Laura Filipa Seiça Matias Santos

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Implementação e estudos de eficácia de um programa de treino da mente compassiva com cuidadores

Tese no âmbito do Doutoramento em Psicologia, especialidade em Psicologia Forense, orientada pelo Professor Doutor Daniel Maria Bugalho Rijo e pela Professora Doutora Maria do Rosário de Carvalho Nunes Manteigas e Moura Pinheiro e apresentada à Faculdade de Psicologia e de Ciências da Educação da Universidade de Coimbra.

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Faculdade de Psicologia e de Ciências da Educação
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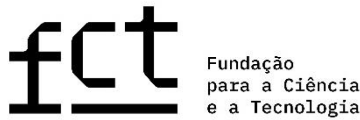

Aos meus pais

Às crianças e jovens em acolhimento e
para aqueles que delas cuidam

Um sopro.
Nada mais que um leve e pesado abalo telúrico.
Os fios de água estremeceram e a tristeza escondeu-se envergonhada.

Era de noite. Tão perto do dia.
Sabia a sal aquele sol.
Sabia a frio aquela distância.
Só o sopro, aquele sopro, a acordou da doce letargia do dia claro.
Quando tudo parecia estar vivo, a solidão apareceu no silêncio do quarto
daquela casa que lhe era estranha.

Mandaram-na para ali.
Para junto da desdita.
E de outros infantes com histórias iguais à sua.
Tantas vezes que lhes disse que parassem.
Mas nunca foi ouvida.

Sobrou, afinal, um copo de sol depois de tanto nunca.
Conheceu negros e breus cantos,
calcou a dor dos outros e cimentou a sua,
soletrando a linguagem das chuvas negras de Novembro
com o pior sorriso de Maio.

O seu ponto de luz
foi aquele recanto de sossego multicolor
onde fez das suas vontades ordens
e das suas fraquezas fortes plenos de lama,
pânico, glória, suor e coração.

Chamou o vento.
Na figura de um educador.
Ou no rosto de uma amiga naquele canto.
Não tinha como não lhe responder.
Esqueceu-se da palavra passe
do código de honra da sua alma,
das cores com que se veste, um outro nome para a solidão...

Escreveu uma prece ao mar perfeito.
Mas ele não tinha como lhe responder.
Não tinha papel de carta, nem tinta permanente.

Ainda hoje lhe dói o nome
Da felicidade que teima em não lhe chegar.
Mas sabe, ó se sabe, que
«embora ninguém possa voltar atrás
e fazer um novo começo,
qualquer um pode começar agora
e fazer um novo fim»

«Meu ponto de luz?
Desligaram-me sem pré-aviso
e deram-me uma fatia de treva
que logo pintei de branco
à espera de um outro brilho.
Sei onde me dói,
Mas não quero que pare de doer.
Para nunca mais me esquecer».

Paulo Guerra
Juiz Desembargador e trabalhador da Infância
(ao som de Brahms)

// Agradecimentos

A jornada percorrida desde 2018, altura em que iniciei este doutoramento, contribuiu não só para o meu crescimento profissional, enquanto psicóloga e investigadora, como também para o meu próprio enriquecimento pessoal, como ser humano, filha, amiga, colega e cuidadora. Posso dizer que nestes últimos anos, eu própria embarquei numa jornada compassiva que contribuiu para uma forma diferente de observar, sentir, estar e de me relacionar comigo, com os outros e com o mundo. Pelo caminho, aprendi que deveria olhar para trás e reconhecer o contributo das pessoas que me fizeram chegar aqui, ao presente momento da minha vida, bem como a alcançar as pequenas conquistas, que não foram conseguidas de forma isolada. Como as jornadas não são apenas feitas de conquistas, mas também de etapas que exigem maior nível de esforço, fracassos, escolhas e perdas difíceis, começo esta tese por olhar para trás e expressar a minha imensa gratidão aqueles que me motivaram a começar esta jornada, aqueles que me apoiaram durante a mesma nos momentos profissionais e pessoais mais exigentes e aqueles que celebraram comigo cada meta alcançada.

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Abreviaturas e Siglas

AIC	*Akaike Information Criteria*
APA	*American Psychological Association/*Associação Americana de Psicologia
BIC	*Bayesian Information Criteria*
BLRT	*Bootstrap Likelihood Ratio test*
CAIDJCV	Comissão de Análise Integrada da Delinquência Juvenil e Criminalidade Violenta
CAR	Casas de Acolhimento Residencial
CBCT	*Cognitively-Based Compassion Training*
CCT	*Compassion Cultivation Training*
CEB	*Cultivating Emotional Balance*
CEDI	Comissão de Ética e Deontologia da Investigação da Faculdade de Psicologia e de Ciências das Educação da Universidade de Coimbra
CFA	*Confirmatory Factor Analyses*/Análise Fatorial Confirmatória
CFI	*Comparative Fit Index*
CID	Classificação Internacional de Doenças
CINEICC	Centro de Investigação em Neuropsicologia e Intervenção Cognitivo-Comportamental
CONSORT	*Consolidated Standards of Reporting Trials*
COREQ	*Consolidated Criteria for Reporting Qualitative Research*
COVID-19	Doença por Coronavírus – 2019
CRD	*Centre for Reviews and Dissemination*
CRT	*Cluster Randomized Trial*/Ensaio Clínico Aleatorizado por Clusters
CS	*Compassion Scale/*Escala da Compaixão
CS-A	*Compassion Scale – Adolescents*/ Escala da Compaixão - Adolescentes
CEWSS-A	*Current Experiences of Warmth and Safeness Scale for adolescents/* Escala de Experiências Atuais de Cuidados e Segurança para Adolescentes

DASS-21 *Depression, Anxiety and Stress Scales/*Escala de Ansiedade, Depressão e Stress

EACELT Escala de Avaliação do Clima Emocional no Local de Trabalho

ECRC-Y *Emotional Climate in Residential Care – Youths*/Escala de Avaliação do Clima Emocional para Jovens em Acolhimento Residencial

EMWSS-A *Early Memories of Warmth and Safeness Scale – Adolescents*/ Escala de Memórias Precoces de Calor e Segurança para Adolescentes

FCS *Fears of Compassion Scales/*Escalas dos Medos da Compaixão

FCT Fundação para a Ciência e a Tecnologia

FPCE-UC Faculdade de Psicologia e de Ciências da Educação da Universidade de Coimbra

IPSS Instituição Particular de Solidariedade Social

ISS Instituto da Segurança Social

LMR *Lo-Mendell-Rubin test*

LPA *Latent Profile Analysis*/Análise de Perfis Latentes

LPCJP Lei de Proteção de Crianças e Jovens em Perigo

MANCOVA Análise Multivariada Mista da Covariância

MANOVA Análise Mista Multivariada da Variância

MBSR *Mindfulness-Based Stress Reduction*

MCAR *Missing completely at random*

MLR *Maximum Likelihood Robust*

MMAT *Mixed Methods Appraisal Tool*

MSC *Mindful Self-Compassion*

NICE *National Institute for Health and Clinical Excellence*

OMS Organização Mundial de Saúde

ONG Organização Não Governamental

ONU Organização das Nações Unidas

OPP Ordem dos Psicólogos Portugueses

PANAS *Positive and Negative Affect Schedule*/ Escala do Afeto Positivo e Negativo

PCS *Peer Conflict Scale/* Escala de Conflito entre Pares

PRISMA *Preferred Reporting Items for Systematic Reviews and Meta-Analyses*

ProQOL-5 *Professional Quality of Life Scale, version 5/*Escala de Qualidade de Vida Profissional, versão 5

PROSPERO *International Prospective Register of Systematic Reviews*

RGPD Regulamento Geral sobre Proteção de Dados

RMSEA *Root-Mean Square Error of Approximation*

SDQ *Strengths and Difficulties Questionnaire/* Questionário de Capacidades e Dificuldades

SELFCS *Self-Compassion Scale/*Escala de Autocompaixão

SEM *Stuctural Equation Modelling*/Modelos de Equações Estruturais

SPSS *Statistical Package for the Social Sciences*

SRMR *Standardized Root-Mean Square Residual*

SSA-BIC *Sample-Size-Adjusted BIC*

SSPS *Social Safeness and Pleasure Scale/*Escala de Proximidade e Ligação aos Outros

SSPS-A *Social Safeness and Pleasure Scale for adolescents*/ Escala de Proximidade e Ligação aos Outros para adolescentes

TIC *Trauma-Informed Care*

TFC Terapia Focada na Compaixão

TIDieR *Template for Intervention Description and Replication*

TMC-C Treino da Mente Compassiva para Cuidadores

UNICEF *United Nations Children's Fund*/ Fundo de Emergência Internacional das Nações Unidas para a Infância

Resumo

Introdução: A compaixão é uma motivação desenvolvida evolucionariamente para prestar cuidados, que promove a aceitação e tolerância ao sofrimento, e incentiva a aquisição de competências para alívio do mesmo, seja nos outros ou no próprio. Apesar das intervenções baseadas na compaixão apresentarem resultados promissores em profissionais e utentes de diversos contextos de prestação de cuidados, a sua aplicação nas Casas de Acolhimento Residencial (CAR) de crianças e jovens não foi ainda concretizada.

Por terem sido expostos a experiências adversas potencialmente traumáticas, crianças e jovens em acolhimento residencial apresentam necessidades e dificuldades psicológicas complexas. Os profissionais das CAR são agentes ativos no processo de acolhimento destas crianças e jovens, tendo a qualidade das relações que estabelecem com os mesmos vindo a ser reconhecida como um fator fundamental na intervenção. Todavia, trabalhar no contexto de acolhimento residencial pode ser emocionalmente exigente, uma vez que os cuidadores têm de lidar com o sofrimento daqueles de quem cuidam e, simultaneamente, com o sofrimento que isso poderá espoletar em si próprios. Paralelamente, as relações interpessoais entre os profissionais poderão constituir uma fonte de stress adicional. Por estes motivos, a incidência de perturbações psicológicas tem sido amplamente reportada nos profissionais das CAR, interferindo na qualidade da prestação de cuidados.

Esta tese teve como principal objetivo promover uma mentalidade afiliativa no acolhimento residencial de crianças e jovens, através do desenvolvimento, implementação e estudos de eficácia de um programa estruturado de Treino da Mente Compassiva para Cuidadores (TMC-C). O programa apresenta o duplo objetivo de: (i) promover um ambiente seguro e relações de proximidade, calor e segurança entre cuidadores e jovens; (ii) proteger e promover a saúde mental e qualidade de vida profissional dos cuidadores.

Metodologia: Esta tese inclui o desenvolvimento do programa de TMC-C e um conjunto de estudos sequenciados: (i) uma revisão sistemática da literatura que pretendeu identificar e avaliar os programas existentes dirigidos a profissionais das CAR, com o objetivo de promover a saúde emocional e mental neste contexto; (ii) dois estudos empíricos (Estudos I e II) que avaliaram as qualidades psicométricas de duas medidas de autorrelato, que avaliam construtos associados ao modelo conceptual da Terapia Focada na Compaixão, adaptadas para adolescentes da comunidade e em CAR; (iii) um estudo empírico (Estudo III) que combinou uma abordagem centrada na variável e uma abordagem centrada no indivíduo para investigar o papel das memórias de experiências precoces e das experiências atuais de cuidados e segurança com

os outros, em sintomatologia de ansiedade e depressão em adolescentes da comunidade e em CAR; (iv) quatro estudos empíricos (Estudos IV, V, VI e VII) que decorreram no âmbito de um ensaio clínico aleatorizado por *clusters* (CRT) para avaliar a eficácia do TMC-C em variáveis individuais (e.g., compaixão, saúde mental dos cuidadores), interpessoais (e.g., sentimentos de proximidade e ligação aos outros) e organizacionais (e.g., clima emocional das CAR). Os Estudos VI e VII investigaram ainda a estabilidade dos efeitos do TMC-C, nos cuidadores e jovens, até seis meses após a sua aplicação.

O CRT incluiu uma amostra de cuidadores (N = 127) e uma amostra de jovens em CAR (N = 154). Participantes de ambas as amostras responderam a questionários de autorresposta em quatro momentos: pré-intervenção, pós-intervenção e dois *follow-ups* (3 e 6 meses). Os cuidadores das primeiras três CAR a concluir o TMC-C foram convidados a participar adicionalmente num grupo focal para um estudo de natureza qualitativa (Estudo V). Os dados quantitativos foram analisados com Análises Multivariadas da Variância (estudo preliminar; Estudo IV) e de Covariância (estudos de *follow-up;* Estudos VI e VII) e os dados qualitativos através de Análise Temática (Estudo V).

