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# Implementing the Compassionate Mind Training Program for Caregivers in Homes for Transition into Adult Life in Spain: A Qualitative Feasibility Study

**Laura Santos**

laurasantos@fpce.uc.pt

University of Coimbra

**Marta Capinha**

Universidade Lusófona

**Carlos Rosón Varela**

Igaxes

**Daniel Rijo**

University of Coimbra

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## Abstract

# Background

Compassionate care involves providing affiliative relationships in a safe environment, both key factors in child welfare services. The Compassionate Mind Training Program for Caregivers (CMT-Care Homes) revealed promising results to this end in residential youth care in Portugal. Its potential value to other child welfare settings and countries have not been explored yet.

# Objective

This study aims to assess the acceptability and feasibility of the CMT-Care Homes program in Homes for Transition into Adult Life (HTAL), in Spain.

# Methods

Participants were 13 care workers from Galician HTAL, who received the CMT-Care Homes program at work. Two focus groups were conducted eight months after the end of the program to understand if the CMT-Care Homes was acceptable and feasible within HTAL in Spain and to explore the perceived effects of compassion within this setting, as well as the factors that might facilitate or hinder the development and maintenance of compassion over time. Data were examined using reflexive thematic analysis.

# Results

Six overarching themes, 11 themes, and seven subthemes were identified. The program seems to facilitate the development of a compassionate mind in care workers, and effects on individual, interpersonal, and organizational levels were identified, mirroring improvements in care workers' emotion regulation, cohesion among co-workers, and more compassionate and effective care practices, which seem to positively impact on youth personal and interpersonal outcomes. Barriers and recommendations to maintain effects over time were addressed.

# Conclusions

The CMT-Care Homes seem to be acceptable and feasible in HTAL in Spain.

## Introduction

Compassion is an evolved motivation, nested in a mammalian affiliative mindset that has been recognized as a cornerstone for ensuring care quality in helping services (Cole-King & Gilbert, 2014;

Crawford et al., 2014; Pestian et al., 2023). According to Gilbert (2010, 2020), compassion is characterized by the sensitivity to suffering and a strong commitment to alleviating and preventing it, which implies awareness, attention, and motivation to accept and attend to distress either in others and the self, as compassion can flow towards others or the self, either from others or from oneself (i.e., self-compassion). Research shows that while these flows of compassion can be diminished or blocked (e.g., due to burnout, fears of compassion) compromising the provision of compassionate care (Kirby et al., 2019; Takmak & Karaçar, 2025), they can also be nurtured through training (Klimecki, 2015). Hence, several compassionate-based training programs have been developed to help professionals from different care settings (e.g., Delaney, 2018; Johansson et al., 2022; McVicar et al., 2021). Findings show these programs tend to be effective in reducing burnout and improving social safeness among professionals, but also in promoting better services and positive client outcomes (Delaney, 2018; Marconi et al., 2019; Patel et al., 2019). In sum, research suggests that compassion-based interventions seem to be useful within high-stress work environments linked with helping services provided to vulnerable people (McEwan et al., 2020).

In this context, a Compassionate Mind Training Program for Caregivers (CMT-Care Homes) working in residential youth care (RYC) was developed to help care workers deal with the common sources of suffering within these settings (Cantos-Egea et al., 2024; Santos, Ferreira et al., 2023). The CMT-Care Homes was designed to counteract burnout and poor well-being that professionals in these settings tend to experience, as well as to facilitate social safeness with youth and colleagues, in a safe/therapeutic environment (Santos et al., 2023b, 2024). A cluster randomized trial (CRT) was conducted in Portugal, indicating that the CMT-Care Homes program was feasible and effective for promoting an affiliative and compassionate mindset in care workers from RYC (Santos et al., 2023b, 2024). Quantitative and qualitative findings (Santos et al., 2023a, 2023b, 2024) indicated that the CMT-Care Homes program's effects occurred at the following levels: (1) individual, in the development of care workers' socioemotional skills, contributing to the protection and promotion of professionals' quality of life and mental health; (2) interpersonal, contributing to greater social safeness between care workers and youth and between co-workers; (3) organizational, contributing to a more compassionate and coherent provision of care among staff and a safer climate in the residential care home (RCH) both for care workers and youth. Findings also show that the improvements observed in the care workers from the intervention group were maintained six months after the program's ending (Santos et al., 2023b, 2024). Notably, changes reported by care workers were acknowledged by youth living in the RCHs where the staff training was delivered (Santos et al., 2023b). According to youth, higher levels of social safeness and a safer climate within the RCH were noticed immediately after the program, but were not sustained over time (Santos et al., 2023b), raising an open question for future research. Moreover, the broader literature lacks insight into how the learning and skills acquired are transferred into the workplace and sustained over time. Longer follow-up studies are necessary to examine the evolution of these learnings (Nielsen & Shepherd, 2022). And although the CMT-Care Homes program has demonstrated effectiveness and utility in Portuguese RCHs, further research is required to evaluate its feasibility across different demographic subgroups (e.g., cultural and geographical contexts) and its

acceptability in new settings (Bowen et al., 2009). Such studies are essential to broaden program's applicability to other emotionally demanding contexts within welfare services.

In Galicia, Spain, Homes for Transition into Adult Life (HTAL) aim to foster youth in alternative care. These youths are usually close to reaching the age of majority and must start an independent life in a short period. These homes ensure they have the support to do so and achieve their "life's project". In the process of transitioning to adulthood, youth in alternative care need support to be able to make decisions, define their identity, acquire values, get a job, or have economic independence. Compared with peers from the general population, they make an earlier, compressed, and accelerated transition to independence, navigating alone the multiple challenges and responsibilities of adulthood (Adley & Jupp Kina, 2017). Consequently, these youth tend to experience stress, grief and powerlessness, before and after leaving care settings. These may interfere with their daily functioning and increase the risk of negative outcomes (Gypen et al., 2017). In fact, studies from different countries show that care leavers are severely disadvantaged in education, employment, economic status, and physical and mental health when compared with peers from the general population (Cameron et al., 2018; Hagleitner et al., 2022; Kääriälä & Hiilamo, 2017). It has been suggested that, in addition to employability and practical support, socioemotional support is essential both before and after the transition. This support facilitates the development of positive relationships beyond the family, critical for successfully achieving autonomy (Doucet et al., 2022; Furey & Harris-Evans, 2021). Thus, care workers can be important figures in the preparation for autonomy (Pinheiro et al., 2015, 2018) and should receive proper training to understand youth difficulties and provide the support they need.

