Mindfulness (2023) 14:2807–2823
https://doi.org/10.1007/s12671-023-02239-9

ORIGINAL PAPER

Compassionate Mind Training for Caregivers in Residential Youth Care: Investigating their Experiences Through a Thematic Analysis

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Accepted: 4 October 2023 / Published online: 26 October 2023

Abstract

Objectives Compassion can be valuable in demanding help settings, both to professionals and clients. Nevertheless, compassion-based interventions have not yet been investigated in residential youth care. This qualitative study aimed to examine the caregivers' experiences with the Compassionate Mind Training program for Caregivers (CMT-Care Homes), as well as their perceptions regarding the barriers/enablers, transfer of learnings, and impact at individual, group, and organizational levels.

Method Three focus groups were conducted, enrolling 19 caregivers after their participation in the CMT-Care Homes. Data were examined using thematic analysis.

Results Four overarching themes, 10 themes, and 14 subthemes were identified. The CMT-Care Homes seemed to enable the development of the three flows of compassion (i.e., compassion towards others, receive compassion from others, and self-compassion). While the program's acceptability, practice, and transfer of learnings seem to facilitate compassion, reported difficulties with some formal practices and fears, blocks, and resistances to compassion might be barriers to its development. Knowledge and practices were transferred to work, both at individual and collective levels, increasing caregivers' emotional health and strengthening team functioning. The program also contributed to improve care practices and to promote an affiliative organizational climate. Indirect impact on youth was also reported, regarding their reactions to the caregivers' compassionate attitudes.

Conclusions Findings demonstrated promising benefits of the CMT-Care Homes in residential youth care settings, at personal, team, and organization levels. Compassion was helpful in working with youth, and in regulating caregivers' own emotions at work. Limitations regarding method and data analysis should be considered.

Keywords Compassionate Mind Training · Compassion · Residential youth care · Caregivers · Focus groups · Thematic analysis

Rooted in an affiliative/caregiving mentality (i.e., affiliative motives, emotions, and competencies), compassion is an evolved motivation that organizes the human mind to offer care to others, receive care from others, and give care to oneself (i.e., self-compassion; Gilbert, 2017b). Given the interpersonal dynamic of compassion, these flows are interdependent and may be blocked due to personal and environmental factors (Hermanto & Zuroff, 2016; Kirby et al., 2019).

There is increasing evidence that compassion can be valuable for people not only as individuals, but also as a group, impacting on interpersonal and collective levels, as it has been found in organizational research (Andersson et al., 2022; Lilius et al., 2011). Research also showed that compassion can be trained through interventions (Gilbert, 2017b; Yarnell & Neff, 2013). Compassion-based interventions seem to be effective in reducing psychological distress and increasing compassion, mindfulness, emotion regulation abilities, and well-being in populations with different conditions and from different settings (Kirby et al., 2017; Matos et al., 2017).

Such interventions may be particularly valuable in work settings linked with help services, where compassion can be enhanced towards clients to improve the care quality and clients' outcomes, but also towards the self to protect

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professionals against mental health concerns (Matos et al., 2022; Sinclair et al., 2016). Furthermore, compassion towards co-workers can encourage cooperative relationships and diminish interpersonal conflicts, establishing the foundation for a secure organizational climate, which in turn could increase the professionals' capacity to handle challenging situations and improve the workplace functioning (Condon & Makransky, 2020; Orellana-Rios et al., 2017). Despite showing promising results in different help settings, these kinds of interventions have not yet been delivered in residential youth care, nor have their usefulness been examined within these settings (Beaumont et al., 2021; Maratos et al., 2019).

Children and youth placed in residential youth care were exposed to maltreatment or inadequate parental care, presenting complex needs (Bronsard et al., 2016; Greger et al., 2015). Professional caregivers are key agents in their recovery, as they can provide safe relationships and foster emotion regulation (Mota et al., 2016; Santos et al., 2023e). Nevertheless, a number of common stressors within these settings (e.g., deal with trauma and aggressive behaviors from youth, reduced staffing rates, qualification fragility, conflicts with colleagues) can negatively impact the caregivers' well-being and subsequently deteriorate care provision (Brown et al., 2013; Santos et al., 2023a). To counteract such difficulties, training for these professionals has been recommended (Quality4children, 2007). Nevertheless, existing programs are mainly focused on skills development (e.g., communication, behavior management), not fully addressing caregivers' emotion regulation needs or the need to establish secure relationships with youth and among themselves (Perry et al., 2020; Santos et al., 2023b). So far, and despite the significant role of compassion in caregiving (Gilbert, 2017b), little is known about how caregivers' motivations and competencies related to compassion can be trained and how caregivers transfer the learnings at the individual and collective levels (i.e., the extent to which participants apply the knowledge and skills that were acquired during training to their routines), which are core features of how compassion training might be valuable for these help settings (Liu & Smith, 2011; Lyddy et al., 2016).

As an attempt to address these needs, a Compassionate Mind Training program for Caregivers working in residential youth care (CMT-Care Homes) was developed. We will elaborate further on the program in the "Method" section. The current work is a qualitative study on CMT-Care Homes nested in a cluster randomized trial (Santos et al., 2023c, 2023d). This study aimed to explore the caregivers' experiences with the CMT-Care Homes program and to investigate its perceived value for residential youth care settings, as well as its impact at individual, group, and organization levels. Since the transfer of learning is considered a potential factor for successful interventions, we also investigated how caregivers transferred the new learnings to their personal and professional routine (e.g., care practices) and corresponding barriers to such transference (Lyddy et al., 2016). Assuming that a compassionate attitude shapes interpersonal relationships, we also examined caregivers' perception regarding possible indirect effects in youth (Lilius et al., 2011).

A qualitative approach was used to understand the adequacy and value of a compassionate-based approach within this challenging help work setting. It can also provide an initial exploratory analysis that captures both first- and second-person perspectives regarding compassion (i.e., to give and to receive compassion, accordingly; Mascaro et al., 2020) and its barriers and enablers that may arise in situ, as well as the transfer of learning, using an intensity sample (i.e., rich cases that provide in-depth information of a phenomenon of interest; Patton, 1990).

Method

This study is nested in a cluster randomized trial, examining the effectiveness of the CMT-Care Homes program. The trial was registered in https://clinicaltrials.gov/ (Identifier: NCT04512092). The current study followed the Consolidated Criteria for Reporting Qualitative Research (COREQ; Tong et al., 2007).

CMT-Care Homes Overview

The Compassionate Mind Training for Caregivers (CMT-Care Homes) is a manualized and structured program aiming to promote an affiliative mentality in residential youth care. It consists of 12 group sessions, each lasting 2.5 hr, weekly delivered at each residential care home (RCH), during approximatively 3 months.

The CMT-Care Homes is based on the integrated biopsychosocial model within the Compassionate Focused Therapy framework and Compassionate Mind Training practices (Gilbert, 2017b), encompassing three modules. The first one comprises six sessions designed to provide psychoeducation about the evolved and socially shaped human mind and the three affect regulation systems (i.e., the threat system, encompassing defensiveness emotions and behaviors aiming protection; the drive system, linked to acting/energizing emotions and behaviors, aiming to seek out and acquiring resources; the soothing system, linked with affiliative emotions of safeness, calmness, and contentment, aiming to reassure; Gilbert, 2017a). The second module has five sessions designed to train the attributes and competencies of compassion, to cultivate the three flows of compassion (i.e., compassion towards others, receive compassion from others, and self-compassion), addressing its fears, blocks,

and resistances. The last module is composed of the final session, designed to revise key information and practices.

