is a strength of this study (Hennink & Kaiser, 2022); particularly given the advanced age of many former caregivers, as well as the sensitive nature of the topic (i.e., child abuse and neglect within welfare care). Furthermore, the study addresses an crucial gap in the research on institutional child abuse by providing insights into the factors influencing quality of care provision and child well-being, from the previously neglected perspective of former caregivers.

4.1. Conclusion

This study set out to investigate intra- and interpersonal factors that promoted or hindered adaptive adjustment and resilience of children affected by CSMP in Switzerland, from the perspective of former caregivers. Four main themes emerged, with two themes identifying intrapersonal factors relating to the children and their self-regulation, and two themes identifying interpersonal factors relating to the social and emotional interactions (or lack thereof) within the welfare environment. Results highlight key areas for action at an intrapersonal level, including the need to better understand the impact of disrupted family systems, emotion (dys-)regulation, and the coping mechanisms of children in care. Results also emphasize key welfare objectives at an interpersonal level, such as addressing potential biases or devaluing attitudes towards children in care, and facilitating appropriate bonding and attachment in child-caregiver relationships. This study demonstrates the necessity of incorporating the caregiver perspective into research on institutional child abuse. By replicating and expanding on these study findings, future research and practice could not only enhance the education, training, and support of care staff, but also improve the safeguarding of (current and future) children in welfare care.

Ethical approval statement: The study was approved by the Ethics Committee of the Faculty of Arts and Social Sciences in the University of Zurich, Switzerland (ID 20.12.16). The study protocol was conducted in compliance with the Declaration of Helsinki.

Participant consent statement: Written informed consent was obtained prior to the interview from all individual participants included in the study, which included informed consent regarding the publishing of their anonymized data.

Authors' contribution statement: Myriam V. Thoma and Shauna L. Rohner were responsible for the conceptualization and methodological design of the project, as well as funding acquisition, project administration, resourcing, and supervising. Shauna L. Rohner was also responsible for the study investigation process and data curation; with Sarah J. Mäder, Melanie Dorigo, and Aileen N. Salas Castillo responsible for the formal analysis. Writing and preparation of the original draft was done by Shauna L. Rohner, together with, Sarah J. Mäder, Myriam V. Thoma, and Aileen N. Salas Castillo; with critical review and commenting by Melanie Dorigo. All authors read and approved the final manuscript.

Data statement: The data that support the findings of this study are included within the article. While the raw data files are not publicly available due to privacy/ethical restrictions, further enquiries can be direct to the corresponding author.

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Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

Data availability

Data will be made available on request.

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Appendix A. Supplementary material

Supplementary data to this article can be found online at https://doi.org/10.1016/j.childyouth.2024.107653.

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