Considering that compassion is context-dependent, meaning that different systems of organization can facilitate or inhibit it (McEwan et al., 2020), the current study aims to assess the acceptability and feasibility of the CMT-Care Homes in a new setting and country – the HTAL in Spain. Using a qualitative methodology, this study aims to understand the care workers' experiences with the CMT-Care Homes within HTAL. It also aims to explore the perceived effects of compassion within this setting, as well as the factors that might facilitate or hinder its development and maintenance across time. Research questions are: (1) Is the CMT-Care Homes program acceptable, appropriate, and feasible in HTAL in Spain? (2) How did Spanish care workers experience compassion? (3) What were the effects of developing a compassionate mind in this setting? (4) What factors can facilitate and hinder the development and maintenance of compassion across time?

## Methods

This is a feasibility study, using qualitative methods. Its procedures were performed in line with the principles of the Declaration of Helsinki and followed the Consolidated Criteria for Reporting Qualitative Research (COREQ; Tong et al., 2007). Approval was granted by the Ethics Committee of the [blinded for review] (CEDI/FPCEUC:53-5-21-07-2021).

# CMT-Care Homes overview

CMT-Care Homes is a manualized program developed for professional caregivers working in RYC. It is based on the biopsychosocial integrative model of Compassion Focused Therapy (CFT; Gilbert, 2020), which is rooted in attachment, evolutionary, and social mentality theories. Main goals are to cultivate a compassionate self and foster a caregiving mentality in RYC. The CMT-Care Homes consisted of twelve 2-hr and a half, structured sessions. These sessions are offered once a week at the workplace in a group format, ranging from six to 12 participants. Sessions are organized across three modules: (1) Our mind according to a compassion-based approach (to provide insight into the evolved and socially shaped mind and the affect regulation systems, i.e., threat, drive and soothing systems); (2) Compassionate mind training (understanding and cultivating the attributes and competencies of compassion in its three flows, and addressing its fears, blocks and resistances); and (3) Final session (revising key information/practices, and its application into the RCH). Formal practices were provided in audio format after each session to encourage daily practices at home and the application of the new learnings at work.

The program was developed by the first author of this paper and was delivered by psychologists working at IGAXES, who received training and supervision.

## Participants

All care workers (n = 32) from six Galician HTAL attended the CMT-Care Homes program. The program was delivered from September 2021 to December 2021 in two HTAL and from May 2022 to July 2022, in four other homes, all from the same organization (i.e., IGAXES, a social services NGO in Galicia). Participants who completed at least 80% of the sessions and concluded the program by July 2022 were invited to attend a focus group eight months after the program conclusion. Thirteen care workers (12 women) from four HTAL, including educators (*n* = 9) and support staff (*n* = 4), agreed to participate.

Participants' ages ranged between 25 and 42 years old, with a mean age of 30.08 (*SD* = 4.99). On average, participants reported having worked in the setting for three years (*SD* = 3.15, range = 1–12 years). Most of them (69.2%) reported working in shifts. Concerning the educational level, all had a higher education degree. Most participants were social educators (84.6%), and the remaining were sociocultural animators (7.7%) and elementary school teachers (7.7%)

## Procedures

Focus groups were used to collect data considering their capacity to yield rich experiential data as a group, reflecting common experiences and shared understanding (Gundumogula, 2020). Two focus groups, with six to seven participants from four HTAL, were conducted eight months after the program ended. Before the focus group, care workers provided written consent regarding their participation and audio recording. Confidentiality and protection of the participants' identities were ensured.

Focus groups were conducted by two trained facilitators (with no prior relationship with participants), following a discussion script, composed of 10 open-ended questions designed to gain insight into participants' experiences with the CMT-Care Homes, its effects, and maintenance across time (supplementary file). During the focus groups, facilitators encouraged participants to explore and clarify individual and shared perspectives. Each focus group took approximately 1 hour and 45 minutes and were audio recorded, transcribed, and revised for accuracy using Happyscribe. Information that could identify participants was removed and replaced by a personal code, where E refers to the educator and V refers to the HTAL where the participant works. Each participant and home were assigned a number.

# Data analysis

Data were analysed using Reflexive Thematic Analysis (RTA; Braun & Clarke, 2021), using a deductive-inductive approach, whereby coding and theme development were informed by participants' accounts while being sensitised by the theoretical framework underpinning the intervention - Compassion Focused Therapy (CFT; Gilbert, 2010). Following the recursive analytic process proposed by Braun and Clarke (2021), the first author familiarised herself with the data through repeated reading of the transcripts and recorded initial analytic observations. She subsequently generated initial semantic and latent codes across the entire dataset using MaxQDA 24.8. Candidate themes were then iteratively developed by two researchers through ongoing engagement with the coded extracts and the dataset. A thematic map was produced and continuously refined to support the interpretation of patterns of shared meaning. Themes were collaboratively reviewed, refined, defined, and named through regular reflexive discussions. Finally, the analytic narrative was produced. For each theme, there is an indication of the number of participants (*n*) and the number of quotations (*f*). Relevant extracts were selected to illustrate the themes, being provided to the anonymous respondent and the HTAL where he/she works, to ensure transparency.

## Results

The RTA yielded six overarching themes, 11 themes, and seven subthemes (Fig. 1. Thematic Map).

# Developing a compassionate mindset

The main goal of the CMT-Care Homes program is to develop a compassionate mind. To achieve a change of mentality and promote compassionate attitudes, it has been recognized the need for a balanced dynamic between the three flows of compassion described in research, as well as a reciprocal feeling of common humanity, perceived through the shared difficulties between co-workers. According to participants, both seemed to have occurred after the program.