Sessions' structure is divided into three parts and metaphorically use vocabulary related with a journey. The first part, named check-in, comprises a grounding exercise (i.e., landing in session), the review of the lessons learned from the previous session, and the evaluation of the compassionate weekly challenge. The second part, named exploration of the session theme, includes psychoeducation and experiential practices (e.g., compassionate imagery, role-play, and group exercises) which are performed to explore the session's goals. These exercises are followed by opportunities to share experiences in group and open discussion in a safe atmosphere. The last part, named check-out, includes a moment to summarize the lessons learned and to reflect about their personal and group application to the self, to youth, and to care practices, followed by the writing in the Compassionate wall (i.e., a mural where the group record the most relevant key ideas from each session). Then, the compassionate weekly challenge is communicated to participants. According to the Caffarella Interactive Program Planning Model (2002), a learning transference task is defined for each session (i.e., the compassionate weekly challenge), to be trained and applied between sessions in order to enhance skills development and to maximize intervention's effects. This challenge comprises two tasks: (1) to apply the session's learnings into daily routine at home and/or at work (e.g., to do informal practices, to identify and validate emotions in self and others); (2) to do daily formal practices (e.g., mindfulness, compassionate imagery). To support practice and transference, participants receive a postcard describing the compassionate weekly challenge and formal practices are provided in audio format. Before ending, participants are invited to assess the session and to listen to the compassionate song from one of their colleagues (i.e., a song with a soothing and reassuring meaning). The session ends with a formal meditation practice (i.e., session take-off).

The program was led by a clinical psychologist trained in cognitive-behavioral and in compassionate interventions, who participated in several compassion and mindfulness training programs and workshops for personal practice and development. A detailed description of the CMT-Care Homes' sessions can be found on previous work (Santos et al., 2022), and materials and instructions can be accessed on the handbook (Santos et al., 2020).

Participants

Participants were sampled from 12 Portuguese RCHs that were enrolled in the clinical trial (for detailed procedures, see Santos et al., 2023c). Caregivers ($n = 32$) from the three RCHs that had participated in the program, between October 2019 and January 2020, were invited to voluntarily participate in a focus group. For sampling, it was asked that at least five professionals with different roles per RCH could join. Nineteen caregivers (17 women; age range: 25–56; without prior meditation experience), including members from the technical (case managers; $n = 9$) and educational (ensure the daily routine and care provision; $n = 10$) teams, volunteered to participate (Table 1). Reasons for declining were not collected.

Procedure

Focus groups allow the collection of a large amount of data in a short time with an intensity sample, facilitating data collection within this specific setting and respecting the program format (Patton, 1990). Two weeks after the program terminus, three focus groups were led by two psychologists (LS and MRP) following a discussion script (see supplementary materials). Focus groups occurred in each RCH with six to seven participants. Because LS was also responsible for program delivery, she had previous relationship with participants. MRP had experience in conducting qualitative studies, and did not have a prior contact with the participants. Focus groups were audio-recorded (with written permission from the participants), transcribed by LS, and translated from Portuguese by a third-party translator. Confidentiality and anonymity were ensured. Confidentiality and

Table 1 Sociodemographic data of participants in focus groups ($n = 19$)

RCH	Duration	Participants	Gender	Job role	Years of work in RCH	No. sessions attended
RCH 1	1h50	$n = 6$	6 female	1 director 1 psychologist 4 educators	1–23 years $M = 9.67$ $SD = 7.55$	8–12 sessions
RCH 2	2h17	$n = 6$	2 male 4 female	1 Director 1 psychologist 1 social worker 3 educators	1–24 years $M = 10.17$ $SD = 8.47$	7–12 sessions
RCH 3	2h39	$n = 7$	6 female	2 directors 1 psychologist 1 social worker 3 educators	1–12 years $M = 8.43$ $SD = 5.13$	7–12 sessions

Note. RCH, residential care homes; *M*, mean; *SD*, standard deviation

anonymity were ensured by replacing participants' identification for a code, where T means a member from the technical team; E means a member from the educational team; and RCH means the residential care home where the participant works. Each participant and residential care home was assigned with a number.

Data Analyses

Data were analyzed using thematic analysis, which provides a systematic, but flexible approach to summarize key features in a large amount of data, while allowing to highlight commonalities and differences across the data set (Braun & Clarke, 2013). An experiential orientation and an essentialist theoretical framework were assumed, using an inductive analytic method.

Following the phases proposed by Braun and Clarke (2012, 2013), firstly, LS did an intensive reading of the transcript data to enhance engagement and familiarization. Secondly, initial coding was conducted across the entire data set based on their semantic or latent meaning. This process was led on hard copy and then refined with the assistance of MaxQDA 2020 software. Then, the codes were reviewed and grouped to generate potential themes, which capture a coherent and meaningful pattern related with the research aims. The relationship between candidate themes was explored and a thematic map was drawn. Following that, LS and MRP reviewed the candidate themes in relation to the coded data and the entire data set to ensure that the codes fitted within the themes. The themes were later refined and named. DR validated the final themes, concluding that the identified themes reflected the data and made theoretical sense based on the program's content and framework. Finally, themes were related in order to respond to the research' aims.

To enhance the trustworthiness and credibility, triangulation via researchers (involving three researchers) and member checking were conducted (Braun & Clarke, 2013). The analysis was validated by three participants (one from each RCH), who volunteered for this procedure. All of them acknowledged the analysis reflected their experiences.

Results

The thematic analysis yielded four overarching themes, 10 themes, and 14 subthemes (Fig. 1). Results are described and illustrated using participant quotations. Additional quotes and the frequency of data extracts are provided on Table 2.

Compassion Development

This theme explores to what extent the CMT-Care Homes contributed to the development of the three flows of compassion (i.e., give compassion to others, receive compassion from others, and self-compassion) and to address fears, blocks, and resistances to compassion in its three flows. Changes in each flow seem to be perceived and valued in different ways.

Compassion Towards Others

As caregivers, some participants felt that they were already available to care for others, and so, the perceived