Resultados: A revisão sistemática da literatura indicou que os programas direcionados para cuidadores para promover a saúde emocional e mental nas CAR são escassos. A maioria direciona-se para o treino de competências dos cuidadores com o intuito de reduzir comportamentos disruptivos dos jovens, e nenhum estudo integrou um ensaio clínico aleatorizado. As duas medidas dos Estudos I e II revelaram-se psicometricamente válidas e os respetivos modelos de medida invariantes por grupos. Já o Estudo III reforçou o papel das experiências afiliativas de calor e segurança, passadas e atuais, no funcionamento psicológico dos adolescentes, evidenciando que as experiências atuais de calor e segurança com os outros parecem ter um papel protetor face a sintomas de ansiedade e de depressão em adolescentes em CAR, mesmo quando as memórias desse tipo de experiências durante a infância eram escassas ou inexistentes.

No que diz respeito aos resultados do CRT, o conjunto de estudos realizado (Estudos IV, V, VI e VII) indicou que o TMC-C demonstrou efeitos a nível individual (promoveu a compaixão e a autocompaixão e reduziu sintomatologia de ansiedade, depressão e de burnout dos cuidadores), interpessoal (promoveu maior proximidade e ligação aos outros) e organizacional (aumentou a perceção de um clima emocional mais seguro). Mais concretamente, de acordo com os resultados do Estudo V, as aprendizagens do programa foram aplicadas a nível profissional e generalizadas para o contexto de vida pessoal dos participantes. O Estudo VI indicou que as mudanças relatadas pelos cuidadores foram percecionadas pelos jovens

residentes nas CAR do grupo de intervenção, com impacto positivo ao nível do sentimento de proximidade e de ligação aos outros e na perceção de um clima emocional seguro e afiliativo. Os resultados dos Estudos VI e VII revelaram ainda que os ganhos observados no grupo de intervenção foram mantidos 6 meses após o término do programa nos cuidadores, mas não nos jovens.

Conclusão: Este trabalho de investigação disponibiliza conhecimento empírico e materiais de avaliação e de intervenção empiricamente validados para o contexto de acolhimento residencial de crianças e jovens. Mais concretamente, disponibiliza um programa manualizado de Treino da Mente Compassiva para Cuidadores (TMC-C). Este programa poderá contribuir para a formação das equipas das CAR, facilitando um modelo compreensivo sobre o funcionamento da mente humana, bem como práticas baseadas em evidência. Quando aplicado junto dos diferentes membros das equipas, este treino poderá facilitar a aquisição de estratégias de regulação emocional adaptativas nos cuidadores, e contribuir para promover o estabelecimento de relações de proximidade e ambientes seguros para quem vive e trabalha nas CAR. Este trabalho disponibiliza ainda duas escalas de autorrelato psicometricamente validadas para adolescentes, que poderão ser recursos úteis para a investigação e para avaliação das práticas de acolhimento, permitindo auscultar as crianças e jovens acerca de indicadores de qualidade da resposta de acolhimento residencial. Globalmente, este trabalho de investigação propõe uma abordagem empírica, compassiva e afiliativa de prestação de cuidados nas CAR, procurando atender às necessidades emocionais das crianças e jovens e, simultaneamente, dos seus cuidadores.

Palavras-chave: acolhimento residencial; compaixão; crianças e jovens em risco; cuidadores; ensaio clínico aleatorizado por clusters; experiencias afiliativas; programas de treino; treino da mente compassiva; saúde mental.

Abstract

Introduction: Compassion is an evolved motivation to care, which promotes acceptance and tolerance of suffering, and encourages the acquisition of competencies to relieve that suffering, either in others or in the self. Despite compassion-based interventions have been showing promising results in staff and users of different care settings, its delivery in Residential Youth Care (RYC) has not yet been investigated.

Most children and young peolple in RYC were previously exposed to potentially traumatic experiences. As a result, they have complex needs and psychological difficulties. RYC professionals are active agents in the RYC process, being the quality of the relationships established with children and youth recognized as a key factor for a successful intervention. Nevertheless, working in RYC can be emotionally demanding, as caregivers have to cope with the suffering of those they care for, and simultaneously with the suffering that caring for others may cause in themselves. At the same time, interpersonal relationships between professionals may also become an additional source of stress. Therefore, the incidence of psychological problems has been widely reported in caregivers, which might interfere with the quality of care they provide.

This thesis aimed to promote an affiliative mentality in RYC, through the development, delivery, and research on the effectiveness of a Compassionate Mind Training program for Caregivers (CMT-Care Homes). The program has two main aims: (i) to promote a safe environment, and warm and secure relationships between caregivers and youth; (ii) to protect and promote caregivers' mental health and the quality of their professional life.

Method: This thesis comprises the development of the CMT-Care Homes program and a set of sequenced studies: (i) a systematic review that intended to identify and evaluate existing programs aimed at RYC professionals, targeting the promotion of emotional and mental health in these settings; (ii) two empirical studies (Studies I and II) that assessed the psychometric properties of two self-report measures, assessing relevant constructs related with the Compassion Focused Therapy framework, adapted for adolescents from the community and RYC settings; (iii) an empirical study (Study III) that combined variable-centered and person-centered approaches to investigate the role of early and current experiences of warmth and safeness with others over anxiety and depression symptomatology in adolescents from the community and from RYC settings; (iv) four empirical studies (Studies IV, V, VI and VII) conducted within a cluster randomized trial (CRT) to assess the effectiveness of the CMT-Care Homes on individual (e.g., compassion, caregivers' mental health), interpersonal (e.g., social safeness) and organizational

(e.g., emotional climate in the residential care home) outcomes. Studies VI and VII also investigated the stability of the CMT-Care Homes' effects on caregivers and youth, up to six months after delivery.

The CRT included a sample of caregivers (N = 127) and a sample of youth (N = 154) within RYC settings. Participants from both samples answered self-report measures on four timepoints: baseline, post-intervention and two follow-ups (3-and 6-month). Caregivers from the first three residential care homes completing the CMT-Care Homes were additionally invited to participate in a focus group within a qualitative study (Study V). Quantitative data were analyzed using Multivariate Analyzes of Variance (preliminary effects, Study IV) and Covariance (follow-up studies, Studies VI and VII), and qualitative data were analyzed via Thematic Analysis (Study V).

Results: The systematic review indicated a scarcity of programs for caregivers aimed at promoting the emotional and mental health in RYC. Available programs were mostly focused on caregivers' skills to reduce disruptive behaviors in youth. No study performed a randomized controled trial. The self-report measures from Studies I and II proved to be psychometrically valid and their measurement models were invariant by group. Study III reinforced the key role of both early and current affiliative experiences of warmth and safeness in the psychological functioning of adolescents, indicating that current experiences of warmth and safeness with others seem to have a protective role against anxiety and depression symtoms of adolescents living in RYC, even when memories of these kind of experiences during childhood were scarce or absent.

Regarding the CRT outcomes, the carried out set of studies (Studies IV, V, VI and VII) indicated that the CMT-Care Homes demonstrated an impact at the individual (promoting compassion and self-compassion and reducing symptomatology of anxiety, depression, and burnout on caregivers), interpersonal (promoting increased proximity and connection with others) and organizational (increasing the perception of a safer emotional climate) levels. Specifically, according to the findings from Study V, the program's learnings were applied at a professional level and generalized to the participants' personal life contexts. Study VI indicated that the changes reported by caregivers were also perceived by youth living in the residential care homes that were interveened, with benefits on social safeness and on the perception of a safer and more affiliative emotional climate. Findings from Studies VI and VII also revealed that the gains observed in the intervention group were maintained 6 months after program delivery in caregivers, but not in youth.

Conclusions: This thesis adds to current knowledge and provides empirically validated assessment and intervention tools for RYC settings. More specifically, it makes available a

Compassionate Mind Training program for Caregivers (CMT-Care Homes). This program could contribute to the training of RYC professionals, facilitating a comprehensive model of the human mind functioning, as well as evidence-based practices. When delivered to the members of different teams, this training could facilitate the development of adaptative emotion regulation strategies to caregivers, and could promote the development of secure relationships and environments for those who live and work in RYC. This thesis also provides two psychometrically validated self-report measures for adolescents, which may be useful tools for research and assessment of care practices, allowing children and youth to be heard about the quality indicators of RYC. Overall, this thesis proposes an empirical, compassionate and affiliative approach to care provision in RYC, trying to meet the emotional needs of children and youth and, simultaneously, the ones from their caregivers.

Keywords: affiliative experiences; caregivers; children and youth at-risk; compassion; cluster randomized trial; compassionate mind training; mental health; residential youth care; training programs.

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Nota introdutória

Uma casa não é apenas um lugar para viver. Na perspetiva da criança, uma casa normalmente significa viver com a sua família, num ambiente que lhe ofereça conforto, sentimentos de pertença e de identidade. Um lugar onde ela se sinta cuidada, amada e segura. Infelizmente, muitas crianças e jovens não têm uma casa/lar que acolha e satisfaça as suas necessidades, sendo expostas a episódios de negligência e abusos que deixam marcas danosas nas suas trajetórias de vida. O trauma causado por estes episódios revela-se um problema psicossocial, que acarreta consequências sérias para as vítimas e para a sociedade (Dozier et al., 2012).

Crianças e jovens expostos a situações que ameaçam gravemente a sua segurança e bem-estar, carecem de cuidados alternativos que assegurem a sua proteção e promovam os seus direitos (Carvalho & Salgueiro, 2018; Guerra, 2022). A preferência por medidas que integrem a criança em contexto familiar tem sido recomendada por vários organismos internacionais (FICE et al., 2007; ONU, 2010; UNICEF, 2010) e pela Lei de Proteção de Crianças e Jovens em Perigo (LPCJP; aprovada pela Lei n.º 147/99, de 1 de setembro, alterada e republicada pela Lei n.º 142/2015, de 8 de setembro, e alterada pelas Leis n.ºs 23/2017, de 23 de maio, 26/2018, de 5 de julho e 23/2023, de 25 de maio), por se revelar uma resposta naturalmente mais ajustada para o atendimento das necessidades desenvolvimentais e individuais das crianças. Todavia, o número de crianças e jovens que necessitam de cuidados alternativos, ultrapassa grandemente o número de famílias de acolhimento existentes, inviabilizando que sejam prestados cuidados de qualidade em contexto familiar a todas as crianças e jovens que se encontram desprotegidos (Garcia Quiroga & Hamilton-Giachritsis, 2016; ISS, 2022). Deste modo, o acolhimento residencial continua a ser a única opção viável para muitas crianças e jovens em todo o mundo (Boel-Studt & Tobia, 2016; Calheiros et al., 2022; Carvalho & Salgueiro, 2018; Jackson et al., 2019; James, 2017; McCall & Groark, 2015; Vashchenko et al., 2010; Wright et al., 2019). Embora seja um número difícil de precisar, estima-se que, globalmente, 2 a 8 milhões de crianças continuem a viver em Casas de Acolhimento Residencial (CAR) ou em instituições similares (Dozier et al., 2012; McCall et al., 2016; Petrowski et al., 2017). Mais especificamente na Europa, um relatório recente da UNICEF e da Eurochild (2021), estima que aproximadamente 302.979 crianças e jovens se encontrem em acolhimento residencial. Face a estes dados, é fundamental que se garanta que a prestação de cuidados e o ambiente de acolhimento sejam significativamente melhores do que aqueles de onde as crianças foram retiradas (Garcia Quiroga & Hamilton-Giachritsis, 2016).

Os modelos de funcionamento das CAR procuram responder a necessidades históricas e sociais de cada país, sendo influenciados pelas respetivas políticas públicas em vigor (Dozier et al., 2012). Por esse motivo, o conceito de acolhimento residencial abrange uma multiplicidade de regimes e modalidades de funcionamento, que variam consideravelmente nos diferentes países (Carvalho & Salgueiro, 2018). Esta multiplicidade é espelhada na literatura desta área, retratando um espectro de respostas sociais caracterizadas como acolhimento residencial, que varia desde abrigos temporários a hospitais psiquiátricos ou centros de detenção juvenil (Lee et al., 2011). Nesta tese, acolhimento residencial corresponde a uma medida de promoção e de proteção constante na LPCJP (alínea f) do artigo 35º), definida nos termos da lei como a "colocação da criança ou do jovem aos cuidados de uma entidade que disponha de instalações, equipamento de acolhimento e recursos humanos permanentes, devidamente dimensionados e habilitados, que lhes garantam os cuidados adequados" (nº 1 do art.º 49º da LPCJP, com as alterações introduzidas pela Lei 142/2015, de 8 de setembro). Esta medida tem como finalidade garantir às crianças e jovens a adequada satisfação das suas "necessidades físicas, psíquicas, emocionais e sociais e o efetivo exercícios dos seus direitos, favorecendo a sua integração em contexto sociofamiliar seguro e promovendo a sua educação, bem-estar e desenvolvimento integral" (nº 2 do art.º 49º da LPCJP, com as alterações introduzidas pela Lei 142/2015, de 8 de setembro).