*“I think that we've achieved a better balance... before, we were very compassionate towards others and not so much towards ourselves... And much less allowing ourselves to receive compassion. Now, I think it's balanced a bit more, right? The fact of prioritizing ourselves at times, understanding that we need our own*

*time, and that our work involves giving a lot and we also need to receive, both in the workplace and outside of it."* (E2, V3)

*"In our day-to-day routine, we're not aware that we all have the same concerns, we all are under the same objective, and well, giving voice and knowing what our colleagues feel is super important because, in the end, we feel that we're all part of the same..., the same group."* (E3, V2)

This overarching theme reflects the development of a compassionate mindset. It encompasses three themes that describe the care workers' perception regarding the development of compassion in its three flows. It is noteworthy that both co-workers and youth living in the HTAL were identified as the main recipients of the flows of giving and receiving compassion.

## Being compassionate towards others (n = 11, f = 44)

Participants identified an increase in the flow of compassion towards others, mentioning colleagues and youth as recipients of compassion: *"I think we try to support each other more… at least I feel more supported and understood."* (E1, V3).

Care workers explained that, based on the programs' framework and through the use of mentalization strategies, they began to make an effort to better understand youth's behavior and what motivates their emotional and behavioral dysregulation: *"…with this training, I believe we learned to stop and see beyond, and to see why they're really upset, why they're frustrated, and not just stay with 'Why did they do this? I don't understand why they did it,' but that there's more beyond what we're seeing and sometimes we have to have the calmness to know to stop, sit down, and so that person, that guy or girl, can find their position and be calm."* (E4, V2). At the same time, they attempt to be compassionate, seeking to have an active attitude of validation and support with young people, even when they have aggressive behaviors: *"we had a boy (…), who was really triggered, and it was really worth it for us to internalize all those tools to apply them with him! And, in fact, there was a drastic change …! And we had to use a lot of validation, listening, not judging, and saying, it was really helpful in that sense, and in fact, well, the boy is wonderful"* (E1, V2). To facilitate this compassionate attitude in emotionally demanding situations, some care workers reported to consciously try not to personalize, using empathic concern and common humanity: *"A boy comes home from work very angry with someone at work, and he speaks to you rudely… well, stop to think that it's about you because it's you, but he's angry with someone and takes it out on you… don't take it personally, knowing that there's always a reason, he's not speaking badly because he wants to, something happened to him behind…"* (E2, V2). *"When [the boys] insult you, say awful things (...) it's not against me… this person just wants to be happy and connect with their emotions, but (...) empathize with distance, from a distance where you can support and it doesn't affect you personally."* (E1, V4).

## Receiving compassion from others (n = 7, f = 15)

Approximately half of the participants reported a reduction in fears, blocks, and resistance to receiving compassion from others, displaying greater openness to receive compassion, not only from co-workers but also from youth.

*"It's easier to receive compassion from the team (...) and enjoy it as well (...). Because maybe before I also received it, but I don't think I used to enjoy it in the same way."* (E3, V4)

*"it's easier, we feel less vulnerable to admit that it's good for us, that compassion helps us… and even though we don't seek it as much (…), we do accept it better."* (E2, V3)

*"Before I was very closed off to receiving compassion from youth, because I felt very vulnerable and didn't want to expose myself. Now, for example, I do see it as way of…, I mean… I relate*

*receiving compassion a lot with, for me, allowing myself to receive compassion is a way of giving it to myself."* (E1, V3)

**Figure 1**

# Thematic map

# Self-compassion (n = 8, f = 28)

Some of the participants mentioned changes in self-compassion: *"It helps me to stop and become aware (…) to be able to connect a moment with myself, to stop and slow down the rest and to be able to feel what I'm feeling, that's something I do very often, and consciously."* (E3, V3). These resulted in an increase in self-care behaviours and a reduction in fears, blocks, and resistance to self-compassion, including self-criticism: *"I keep in mind the need of self-care very present, try to work on it a lot because we are very aware in general, but I think it's necessary to remind ourselves and talk about it to be able to gradually implement it, and also with girls."* (E4, V3); *"I do think that the way of thinking about self-compassion has changed, like… not being something soft or, you know, being weak, but as a possibility for self-care, (…) I perceive difficulties in receiving it [compassion], but I do see it in a better light towards myself, when I give it to myself [self-compassion]."* (E3, V4); *"It helped me (…), especially in how I speak to myself, how I treat myself… To stop and make that reflection, that exercise of, how would you talk to a person who did this and how do you talk to yourself? (…) Sometimes it keeps happening because self-criticism is there (…) but it changes when you have it present, it is another perspective."* (E4, V3).

**Fears, blocks, and resistance to compassion, as obstacles to the development of a compassionate mindset ( n = 12, f = 26)**

This overarching theme refers to the care workers' fears, blocks, and resistance to compassion as obstacles to the development of a compassionate mind. More specifically, some participants mentioned that due to their profession and cultural issues, compassion towards others is easier compared to the flows of receiving compassion from others and self-compassion: *"I think what comes easiest to me is*

*being compassionate towards others, but well, I think that also comes from my vocation, from working in the social sector."* (E1, V2); *"Personally, receiving compassion is hard for me (…) There's something that makes it harder for you to receive because it's like I'm doing something wrong or I have something wrong so that others have to pity me… so really turning that thought around and saying: no, they're not pitying me but they're giving me feedback, they're giving me help to say 'hey, I'm here to support you, you don't have to carry all this weight alone' so it really helped me to see this thought."* (E4, V2); *"I do see differences, well, self-compassion seems more difficult, … but also, I think I have it more present."* (E4, V3). It was also recognized that changing the mindset requires daily practice and time, and that the CMT-Care Homes triggered that change: *"I think there are stages (…) you start to make changes to get where you want to be, and that always take time (…) to take that awareness, and from there, well, to keep working and improving… but it was after the training."* (E4, V2). However, some of the participants expressed difficulties in carrying out formal meditation practices: *"The meditation, no, I wanted to, but it was hard, I'm very active, my brain goes too fast, it's very difficult for me"* (E3, V2).