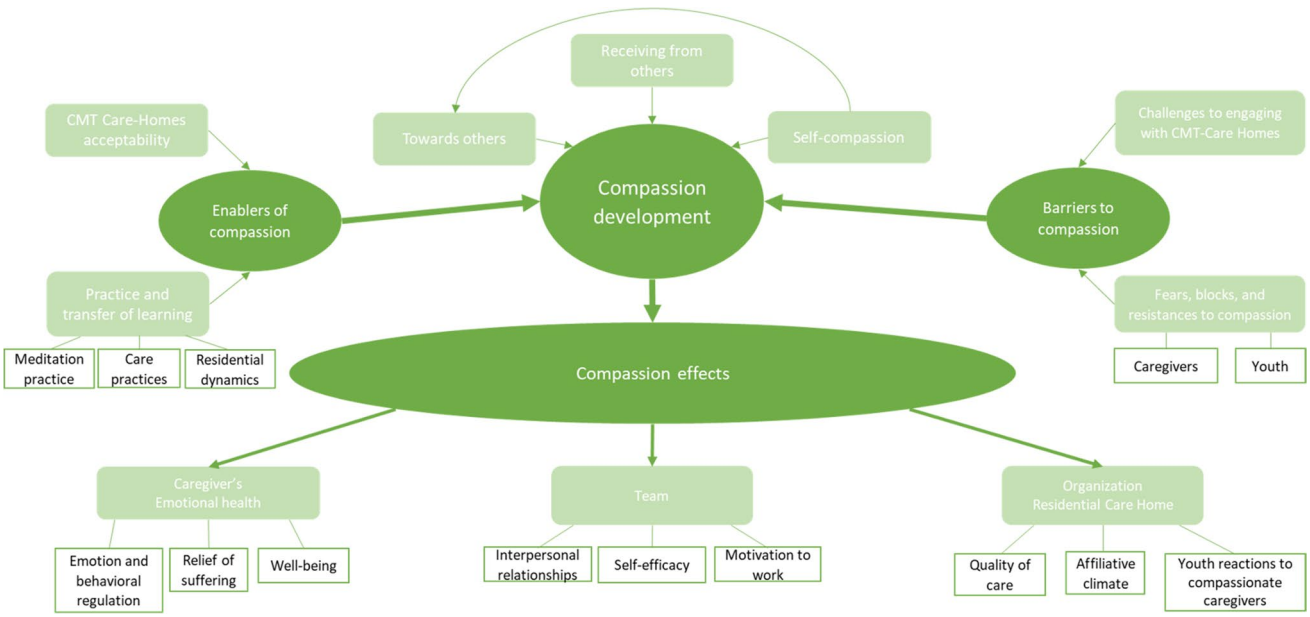

Fig. 1 Thematic map

Table 2 Overarching themes, themes and subthemes, illustrative quotations, and frequency of data extracts

Overarching theme	Themes and subthemes	Illustrative quotations	Frequency of data extracts
1. Compassion development	1.1. Compassion towards others	"We are caregivers, so we are much more prone to give compassion, than to receive it" (T21, RCH2) "I think that suffering was valued. Before the program, sometimes we used to think - she is suffering, but she is also rude - Now I try to understand that behind that behavior there is suffering and I try to understand what is going on" (E31, RCH3)	43
	1.2 Receiving compassion from others	"I'm more open to receive compassion. Before the program I was afraid of people, when they approached me, because I thought they were always waiting to get something in return. Now I'm more open and it's good" (E21, RCH2) "This training contributed to being more available and open to receiving compassion. Maybe I was more available to give compassion than to receive it. I always had some resistance, fear. Now I feel more open to receive compassion and also more aware of its importance" (E23, RCH2)	15
	1.3 Self-compassion	"I give much more importance to my well-being and I realized that if I feel well, I can do my job better, and be more available to take care of others" (T22, RCH2) "People have more time for themselves, to take care of themselves, to value themselves, to validate what is less good. I think there is more time and space for that" (T34, RCH3)	58
			Overarching theme 1 total = 116
2. Barriers to compassion	2.1 Challenges to engaging with CMT-Care Homes	"The exercises became more difficult as the sessions proceeded, and I began to have more difficulty in staying focused and doing them" (T12, RCH1) "I've always been a bad student in relation to homework. It has to do with our available time" (T32, RCH3)	7
	2.2 Fears, blocks, and resistances to compassion		42
	2.2.1 From caregivers	"I think we are educated to be critical of ourselves" (T32, RCH2) "Some people develop compassion more easily than others" (E31, RCH3) "For me it was difficult to let others be compassionate to me" (T33, RCH3)	(23)
	2.2.2 From youth	"Little time has passed; it has to be something to be continued" (E11, RCH1) "Sometimes some youngsters get annoyed with our calmness" (T11, RCH1)	(19)
			Overarching theme 2 total = 49
3. Enablers of compassion	3.1 CMT-Care Homes acceptability	"We shared some things that otherwise we hadn't shared" (T11, RCH1) "We learned interesting things that were and will be useful to us" (T12, RCH1) "I think this was the training that helped me the most to work with youth" (E21, RCH2) "It was useful to my personal and professional life, and on the relationship with myself" (T23, RCH2)	78
	3.2 Practice and transfer of learning		207
	3.2.1 Meditation practice	"I have been practicing mindfulness daily… I often go to my safe place" (T11, RCH1) "Before, we only had the critical friend. Now we also have a compassionate friend, who validates the negative things that happen to us and helps us to have a different perspective, who softens situations and who gives us strength and encourages us. This is good because it gives us some balance" (T34, RCH3)	(59)
	3.2.2 Care practices	"I was able to reassure the youth, I may not have been able to change the situation, but the youth was calmer, less stressed and so was I" (T22, RCH2) "First, I understand that behind that behavior there is suffering and I try to understand what is going on…. If we can talk, I try to soothe her. If not, I give her some space. Before, maybe I'd start to be a little rougher" (E31, RCH3) "Now it's easier for me to give a hug" (E32, RCH3)	(97)
	3.2.3 Residential dynamics	"I think that the knowledge around the affect regulation systems was important. Sometimes we felt angry, stressed, and we couldn't understand it, or know how to deal with it. Now we understand how it works and what each system means, what can be done to manage it. I remember several situations, almost always with the same kid, where I got nervous, I felt like screaming, and after being able to understand – I'm in the red-, and what it means, what I can do to manage it, it helped me" (T12, RCH1) "One important thing that we have learned and that we apply in everyday life is that we should not focus only on ourselves, and we realized that other people around us also have problems" (E14, RCH1) "We put on glasses of compassion to observe and interpret others' behaviors" (T34, RCH3)	(51)
			Overarching theme 3 total = 285

Table 2 (continued)

Overarching theme	Themes and subthemes	Illustrative quotations	Frequency of data extracts
4. Compassion effects	4.1 Caregiver's emotional health		178
	4.1.1 Emotion and behavioral regulation	"I think more about what I'm going to say and the way I'm going to say it" (E13, RCH1) "We end up stopping and reflecting and not acting right away" (E14, RCH1) "The training helped me to control myself, to manage my emotions, my self-criticism" (E21, RCH2) "Now I do not go home focused on a problem that happened here. I can get a little farther away from it" (T33, RCH3)	(102)
	4.1.2 Relief of suffering	"I don't feel so guilty" (T12, RCH1) "I get less angry with myself" (T22, RCH2) "I don't stress so much" (E31, RCH3)	(33)
	4.1.3 Well-being	"I feel good, I feel calm, I don't always have those thoughts and the frustration of everyday life or the stress of work... I've even been more Zen with the girls" (E33, RCH3) "I feel more at ease, better with myself, more serene inside" (T32, RCH3) "I still do certain practices that I learned in the program and it helps me to feel calmer in my daily life" (T34, RCH3)	(43)
	4.2 Team		61
	4.2.1 Interpersonal relationships	"Be aware and be able to say - am I prepared to deal with this situation at this moment or should I call another team member? - Maybe there was no predisposition for me before to withdraw from a situation, to understand that there was someone else in better conditions to intervene at that moment…. I think that we became a more united team. We avoided conflict situations, we gave more importance to solving situations at the moment and focus in what is important, which are the youth under our care" (T22, RCH2) "It was created more relationship between team members" (T31, RCH3)	(24)
	4.2.2 Self-efficacy	"Little by little I think it gives us security, confidence" (T32, RCH3) "The model entered our language. We already have a language code - Today you are in the red, please calm down" (T32, RCH3) "On that day we did a good teamwork" (T33, RCH3)	(20)
	4.2.3 Motivation to work	"More willing to help, to work" (E21, RCH2) "It boosted me, it gave me energy and at the same time I feel calmer. But with more energy to intervene, with more willingness to work" (T33, RCH3)	(17)
	4.3 Organization/residential care home		158
	4.3.1 Quality of care	"We now have a more assertive behavior… I used to apply more sanctions before. At the moment it doesn't mean that I don't do that, but I'm more receptive to listen" (T11, RCH1) "Being compassionate helped me to solve the conflict" (E21, RCH2) "Before, I was very firm, directive, and, for example, this morning, if I acted like that, maybe I wouldn't have been able to take two girls to school… on Friday, if we acted as before, we would have restrained a youngster and we avoided that, she didn't have to experience that. I think the program could have avoided problematic situations" (T32, RCH3)	(71)
	4.3.2 Affiliative climate	"I felt that I am now much more tolerant with myself and with the youth; I end up having a positive influence when I interact with them and they interact with me" (T22, RCH2) "There is no longer so much confusion, so much noise, so much loud talking" (T32, RCH3)	(48)
	4.3.3 Youth reactions to compassionate caregivers	"The kid became calmer, less stressed" (T22, RCH2) "It is easier to gain the trust of the youngsters" (T33, RCH3) "When I have this attitude, they are less defensive and respond differently" (T34, RCH3)	(39)
			Overarching theme 4 total = 397