Apesar das mencionadas diferenças entre países nas respostas de acolhimento residencial, as necessidades básicas das crianças e jovens que carecem desta resposta são universais. Todos carecem de cuidados responsivos e afetivos, prestados num ambiente seguro. Ao percorrer esta tese, é importante que o leitor mantenha em mente que a maioria das crianças e jovens em acolhimento cresceram num ambiente relacional patológico, onde desde cedo tiveram de aprender a sobreviver. Cresceram com o paradoxo de serem maltratadas por aqueles que tinham o dever de as proteger e tranquilizar, tendo-lhes sido negada a possibilidade de florescer num ambiente caloroso, que lhes fornecesse alicerces seguros para o seu desenvolvimento. De forma menos óbvia, mas igualmente danosa, encontra-se a crónica e insidiosa dor por se ter crescido sem se sentir amado ou valorizado, dor essa que deixa feridas tão grandes como os maus-tratos a que foram sujeitas (Sieff, 2017). Consequentemente, estas crianças e jovens chegam normalmente às CAR com poucos pertences, mas com uma grande bagagem, que contem, do ponto de vista emocional, feridas psicológicas consideráveis. Estas crianças e jovens trazem consigo memórias perturbadoras e confusas, experiências de medo, de perda, de vergonha e de solidão. Os comportamentos que manifestam revelam as estratégias aprendidas ao longo da vida para sobreviver no contexto hostil onde cresceram. Tais estratégias

podem agora revelar-se desajustadas, atendendo à mudança de contexto, mas são, frequentemente, as únicas estratégias de que a criança dispõe para lidar com a insegurança sentida (Jackson et al., 2019). O acolhimento pode ser encarado como um lugar desconhecido onde existem novas regras e exigências, definidas por pessoas desconhecidas, que se revelam "estranhamente" simpáticas. No entanto, espera-se que, com o tempo, o acolhimento possa proporcionar à criança uma oportunidade para encontrar modelos relacionais saudáveis de identificação e relação, que lhe permita integrar as memórias dolorosas do passado e cicatrizar as suas feridas (Henriques et al., 2014). A qualidade da relação estabelecida entre as crianças/jovens e os cuidadores das CAR é um veículo que poderá facilitar o processo de recuperação da criança/jovem, estando essa qualidade associada a melhores resultados da resposta de acolhimento (Holmes et al., 2018).

Cuidar destas crianças e jovens é um processo de interação humano modelado por emoções, receios, resistências e aprendizagens. Nesta tese, será utilizada a palavra cuidador para nos referirmos aos profissionais das CAR que cuidam e prestam serviços diretos às crianças e jovens em acolhimento, independentemente da sua função na casa e da categoria profissional a que pertencem (i.e., membros da equipa técnica, educativa e de apoio).

O papel de cuidadora foi desempenhado e experienciado pela doutoranda, nos cinco anos prévios ao seu ingresso no programa de doutoramento. De acordo com a sua experiência profissional em contexto de acolhimento residencial, quem trabalha nestas casas dá o seu melhor para cuidar das crianças e jovens que lá residem, sendo o trabalho diário um processo contínuo de aprendizagem entre cuidadores e jovens, que se influenciam mutuamente. No entanto, esta determinação e bem-querer não se revelam suficientes para responder de forma adequada às necessidades apresentadas pelas crianças e jovens. Cuidar de crianças maltratadas, que exibem necessidades complexas, exige que os cuidadores tenham conhecimentos teóricos, competências relacionais e treino específico para reconhecer o trauma (nos outros e em si), saibam lidar com comportamentos disruptivos das crianças e jovens e prevenir a sua ocorrência, e tenham capacidade de ajudar e modelar os jovens para lidarem adequadamente com as suas emoções intensas e o sofrimento experienciado (Krueger, 2007; ONU, 2010). Este trabalho tem de ser planeado de forma intencionalmente terapêutica e executado com recurso a práticas baseadas em evidência, para que não seja realizado de forma intuitiva, e consequentemente passível de ser incompleto e até errático (Macdonald et al., 2012).

Neste sentido, é importante compreender os desafios diários inerentes a este trabalho e empatizar com as dificuldades transversalmente sentidas por quem trabalha nestas casas. Os cuidadores encontram-se expostos a ameaças físicas e psicológicas de carácter imprevisível,

num contexto com recursos limitados (humanos, materiais, económicos), propício a sobrecarga de trabalho, stress ocupacional, desgaste físico e emocional (Steinlin et al., 2017; Kind et al., 2016). Profissionais mentalmente exaustos apresentam recursos psicológicos limitados para cuidar de crianças que carecem constantemente de afeto e de cuidados intencionalmente terapêuticos (Baugerud et al., 2018). Para corresponder às necessidades destas crianças e jovens, os cuidadores precisam também de ser cuidados (Krueger et al., 2007). Diversas associações na área da proteção da infância e da juventude destacam a necessidades de ajudar os cuidadores a regular as suas emoções para manter o seu bem-estar, bem como a conexão aos jovens e assegurar-lhes cuidados calorosos, consistentes e adequados (NCTSN, 2016). Neste sentido, a criação de um clima afiliativo e seguro nas CAR aparenta ser tão importante para as crianças e jovens, como para os seus cuidadores (Huefner & Ainsworth, 2021; Jenney, 2020; Steinlin et al., 2017).

Dada a relevância do papel do cuidador nas CAR, a relação estabelecida entre a crianças e os cuidadores, tanto tem potencial de alterar os padrões de vinculação previamente estabelecidos, como tem o poder de perpetuar o dano causado (Garcia Quiroga & Hamilton-Giachritsis, 2016). Da experiência e sensibilidade da doutoranda sobre esta matéria, esta não é de todo a intenção dos profissionais destas casas. A perceção de ineficácia, acoplada ao sentimento de fracasso face às necessidades complexas destas crianças e jovens, tendem a aumentar a frustração e a potenciar o cansaço das equipas, por sentirem que nada funciona. Este mau-estar tende a potenciar consequências indesejadas no funcionamento das equipas e das CAR, que comprometem os resultados esperados. A sensibilidade face às dificuldades sentidas e observadas, motivaram a doutoranda a procurar respostas no domínio científico que pudessem responder à necessidade de capacitar os profissionais das casas, técnica e psicologicamente.

A promoção de uma mentalidade afiliativa nas CAR foi a resposta encontrada para apoiar os cuidadores que trabalham nestas casas a ajudar as crianças e jovens a florescerem, e não apenas a sobreviverem. De acordo com a literatura, a mentalidade afiliativa poderá ser cultivada através do treino da compaixão. A compaixão é conceptualizada como uma motivação evolucionariamente desenvolvida para cuidar de indivíduos vulneráveis, revelando-se por isso um alicerce fundamental do processo de prestação de cuidados (Adams et al., 2006; Gilbert, 2020; Goetz et al., 2010).

Apesar da compaixão não ser um conceito novo, tem vindo a conquistar a atenção da comunidade científica durante as últimas décadas (Gilbert, 2020; Leaviss & Uttley, 2015; Singer & Klimecki, 2014). Investigação nas áreas da psicologia, neurociências e ciência evolutiva, tem

sido orientada para compreender as componentes da compaixão e para desenvolver programas para cultivar uma mente compassiva (Gilbert, 2014). Normalmente, estes programas procuram ativar respostas fisiológicas de tranquilidade associadas a sentimentos de segurança (Porges, 2007), a fim de facilitar relações afiliativas e ambientes de apoio (Gilbert, 2015b). Contudo, a compaixão não facilita apenas a criação de laços e relações positivas com os outros, é também fundamental para a regulação emocional do próprio indivíduo (Crocker & Canevello, 2017; Hermanto et al., 2016; Kelly & Dupasquier, 2016).

Contrariamente à ideia de que os profissionais eficazes devem ser estoicos e ser capazes de suprimir os seus sentimentos, estudos recentes destacam que pensamentos e ações autocompassivas, que permitem atender de forma gentil e atenta às necessidades do próprio, tendem a facilitar recursos internos para lidar com os desafios inerentes a contextos de trabalho exigentes (Reizer, 2019). Neste sentido, têm sido desenvolvidos programas para cultivar a compaixão dirigida aos outros e ao próprio em contextos de trabalho de prestação de cuidados (Beaumont et al., 2016b; Delaney, 2018; Johansson et al., 2022; Matos et al., 2022a; McEwan et al., 2020; McVicar et al., 2021; Orellana-Rios et al., 2017; Scarlet et al., 2017; Seppala et al., 2014). Normalmente, estes programas têm o duplo objetivo de promover cuidados compassivos e humanizados aos utentes, combinado com a promoção do autocuidado e do bem-estar dos profissionais (Beaumont et al., 2016b; Delaney, 2018; Johansson et al., 2022; McEwan et al., 2020; McVicar et al., 2021; Orellana-Rios et al., 2017; Scarlet et al., 2017; Seppala et al., 2014). Todavia, a abordagem focada na compaixão não havia ainda sido estendida e testada em contexto de acolhimento residencial e crianças e jovens.

Apesar de se considerar que a medida de acolhimento familiar deva ser uma prioridade das políticas públicas, a melhoria da prestação de cuidados nas CAR não deve ser esquecida ou negligenciada, uma vez que essa resposta social continuará a assistir muitas crianças e jovens (Garcia Quiroga & Hamilton-Giachritsis, 2016; McCall & Groark, 2015; Vashchenko et al., 2010). A investigação indica que, se a qualidade da prestação de cuidados for otimizada e monitorizada, o acolhimento residencial poderá revelar-se uma opção adequada, face à inexistência de respostas familiares disponíveis (Wright et al., 2019). Justifica-se assim a necessidade de continuar a conduzir investigação na área do acolhimento residencial de crianças e jovens, de forma a desenvolver práticas baseadas em evidência que respondam adequadamente não só às necessidades físicas básicas das crianças e jovens, mas também às suas necessidades psíquicas, emocionais e sociais (Garcia Quiroga & Hamilton-Giachritsis, 2016; Hermenau et al., 2017; McCall et al., 2016).

Ao aliar a ciência à prática, este projeto de investigação pretendeu contribuir para a melhoria da prestação de cuidados nas CAR destinadas a crianças e jovens em perigo. No global, este projeto disponibilizou um programa estruturado e empiricamente testado, que designamos por Treino da Mente Compassiva para Cuidadores (TMC-C). Disponibilizou ainda escalas de avaliação psicológica validadas para adolescentes em acolhimento residencial, bem como conhecimento empírico sobre a relevância da compaixão e da mentalidade afiliativa nas CAR e da qualidade das relações de calor e afeto estabelecidas entre cuidadores e jovens em acolhimento.

O programa de TMC-C foi o produto central deste projeto de doutoramento, em torno do qual se desenvolveu o objetivo geral da presente tese, operacionalizado em um ensaio clínico aleatorizado por *clusters,* que foi conduzido para desenvolver, implementar e estudar a eficácia do TMC-C. Os estudos sobre os efeitos do programa incluíram diferentes informantes (cuidadores e jovens) e indicadores de carácter pessoal, interpessoal e organizacional, colhidos com recurso a métodos quantitativos e qualitativos. Foi ainda testado se os resultados observados após a intervenção se mantinham estáveis durante um período de *follow-up* de três e seis meses.

A presente tese engloba um estudo de revisão sistemática da literatura e sete estudos empíricos, que foram planificados para dar resposta a questões e objetivos específicos. À data de entrega da tese, encontram-se publicados em revistas internacionais com revisão por pares sete artigos, encontrando-se o oitavo em processo de revisão em revista da mesma categoria. A tese integra ainda um estudo de viabilidade do programa de TMC-C (não publicado).

Em anexo, encontra-se uma sessão integral do programa de TMC-C (Anexo A), bem como os formulários desenvolvidos para avaliar componentes do programa (Anexo B) e exemplos ilustrativos do Muro da Compaixão (i.e., mural construído pelos cuidadores em cada CAR ao longo das sessões do TMC-C; Anexo C). Encontra-se ainda disponível, em anexo, um estudo empírico com coautoria da doutoranda, referente à adaptação e validação de uma escala integrada no protocolo de avaliação do presente ensaio clínico (Anexo D).

Esta tese encontra-se dividida em quatro partes e incluiu oito capítulos que passamos a apresentar.

A **Parte I - Enquadramento teórico**, apresenta uma revisão da literatura internacional e nacional sobre as temáticas centrais em estudo nesta tese. O enquadramento teórico divide-se no **Capítulo 1**, intitulado "O acolhimento residencial de crianças e jovens: Necessidades de

intervenção para a melhoria da prestação de cuidados" e no **Capítulo 2** sobre "O Programa de Treino da Mente Compassiva para Cuidadores: Bases conceptuais, estrutura e conteúdos".

O **Capítulo 1** pretende contextualizar e definir a resposta de acolhimento residencial, caracterizar as necessidades das crianças e jovens em acolhimento e destacar o papel dos cuidadores no processo de recuperação das crianças e jovens, evidenciando as dificuldades encontradas pelos mesmos nesse processo. Neste capítulo são ainda sintetizados os resultados de revisões sistemáticas da literatura sobre os programas de treino/intervenção disponíveis para cuidadores, fazendo-se referência aos resultados da revisão sistemática da literatura, conduzida no âmbito da presente tese, sobre programas para cuidadores das casas de acolhimento destinados à promoção da saúde mental e emocional neste contexto.