**Acceptability of the CMT-Care Homes as a facilitator to the development of a compassionate mindset ( n = 12, f = 51)**

This overarching theme refers to the positive reaction of participants to the program as a facilitator for learning and training compassionate skills. Features linked with the climate of openness and safeness in sessions, knowledge about the human mind functioning and the affect regulation systems, as well as compassionate mind training exercises (e.g., formal and informal meditation practices, self-critical and self-compassionate internal speech, role-plays, compassionate song), were highlighted also as relevant and useful for carrying out a joint reflection regarding the intervention at each HTAL and for getting to know colleagues better.

*"The fact of establishing a secure base within the team, knowing that when those situations happen, we follow the same line, we will have the support of our teammates, we don't have to feel insecure, we can take steps and try… for me that's what worked in the program."* (E2, V3)

*"they gave us strategies that no one had ever proposed to us before… and tools… it was another way of seeing things."* (E2, V2)

*"I like the meditations, and it works well for me… I had never meditated before… it does leave me very relaxed."* (E4, V2)

*"When I remember the training, I remember us in the common room with the joy of getting to know each other and especially seeing what is behind, many times, the educational lines of each one, you know? … the fears of our colleagues."* (E1, V4)

*"For me, well, at least once a week, I do like to have a little time – I don't know if you can call it meditation – to be aware of how I'm feeling, do a little check-in: 'everything okay around here?'"* (E1, V1)

# Effects from the compassionate mindset promoted by the program

This overarching theme describes the effects linked with the development of a compassionate mind within the course of the CMT-Care Homes, which were found on individual, interpersonal, and organizational levels. The interaction between the changes perceived at these three levels seems to reflect behavioural and relational changes in youth living in the HTAL. Furthermore, although the program was applied in a work context, some of the changes reported were also perceived in the personal lives of care workers.

*“What I carry out more often is the colours [from the 3 affect regulation systems model]… both in my personal life and at work, when talking to youth, I do try to get them to look at how their week went and how they can improve, I try to give them from Monday to Sunday which colour they can assign to each day of the week… and the same goes for my personal life, when talking to friends or when they have a problem, I do try to analyse a bit, with that" (E1, V4)*

# Individual level: Caregiver’s emotional health

This theme comprises the positive effects of the compassionate mind on emotion regulation and, consequently, on the reduction of negative affect.

**Improvements on emotion regulation (n = 12, f = 50).** Knowledge about the functioning of the human mind, paired with mind training exercises, seems to be associated with an increased level of awareness and self-knowledge, particularly related to one's emotional states: *“I think I improved a lot in terms of self-awareness, of thinking a lot and checking in with myself, not so much from a critical standpoint (…) but a bit more on a reflective level, of thinking about how you are in each moment… because it's not only bad to be in the red all the time [threat system] (…) but also, for me, the blue [drive system]"* (E2, V3); *“I think we gained reflection, in taking a moment to think about yourself, because sometimes, we get caught up or we go into autopilot mode (…) so it's a bit like thinking, ‘today I'm feeling blue because such and such happened’"* (E2, V2). In line with this emotional self-awareness, participants report having started to take a moment to stop and self-regulate: *“To stop more and think about how I'm feeling… why I'm feeling this way… to say Stop!”* (E3, V2). In general, care workers reported being more able to cope and regulate their emotions: *“For me, what impacted me the most was realizing that I was, like, 70% of the day in the red [threat system] and how I managed to reduce that a lot! … if you're in the red and the other person is in the red, don't keep pushing there because that won't lead to anything good, and that's clear, I consider that a huge change.”* (E1, V4).

**Reduction of negative affect (n = 3, f = 7).** As a result of this more effective emotion regulation is the reduction of negative affect. Specifically, some participants reported feeling less guilty and frustrated: *“I think to some extent taking away blame, and the criticism of myself, the feeling bad, the frustration.”* (E4, V3); *“It helped me, personally and at work, to control frustration…”* (E3, V2).

# Interpersonal level: Between team members and with youth

This theme comprises the effects reported at an interpersonal level. The effects were felt in the work team with reports of greater social safeness between colleagues. In addition, after the program, interpersonal relationships established with youth were used as a tool to model more compassionate behaviours and emotions.

**Social safeness between team members (n = 10, f = 27).** It was consistently reported a greater sense of social safeness between colleagues from the same HTAL, which translated into greater cohesion within teams: *“I felt understood, supported, and it helped me to get closer to everyone”* (E1, V3); *“It helped to understand each other better, to be more united, and I believe this is also reflected in the girls and the daily work of the girls.”* (E2, V3).

**Modelling a compassionate mindset in young people (n = 9, f = 22).** Behaviours can be socially learned. In this sense, care workers seem to have used social interactions with youth as a tool to model compassionate behaviours and more adaptive emotion regulation strategies: *“One change I notice a lot is talking more with the girls about if one day I'm not feeling well (…) if something happened to me or if I need a moment… being able to show them that we are human beings (…)and for them to understand that it's not only important for them to receive care, but also for them to self-care, and that they also matter in those cares, to understand how we are feeling and to be there in those moments”* (E2, V3); *“I'm feeling this and it's not the time to talk about it, not to convey anything to you, not to explain, nor will I be understanding… so that they also understand and are able to say “not right now” and then seek you out at another time to do it, it's great!”* (E4, V4). In this context, it is also mentioned that some youth noticed changes in their care workers' behaviours: *"In our home, there was a girl who said to an educator: 'Wow, how does it show that you guys are doing this training!'* (E4, V4)

# Organizational level: The Homes for Transition into Adult Life

The teams from HTAL seem to have benefited from sharing a model that helps them to understand the human mind's functioning. After the program, they also shared a common language and reported using intervention strategies in a more consistent way between co-workers. The intervention and care practices were described, not only as more compassionate, but also as more efficient. After the program, the home climate was also perceived as more affiliative and calmer.