changes were more evident in the two remaining flows of compassion: "Regarding compassion towards others, I think I have always considered myself a compassionate person" (T33, RCH3). In fact, in what concerns compassion towards others, participants felt that the program reinforced their motivation to care for others: "I was already quite compassionate towards other people, but this was reinforced" (E32, RCH3). Some participants also reported that other compassion attributes, such as sensitivity and acceptance of others' suffering, empathy, and a non-judgmental attitude had increased: "This training came, above all, to reinforce the idea of trying not to judge the kids for what they do" (E23, RCH2); "accept the suffering" (T33, RCH3); "putting myself in the other person's shoes and trying to be more compassionate when the situation demanded it" (E13, RCH1); "Before this program, I was more directive in my intervention, and now I have started to try to see the girls' side, to try to better understand them" (T32, RCH3).

Despite some participants having seen themselves as already having an intrinsic motivation to care for others, reports in the first person suggest that compassion attributes (e.g., sensibility to suffering, empathy) and competencies (e.g., compassionate thinking and behaviors) were strengthen (Gilbert, 2017b; Mascaro et al., 2020). Compassion seems to be felt and expressed not only towards youth, but also towards colleagues.

Receiving Compassion from Others

Caregivers from two RCHs reported that they started to notice their fears and blocks regarding receiving compassion from others, and perceived a greater openness to receive compassion from others, namely from colleagues: "I try not to interpret negatively the intention of the other and maybe I'm also more aware of the obstacles of compassion, related both with receiving and giving compassion. I try to get around them – Ok he's just trying to offer you compassion, accept it" (T34, RCH3); "I'm more open to receive compassion. It was important for me, because I was always used to just giving, giving, giving; I'm that kind of person who could never say no. This training helped me to let others come in" (E21, RCH2).

This subtheme allowed to understand that caregivers started to become more available and open to receive compassion from others, including from their own colleagues in the workplace. Considering the interpersonal dynamic process of compassion between those who give it and those who receive it (Hermanto & Zuroff, 2016), when taken together, findings from this subtheme and the previous one suggest the existence of compassionate interchanges between team members.

Self-compassion

It was unanimous that self-compassion was the flow where more changes were noticed: "The most significant changes were in self-compassion, but of course there were also features that changed both in giving and receiving it" (T12, RCH1). Participants from all RCHs recognized the importance of self-compassion, reporting that the tone and content of their internal speech were becoming more caring and supportive: "To me, it had some impact because I am very critical of myself, very demanding and it helped me to be more compassionate with myself and to think and act differently with myself and others, to quit from being so self-critical and highly demanding with myself" (E21, RCH2). Participants also mentioned some reduction in fears, blocks, and resistances concerning self-compassion: "I felt the biggest difference on self-compassion. In fact, I thought more about it, I had not thought about it before. I started to become more aware about it. I need it too, I'm here too, let me take care of myself now" (E32, RCH3). In some RCHs, participants reported an increase in their motivation to take care of their own needs, and it was often said: "if we take care of ourselves first, we will be more able to take care of others as well. That is, if we can manage our emotions first and manage them well, our way of relating with others will be different, much more tolerant, much more compassionate" (T22, RCH2). Self-kindness was also highlighted: "For me, it was more about self-compassion, being kind to ourselves. It was something that had never occurred to me before. It was easier to be kind to others" (T11, RCH1).

Despite the reported changes in all compassion flows, considering the specificities and challenges from this work setting, caregivers seemed to value that they also need to be cared for, with most caregivers highlighting the relevance of becoming more self-compassionate. The necessity to take care of their own needs, in order to take better care of youth in residential youth care, was greatly emphasized.

Barriers to Compassion

This theme examined the challenges and difficulties that might have hampered the development of compassion.

Challenges to Engaging with CMT-Care Homes

Some participants expressed difficulties with formal practices of meditation, as well as in accomplishing the weekly practice: "To me, it was very difficult to keep my mind in the present moment" (E13, RCH1); "The day is very busy, there were days that I could do the homework, others that I didn't have the possibility to listen to the audios" (T31, RCH3). Sessions' duration and frequency were considered an additional load for caregivers who worked in shifts: "These sessions, for some of us, were an extra working hour. For some

people it meant coming to work on days off or before working hours, when they would still have 8 hours of work after the session" (T21, RCH2).

These findings suggest that barriers to compassion can reside in individual and organizational factors, related with challenges in engaging with such kind of program, mainly due its contemplative nature. Sessions' frequency and between sessions practices can be challenging in a setting where the work overload is already demanding.

Fears, Blocks, and Resistances to Compassion

In addition to training constraints, common fears, blocks, and resistances to compassion in its three flows (i.e., give compassion to others, receive compassion from others, and self-compassion) were also noticed. Being compassionate towards others was reported as demanding: "I think this is a more demanding kind of care" (T31, RCH3). Receiving compassion from others was somehow difficult for some participants: "I still have to progress a little bit more in terms of receiving compassion" (T32, RCH3). Despite being referred as the flow where major improvements were felt, self-compassion was also the flow where most fears, blocks, and resistances were experienced and reported: "It is self-compassion that we have to work on. It is the more difficult one" (E12, RCH1); "My self-criticism is still not in the right place" (E22, RCH2).

Since compassion is dynamic and reciprocal, fears, blocks, and resistances to compassion expressed by youth might also work as a barrier to compassion in residential youth care. Caregivers from two RCHs mentioned that some youths react with strangeness to the changes in caregivers' behavior: "They are not used to this kind of intervention at all. In their family home they went through violence and shouting, so it makes them a bit angry when we are compassionate towards them, but of course, with time, they will eventually see that this is the right way" (T33, RCH3). Participants from the three RHCs also recognized that the establishment of warmth and close relationships is a process that takes time: "It is a construction that has yet to be done. We are working on it, but it takes its own time" (E31, RCH3). It was also referred that, given the endured mental health difficulties of traumatized youth, specific interventions tailored to youth are needed so that major changes can occur: "If the intervention that caregivers had was also delivered to youth, I think the outcomes would be different, we would have another type of outcomes" (T22, RCH2).