No **Capítulo 2** justifica-se a escolha do modelo e práticas da Terapia Focada na Compaixão (TFC) para procurar responder às necessidades de intervenção evidenciadas no contexto de acolhimento residencial. São apresentadas as bases conceptuais do programa de Treino da Mente Compassiva para Cuidadores, o estado da arte sobre programas baseados na compaixão e respetivos resultados, decorrentes da aplicação dos mesmos em diferentes contextos laborais. Por último, é fundamentado o desenvolvimento do programa de Treino da Mente Compassiva para Cuidadores, sua finalidade, a estrutura, os conteúdos.

A **Parte II – Metodologia,** é composta pelo **Capítulo 3** (Metodologia geral e objetivos de investigação), onde é realizada uma caracterização geral do presente trabalho de investigação, apresentados os objetivos e as opções metodológicas (participantes e desenho de investigação, instrumentos, procedimentos, análise de dados). Neste capítulo, são ainda descritos os procedimentos e resultados do estudo de viabilidade. Por último, são apresentados os princípios éticos que guiaram a conceptualização, operacionalização e implementação do presente trabalho de investigação.

Na **Parte III - Revisão Sistemática da Literatura e Estudos Empíricos** é composta por quatro capítulos que englobam a revisão sistemática da literatura **(Capítulo 4)** e os sete estudos empíricos incluídos nesta tese **(Capítulos 5, 6 e 7)**. Os estudos são apresentados no formato de artigo científico, de acordo com as normas das revistas científicas onde se encontram publicados ou a que foram submetidos para publicação, encontrando-se por essa razão redigidos em língua inglesa.

O **Capítulo 4** - Programas para cuidadores destinados a promover a saúde mental e emocional nas casas de acolhimento residencial – uma revisão sistemática - inclui a revisão sistemática da literatura (Fostering emotional and mental health in residential youth care facilities: A systematic review of programs targeted to care workers), que tem como objetivos

identificar programas de treino/intervenção dirigidos a profissionais das casas de acolhimento com a finalidade de promover a saúde emocional e mental no acolhimento residencial, e avaliar sistematicamente o efeito dos programas nos cuidadores, jovens ou clima relacional/organizacional.

O **Capítulo 5** - Validação de medidas de autorrelato para adolescentes - inclui dois estudos empíricos. No estudo empírico I (Emotional Climate in Residential Care Scale for Youth: Psychometric properties and measurement invariance) e no estudo empírico II (Development and validation of the Current Experiences of Warmth and Safeness Scale in community and residential care adolescents) foram adpatadas e validadas escalas de avaliação de construtos psicológicos de relevo para o modelo teórico de base do programa, sendo, posteriormente, integradas como medidas no ensaio clínico.

O **Capítulo 6** - Memórias precoces e experiências atuais de cuidados e segurança: Impacto no sofrimento psicológico dos adolescentes - inclui o estudo empírico III (Impact of early memories and current experiences of warmth and safeness on adolescents' psychological distress). Este estudo combinou modelos centrados na variável com modelos centrados no indivíduo, com o objetivo de explorar, em duas amostras diferentes de adolescentes (i.e., adolescentes da comunidade e adolescentes em acolhimento residencial), o papel das memórias de experiências precoces e das experiências atuais de cuidados e segurança com os outros, no desenvolvimento e manutenção de sintomatologia de ansiedade e depressão.

O **Capítulo 7** - Avaliação da eficácia do programa de Treino da Mente Compassiva para Cuidadores: Ensaio clínico aleatorizado por clusters e estudo qualitativo - integra quatro estudos empíricos realizados no âmbito do ensaio clínico, que têm como objetivo contribuir para a produção de evidência empírica sobre a eficácia do TMC-C. O estudo empírico IV (Compassionate mind training for caregivers of residential youth care: Early findings of a cluster randomized trial) teve como objetivo testar os efeitos preliminares do programa de TMC-C na promoção de uma mentalidade afiliativa nos cuidadores. O estudo empírico V (Compassionate Mind Training for caregivers in residential youth care: Investigating their experiences through a thematic analysis) foi conduzido com recurso a metodologia qualitativa, com o objetivo de compreender a experiência dos cuidadores com o programa de TMC-C e o processo de transferência das aprendizagens do programa para as práticas de acolhimento. Este estudo pretendeu ainda avaliar o impacto do desenvolvimento de uma motivação e atitude compassiva a nível pessoal, da equipa e da organização, bem como o impacto indireto do programa nos jovens em acolhimento residencial. Os dois estudos seguintes procuraram avaliar a estabilidade das mudanças associadas ao programa, durante os seis meses seguintes à intervenção. Mais

concretamente, o estudo empírico VI (Fostering an affiliative environment in residential youth care: A cluster randomized trial of a compassionate mind training program for caregivers enrolling youth and their caregivers) procurou testar a eficácia do programa e a manutenção dos ganhos em variáveis afiliativas e associadas ao clima emocional das casas de acolhimento, através do autorrelato de cuidadores e de jovens em acolhimento. O estudo empírico VII (The effects of the Compassionate Mind Training for Caregivers on professional quality of life and mental health over time: A cluster randomized trial in residential youth care) procurou testar a eficácia do TMC-C e manutenção dos resultados relativamente à qualidade de vida profissional e saúde mental dos cuidadores.

A última parte desta tese, **Parte IV – Discussão**, contém o **Capítulo 8** (Discussão geral), que apresenta as principais conclusões e contribuições desta tese para investigação futura e para as práticas do acolhimento residencial. Inclui uma síntese e discussão integrada dos principais resultados dos oito estudos incluídos na presente tese, procurando discutir os mesmos em conformidade com a investigação publicada. Inclui uma reflexão sobre as potencialidades e as limitações dos estudos incluídos nesta tese, bem como recomendações para investigação futura. O capítulo termina com uma reflexão sobre as implicações do presente projeto de investigação para os processos, práticas e políticas de acolhimento residencial.

Por último, a lista final de **Referências bibliográficas** concentra as obras citadas ao longo desta tese. São exceção as obras citadas nos estudos empíricos, incluídos na Parte III desta tese, que foram tratadas de forma independente, sendo apresentadas na lista das referências específicas de cada artigo.

Para concluir esta nota introdutória, gostaríamos de destacar que os estudos e produtos desenvolvidos no âmbito do presente trabalho de investigação têm por base a missão de fortalecer o elo entre a ciência e a prática, pretendendo colocar a ciência ao dispor dos processos, das práticas e das políticas de acolhimento residencial, de forma a sustentar, melhorar e otimizar os mesmos. Neste sentido, importa referir que o Manual do TMC-C se encontra registado como marca da Universidade de Coimbra. O processo de transferência de conhecimento foi iniciado em 2021/2022, através da realização de duas prestações especializadas de serviço da Unidade de Psicologia Clínica Cognitivo-Comportamental (UpC3) à IGAXES (ONG na Galiza) e ao Instituto da Segurança Social da Madeira (IP-Ram), das quais resultou a formação e supervisão de técnicos para aplicação do programa nas respetivas regiões. Atualmente, para além das casas de acolhimento do ensaio clínico, beneficiaram do TMC-C seis casas de autonomia localizadas na Galiza e as dez CAR na Ilha da Madeira, encontrando-se

atualmente em curso o estudo dos efeitos do programa nestes dois contextos de acolhimento, envolvendo mais de 200 participantes.

PARTE I

ENQUADRAMENTO TEÓRICO

CAPÍTULO 1

O ACOLHIMENTO RESIDENCIAL DE CRIANÇAS E JOVENS: NECESSIDADES DE INTERVENÇÃO PARA A MELHORIA DA PRESTAÇÃO DE CUIDADOS

1. Introdução

A Convenção Universal dos Direitos da Criança (ONU, 1989) proclama que todas as crianças têm direito a viver com os seus pais e a manter contacto com os mesmos, desde que esse contacto não comprometa o seu desenvolvimento e bem-estar. Declara ainda que cada criança tem direito a crescer num ambiente que lhe ofereça suporte, proteção e cuidados adequados que promovam o seu desenvolvimento integral. Porém, crianças e jovens de todo o mundo vêm os seus direitos comprometidos devido a circunstâncias pessoas e sociais de natureza diversa, tais como exposição a maus-tratos (i.e., diferentes formas de abuso e negligência), a violência, a pobreza, a guerras, a catástrofes naturais, que afetam e prejudicam a sua segurança, saúde, formação, educação e/ou desenvolvimento saudável (OMS, 2020; SOS Children's Villages International & University of Bedfordshire, 2014; UNICEF, 2006). Quando a família não se afigura capaz de proteger a criança face a estas ou outras situações, a criança fica desamparada e vulnerável, carecendo de proteção, cuidados alternativos e assistência promovida pelo Estado, de forma a assegurar o seu bem-estar e desenvolvimento saudável (Briggs et al., 2012; Collin-Vézina et al., 2011; Garcia Quiroga & Hamilton-Giachritsis, 2016; ONU, 1989).

Historicamente, as instituições de acolhimento instituíram-se como respostas sociais direcionadas para assegurar a prestação de cuidados alternativos a crianças e jovens face à ausência de cuidados familiares (Lee et al., 2011). Ao longo do tempo, fatores históricos, sociais e políticos, bem como mudanças nas perspetivas em torno do desenvolvimento infantil, motivaram mudanças de paradigma das respostas sociais de prestação de cuidados alternativos, que evoluíram de forma distinta, ao ritmo das políticas públicas de cada país (Dozier et al., 2012).

Em Portugal, as primeiras instituições desta natureza eram geridas por ordens religiosas, possuindo um pendor marcadamente assistencialista e caritativo, direcionado para o acolhimento de crianças órfãs ou oriundas de famílias com poucos recursos económicos (Henriques et al., 2014). Fruto de mudanças históricas e sociais, nos últimos anos verificou-se uma alteração significativa do perfil da criança e jovem em acolhimento (Carvalho & Salgueiro, 2018; Rodrigues et al., 2013). Grande parte deixou de se inserir na categoria "sem família", passando a ser proveniente de famílias multi-problemáticas e ambientes hostis e desorganizados, evidenciando dificuldades de inserção social frequentemente acopladas com problemas de saúde mental (Henriques et al., 2014; Steels & Simpson, 2017). Tais mudanças têm vindo a exigir um conjunto de respostas diferenciadas em função das necessidades de cada criança ou jovem, estimulando transformações no funcionamento da resposta social de acolhimento residencial. Assim, as instituições ou orfanatos de grande escala têm vindo a dar

lugar a unidades de menor dimensão, com uma estrutura de funcionamento e ambiente mais semelhantes ao de uma família (Henriques et al., 2014). O Plano DOM – Desafios, Oportunidades e Mudanças, executado pelo Instituto de Segurança Social entre 2007 e 2011, implementou medidas de capacitação de recursos e equipas das Casas de Acolhimento Residencial (CAR) (Despacho nº 8393/2007, de 10 de maio, do Ministério do Trabalho e da Solidariedade Social). Em 2012, o Plano SERE + (Sensibilizar, Envolver, Renovar, Esperança, MAIS) também promovido pelo mesmo instituto, tem procurado implementar medidas de especialização das CAR que possam responder às complexas e múltiplas necessidades das crianças e jovens, tendo em vista a sua reorganização psicológica e inserção social (Despacho nº 9016/2012, de 4 de julho, do Ministério do Trabalho e da Solidariedade Social). Em 2015, a própria Lei de Proteção de Crianças e Jovens em Perigo (LPCJP; Lei n.º 142/2015, de 8 de setembro, segunda alteração à LPCJP, aprovada pela Lei n.º 147/99, de 1 de setembro, alterada pela Lei n.º 31/2003, de 22 de agosto) substituiu a terminologia de acolhimento institucional para acolhimento residencial. As sucessivas alterações à LPCJP procuram ir ao encontro da necessidade de mudança do paradigma do modelo de acolhimento, que procura progressivamente passar de uma lógica funcional, baseada na satisfação das necessidades básicas das crianças e jovens, para um modelo terapêutico, assente na lógica da diversidade, baseado na intervenção individualizada e na transformação interna da criança/jovem acolhido (Guerra, 2022).