**Common language and shared theoretical framework and intervention model (n = 13, f = 54).** Eight months after the program, the team maintains a common language based on the program's theoretical framework (e.g., affect regulation systems). The model is used to communicate emotional states and to understand situations that occur in the HTAL (e.g., linked with youth behaviour), guiding the intervention: *“I remember the emotions and how we equated them to a colour (…) and I found it very positive to identify it*

*and manage emotions and understand why they were coming"* (E4, V2); *"We created our own language, so many times we say 'Careful, today they're in the red' [threat system], you know? or 'Go green' [soothing system], you know? I think this was very important."* (E3, V4); *"I applied it with youngsters (…) sometimes they expressed how they felt and I tried to give them that explanation of saying 'It's because of this… and saying that 'you have to seek the blue but from the green' explaining how to transform the colours."* (E1, V4). In this way, intervention strategies are chosen with a therapeutic intention, being applied more coherently and consistently among the team: *"We share a common line… now I see that before the interventions were a bit more scattered, we didn't follow a common line"* (E2, V4); "*Looking at it overall, this model was already being instilled in us by coordination even before the course started. But after taking the course, we're much more aware of it; and by being more aware, we also help the youth realize it and understand how we work with them. Before, we didn't really stop to think about a lot of things, especially regarding how we interact with the youth—that's always been a strong focus for us. But when it comes to how things affect us, that part tends to get overlooked a lot…*" (E4, V4).

**Caregiving is more compassionate and efficient (n = 13, f = 80).** The program led to changes in caregiving practices. Participants mentioned that there is more space for dialogue with youth, and people are also more available to try to understand them: *"Within the home, I do notice a lot of changes, being able to talk more openly about feelings, about how we are at each moment, supporting each other more, supporting the girls."* (E2, V3); *"When we are concerned about them, when we're asking how they feel, even when they arrive and you see they're not doing well, that they're a bit tense or almost crying, at that moment they don't want to talk and even giving them time to pull themselves together and then if they want to come talk to you because they know we are here, even when you tell them."* (E4, V2). In particular, the intervention becomes more compassionate and adapted to the specific needs of each youth: *"Taking into account the emotions and the moment each boy and girl is in, I mean, knowing where everyone is at and what they need, that's something super important in the shift changes, (…), and how I should intervene if something happens."* (E4, V2). Other examples of changes in care practices are greater flexibility in the management of free time linked to leisure, a reduction or adjustment of punishments, the set of compassionate limits, and the prioritization of direct intervention with youth instead of bureaucratic tasks: *"Sometimes, there is an activity at home that they don't want to participate in because they'd rather be with their outside friends. So, what we've been refining in the schedule, even though most of it is based on their proposals, and putting ourselves in their shoes and finding less intrusive activities, while also facilitating that they come to an agreement among themselves."* (E3, V4); *"Sometimes the time is reduced, but from another perspective… this hasn't been fixed and now you have this, but rather explaining and making them understand. And sometimes giving them the space to think for themselves. What measures would you take? What consequences do you think there should be? … like listening more and giving them more protagonism… also for correcting themselves."* (E3, V2); *"I believe boundaries are necessary and we have to set them. Being compassionate doesn't mean not setting boundaries."* (E4, V4); *"what involves more paperwork and office work, we take it into the evenings, to leave the daytime for interventions with the boys, and to be there with them"* (E4, V2). Taken together, these changes seem to have contributed to increasing the quality of the care practices, which were described as more compassionate, coherent,

effective, and less harmful: *"It has unified work lines and marked heavily where we want to emphasize in the intervention."* (E3, V4); *"I think it's that you find there's another way and it works… Because sometimes you think it's more necessary to set strict limits and assert yourself, thinking that being stern will make them understand better, and you think doing it another way won't work. But what happens? You discover that it does work, you feel better, and they understand it better."* (E4, V3).

**Affiliative climate at the home for transition into adult life (n = 8, f = 26).** Participants noticed a reduction in moments of conflict and tension in the HTAL, reporting a safer and calmer climate: *"I think you can tell that the home has a better vibe, a better atmosphere in terms of how we speak calmly. The boys and girls understand when we are doing a specific intervention, they are aware, and there isn't that angry atmosphere."* (E4, V2); *"You can tell, I think it creates a warmer atmosphere."* (E3, V2); *"this creates a sense of trust towards us for them."* (E3, V3).

# Behavioural and relational changes in young people (n = 9, f = 42)

Participants reported changes in youths' personal and interpersonal behaviors: *"I notice a big improvement. I see that they feel secure to reach out when they're not okay (...) that creates closeness, and in the end, you start building a bond little by little, and in that, I notice a lot of improvement."* (E4, V4). The common language existing within the team also began to be shared by some youth: *"In our case, the youth would say, today I feel in the red [threat system], today I'm in the green [soothing system], this situation puts me in the red [threat system], give me some space… and they took it really well because it was simple for them. So, very visual and clear, adapting it to them worked wonderfully for us"* (E4, V4). A greater openness of youth to the care provided by care workers was reported and a greater sense of social safeness was felt between care workers and youth: *"A girl we had changed a lot, drastically! She came in not letting anyone help her and left being the complete opposite, accepting help and being grateful. And it wasn't easy for her to accept it."* (E1, V4); *"I think that makes more trust, more communication, and more closeness with the youths."* (E4, V3). These changes also seem to manifest a positive influence between peers in the HTAL: *"The girls support each other more."* (E2, V3).

# Obstacles to the maintenance of the program's effects

It is possible to identify two main areas that could compromise the maintenance of the positive effects of the program. On the one hand, the difficulty faced by care workers in maintaining and/or establishing regular formal meditation practices. On the other hand, obstacles inherent to the organizational context of this sector, for example, in retaining human resources.