Baseline levels of fears, blocks, and resistances to compassion, both from caregivers and youth in care, could make more difficult the experience and development of a compassionate motivation and attitude from caregivers. Organizational factors, such as lack of time, were also mentioned as a barrier to be compassionate with others. Due to earlier adverse experiences with caring figures, caregivers also acknowledged youth's difficulties when facing compassionate care. Nevertheless, caregivers also showed perseverance and recognized that a consistent compassionate approach across time, eventually paired with individual therapy to youth, could be able to reduce resistances presented by youth and improve residential care outcomes.

Enablers of Compassion

This theme examined factors that might have enhanced the development of compassion.

CMT-Care Homes Acceptability

Participants from the three RCHs expressed their satisfaction with their experience of participation in the CMT-Care Homes, acknowledging its utility and value to the residential youth care setting: "I identified myself very much with this program, it helped me to reflect, and it helped me a lot in the intervention with the youth, with myself, and with the team. For me, it was very valuable" (T33, RCH3); "This training was very positive in all aspects, I liked it very much. Until now, I think it was the training that helped me the most to work with youth, to work with my colleagues, even in my personal life"(E21, RCH2). Participants also expressed their satisfaction regarding the fact that the program was specifically tailored to caregivers, aiming at the improvement of their own well-being, but also providing important, interesting, and useful new tools for work: "We can say that this training is like a 2 in 1. Usually, when we go to a training, we learn to intervene with our target public, and in this training, in addition to that, we learned other things that have to do with ourselves and our own well-being. Especially with meditation practices, we were able to find gains that we wouldn't have found in other strategies. It was fundamental for us to complement our daily tools and our intervention strategies, but also quite important in the care for ourselves that we usually don't worry about and which also wears us down in our daily lives" (T34, RCH3); "We touched upon some quite interesting and useful concepts for the field of residential care" (E23, RCH2). Furthermore, participants recognized the relevance of within sessions experiential exercises and between sessions practices: "Practical exercises were the ones that I liked the most and the ones I found most important. Even to get to know each other better" (E22, RCH2); "The weekly tasks were a way to practice and put into practice the learnings we had achieved in the sessions; I think it was important" (T22, RCH2). The safe group atmosphere was highlighted as enabling the sharing of personal experiences: "The sharing, I found it very interesting. I think it's important for the team" (E22, RCH2).

The program and its compassionate-based approach seemed to be well received and considered valuable, both individually and collectively. Its aims, format, contents, and practices seemed to be adequate and to facilitate adherence and expectations regarding program outcomes. The fact that the program was not only designed to improve professional skills, but also to target caregivers' own emotional needs and well-being, was highlighted in face of the daily challenges felt by the participants. The group format seemed to have allowed caregivers to share difficulties and insights and to show compassion towards other participants, after understanding that they were not alone in their difficulties. The theoretical framework and experiential practices were considered helpful. Satisfaction with the program and the recognition of its value to these settings might have facilitated the compliance with practices and transfer of learning.

Practice and Transfer of Learning

Despite the mentioned difficulties reported with the weekly challenge practice, it was referred that, in general, caregivers had integrated the new learnings into their daily lives. Regarding meditation practices, participants reported using compassion exercises (e.g., compassionate friend and safe place) and mindfulness practices. It was stated that they tried to bring the focus of attention to the present and to breathe mindfully, and to appreciate the present moment: "On a personal level, I became more aware of things, being focused on the present moment; I took some exercises that we practiced here and tried to practice them on a daily basis. I think it had a positive effect. I think we spend most of our days on 'automatic pilot' and life goes by without one being aware of what we are doing, not having the capacity to enjoy the moment. I think the training was positive and it was something I also applied to my daily life" (E23, RCH2); "I started to be a little more in the present. Still planning, but without ceasing to enjoy the moment" (T11, RCH1). Participants also reported that they were more aware about the focus of their attention and their emotional states, recognizing their need to slow down: "The practical exercises that we did between sessions allowed me to become more aware of the need to slow down the mind, the body, to be more present" (T21, RCH2). Some participants also reported that they applied some practices with their relatives or that they did some practices together: "This week my husband was very stressed. So, I took home these practices and explained to him how it works. We started doing exercises together. We talked about the safe place. He's trying to create his safe place on his mind. So, I'm applying that at home as well" (T12, RCH1).

Participants from the three RCHs also specified that the program was particularly useful to help them in dealing with youth. During care provision, participants sought to use a more compassionate communication, using a calmer voice tone, congruent with a friendly facial expression. In addition, they reported to start using more affective and proximity behaviors (e.g., hugging, touching): "Speaking with a calmer voice, valuing touch, our facial expression; having the notion that this is very important. Those non-verbal signals that we express have great impact on youth" (T11, RCH1); "We do not have to be afraid of giving affection. I can say that touch has become more important to me" (T22; RCH2). This non-verbal language was combined with a more compassionate intervention, in the sense of trying to better understand youth, placing themselves in their perspective, mostly in order to stimulate a more soothing response in youth: "I can perceive some changes from the whole team towards the youths. I have a much more active attitude in giving compassion to youths. Maybe I have a much more active attitude in noticing and being more attentive when the youth is suffering, being with him or her and trying to alleviate their suffering" (E23, RCH2). This greater willingness to listen and understand was used to mediate and solve conflicts and to create more moments of dialogue with the youngsters: "I am more receptive to listening; things are now more talked about" (T11, RCH1); "the compassionate mind training is useful to the daily relationship with the youngsters and to solve the basic conflicts that arise on a daily basis. It is also useful to find a strategy that better suits the situation, not putting the youth 'in the red', nor us, and trying to avoid the conflict and solve it in a different way" (E31, RCH3). Some participants also reported that they had tried or had the intention to do some practices with youngsters: "One caregiver did mindfulness with the youngsters" (T11, RCH1).

In addition to the care practices, participants from the three RCHs also tried to apply the programs' theoretical model in the daily work dynamics, using it in relation to themselves, colleagues, and youth. For example, the three affect regulation systems and related colors (i.e., red for threat, blue for drive, and green for soothing, Gilbert, 2017a) seemed to be frequently used both to understand and express one's emotions, as well as to identify the emotional state of colleagues and youth. "Glasses of compassion" and "Common Humanity" were key terms of the CMT-Care Homes also frequently used: "We interpret the behavior of others in the light of the three systems. Previously, if a colleague arrived in a bad mood, I would think something like – here she goes again, turned inside out! – But now I might think – OK, she is in the red system, I won't criticize her, I won't judge her attitude, because something happened to her to be in the red system – I think that the knowledge of these emotion regulation systems makes it easier, not to criticize so much, not to judge so much and we really put on the glasses of compassion and try to better understand the behavior of others. Before, we didn't put on our glasses of compassion; and now, we stop and put on our glasses to think - What is

she feeling? Why is she behaving in this way? How can I help her?" (T34, RCH3).