Ainda que possua uma história de longa data, o acolhimento residencial é uma resposta social controversa, que tem vindo a ser reduzida e até extinta em alguns países (Dozier et al., 2012). Um conjunto vasto de estudos sobre o impacto do processo de institucionalização no desenvolvimento das crianças criadas em meio institucional, tem levantando preocupações em torno da qualidade da prestação de cuidados e subsequentes efeitos prejudiciais nas crianças, que não podem ser negligenciados (Lee et al., 2011). A investigação tem indicado, de forma recorrente, que a débil qualidade dos cuidados interativos em contexto institucional pode resultar em comportamentos sociais disfuncionais, atrasos no desenvolvimento físico, défices no desenvolvimento cognitivo, desregulação emocional e problemas de vinculação da criança, que tendem a perpetuar-se ao longo da sua vida (Dozier et al., 2012; Smyke, 2012). Uma revisão sistemática da literatura recente indica, no entanto, que a experiência de acolhimento residencial *per se*, pode não implicar necessariamente resultados prejudiciais, desde que a resposta de acolhimento integre determinados fatores protetores (Wright et al., 2019). Neste âmbito, a adoção de normas de qualidade e de intervenções e práticas baseadas em evidência, parecem contribuir para alcançar melhores indicadores de ajustamento das crianças e jovens em acolhimento (De Swart et al., 2012; Wright et al., 2019). Alguns estudos indicam que, se a

qualidade da prestação de cuidados for otimizada e assegurada num ambiente terapêutico, o acolhimento residencial poderá revelar-se uma opção adequada, quando outras respostas sociais de cuidados individualizados (e.g., adoção, acolhimento familiar) não estiverem disponíveis ou não se revelarem apropriadas (e.g., adolescentes com problemas de saúde mental; Vashchenko et al., 2010; Wright et al., 2019).

No paradigma de acolhimento terapêutico, é atribuída grande relevância aos recursos humanos das casas de acolhimento (i.e., cuidadores), enquanto agentes ativos no processo de mudança (Holmes et al., 2018; Li & Julian, 2012). A alteração do perfil das crianças e jovens requer não só alterações nos recursos e funcionamento das casas, como também a atualização de conhecimentos e de mentalidade por parte dos cuidadores, no que respeita à prestação de cuidados. Cuidar de crianças maltratadas que exibem necessidades complexas, não pode limitar-se exclusivamente a uma prestação de cuidados fundamentalmente intuitiva e assistencialista, mas requer antes uma intervenção planeada de forma intencional terapêutica (Macdonald et al., 2012; Rodrigues et al., 2013). Tal intervenção exige que os cuidadores tenham conhecimento sobre o funcionamento da mente humana e treino para ajudar as crianças e jovens a lidarem adequadamente com as emoções e sofrimento experienciados, bem como conhecimentos que lhes permitam apoiar as crianças e jovens acolhidos a desenvolverem competências pessoais e interpessoais (NCTSN, 2016).

A atuação dos cuidadores tem o poder de promover uma base segura para a mudança (Jenney, 2020; Li et al., 2017), assim como tem potencial para impactar negativamente o ajustamento das crianças e jovens em acolhimento (Steels & Simpson, 2017). Problemas associados à falta de formação especializada e à incidência de níveis elevados de stress ocupacional entre os profissionais, têm sido apontados como potenciais ameaças à qualidade da prestação de cuidados em contexto de acolhimento residencial (Bürgin et al., 2020). De acordo com a Organização Mundial de Saúde (2010), stress ocupacional refere-se à resposta experienciada pelo indivíduo quando confrontado com exigências e pressões laborais incomensuráveis em relação aos seus conhecimentos e competências, e que limitam a sua capacidade de lidar com as mesmas. Quando experienciado de forma crónica, o stress ocupacional pode desencadear problemas de ordem psicológica, social, física e profissional, e consequentemente comprometer a qualidade da prestação de cuidados (Del Valle et al., 2007; Kind et al., 2018; Lizano & Mor Barak, 2012; Middleton & Potter, 2015; Obermann, 2017). Por sua vez, a falta de treino e formação especializada para lidar com as necessidades complexas das crianças e jovens, pode aumentar o nível de stress experienciado pelos profissionais (Bürgin et al., 2020). A fim de prevenir o stress ocupacional, a literatura tem apontado ainda para a

necessidade de encorajar o próprio cuidador a cuidar da sua saúde emocional e mental (NCTSN, 2016). Deste modo, é recomendado que as organizações possam disponibilizar aos seus colaboradores treino e formação contínua, com o intuito de auxiliá-los a compreender as necessidades das crianças e jovens e a responderem adequadamente às mesmas. Este treino deve ser complementado com estratégias de autorregulação emocional, com a finalidade de manter o bem-estar do cuidador, bem como a sua ligação às crianças e jovens e assegurar a qualidade nas práticas e processos de acolhimento (Lizano & Mor Barak, 2012; NCTSN, 2016; Steels & Simpson, 2017).

A história de vida de crianças e jovens em todo o mundo continuará a incluir episódios temporários de acolhimento residencial. Para que essas histórias possam contar experiências afiliativas, com um tom caloroso e seguro, e permitirem descrever percursos de vida mais inclusivos e saudáveis, revela-se necessário continuar a conduzir investigação que possa contribuir para desenvolver práticas de acolhimento desenvolvimentalmente adequadas e responsivas (Carvalho & Salgueiro, 2018; Hermenau et al., 2017; McCall & Groark, 2015; Rodrigues et al., 2013).

O primeiro capítulo desta tese tem como objetivo apresentar o estado da arte em torno do funcionamento do sistema de proteção de crianças e jovens em perigo, destacando o funcionamento e resultados da resposta social de acolhimento residencial. São descritas as dificuldades e necessidades das crianças e jovens que carecem de proteção estatal e as abordagens de prestação de cuidados mais comuns em vigor nas casas de acolhimento. É enfatizado o papel dos cuidadores na promoção da recuperação física e psicológica da criança/jovem, e descritas as dificuldades enfrentadas pelos menos neste contexto específico de prestação de cuidados. Por fim, são sintetizados os esforços da investigação para disponibilizar programas de treino para cuidadores e práticas baseadas em evidência, que permitam adequar a prestação de cuidados às necessidades das crianças e jovens, com o intuito de melhorar a resposta de acolhimento residencial.

2. Acolhimento residencial no século XXI: Orientações e modelos de funcionamento

Proteger e prestar cuidados alternativos a crianças e jovens continua a ser uma necessidade à escala global (Carvalho & Salgueiro, 2018). Face à inadequação da intervenção parental ou incapacidade da família de proteger a criança, o Estado e respetivas entidades com competência em matéria de infância e juventude, têm o dever e legitimidade de executar medidas de promoção e proteção, que assegurem a proteção e assistência à criança e promovam os seus direitos essenciais (cívicos, sociais, económicos e culturais), com vista a

garantir o seu bem-estar e desenvolvimento integral (Carvalho, 2013). Apesar das leis e políticas de proteção da infância e juventude variarem consideravelmente entre países, por norma, os sistemas de proteção apresentam um contínuo de medidas (Rodrigues et al., 2013; Tarren-Sweeney, 2008). Este contínuo pode variar entre medidas executadas em meio natural de vida (e.g., apoio junto dos pais, apoio junto da família alargada) e medidas executadas em regime de colocação, onde a criança pode ser colocada junto de uma família de acolhimento ou, em última instância, numa casa de acolhimento residencial (art.º 35º da LPCJP, na sua redação atual).

As orientações internacionais (Dozier et al., 2014; ONU, 2010) e nacionais (alínea h) do art.º 4º da LPCJP na sua redação atual) indicam que deve ser dada prevalência a intervenções que envolvam a família. Quando esta não se afigura uma resposta adequada ou disponível, a primazia deve ser dada a medidas executadas em meio natural de vida, onde a criança possa crescer em ambiente familiar, considerando-se que tal opção seria a mais normativa. É ainda indicado que o acolhimento residencial deve ser utilizado como medida de último recurso, apenas quando outras opções menos restritivas se encontrarem esgotadas (Dozier et al., 2014). Quando executada, a medida de acolhimento residencial deve ser de carácter temporário, tendo em vista a reintegração da criança na família (nuclear ou alargada), ou o encaminhamento para futura adoção ou apadrinhamento civil (Carvalho, 2013). Não obstante, são várias as exceções as estas orientações. Devido à carência da resposta de acolhimento familiar, ou a dificuldades de implementação dessa mesma resposta em diversos países (e.g., falta de supervisão e apoio às famílias), o acolhimento residencial continua a ser, em muitos casos, a única alternativa viável para crianças e jovens em todo o mundo (Boel-Studt & Tobia, 2016; Calheiros et al., 2022; Jackson et al., 2019; James, 2017; McCall & Groark, 2015; UNICEF, 2010; Vashchenko et al., 2010; Wright et al., 2019). Por outro lado, devido às elevadas taxas de disrupção nos processos de acolhimento familiar de jovens com historial de problemas de saúde mental e necessidades especiais (Chow et al., 2014; Leloux-Opmeer et al., 2016; Whittaker et al., 2016), a medida de acolhimento residencial tem sido frequentemente implementada com jovens com necessidades de intervenção específicas ao nível da saúde mental (De Swart et al., 2012; Holmes et al., 2018; Jackson et al., 2019) ou outras necessidades especiais (McCall & Groark, 2015).

De acordo com as Orientações para os Cuidados Alternativos de Crianças, aprovadas pela Assembleia Geral nas Nações Unidas (ONU, 2010), as CAR devem ser estruturas de pequena dimensão, organizadas em torno dos direitos e necessidades das crianças, onde a prestação de cuidados ocorra numa modalidade o mais aproximada possível do que seria uma família. O acolhimento de crianças e jovens com necessidades de intervenção ao nível da saúde mental tem vindo a criar a necessidade de adaptar e especializar a intervenção das CAR e dotar as

mesmas de um ambiente terapêutico, que dê resposta às necessidades de intervenção educativa e/ou terapêutica desses jovens (Arteaga, 2009; Rodrigues et al., 2013). De acordo com a Declaração Internacional sobre Acolhimento Residencial Terapêutico (Whittaker et al., 2016), este é definido como um serviço residencial cuidadosamente planificado, direcionado para jovens com problemas de comportamento e de saúde mental, tendo como objetivo oferecer tratamento e educação, emparelhado com relações estruturantes e seguras, em estreita colaboração com a família e a comunidade. Segundo Huefner & Ainsworth (2021), o acolhimento residencial terapêutico deve facilitar um ambiente afetivo, estruturado e disciplinado, tratamento psicológico e promoção de competências sociais, académicas e de autonomia.

A resposta social de acolhimento residencial varia consideravelmente entre países, de acordo com as suas características e necessidades históricas, sociais e culturais, e respetivos quadros normativos em vigor (Boel-Studt & Tobia, 2016; Chow et al., 2014; De Swart et al., 2012; Farmer et al., 2017b; Garcia Quiroga & Hamilton-Giachritsis, 2017; McCall & Groark, 2015; Rodrigues et al., 2013; UNICEF & Eurochild, 2021). As diferenças existentes prendem-se, nomeadamente, com o número de vagas disponível, o público-alvo (e.g., idade, história de maus-tratos, doença mental, consumo de substâncias), a função (generalista, especializada, autonomização), o nível de restrição (aberto vs fechado) e diferentes modelos de intervenção (Lee & Barth, 2011). Perante esta heterogeneidade, não é surpreendente o facto de a investigação reportar resultados díspares relativamente à eficácia desta reposta social (Boel-Studt & Tobia, 2016; Chow et al., 2014; Knorth et al., 2010).

Estudos de revisão sistemática e de meta-análise indicam efeitos positivos, de tamanho pequeno a moderado, relativos a melhorias nos problemas emocionais, redução de problemas de externalização, bem como melhorias ao nível das competências interpessoais e académicas (De Swart et al., 2012; Knorth et al., 2008; Steels & Simpson, 2017). No entanto, estes ganhos aparentam não ser mantidos a longo prazo (Boel-Studt & Tobia, 2016; Knorth et al., 2008). A investigação sugere ainda que o acolhimento residencial prejudica significativamente o desenvolvimento físico, mental e socioemocional da criança quando esta é acolhida durante os primeiros anos de vida, devendo por isso ser evitado (Hamilton-Giachritsis & Garcia Quiroga 2014; McCall & Groark, 2015). O acolhimento residencial poderá também ter um efeito prejudicial em jovens com problemas de saúde mental ou de comportamento, quando a prestação de cuidados não integra tratamento e práticas baseadas em evidência (De Swart et al., 2012). Por último, comparativamente a outras medidas, o acolhimento residencial acarreta

custos financeiros consideravelmente mais elevados (Boel-Studt & Tobia, 2016; Chow et al., 2014; James, 2017).

Não obstante, o acolhimento residencial continua a ser a medida de promoção e proteção em regime de colocação mais executada em diversos países, incluindo em Portugal (Calheiros et al., 2022; Carvalho & Salgueiro, 2018; UNICEF, 2023; Rodrigues et al., 2013). De acordo com o Relatório de Caracterização Anual da Situação de Acolhimento (CASA; ISS, 2022), em 2021, encontravam-se em situação de acolhimento 6.369 crianças e jovens, 84.8% das quais encontrava-se a residir em casa de acolhimento generalista, 2.53% em casa de acolhimento especializada, 2.5% em apartamento de autonomização, 3.2% em família de acolhimento e 6.9% em outras respostas do sistema. A adolescência é a faixa etária mais representada, nomeadamente jovens dos 15 aos 17 anos (51%), sendo também o grupo que apresenta maior percentagem de problemas de comportamento. Verifica-se ainda uma tendência crescente de jovens da faixa etárias dos 21 aos 24 anos em acolhimento residencial, em virtude da revisão da LPCJP em 2017, que alarga a possibilidade de atuação para jovens até aos 25 anos, desde que se encontrem em processos educativos ou de formação profissional (Guerra, 2022). Os dados disponíveis mais recentes, referentes a 2021, mostram que a negligência foi apontada como o principal motivo de acolhimento (70% dos casos), seguida de outras situações de perigo (13%; e.g., ausência temporária de suporte, comportamentos desviantes, abandono), maus-tratos psicológicos (11%), maus-tratos físicos (4%) e violência sexual (3%) (ISS, 2022).