# Difficulties in establishing and/or maintaining a formal meditation routine (n = 8, f = 12)

Although participants have mentioned that they seek to integrate knowledge associated with mindfulness and compassion in an informal way into their daily lives, some participants mentioned that they had difficulty establishing a formal daily meditation routine. In some cases, although this routine

was upheld throughout the program, difficulties emerged in sustaining it after its completion: *“Honestly, I haven't gone back to meditating, because... it's hard for me. I think during the training it was easier because it was like a routine of 'I have to do this'”.* (E2, V2)

# Organizational obstacles (n = 10, f = 23)

Obstacles at the organizational level are linked to the reduced number of educators per each HTAL, which makes it difficult to prioritize intervention with youth in the face of the required bureaucracy, as well as the turnover of employees within this social sector: *“we are still creating the teams a bit and settling the way of working, organizing, and all that…”* (E3, V2). Turnover causes changes in the team, and since the new members did not participate in the program, they do not share the same language, knowledge, and intervention strategies: *“In my case, it's a shame because only two of us are left, two colleagues who did the training (...) that's also the downside that maybe it was hard for us to keep it going.”* (E1, V1); *“We all have a clear educational line, and when new people arrive, it's already hard for them to internalize this line. And not having acquired those tools that we got in the training really shows.”* (E1, V2). On the other hand, the group of youth also changes a lot, which requires the establishment of a common language with them: *“We had many changes of girls and at the beginning, when we did the training sessions, since we had the posters with phrases stuck up in the living room, they would be in the living room, reading and asking questions. But, honestly, with the new arrivals we had, this kind of practice got lost.”* (E1, V4).

# Recommendations to maintain the effects of the program

Two main suggestions emerged to facilitate the maintenance of the program's effects. On the one hand, participants mentioned that it was important to facilitate follow-up sessions to reinforce learning and maintain practices with staff who participated in the program. On the other hand, it also emphasized the need to provide the CMT-Care Homes training for new staff members.

# Follow-up sessions (n = 7, f = 16)

Participants mentioned they need support to maintain the program’s learning and practices. In this sense, they suggested as useful the possibility of holding regular follow-up sessions with a specialist (not a member of the team itself): *“It would be nice if it was like an initial training that then had continuity, that could review, I don't know if monthly or so, or even to introduce follow-ups in the team meeting itself.”* (E1, V1); *“I think we would need someone's guidance because, of course, we're not specialists in this. So, I believe we should have a professional's guidance because otherwise… (…) I don't think it would be as focused on the compassionate mind”* (E1, V2). These sessions would also be useful to maintain the safe space for group sharing created during the program: *“Being able to learn new ways to manage certain aspects was very relevant, especially because we put our concerns on the table, what we were doing, we could give each other feedback, see how our colleague felt, and even empathize with her.”* (E4, V2). It was also suggested that it might be useful to carry out meditation exercises before team meetings: *“Every now and then, having a team meeting like that, with that atmosphere. Maybe we should start having*

*meetings with meditation because, honestly, it created a really good atmosphere and we could say, well, I have these difficulties when this happens...”* (E1, V4).

# Providing training for the new staff members (n = 10, f = 17)

The need for agreement between team members when interpreting situations was frequently mentioned, so that there is coherence and consistency in the intervention, highlighting the need for the entire team to participate in this program: *“Not all of us participated; out of six, four of us took part and I did notice the difference at that time, and I did miss it. I would have liked all of us to be there and I think it would also have a positive influence, not just for the girls, but also for us as a common team…”* (E2, V3). Given the turnover, it was also suggested that the CMT-Care Homes program could be part of the initial training of new staff: *“When we started, we were all new, I mean, recently arrived, and it was like we learned together and now we have some ideas, share strategies, and are comfortable as a team.”* (E2, V2).

## Discussion

The present study aims to examine the acceptability and feasibility of delivering the CMT-Care Homes program in a new setting and country - HTAL in Galicia, Spain. Findings partially replicate the findings from the study conducted on Portuguese RYC (Santos et al., 2023a), adding new knowledge regarding potential personal and organizational factors hindering the maintenance of effects across time, as well as some recommendations to overcome them.

Firstly, the program seems to be suitable and appropriate to be delivered in this new setting in a different country. Regarding the acquisition of knowledge and skills, the main goal of the CMT-Care Homes program seemed to be achieved. Participants reported that they have become more compassionate and recognize the relevance of developing the three flows of compassion in a balanced way and common humanity within the group (by recognizing and sharing their own vulnerabilities and difficulties). This seems to be relevant, as the literature indicates that both inner resources for compassionate caring and a sense of togetherness are key aspects of compassionate care (Cole-King & Gilbert, 2014). Also, as in other studies (Maratos et al., 2019), participants recognized the ease of giving compassion to others when compared with the other two flows of compassion. The importance of these two other flows (self-compassion and compassion towards the self) was highlighted for working within this setting. This is in line with studies conducted with professionals from RYC in Portugal (Santos et al. 2023a) and in the Netherlands (Plugge et al., 2025), suggesting that for care workers, it can be difficult to view the self as a receiver of compassion since they are used to attending and taking care of others’ needs (Figley, 2002). Yet, participants also recognized the relevance of balancing the three flows of compassion, which seems to be important in care settings to prevent the costs of caring, like with empathy-based stress and indirect trauma (Ravoula et al., 2019).

In what concerns participants' experiences with the CMT-Care Homes program, positive reactions were expressed regarding this new approach to HTAL. In general, the CMT-Care Homes seem to be appropriate, being considered meaningful, relevant, and useful regarding its contents, design (e.g., multiple learning strategies, role play, modelling), and practices (e.g., resemble real-life situations) for this job, for example, in establishing a safe connection with youth and cope with their challenging and aggressive behaviour. The sessions' safe climate was highlighted as a key vehicle to enhance common humanity among co-workers, as a precursor of compassion.

Yet, learning to take care of oneself and respect one's own needs demands a mindset switch, and some care workers still manifested some fears, blocks, and resistances (Gilbert et al., 2011), namely in self-compassion and in receiving compassion from others. Such difficulties are also stated in studies conducted with professionals from RYC (Plugge et al., 2025; Santos et al., 2023a) and health care (Beaumont et al., 2021). These findings may be explained, again, due to the vocational role of targeting care for others and by an inherent difficulty of expressing compassion towards oneself (Gilbert et al., 2011). In addition, the current study and the ones led in RYC were mostly conducted with female participants. Research suggests that, due to evolutionary social roles, women tend to be more nurturing and caring, hence presenting higher levels of compassion towards others and lower self-compassion than men (López et al., 2018; Yarnell et al., 2015). It was also stated that the development of compassion requires time and training, although formal meditation practices were difficult to include in the daily routine for some participants. As in other studies (Lyddy et al., 2016; Santos et al., 2023a), informal practices (i.e., brief meditation practices incorporated into daily activities), which require less burden and are linked with increased engagement (Xie et al., 2024), were more easily integrated into daily life and seem to be kept across time. In fact, care workers not only applied the new learnings at workplace, but extended them to their personal life context, as occurred in RYC in Portugal (Santos et al., 2023a).