Despite the mentioned difficulties with formal meditation practices and with some the weekly challenge practice, formal and informal practices were used by some participants to enhance mindful attention and compassionate emotions, thoughts, and behaviors. Transfer of learnings related with the theoretical framework and compassion competencies seemed to occur to personal and professional life contexts, concerning themselves, co-workers, and youth. Particularly, caregivers referred that the new knowledge and skills were greatly applied when providing care and to solve conflicts. Collectively, caregivers seemed to create more space to listen and dialogue with youth, while trying to communicate and act in a more compassionate way, resorting to a soothing voice tone, touch, and affection. Theoretical knowledge regarding the evolutionary perspective about the human mind and suffering and the role of compassion in the regulation of the three affect regulation systems (i.e., the threat, the drive, and the soothing systems; Gilbert, 2017a) seemed to be acknowledged and used between colleagues in the work dynamics, facilitating the awareness, communication, and regulation of their own and others' emotional states. Despite not being asked to do so, some caregivers took the initiative to teach and practice meditation with their own relatives and with youth in care.

Compassion Effects

This theme examines the potential effects of compassion at individual (i.e., caregiver), group (i.e., team), and organizational (i.e., residential care home) levels.

Effects on Caregivers' Emotional Health

At the individual level, participants reported enhanced emotion and behavior regulation, reduced suffering, and increased well-being. Acquiring knowledge about the functioning of the human mind, as well as the mind training practices, seemed to enhance self-awareness and encourage self-reflection, facilitating healthier cognitive emotion regulation strategies, such as stop and think before acting, perspective taking, change priorities, and reducing both rumination and self-criticism: "From a personal point of view, I think that it has created in me a greater awareness about my emotions, my way of functioning, how they affect my behavior... I am more aware of the changes that occur throughout the day, and, therefore, there is also a greater intentionality not to be taken over by these emotions and try to regulate them in a more positive direction" (E23, RCH2); "It helped me to change the perspective" (E32, RCH3); "I am not so distressed in my day to day thinking – oh I failed, I failed, I failed" (E13, RCH1); "Especially when I fail or things do not go the way I wanted, instead of beating myself up, I adopt an attitude of trying to better understand myself and what is happening" (T23, RCH2). Caregivers reported being able to manage their emotions, having less reactive behaviors, and perceiving a greater level of self-control: "I feel that I already react differently to certain situations, I'm not so explosive" (E13, RCH1).

The CMT-Care Homes seemed to help caregivers to better tolerate and deal with difficult emotions and stressful situations, contributing to a reduction of negative affect. Particularly, participants reported feeling less stress and guilt, as well as less emotional exhaustion: "During this program, there were so many difficult situations in this care home, that it would have probably taken me further down" (T33, RCH3); "I feel that I have changed, I am less stressed" (T22, RCH2); "I stopped blaming myself so much" (E12, RCH1); "Before doing this training, I would feel much more tired, much more exhausted, and maybe it would impact the rest of the working day" (T32, RCH3). Caregivers also perceived an increased well-being: "It helped me very positively, it brought me a lot of awareness, as the days went by, I began to feel better and better in the workplace" (E21, RCH2). Particularly, they highlighted an increase in positive affect linked to the emotional states related with the soothing system (calmness, easiness, peacefulness): "I feel good, I feel calm, quieter" (E33, RCH3); "I think it gave me a little bit more peace, personal peace" (T1, RCH1); "The truth is I'm much happier with myself" (T32, RCH3).

This subtheme allowed to understand that participants became more aware of their own emotions and started to use healthier emotion regulations strategies, reducing rumination, self-criticism, and reactive behaviors. Findings also suggested that participants seemed to cope better with stressful experiences that previously were sources of suffering. Negative affect seemed to reduce, while positive affect seemed to increase, rising the perception of well-being.

Effects on the Team

Effects of compassion were also felt at the team level, namely on interpersonal relationships, self-efficacy, and motivation to work. In what concerns relationships between team members, in the three RCHs, a greater ease of communication, more positive interactions, and cohesion were noticed: "The communication between the whole team became very positive" (E21, RCH2); "I think it was positive concerning relational issues; at least, I felt much less stressed in the team meetings" (T22, RCH2); "the fact that we are more united strengthens the functioning of the whole team" (T11, RCH1). At one RCH, participants stated greater openness to ask colleagues for help, when facing difficulties: "We are more able to trust in each other, to be able to

call someone else when we think we are unable to solve a particular issue" (E23, RCH2).

Enhancements in self-efficacy seem to have also been found. Participants reported increases not only on self-confidence, but also on holding a common language based on the theoretical model (e.g., three affect regulation systems; Gilbert, 2017a), and higher coherence concerning attitudes and actions among team members: "It gives us more confidence in our daily practice" (T34, RCH3); "Between us, we can even talk about the red, the green and the blue... we can even share situations and knowledge or strategies in another way" (T11, RCH1); "There was a positive impact on the team, there was more trust between the members, in the work that each one of us had to do" (T22, RCH2). At last, CMT-Care Homes also seemed to contribute in improving motivation to work, with caregivers reporting also higher professional accomplishments: "I wanted to come to work again, to be here, to enjoy my work" (T22, RCH2); "We feel much more fulfilled" (T33, RCH3).

Overall, this approach may have contributed to improve relationships between colleagues, namely by increasing cohesion, facilitating communication based on a shared theoretical framework, and safeness in relying on colleagues for help. It may also have enhanced motivation to work, as well as the confidence and sense of professional achievement.

Effects on the Residential Care Home

At the organizational level, compassion effects were perceived on the quality of care, on the climate felt at the RCH, which became more affiliative, and on youth reactions to caregivers' interventions. Care provision became more intentional, based on selected techniques, reducing the probability of resulting from automatic reactions to the behavior of others: "We are aware that if we use a certain strategy, we will obtain certain behaviors or reactions, having a different receptivity" (T11, RCH1). Participants stated that they now use more appropriate and assertive care practices, which are more effective as well: "We provide care in a more appropriate way" (T11, RCH1); "I think that the Compassionate Mind Training promotes such a balance between what we have to do, and the way we do it. We now act in a more assertive way" (T32, RCH3); "we can more easily reach the goal, when adopting a compassionate posture" (T34, RCH3). A more compassionate intervention focused on understanding the emotional needs of youth appeared to be useful for managing critical episodes, avoiding escalating behavior and physical restraints, as well as reducing punishments: "I think it has a direct impact on how critical episodes can be managed" (T21, RCH2); "With a more compassionate attitude you don't perpetuate so much instability, aggression, so we don't need to use so many physical restraints" (T34, RCH3), "I don't penalize so much; I try to be a little bit more understanding in order to try to understand what's going on" (E31, RCH3).

Caregivers from the three RCHs concluded that CMT-Care Homes seemed to contribute to promote an affiliative climate at the RCH. Although recognizing that it is not always easy to establish a close and trusting relationship with some youth, participants mentioned increases in affectivity, proximity, and positive interactions: "I feel a change in being more open to receiving compassion, you can see that in the connection I make now with youngsters. I am more available for a hug. It has contributed positively to a closer relationship with them" (E23, RCH2). Even though difficulties still exist, the RCH was also reported as a calmer and more peaceful place: "The house is calm" (E11, RCH1). In two RCHs, participants also mentioned a greater tolerance of caregivers, not only in relation to others (colleagues and youth), but also regarding their own shortcomings, as well as greater interpersonal trust in one another: "We are more able to trust each other" (E23, RCH2); "I felt that I was much more tolerant with myself and with the youth… Changes in the team that ended up being felt by the youth; the fact that we were more tolerant towards each other" (T22, RCH2).