De acordo com a LPCJP, as medidas de promoção e de proteção devem garantir a recuperação física e psicológica das crianças e jovens (art.º 34º). Deste modo, as CAR devem garantir a satisfação das necessidades físicas, educacionais e sociais das crianças e jovens, mas também satisfazer as suas necessidades emocionais (art.º 49º). Devem promover o estabelecimento de laços afetivos, seguros e estáveis, e contribuir para a construção da identidade da criança e integração psicológica da sua história de vida (art.º 3º do Decreto-Lei n.º 164/2019).

Em Portugal, as CAR são maioritariamente equipamentos privados, com acordo de cooperação com o Estado (art.º 52º, LPCJP), supervisionados pelo Instituto da Segurança Social (Carvalho, 2013; Rodrigues et al., 2014). A fim de promover um acolhimento residencial qualificado e de qualidade, as CAR devem dispor de instalações, equipamentos e recursos humanos permanentes, devidamente dimensionados e habilitados, que garantam uma prestação adequada de cuidados (art.º 49º, LPCJP). Em Portugal, a maioria das CAR é generalista e funciona em regime aberto, sendo reduzido o número de unidades especializadas existentes (Carvalho, 2013; Carvalho e Salgueiro, 2018).

Os recursos humanos das CAR encontram-se normalmente organizados em três equipas multidisciplinares (art.º 54º, LPCJP). A equipa técnica integra um diretor técnico e profissionais da área da psicologia e do serviço social, que assumem funções de gestão de caso (e.g., diagnóstico da situação da criança, contacto com famílias e escolas, elaboração de relatórios para entidades com competência em matéria de infância e juventude). A equipa educativa integra profissionais cuja formação profissional específica não é de carácter obrigatório, sendo normalmente composta por auxiliares de ação educativa. Estes profissionais prestam cuidados diretos às crianças e jovens, sendo responsáveis pelo seu acompanhamento socioeducativo diário. A equipa de apoio integra colaboradores de serviços gerais e outros profissionais de apoio (e.g., cozinheiro).

Durante o processo de acolhimento, são elaborados um projeto de promoção e proteção e um plano de intervenção individual, que definem e integram os objetivos de intervenção baseados no diagnóstico de necessidades, vulnerabilidades e potencialidades da criança. Estes documentos devem ser elaborados pela equipa técnica da CAR, em articulação com o técnico gestor do processo de promoção e proteção, conjuntamente com a criança ou jovem e a sua família de origem, salvo decisão judicial em contrário (art.º 9 e 10 do Decreto-Lei n.º 164/2019). A medida de promoção e proteção em acolhimento residencial é revista de seis em seis meses pelas autoridades competentes, até se afigurarem as condições necessárias para ser alterada ou cessada (Guerra, 2022).

3. Crianças e jovens em acolhimento residencial: Problemas e necessidades de intervenção

O trauma é uma condição prevalente entre as crianças e jovens acompanhadas pelos serviços de proteção (SAMHSA, 2014; Zhang et al., 2021). A investigação indica que a maioria das crianças e jovens em acolhimento residencial experienciou, pelo menos, um acontecimento traumático, e mais de metade foi exposta a múltiplos acontecimentos dessa natureza (Briggs et al., 2012; Schmid et al., 2013; Zelechoski et al., 2013). O trauma resulta da exposição a um acontecimento ou conjunto de acontecimentos percecionados como física ou emocionalmente ameaçadores, do qual/quais resultam efeitos adversos, de carácter duradouro, para o funcionamento mental, físico, social, emocional ou bem-estar do indivíduo (SAMHSA, 2014). A investigação indica que o trauma é agravado pela ausência de uma figura de suporte aquando da ocorrência do acontecimento ameaçador (Sieff, 2017). Deste modo, um acontecimento traumático isolado, terá um impacto distinto de maus-tratos perpetrados de forma crónica por figuras de vinculação (Terr, 2003).

A investigação sugere que a incapacidade dos pais ou cuidadores primários responderem adequadamente às necessidades da criança poderá potenciar uma resposta traumática (Siegel, 2015). Considerando que, durante os primeiros anos de vida, as tarefas desenvolvimentais da criança ocorrem em contexto de prestação de cuidados, com os pais ou com outras figuras que desempenhem essa função, a vinculação derivada da qualidade da prestação de cuidados e da responsividade do cuidador primário às necessidades da criança assume um papel fundamental para o seu desenvolvimento físico, social e emocional (Bowlby, 1982). Um padrão seguro de vinculação resulta de interações sucessivas entre os pais/cuidadores e a criança, marcadas pela proteção, conforto e assistência adequada às necessidades da criança (Ainsworth, 1967; Cyr et al., 2010). Quando estas interações ocorrem num ambiente seguro e afetuoso, têm a capacidade de acalmar e regular a criança (Depue & Morrone-Strupinsky, 2005). No sentido inverso, quando os pais/cuidadores demonstram insensibilidade, inconsistência ou rejeição relativamente às necessidades expressas pela criança, poderão ser desencadeados padrões inseguros de vinculação (evitante e ansioso) (Ainsworth, 1967; Cyr et al., 2010). As experiências relacionais precoces, e os padrões de vinculação daí resultantes, estabelecem a base para o desenvolvimento de modelos internos dinâmicos, responsáveis pela perceção que a criança desenvolve de si mesma, dos outros e do mundo, influenciando o seu autoconceito e as relações que estabelece com os outros (Bretherton & Munholland, 2016).

Experiências adversas com os cuidadores primários, como os maus-tratos, têm um duplo prejuízo, uma vez que expõem a criança a situações de perigo (e.g., abuso, violência) e limitam a possibilidade da mesma ser securizada e confortada, visto que a figura de vinculação e de prestação de cuidados tanto é fonte de eventual ameaça, como de conforto (Cyr et al., 2010; Sieff, 2017). Além disso, as experiências de calor e segurança com as figuras de vinculação podem ser inconsistentes ou mesmo estar ausentes. Assim, a figura de vinculação não modula ou apazigua a criança perante uma situação de desconforto ou stress, comprometendo o desenvolvimento de estratégias adaptativas de regulação emocional por parte da mesma (Schore, 2001). Ademais, para se adaptar e sobreviver em ambientes desta natureza, a criança é forçada a recorrer a comportamentos de defesa e proteção (e.g., isolamento, submissão, agressão) face aos outros (Cook et al., 2005; Zelechoski et al., 2013). Deste modo, a vivência de experiências adversas e a ausência de experiências de calor e segurança podem comprometer o desenvolvimento de um estilo de vinculação seguro, fundamental para o desenvolvimento saudável da criança (Mikulincer & Shaver, 2012), conduzindo ao invés, a estilos de vinculação inseguros ou desorganizados (Cicchetti et al., 2006; Cook et al., 2005). Tais estilos de vinculação

podem instigar estilos interpessoais evitantes, desconfiados, exigentes ou manipuladores, originando e mantendo dificuldades interpessoais a longo prazo (Mikulincer & Shaver, 2012).

Os maus-tratos (i.e., diferentes formas de abuso e de negligência) são experiências adversas, potencialmente traumáticas, frequentemente apontadas como os motivos principais para acolhimento de crianças e jovens (Briggs et al., 2012; Collin-Vézina et al., 2011; Garcia Quiroga & Hamilton-Giachritsis, 2016; Greger et al., 2015; ISS, 2022; Schmid et al., 2013). Tais experiências adversas são habitualmente perpetradas, de forma crónica e prolongada, por figuras significativas responsáveis pela prestação de cuidados à criança (Fischer et al., 2016). A investigação indica que a exposição continuada a esse tipo de experiências, de natureza relacional, em idade precoce, influência substancialmente o desenvolvimento da criança a curto e a longo prazo (De Bellis & Zisk, 2014; Chu et al., 2013; Cook et al., 2005; Danese et al., 2009; Jonson-Reid et al., 2012; McCrory et al., 2010; Schmid et al., 2013; Widom et al., 2007). De facto, crianças e jovens em contacto com o sistema de proteção apresentam frequentemente mais problemas de saúde física e mental, problemas de desenvolvimento, dificuldades cognitivas, sociais e educacionais, e pior qualidade de vida, comparativamente a crianças e jovens da população geral (Cook et al., 2005; Cousins et al., 2010; Ford et al., 2007; Greger et al., 2016; Milburn et al., 2008). Por estes motivos, estas crianças e jovens são considerados um dos grupos mais vulneráveis da sociedade, encontrando-se em risco futuro de exclusão social, pobreza, desemprego e criminalidade (Carvalho, 2013; Carvalho & Salgueiro, 2018; Cederbaum et al., 2017; Collin-Vézina et al., 2011; Cousins et al., 2010; Danese et al., 2009; Ford et al., 2007; Social Exclusion Unit, 2006; Tarren-Sweeney 2008).

Especificamente, no que diz respeito à saúde mental, crianças e jovens vítimas de maus-tratos encontram-se particularmente propensas a desenvolver perturbações mentais e desenvolvimentais (Magalhães & Camilo, 2023; Schmid et al., 2013; van der Kolk, 2015; Vilariño et al., 2022). A investigação indica uma relação consistente entre experiências adversas, potencialmente traumáticas, e problemas de comportamento (Hecker et al., 2014), stress pós-traumático (Alisic et al., 2014), depressão (Chu et al., 2013; Widom et al., 2007), ansiedade (Chu et al., 2013; Cougle et al., 2010), consumo de substâncias (Dube et al., 2003; Fischer et al., 2016) e perturbações da personalidade (Schmid et al., 2013). A frequência e contexto de ocorrência destas experiências têm influência na severidade dos problemas manifestados (Greger et al., 2015). Quando estas experiências são recorrentes e ocorrem no âmbito de relações interpessoais, acarretam maior severidade e comorbilidades, encontrando-se especificamente associados a problemas de regulação emocional e a sintomatologia internalizante (Collin-Vézina et al., 2011; Fischer et al., 2016; Greeson et al., 2011; Greger et al., 2015; Magalhães & Camilo,

2023; Schmid et al., 2013). Neste âmbito, a mais recente revisão da Classificação Internacional de Doenças (CID-11) da Organização Mundial da Saúde (OMS) inclui o diagnóstico de Stress Pós-Traumático Complexo, que descreve um conjunto de dificuldades manifestadas por indivíduos expostos a acontecimentos repetidos e prolongados no tempo, que ameaçam gravemente a sua segurança. Este diagnóstico inclui os critérios da Perturbação de Stress Pós-traumático (reexperienciação, evitamento e hiperativação/hipervigilância à ameaça) e problemas severos e persistentes de: (i) regulação emocional; (ii) crenças negativas sobre o próprio, caracterizadas por uma visão de si pautada por temas de inferioridade, acompanhada por sentimentos de vergonha, culpa e fracasso; (iii) dificuldades em manter relacionamentos interpessoais e de se sentir ligado aos outros. Estudos no domínio da saúde mental indicam diferenças de género, sugerindo que os elementos do sexo feminino tendem a experienciar significativamente mais acontecimentos adversos traumáticos do que os elementos do sexo masculino, apresentando também maior comprometimento da saúde mental (Alisic et al., 2014; Collin-Vézina et al., 2011; Fischer et al., 2016; Greeson et al., 2011; Gutterswijk et al., 2022; Hetzel-Riggin & Roby, 2013; Jozefiak et al., 2016).