Regarding the effects of compassion, findings also replicate the effects reported by Portuguese care workers (Santos et al., 2023a), perceiving the positive impact of becoming more compassionate on personal, interpersonal, and organizational levels. However, some variations were found. At the personal level, participants reported that they have been more aware of their own emotions and used healthier emotion regulation strategies to regulate them, diminishing difficult emotions, such as guilt and frustration at work. These findings highlight the role of compassion in the relief of suffering, being aligned with the intervention's framework (Gilbert, 2010) and previous research with clinical and non-clinical populations (Kirby et al., 2017; Petrocchi et al., 2024).

As training aimed to promote an affiliative mentality, improvements in interpersonal relationships were expected. In fact, within this setting, the CMT-Care Homes seem to help to create a sense of social safeness between staff members and to model compassion in youth. The reported openness to receiving compassion from others may have helped care workers to feel safer with colleagues (Santos et al., 2022, 2023a, 2023b), transforming the team into a secure base. This is important to professionals' emotion regulation and resilience, helping them to cope with the emotional demands of their work

(Biggart et al., 2017). Also, delivering quality care requires high-functioning teams (Pestian et al., 2023). This seems particularly relevant within these settings, as teams function as a “group home family system”, where care workers are key change agents (Li & Julian, 2012). As reference figures, they seem to have used their role to model more compassionate behaviours and emotions in youth.

At the organizational level, care workers reported that teams shared a common language based on a theoretical model, which they learn, shared, and used to better understand youth dysregulation and intervene in a more intentional and technical way. Caregiving practices seem to become more consistent, compassionate (e.g., more dialogue and comprehension, more flexible practices to attend to youth needs), and effective. Noteworthy, this theme revealed the highest weight, suggesting that the CMT-Care Homes might facilitate the improvement of care practices within HTAL. It is also notable that a reduction in punishments was reported, which is relevant given that harsh disciplinary practices are a widespread problem in these settings (Hermenau et al., 2014). The CMT-Care Homes also seem to contribute to improving the organizational climate, which was described as calmer, as previous findings in RYC in Portugal (Santos et al., 2023a, 2023b).

Regarding the perceived impact of the CMT-Care Homes on youth, after eight months, changes were noticed and reported, namely on personal and interpersonal behavior (e.g., social safeness), and on the greater openness to be cared for. In Portugal, care workers acknowledged that after the program's completion, more time is needed to evaluate lasting changes (Santos et al., 2023a). Although youth-reported outcomes on social safeness and RCH’s climate showed post-intervention improvements, these effects were not sustained at the six-month follow-up, possibly due to pandemic-related lockdowns and isolation measures (Santos et al., 2023b). In contrast to previous research conducted in Portugal (Santos et al., 2023b), the findings of the present study suggest that more pronounced changes emerge over time. This seems to underscore the therapeutic role of consistent care practices in shaping youth emotional and behavioral expression and regulation, serving as a valuable complement to individual therapy.

Furthermore, findings also contribute to identifying and understanding other factors that may have thwarted the maintenance of compassion effects across time in the Portuguese CRT (Santos et al., 2023b). In line with the literature about compassionate care (Cole-King & Gilbert, 2014; Crawford et al., 2014) and studies on the facilitators and barriers of compassion in alternative care settings (Plugge et al., 2025), personal and organizational factors were addressed. This allows for the identification of context-related, individual, and training-related factors that influence transfer (Nielsen & Shepherd, 2022).

The main personal obstacle identified by participants refers to the maintenance of formal meditation practices after the end of the program. This obstacle was expected, considering some participants express difficulties in including such practices into their daily routine during the training, as reported in other studies (Arimitsu, 2016; Lyddy et al., 2016). Given the relevance of regular practice of formal meditation (Galante et al., 2014), the difficulty expressed by some participants, not only in getting involved with some practices, but also in persisting with a meditation routine, may undermine the

program's potential effects (Lam et al., 2023). Yet, it is important to highlight that informal practices of meditation and the transfer of compassionate skills into daily life (e.g., compassionate actions, friendly voice tones) seem to continue to be carried out, which could function as a facilitator of the effects of these kinds of programs (Steindl et al., 2018; Xie et al., 2024).

Regarding organizational barriers, problems linked with the reduced number of care workers per youth, the great number of bureaucracies, and turnover were stated. All of them are common problems in RYC (Pinheiro et al., 2022) and were also identified as barriers to compassion in previous studies (Maddox & Barreto, 2022; Pestian et al., 2023; Plugge et al., 2025; Santos et al., 2023a). Despite efforts to leave bureaucracies to the night shift, the reduced number of workers and the number of administrative tasks minimize the availability of workers to spend time with youth and prioritize care provision as intended, as previously reported in other studies (Pinheiro et al., 2022). Turnover is considered a common threat to the application and maintenance of new models and evidence-based practices within these settings (James, 2017). Therefore, turnover was among our initial prepositions to prevent the maintenance of programs' effects on youth, due to the lack of implementation consistency between team members (Santos et al., 2023b). This study findings seem to corroborate such prepositions.

Participants express their intention to continue to use the program's learnings and provide some recommendations to overcome the identified barriers to the maintenance of knowledge and skills learned in training over time. Recommendations lie, on the one hand, in providing continued group follow-up sessions to facilitate practice, group discussion, and transfer of learning. On the other hand, they suggest including CMT-Care Homes as initial training for new staff, aiming to maintain a common language and intervention model within the whole team and organization. In fact, the CMT-Care Homes program recommends the inclusion of follow-up sessions to supervise learning and practices' transference. In the same sense, literature stated that post-training supervision plays an important role in triggering the mechanism of transfer attempts (Nielsen & Shepherd, 2022). These recommendations are also aligned with previous research about compassion training (Crawford et al., 2014; McEwan et al., 2020; San Román-Niaves et al., 2024) and training transfer in child welfare services (Liu & Smith, 2011). Ongoing training and supervision to facilitate the adoption of compassion at all levels of the organization are recommended for successful implementation within real-life settings and lasting positive effects (McEwan et al., 2020).