Besides showing fears, blocks, and resistance in being treated with compassion, some changes were spotted on youth, and were interpreted by caregivers as reactions to a compassionate care approach. Caregivers mentioned that youngsters were more available to talk, they were less defensive, and expressed less reactive behaviors: "The way I react has changed, and so has changed everything else. We can even talk about what happens, and he/she does not need to yell or react in a bad way. Yes, things have changed" (T12, RCH1); "I noticed that when he comes to talk to me, even if he has messed up, he comes much more predisposed to talk because he also knows that he will be more heard" (T11, RCH1); "When we ask to talk to them, they don't ask anymore 'What have I done?'" (T33, RCH3); "They have changed, they end up lowering and changing their voice tone. There are immediate outcomes" (T22, RCH2). Caregivers from two RCHs have also reported that youngsters seemed calmer and more stable, showing fewer conflicts in the peer group: "The boys are in a quieter time" (E13, RCH1); "I believe most of the girls are stable" (T32. RCH3), "They don't provoke each other so much anymore" (E21, RCH2). One RCH reported that youth would more easily apologize and some youngsters seemed to show greater self-control: "When they get nervous and are under stress, if we respond more calmly, they even realize more quickly that they are making a mistake and right away or shortly afterwards they apologize" (E14, RCH1); "I believe the boy is able to control himself a little bit more, he does not react so impulsively anymore, not even with his colleagues" (E13, RCH1).

After the program delivery, care provision seems to be provided in a more intentional and technical way, being considered more adequate and assertive, as well as less authoritarian and/or based on punishments. Hence, care quality seems to have improved, becoming more efficient as well. The organizational climate may have become more tolerant, calm, and affiliative, and these are key factors to the healing process.

Regarding the perceived indirect impact of CMT-Care Homes on youth, caregivers recognized that, immediately after the program delivery, more time is needed to assess for stable behavioral changes. After the program completion, changes were observed concerning youth reactions to the caregivers' attitudes, and youth were described as being less reactive and defensive, and more open to talk and to apologize. Considering that most youths placed in RCH have been exposed to traumatic experiences and present mental health difficulties, caregivers recognized that youth would benefit from a compassionate-based intervention specifically tailored to attend their difficulties.

Discussion

By including a qualitative approach in a larger cluster randomized trial (Santos et al., 2023c, 2023d), this study brought new insights about offering a compassion-based intervention in demanding workplaces, such as residential youth care. It also contributes to expanding the knowledge about how the transfer of learning occurs, as well as the effects of compassion across different levels, within help settings.

By including first- and second-person perspectives, this study reinforces and expands the existing literature, showing that the three flows of compassion can be trained in demanding workplaces (Beaumont et al., 2021; Matos et al., 2022). Interestingly, the most evident changes were described concerning the flows of self-compassion and receiving compassion from others. As in other studies with caregivers, some participants did not report a significant change in compassion towards others (Orellana-Rios et al., 2017; Sinclair et al., 2021). This finding may suggest that this flow may be seen as intuitive and/or caregivers already have high baseline levels of compassion towards others, not necessarily meaning that care is provided from an evidence-based perspective (Beaumont et al., 2017; Sinclair et al., 2016).

As in other studies, self-compassion was recognized as particularly valuable to care professionals, to be able to better take care of others (Gustin & Wagner, 2013). As a result, and also as in other studies with helping professionals, participants became more motivated to attend their own needs and developed a more supportive internal speech (Beaumont et al., 2021; Scarlet et al., 2017). The link between self-care and care for others has also been reported in research with teachers (Maratos et al., 2019), and reinforces the interplay between the flows of compassion (Gilbert, 2017b; Hermanto & Zuroff, 2016). Linked with the necessity of attending their own needs, caregivers seem to have become more available and open to receive compassion from others, namely from colleagues. This flow has been neglected in former research assessing compassionate-based programs in help settings (e.g., Beaumont et al., 2021; Maratos et al., 2019), and when assessed, no changes were found (Matos et al., 2022). Considering the interplay between the flows of compassion, the association between being open to receive compassion from others and mental health (Kirby et al., 2019), and also the need for cohesion and good relationships between team members (Santos et al., 2023a), our findings add to current knowledge by including the full assessment of compassion in its three flows and showing its impact across different levels.

As a motivation, compassion can be enhanced or inhibited. This makes relevant the identification of possible barriers and enablers to compassion (Kirby et al., 2019). Current findings suggest there are barriers linked with personal and organizational factors. As in other studies, the sessions' schedule was challenging given the work in shifts and demanding work schedules (Valley & Stallones, 2018). Yet, the average number of attended sessions (79% of sessions) might suggest that, despite the difficulties they faced, caregivers made efforts to attend the program, probably due to the perceived relevance for their professional and personal lives. In addition, as in other trainings of contemplative practices, difficulties with formal meditation practices and homework assignments have also been found (Lyddy et al., 2016; Valley & Stallones, 2018). Such difficulties might have interfered with adherence to some formal practices, hindering the development of compassion, if we take into account that daily practice has been considered a key factor to maximize intervention effects (Lyddy et al., 2016; Maratos et al., 2019).

Additionally, compassion may in part be contingent to common fears, blocks, and resistances presented by individuals at baseline or that may emerge during the program (McEwan et al., 2020; Sinclair et al., 2016). These obstacles may make the development of self-compassion and being open to receive compassion from others difficult, which are often more challenging to improve (Beaumont et al., 2021; Scarlet et al., 2017). Regarding compassion towards others, the lack of time has been commonly highlighted by helping professionals as a bottleneck (Sinclair et al., 2016). In line with previous research, current findings suggest that organizational factors such as shortage of staff and paperwork may pose barriers to compassionate care (Brown et al., 2014; McEwan et al., 2020). A specific barrier linked with these settings may reside in youth's own fears, blocks, and resistances when treated with compassion. Due to their past adverse emotional memories linked with trauma and neglect, they might perceive care and compassion as a threat and,

consequently, reject, avoid, or aggressively react to such care (Gilbert et al., 2011; Kirby et al., 2019). These challenging reactions might put an emphasis on caregivers' own fears of compassion (e.g., fear of being ineffective, fear of extending compassion to someone that does not deserve it), and interfere with their own motivation to care (Condon & Makransky, 2020; Gilbert et al., 2011).

Despite the abovementioned challenges and barriers, the program was considered valuable regarding its aims, format, contents, and practices, being frequently reported its capacity to fit caregivers' emotional needs and promote their well-being. As in other studies, the group format seemed to facilitate the flows of giving and receiving compassion (Condon & Makransky, 2020; Maratos et al., 2019). These are relevant findings because it allows to overcome the gaps reported in research regarding the need to provide strategies to protect staff well-being (Perry et al., 2020; Santos et al., 2023b), reinforcing the option of bringing this framework into these settings.

The program's acceptability and the expectations regarding its outcomes might have motivated caregivers to practice and transfer what they have learned (Curry et al., 2005). Also, the interactions among colleagues in a safe context and atmosphere, such as the ones reported during sessions, might have encouraged collective support for new practices (Liu & Smith, 2011). Considering that intervention outcomes are often limited due to challenges in the transfer of learning, there was a particular interest in identifying how this process occurred at individual and collective levels (Liu & Smith, 2011). On the individual level, informal practices seemed to be mostly used instead of formal ones, as occurred in other studies (Lyddy et al., 2016). At a collective level, the theoretical framework, compassionate communication, and behavior were used during the care provision and in daily work dynamics with colleagues. As in the study by Lyddy et al. (2016), some caregivers took the initiative to teach and practice meditation with others inside and outside work.