Devido a estas condições, a maioria das crianças e jovens em acolhimento residencial apresenta problemas em vários domínios e contextos de vida (Briggs et al., 2012; Leloux-Opmeer et al., 2016; Tarren-Sweeney, 2008). A nível da saúde mental, estudos conduzidos em diversos países indicam uma maior incidência, severidade e comorbidade de problemas de internalização e de externalização (Cousins et al., 2010; Duppong-Hurley et al., 2017; Fernández-Daza & Fernández-Parra, 2013; González-García et al., 2017; Greger et al., 2015; Jozefiak et al., 2016; Leloux-Opmeer et al., 2016; Luke et al., 2014; Magalhães & Calheiros, 2014; Mota et al., 2016; Schmid et al., 2008; Tarren-Sweeney, 2008), maior probabilidade de efetuar tentativas de suicídio (Evans et al., 2017; Greger et al., 2015), e maior risco de enveredar por percursos desviantes (Ryan et al., 2008), comparativamente a crianças e jovens colocadas em outras respostas dos serviços de proteção ou que vivem com as suas famílias. Tem sido ainda apontada uma incidência significativa de comportamentos perturbados da vinculação (Bakermans-Kranenburg et al., 2011; Garcia Quiroga & Hamilton-Giachritsis, 2016; Lecannelier et al., 2014; Silva, 2011) e consequentes dificuldades interpessoais (Crawford, 2006; Lino & Nobre-Lima, 2017). De acordo com a investigação, estas devem-se não só às experiências precoces adversas, atrás mencionadas, como também às experiências atuais vivenciadas em contexto de acolhimento residencial, tais como a inexistência de um cuidador preferencial, ausência de visitas da família, à precariedade da prestação de cuidados, e a múltiplas transferências de CAR (Silva, 2011). A nível da saúde mental, têm sido também descritas diferenças de género. Jovens

do sexo feminino em CAR tendem a manifestar níveis mais elevados de psicopatologia do que jovens do sexo masculino, apresentando também maior risco de tentativas de suicídio (Bronsard et al., 2011). Por comparação com crianças de outros contextos, as crianças e jovens em acolhimento residencial tendem a padecer de pior saúde física e pior qualidade de vida, a apresentar maior prevalência de dificuldades de aprendizagem, pior aproveitamento escolar e maior risco de exclusão escolar (Crawford, 2006; Fernández-Daza & Fernández-Parra, 2013; Greger et al., 2016; Leloux-Opmeer et al., 2016; Melkman et al., 2016; Parry et al., 2022).

Deste modo, crianças e jovens em acolhimento apresentam necessidades múltiplas e complexas, em diversos contextos de vida (e.g., pessoal, social, familiar, escolar, comunitário). Considerando as trajetórias de vida e a privação emocional a que foram sujeitos, as necessidades biossociais de afeto, proximidade, proteção, segurança e autonomia destas crianças e jovens, podem não ter sido adequadamente atendidas (Jenney, 2020). Estas crianças tendem a ser hipervigilantes a potenciais situações de perigo, desconectadas dos outros e tendem também a experienciar níveis elevados de vergonha, sentindo-se fundamentalmente inadequadas e indignas de ser amadas (Sieff, 2017). Estas características individuais, derivadas de um modo de sobrevivência face ao trauma, poderão dificultar o estabelecimento de relações que promovam um sentimento de segurança, necessário ao seu desenvolvimento saudável e facilitam a perpetuação de ciclos interpessoais disfuncionais que mantém as dificuldades associadas ao trauma (Sellers et al., 2020; Sieff, 2017). Por um lado, a hipersensibilidade e hipervigilância a estímulos potencialmente ameaçadores, faz com que estas crianças e jovens ativem facilmente estados internos e comportamentos automáticos que visam a sua proteção (Cook et al., 2005). Por exemplo, estas crianças tendem a interpretar comportamentos neutros como hostis e a reagir de forma automática a determinadas expressões faciais (e.g., irritação), o que pode desencadear comportamentos agressivos ou reações defensivas associadas ao trauma (Ford et al., 2010; Gaskill & Perry, 2011; Pollak, 2008). Tendem, ainda, a apresentar um enviesamento seletivo da atenção para sinais sociais de ameaça, como crítica, humilhação ou rejeição, em detrimento de sinais de segurança e de suporte emitidos pelos outros (Gilbert et al., 2003). As pessoas com quem se relacionam poderão facilmente ser percecionadas como potencial fonte de ameaça (Gilbert, 2003), comprometendo a procura de calor e segurança junto dos outros, enquanto estratégia inata para a regulação do afeto (Perry, et al., 1995), e recorrendo, ao invés, a estratégias comportamentais pouco flexíveis e disfuncionais (e.g., agressão, isolamento, comportamentos autolesivos). A desconexão e a vergonha podem também dificultar o estabelecimento de relações com os outros, uma vez que, na sua perspetiva, a proximidade aos outros poderá expor as inadequações do próprio (Sieff, 2017). Deste modo, a prestação de

cuidados nas CAR pode desencadear diferentes estados internos (e.g., medo, resistência) na criança, que poderão interferir na qualidade da ligação entre criança e cuidadores e na regulação adequada das emoções e comportamentos da criança (Bretherton & Munholland, 2016). Outros fatores, como a perceção de rotura relacional, perda ou rejeição por parte da família, que apesar de disfuncional, é sinónimo de pertença, podem comprometer a aceitação da medida de acolhimento (Mota et al., 2016). A resistência face ao acolhimento e à prestação de cuidados pode dificultar a colaboração com os atuais cuidadores (Luke et al., 2014), sendo um desafio para quem cuida destas crianças e jovens, protegê-los de comportamentos de risco e promover o seu desenvolvimento e bem-estar.

4. O papel dos cuidadores no processo de acolhimento

O processo de promoção e proteção deve garantir a recuperação física e psicológica das crianças e jovens, permitindo que as mesmas processem as suas perdas e recuperam do trauma (Garcia Quiroga & Hamilton-Giachritsis, 2016; Guerra, 2022). Este processo requer, não só, compreender e integrar as experiências que se carregam do passado, como também vivenciar experiências saudáveis no presente (Sieff, 2017). De acordo com a literatura, o trauma desenvolvido em contexto interpessoal requer reparação relacional (Gharabaghi, 2019; Treisman, 2017). Complementarmente às intervenções psicológicas desenhadas para indivíduos expostos a situações traumáticas (e.g., Terapia Cognitivo-Comportamental Focada no Trauma, Dessensibilização e Reprocessamento através dos Movimentos Oculares; Leenarts et al., 2013), o processo de recuperação psicológica de crianças e jovens em acolhimento deve também contemplar o estabelecimento de relações seguras com figuras de referência atuais (Hummer et al., 2010; Luke et al., 2014; Sellers et al., 2020; Tarren-Sweeney, 2008).

De acordo com a investigação, o estabelecimento de relações de qualidade entre crianças e cuidadores é fundamental para o desenvolvimento de competências emocionais, sociais e comportamentais da criança (Huefner & Ainsworth, 2021; Wright et al., 2019). Neste contexto, entende-se como relações de qualidade, aquelas que envolvam proximidade, apoio, afeto, sentimentos de calor e de confiança entre o cuidador e a criança ou jovem (Pinheiro et al., 2022; Silva et al., 2021). Estes tipos de relações encontram-se associadas a um melhor ajustamento psicossocial e académico, níveis mais elevados de bem-estar e qualidade de vida e à redução de problemas comportamentais da criança e eventuais efeitos iatrogénicos do acolhimento (Cederbaum et al., 2017; Duppong-Hurley et al., 2017; Farmer et al., 2017a; Ferreira et al., 2020; Li & Julian, 2012; Luke et al., 2014; Magalhães & Calheiros, 2017; Melkman et al., 2016; Mota et al., 2016). Paralelamente, a qualidade destas relações encontra-se

positivamente associada ao sentimento de segurança reportado por crianças e jovens em CAR (Sellers et al., 2020; Slaatto et al., 2023). Deste modo, o potencial terapêutico das CAR reside na capacidade de os cuidadores estabelecerem relações afetivas com as crianças e jovens e na sua sensibilidade e responsividade às necessidades manifestas pelos mesmos. Esta relação disponibiliza não só um refúgio seguro para apaziguar a criança/jovem e ajudá-la a lidar com a adversidade, como uma base segura para promover o seu crescimento, aprendizagem, autonomia e projeto de vida (Briggs et al., 2012; Garcia Quiroga & Hamilton-Giachritsis, 2016; Jackson et al., 2019; Lecannelier et al., 2014; Sellers et al., 2020; Zegers et al., 2006). A qualidade da prestação de cuidados e da interação que o cuidador estabelece com a criança é considerada tão ou mais importante do que a qualidade das instalações físicas da CAR (McCall & Groark, 2015).

Nesta perspetiva, os cuidadores têm um papel fundamental enquanto agentes de mudança (Holmes et al., 2018; Li & Julian, 2012; NICE, 2015), devendo assumir não só funções educativas, mas também terapêuticas (Bastiaanssen et al., 2014; Knorth et al., 2010; Moses, 2000; Garcia Quiroga & Hamilton-Giachritsis, 2016). Para além de exercerem uma função assistencialista, que satisfaça as necessidades básicas das crianças e jovens (e.g., abrigo, alimentação, higiene) e de gestão comportamental (i.e., estabelecer rotinas, limites, disciplina), os cuidadores devem proporcionar suporte, conforto, afeto e segurança (Huefner & Ainsworth, 2021). Considerando que as CAR podem acolher utentes de faixas etárias diversas (e.g., 0 aos 25 anos), às quais correspondem tarefas desenvolvimentais específicas (Erikson & Erikson, 1998), os cuidadores devem ter capacidade de reconhecer as diferenças individuais de cada criança e jovem, de modo a poderem responder de forma individualizada e desenvolvimentalmente apropriada às necessidades afetivas, emocionais e relacionais daqueles de quem cuidam (Bastiaanssen et al., 2012; Huefner & Ainsworth, 2021; Seti, 2008). Para além disso, através da relação que estabelecem com a criança ou jovem, os cuidadores devem facilitar o desenvolvimento de competências pessoais, sociais e de autonomia, bem como competências de regulação emocional, ajudando a criança/jovem a identificar as suas emoções e motivando a mesma para utilizar estratégias adequadas de regulação emocional, inclusive enquanto modelos de autorregulação (Holmes et al., 2018; Whittaker et al., 2016).

A investigação indica que a qualidade das relações estabelecidas entre cuidador e criança/jovem depende não só de características individuais do cuidador (e.g., ser caloroso, empático, disponível, atento e responsivo), como de fatores organizacionais da CAR como, por exemplo, a cultura e o clima organizacionais (Ferreira et al., 2020; Glisson & Green, 2011; Pinheiro et al., 2022; Silva et al., 2021). Cultura organizacional refere-se às expectativas e

normas comportamentais que orientam o trabalho (e.g., hierarquia, envolvimento dos colaboradores na tomada de decisão). O clima organizacional refere-se à perceção dos colaboradores relativamente à qualidade do ambiente social do local de trabalho e como o mesmo impacta o seu próprio funcionamento e bem-estar (Glisson et al., 2012). Um clima que envolva suporte e pouco conflitos, combinado com uma cultura organizacional que estabeleça funções bem definidas, facilita as condições necessárias para o estabelecimento de relações de qualidade, encontrando-se também associado a melhores resultados dos serviços (Colton & Roberts, 2007; Gilsson, 2010; Pinheiro et al., 2022; Silva et al., 2021).

O conceito de clima social é semelhante ao conceito anterior, referindo-se a outra dimensão organizacional também destacada na literatura, devido ao seu contributo potencial para maximizar os resultados das CAR (Costa et al., 2019; Leipoldt et al., 2019). O clima social pode ser definido como o conjunto de condições materiais, sociais e emocionais, de um dado contexto, que exerce influência nos indivíduos que partilham esse contexto (Moos, 2003; Leipoldt et al., 2018). O clima social de uma CAR encontra-se relacionado com características dos próprios cuidadores (e.g., tempo de serviço, nível de responsividade), e com a formação contínua proporcionada aos mesmos, bem como com características dos jovens (e.g., trauma e acolhimentos prévios; Leipoldt et al., 2019). É considerado positivo ou aberto, quando os cuidadores são responsivos e calorosos, promovem oportunidades de desenvolvimento, num ambiente seguro e estruturado, no qual as crianças e cuidadores se respeitam mutuamente (Leipoldt et al., 2019). Para promover a motivação para a aprendizagem e a mudança, o clima social da CAR deve satisfazer as necessidades básicas de competência, relação interpessoal e autonomia das crianças e dos jovens (Deci & Ryan, 2000; Strijbosch et al., 2014). O clima é considerado negativo ou repressivo quando existe assimetria de poder, pouca autonomia, penalizações e agressividade recorrente e ausência de respeito mútuo (Moos, 2012; Strijbosch et al., 2014). Um clima repressivo encontra-se associado a stress, medo, desconfiança e menos empatia entre cuidadores e jovens (Strijbosch et al., 2014), bem como a piores correlatos de saúde física e mental nas crianças e jovens (Hermenau et al., 2017).

Considerando que o clima de uma casa ou organização se organiza em torno de emoções, deve ser também considerado o conceito de clima emocional. Este refere-se à perceção da qualidade das interações sociais e emocionais num determinado contexto, refletindo a forma como os membros se sentem nesse mesmo contexto (de Rivera & Paez, 2007). Num clima emocional seguro, os padrões interpessoais da criança ou jovem podem ser mais facilmente regulados, através do estabelecimento de relações seguras e saudáveis com os

cuidadores, para serem, posteriormente, generalizados para outros contextos com maior facilidade (Moses, 2000).