By expanding the scope of the CMT-Care Homes program and the compassion-based interventions into another care setting in a different country, this study brings new contributions for practice as well as for research, providing recommendations for organizations to enable and maintain compassionate care and its effects.

Yet, some limitations must be addressed. Firstly, focus groups were conducted with volunteer participants. This may have biased the sample to participants who enjoyed the program and more successfully adopted some practices, not representing the perceptions of all care workers. Secondly, as

with most qualitative research, these findings may not generalize to other contexts and should be considered initial propositions for understanding this approach in HTAL.

Future studies should explore the perspectives of youth, as informants to understand the impact of a compassionate approach within this setting. Also, complementary alternatives to formal meditation should be explored, as they seemed to be consistently mentioned as a difficult strategy by participants across studies using meditative practices (Arimitsu, 2016; Lyddy et al., 2016; Santos et al., 2023a).

To conclude, CMT-Care Homes seem to be feasible and appropriate for HTAL, in Spain. Findings indicate improvements in care workers' emotion regulation strategies, and a sense of social safeness within work teams and with youth. The program seems to enable taking steps forward into better and more effective care practices, that seem to impact youth personal and interpersonal behavior across time. Furthermore, the program is manualized (in Portuguese and Spanish), facilitating training of the trainer and its delivery in different regions and care settings, aiming to improve care practices and ensure better professional quality of life for care workers.

## Declarations

# Competing Interests

Carlos Roson Varela reports a relationship with IGAXES that includes board membership. Laura Santos has patent CMT-Care Homes licensed to University of Coimbra. Nothing more to declare.

# Author Contribution

LS: designed the study, collected data, conducted the data analyses, and wrote the paper. MC: collected data, assisted in data analyses, and reviewed the manuscript. CRV: organized intervention delivery and data collection, reviewed the manuscript. DR: collaborated with the study design, assisted in data analysis and reviewed the manuscript. All authors approved the final version of the manuscript for submission.

# Data Availability

The data generated and analysed during this qualitative study are not publicly available due to the sensitive and potentially identifiable nature of the qualitative data. Making the data publicly accessible could compromise participants’ confidentiality and privacy. The data may be available from the corresponding author upon reasonable request, subject to ethical and confidentiality restrictions.

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# Figures

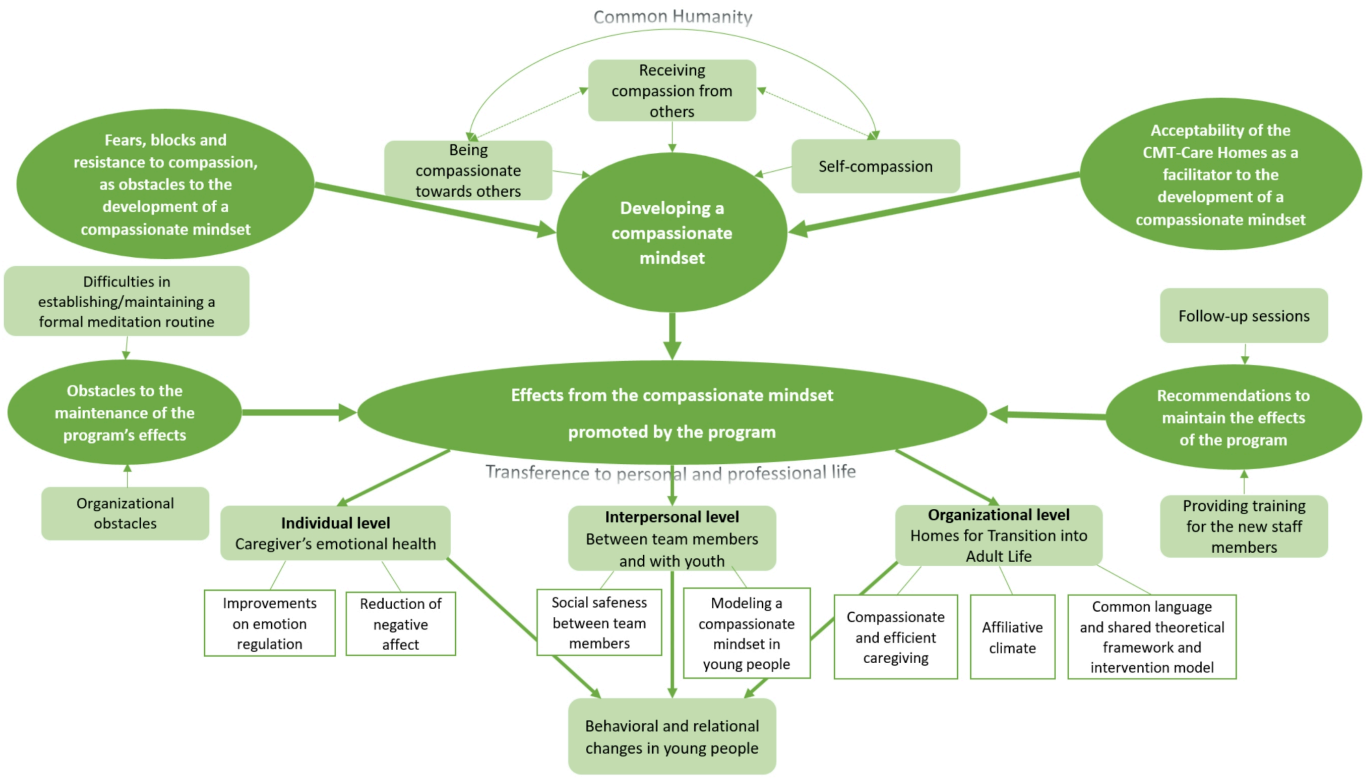



**Figure 1**

*Thematic map*

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