Ultimately, the development and the use of compassion at work seemed to impact the workplace at three different levels, including caregivers' emotional health, team functioning, and the organization as a whole. The caregivers' emotional health was the most salient one. In line with previous research, by cultivating a compassionate self, caregivers seemed to soothe and regulate their difficult emotions in a helpful manner, as well as to react with compassion rather than (self)criticism when facing difficulties (Leary et al., 2007). These findings highlight the role compassion plays in the relief of suffering and enhancement of well-being, in line with previous research in organizational (Lilius et al., 2008) and help settings (Beaumont et al., 2021; Matos et al., 2022). By enhancing caregivers' emotional health and self-regulation, this program might be helpful in preventing or decreasing burnout, commonly high within these settings, as well as the risk of coercive interactions and of modeling inappropriate coping strategies in youth (Barford & Whelton, 2010).

As a training designed to promote an affiliative mentality and to be delivered in a whole-group format, effects on team level were also expected to occur. As in previous studies, positive relationships with colleagues were reported by participants (Maratos et al., 2019). The described openness to receive compassion from others may have helped caregivers to feel safer with others, facilitating the perception of co-workers as a resource, rather than a threat (Gilbert, 2017b). This may have facilitated team cohesion and the reliance on colleagues for help, which seems to be particularly relevant when the caregiver feels overwhelmed (van Gink et al., 2018). Moreover, since residential care teams function as a group home family system, good and consistent communication among members can model youth's functioning (Brown et al., 2013). In addition, as in previous research, CMT-Care Homes also seemed to be helpful in increasing motivation to work and compassion satisfaction to some degree, which is described as the sense of pleasure, accomplishment, and competence when a caregiver is able to help those in need, which had been suggested to act as a buffer to stress and burnout (Beaumont et al., 2021; Stamm, 2010). As it occurred with other programs, after this training, teams shared a common language based on an evidence-based approach, which might build a shared approach to care provision (Brown et al., 2013; van Gink et al., 2018).

A parallel effect of compassion was described at the organizational level. Care quality and efficacy seemed to be improved, being provided in a more intentional and technically informed way. Compassionate care and communication can positively impact caregiver and care receiver interactions (Brown et al., 2014; Sinclair et al., 2016). In this sense, and as other trainings, the CMT-Care Homes also seemed to impact on the way critical episodes and conflicts were dealt with and seemed to have contributed to avoid escalating situations (Good et al., 2016; van Gink et al., 2018). In addition, it has also contributed to reduce the number of punishments. These are relevant findings because harsh disciplinary practices are considered a widespread problem in institutions and may interfere with youth recovery (Hermenau et al., 2014). Furthermore, changes in caregivers' emotion regulation and their engagement in a more compassionate care might have decreased negative interactions when dealing with youth, contributing to a less threatening and a more affiliative climate within the RCH. This is in line with the quantitative findings from the trial where the current work is nested (Santos et al., 2023c), and also with findings of a compassionate mind training delivered to teachers (Maratos et al., 2019). These findings are of major relevance for residential youth care outcomes, bearing in mind the key role of affiliation and

a safe environment for the youths' healing process (Leipoldt et al., 2019; Santos et al., 2023e).

Regarding the perceived indirect impact of CMT-Care Homes on youth, immediately after program delivery, youth seemed to have become less reactive and defensive to caregivers' interventions. Similar findings were found in a study providing trauma-informed practices to caregivers (Parry et al., 2021). Considering that most youths placed in residential care have been exposed to potentially traumatic experiences and present some kind of mental health problems, specific psychotherapeutic interventions designed to youth are needed to achieve greater behavioral changes (Bronsard et al., 2016). Hence, aligned with a therapeutic milieu framework (Brown et al., 2013), CMT-Care Homes may be considered a staff training that can add to mental health interventions delivered to youth.

Overall, this study provides evidence about the relevance of compassion training in demanding workplaces, as it is the case of residential youth care. Caregivers were able to transfer and apply the knowledge, techniques, and the theoretical background into their personal and professional life contexts. After the program delivery, no potentially aversive effects were reported. The benefits of compassion were recognized as providing well-being to caregivers, better team functioning, increased quality of care, and safer climate into residential youth care.

Limitations and Future Research

Current findings should be interpreted in light of some limitations. First, focus groups were conducted with volunteer participants from the first three RCHs that concluded the training. The remaining RCHs could not be involved due to the pandemic constraints. This may have biased the sample to participants who enjoyed the program and more successfully adopted some practices. Caregivers who did not participate could have had a different experience. Adding to this, although all participants were encouraged to express their opinion, not all of them contributed equally to the focus groups. Secondly, intervention delivery, data collection, and data analysis were undertaken by the same researcher, which might have contributed to some bias in data collection and analysis. Specifically, the prior relationship with the researcher might have influenced participants to answer in a desirable way and the researchers' sympathy for the program might have resulted in a positivity bias (Frank & Marken, 2022). To counteract that, researcher triangulation and member checking were conducted (Braun & Clarke, 2013). Yet, only three participants were involved on member checking, in order to avoid additional burden to caregivers, who already struggle with daily bureaucratic tasks. Thirdly, thematic analysis flexibility could be a strength, but also a disadvantage, which could bring potential bias (Braun & Clarke, 2006). If another method was used, different findings could have been achieved (Frank et al., 2019). In addition, thematic analysis did not allow to properly quantify the number of participants who shared the same impressions. Hence, individual differences about the CMT-Care Homes' benefits may exist, and that should be addressed in future research. Considering these shortcomings, findings may not generalize and should be considered initial propositions for understanding this new approach in residential youth care.

Such limitations may pave the way for future research. Longitudinal studies using larger samples should be conducted by independent researchers. They should use a multimodal assessment approach, including youth as informants, to assess the impact of the program on care practices, as well as its indirect impact on youth. Change mechanisms and moderators' effects should also be investigated.

Supplementary Information The online version contains supplementary material available at https://doi.org/10.1007/s12671-023-02239-9.

Acknowledgements We thank the Portuguese Residential Care facilities and their caregivers that collaborated on this study. We also thank Gisel Domingues for the translation of participants' reports from Portuguese to English language.

Author Contributions LS: designed and executed the study, developed the resources and materials used in the study, delivered the intervention program, collected data, transcribed the focus groups, conducted the data analysis, and wrote the original and final draft of the manuscript. MRP: collaborated with the study design, developed the resources and materials used in the study, assisted data collection and data analysis, and reviewed the final manuscript. DR: collaborated with the study design, developed the resources and materials used in the study, assisted data analysis, and reviewed the final manuscript. All authors approved the final version of the manuscript for submission.

Funding Open access funding provided by FCT|FCCN (b-on). This work was supported by the Portuguese Foundation for Science and Technology (SFRH/BD/132327/2017 and COVID/BD/152441/2022).

Data Availability Data cannot be made openly accessible due to ethical constraints.

Declarations

Ethics Approval The Ethics Committee of the Faculty of Psychology and Educational Sciences of the University of Coimbra approved the study (CEDI22.03.2018). All procedures comply with the ethical standards of the relevant national and institutional committees and with the Declaration of Helsinki for experiments involving humans.

Conflict of Interest The authors declare no competing interests.

Use of Artificial Intelligence The authors did not use any artificial intelligence tool to write the manuscript.

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