Apesar da relevância atribuída aos fatores sociais e contextuais (Wright et al., 2019), o número elevado de crianças e jovens que cada cuidador tem a seu encargo limita, frequentemente, a prestação de cuidados às funções assistencialistas básicas (e.g., alimentação, higiene), sendo esses cuidados prestados usualmente de forma superficial, sem interação individualizada (McCall & Groark, 2015). Para além disso, a fim de manter a ordem e controlar problemas de oposição e de comportamento, a intervenção nas CAR encontra-se frequentemente focada na administração de contingências (Bastiaanssen et al., 2012; Eenshuistra et al., 2019). Apesar deste tipo de intervenção poder fomentar comportamentos socialmente desejáveis durante o tempo de acolhimento, corre o risco de focar a intervenção maioritariamente na redução de comportamentos indesejáveis, reduzindo a ênfase na promoção de alternativas adequadas e, a longo prazo, tende a não promover alterações no funcionamento interno da criança ou jovem (Bastiaanssen et al., 2012; Rijo et al., 2017). Paralelamente, junto de determinados jovens, esse tipo de intervenção pode suscitar maior resistência e incrementar os problemas de externalização, uma vez que pode desencadear sentimentos de revolta e de vergonha (Bastiaanssen et al., 2014; Rijo et al., 2017). O foco excessivo no controlo comportamental, sem atender à satisfação das necessidades afetivas, emocionais e sociais necessárias à recuperação do jovem (Muhamedrahimov et al., 2004; Pereira, 2009), encontra-se associado a piores resultados da medida de acolhimento (Harder, 2018) e, em última instância, à retraumatização e/ou perpetuação da situação de negligência (Vashchenko et al., 2010; Zelechoski et al., 2013).

Em sentido oposto, quando o modelo de intervenção das CAR adota uma abordagem terapêutica, que enquadre uma visão compreensiva do trauma e das suas sequelas, o comportamento da criança/jovem passa a ser compreendido não como um "mau comportamento", mas como uma estratégia desenvolvida para lidar com as experiências adversas e respetivo sofrimento, que pode ter sido anteriormente útil, ainda que no contexto atual possa ser pouco adaptativo ou desajustado (Briggs et al., 2012; Hodgdon et al., 2013; Jackson et al., 2019). Nesta perspetiva, a intervenção diária e eventuais momentos de crise, são momentos privilegiados para a promoção de competências sociais e de regulação emocional e comportamental, devendo o foco da intervenção estar maioritariamente colocado nos correlatos emocionais, e não exclusivamente no comportamento em si (Huefner & Ainsworth, 2021; Rijo et al., 2017). Para este fim, os cuidadores deveriam estar preparados e capacitados para fazer do seu estilo relacional um veículo privilegiado de mudança, possuindo para esse

efeito um conjunto de competências pessoais e interpessoais e de regulação emocional e comportamental (Huefner & Ainsworth, 2021; Rijo et al., 2017). Esta abordagem deveria ser encarada a nível organizacional, de forma que todos os colaboradores possam agir de modo consistente, tendo em vista o desenvolvimento de modelos relacionais mais adaptativos, promotores de regulação emocional e de bem-estar mental.

Apesar da investigação sugerir que intervenções baseadas em evidência apresentam melhores resultados no processo de acolhimento (De Swart et al., 2012), o uso de modelos de intervenção e de práticas baseadas em evidência científica continua a ser escasso nas CAR (James et al., 2017; Rodrigues & Barbosa-Ducharne, 2017). Um estudo recente (Sellers et al., 2020), indicou que um terço das crianças e jovens em acolhimento referiu que nunca ou muito raramente se sente seguro. Estes resultados aparentam dever-se não só a características individuais da criança, mas sobretudo a fatores organizacionais das CAR, encontrando-se o sentimento de segurança fortemente associado à perceção que a criança tem sobre a qualidade da relação estabelecida com o cuidador (Sellers et al., 2020). Neste sentido, um outro estudo indicou que apenas metade dos jovens em acolhimento conseguiu identificar um cuidador significativo com quem estabelece uma relação de proximidade e confiança (Campos et al., 2019). Estas lacunas e as dificuldades mencionadas na investigação expõem ameaças à qualidade da prestação de cuidados nas CAR.

5. Desafios e exigências do trabalho em contexto de acolhimento residencial: Ameaças à qualidade da prestação de cuidados

Para além das dificuldades já referidas, relativas à ausência de modelos e de práticas baseadas em evidência que orientem a prestação de cuidados, o próprio trabalho em contexto de acolhimento residencial revela-se, por si só, muito exigente (Eenshuistra et al., 2019; Steels & Simpson, 2017; Wilke et al., 2020). Os cuidadores são diariamente confrontados com situações complexas e emocionalmente intensas, num ambiente de trabalho imprevisível e com poucos recursos disponíveis (Lizano & Mor Barak, 2012; Raskin et al., 2015; Smith et al., 2019). Por um lado, estes profissionais prestam cuidados a crianças e jovens que carregam histórias de vida marcadas por experiências traumáticas, contatando com as histórias dramáticas por detrás do trauma vivenciado. Adicionalmente, a prestação de cuidados exige gerir crises derivadas dos problemas emocionais e de comportamento manifestados pelas crianças e jovens. Durante a prestação de cuidados, os cuidadores correm o risco de ser expostos a agressões verbais e/ou físicas, perpetradas pelos utentes que são normalmente resistentes ao acolhimento e às suas regras, à intervenção e, sobretudo, a deixarem-se cuidar (Bürgin et al., 2020; Eenshuistra et al.,

2019; Kind et al., 2018; Molnar et al., 2017; Seti, 2008; Smith et al., 2019; Winstanley & Hales, 2015). Por outro lado, as próprias características de funcionamento das CAR, como o trabalho por turnos, o desequilíbrio no rácio de cuidadores por utente e os poucos recursos disponíveis (humanos, financeiros, materiais), acarretam sobrecarga de trabalho (Eenshuistra et al., 2019; Hermon & Chahla, 2019; Lizano & Mor Barak, 2012; Rodrigues & Barbosa-Ducharne, 2017; Seti, 2008; Smith et al., 2019), trabalho esse que, na generalidade, é mal remunerado (Barford & Whelton, 2010; Eenshuistra et al., 2019). Para além do exposto, é ainda frequentemente reportada a falta de suporte dos colegas e das chefias e a existência de conflitos interpessoais nas equipas (Del Valle et al., 2007; Santos et al., 2023a), o que se repercute num clima organizacional negativo. Este pode, por sua vez, afetar o bem-estar dos cuidadores, o funcionamento da equipa e, em última instância, ter um impacto nocivo na qualidade dos cuidados prestados e no próprio funcionamento dos jovens (Brown et al., 2013; Glisson, 2007).

Cumulativamente, as elevadas exigências e as precárias condições de trabalho podem originar insatisfação e desmotivação laboral, bem como níveis elevados de stress ocupacional e síndromes laborais, como *burnout*, Stress Traumático Secundário (STS) e/ou stress empático, comumente denominado por fadiga da compaixão (Eastwood & Ecklund, 2008; Del Valle et al., 2007; Hermon & Chahla, 2019; Klimecki & Singer, 2012; Leake et al., 2017; Santos et al., 2023a; Seti, 2008; Wilke et al., 2020; Winstanley & Hales, 2015). O stress empático ocorre quando o cuidador internaliza o sofrimento do utente e não dispõe de recursos adequados para lidar com o mesmo, sentindo-se emocionalmente sobrecarregado (Figley, 1995; Klimecki, 2015). Apesar de este processo ser recorrentemente apelidado como fadiga da compaixão na literatura, de acordo com estudos da área das neurociências, este processo envolve a ativação de zonas e redes neuronais distintas daquelas ativadas pela compaixão, indicando que este processo é melhor designado como stress empático (Hofmeyer et al., 2020). O stress empático refere-se, assim, à ativação de uma reposta emocional aversiva ao sofrimento, acompanhada pelo desejo de se afastar e desconectar das pessoas em sofrimento, com o objetivo de proteger o próprio cuidador (Singer & Klimecki, 2014).

Ao cuidar de pessoas que experienciaram situações traumáticas, estes profissionais podem ainda desenvolver STS. Este quadro é caracterizado pelo desenvolvimento de sintomas semelhantes à perturbação de stress pós-traumático, em indivíduos expostos a histórias traumáticas das pessoas de quem cuidam (Figley, 1995). Já o *burnout* é uma síndrome que resulta da exposição prolongada a fatores de stress crónico (e.g., emocionais e interpessoais) no trabalho, e pode ser caracterizado por exaustão emocional, cinismo, negatividade e despersonalização face aos utentes, sentimento de ineficácia, falta de realização e satisfação

com o trabalho (Maslach et al., 2001). Enquanto o *burnout* pode afetar profissionais de todas as áreas, o stress empático e o STS são mais comumente experienciados por profissionais que lidam e/ou cuidam de pessoas em sofrimento ou com trauma (Duarte & Pinto-Gouveia, 2017). Estas condições psicológicas debilitam o funcionamento psicológico (e.g., comprometem o bem-estar), físico (e.g., afetam o sistema imunitário) e social (e.g., conflitos interpessoais) do cuidador, encontrando-se associadas a baixas médicas mais frequentes, despedimentos e elevada rotatividade de colaboradores nas CAR (Del Valle et al., 2007; Hermon & Chahla, 2019; Krueger, 2007; Leake et al., 2017; Lizano & Mor Barak, 2012; Seti, 2008; Smith et al., 2019; Tuithof et al., 2017). No sentido oposto dos quadros associados ao stress laboral, encontra-se o conceito de satisfação por compaixão, que é caracterizado pela satisfação e realização profissional resultante da prestação de cuidados (Stamm, 2010). A satisfação por compaixão tem sido considerada um fator atenuante e de resiliência face às condições psicológicas atrás descritas (Baugerud et al., 2018; Samios et al., 2013).

Às dificuldades psicológicas mencionadas, acresce frequentemente sintomatologia ansiosa e depressiva (Muhamedrahimov et al., 2004; Raskin et al., 2015). Conjuntamente, estas condições afetam não só a qualidade de vida do próprio cuidador, assim como a qualidade dos cuidados prestados e a saúde mental dos próprios utentes (Bürgin et al., 2020; Cederbaum et al., 2017). O estado psicológico e de humor do cuidador limita a sua disponibilidade, sensibilidade e capacidade de atender às necessidades das crianças e jovens, comprometendo a prestação de cuidados, mais concretamente junto de utentes mais exigentes (de Schipper et al., 2008; Hamre & Pianta, 2004; Hodgdon et al., 2013). Paralelamente, a perceção de incapacidade em situações de maior tensão ou agressividade encontra-se associada a uma diminuição da perceção de autoeficácia e a aumento do stress. Quando os cuidadores se sentem emocionalmente exaustos e desconectados, podem estabelecer ciclos interpessoais negativos face a comportamentos de oposição e agressividade dos jovens (Winstanley & Hales, 2015). Se, por um lado, estes ciclos podem deteriorar o estado psicológico do cuidador (Winstanley & Hales, 2015), por outro, nestas circunstâncias são recorrentemente adotadas estratégias mais autoritárias e repressivas (e.g., contenções físicas, coerção, intimidação), que comprometem o estabelecimento de relações seguras e de um ambiente terapêutico (Cimmarusti & Gamero, 2009; Huefner & Ainsworth, 2021). Para além de aumentar a resistência dos jovens, pois invalidam as suas emoções e necessidades, este tipo de estratégias pode ativar memórias traumáticas e subsequentes reações, exacerbando a sintomatologia e a desregulação emocional e comportamental do jovem (Cimmarusti & Gamero, 2009; LeBel et al., 2010), o que se associa a piores resultados no acolhimento (Farmer et al., 2017a).

Outro problema vigente nas CAR diz respeito ao nível de formação profissional dos cuidadores. A baixa escolaridade dos profissionais (nomeadamente das equipas educativas) e a ausência de formação especializada oferecida aos mesmos, são desajustadas face ao nível de exigência e complexidade requerido na prestação de cuidados a estas crianças e jovens (Garcia Quiroga & Hamilton-Giachritsis, 2017; Seti, 2008). Perante a falta de formação especializada e de um modelo de intervenção e práticas baseadas em evidência (James et al., 2017; Rodrigues & Barbosa-Ducharne, 2017), os cuidadores tendem a utilizar as suas próprias referências educativas e estilos parentais, podendo surgir diferentes opiniões relativamente à melhor forma de cuidar destas crianças e jovens (Cimmarusti & Gamero, 2009; Steels & Simpson, 2017). Isto pode acarretar dificuldades no estabelecimento de regras consistentes e coerentes e consequentes problemas de gestão comportamental, instabilidade e inconsistência na prestação de cuidados (Steels & Simpson, 2017).

Dado o papel-chave dos cuidadores no processo de acolhimento, o desequilíbrio entre a exigência dos cuidados e a formação profissional dos cuidadores pode acarretar sérias implicações para a qualidade da resposta de acolhimento (Garcia Quiroga & Hamilton-Giachritsis, 2017; Hamre & Pianta, 2004). Neste sentido, é fulcral disponibilizar formação especializada aos cuidadores com o intuito de lhes oferecer modelos comuns de leitura e intervenção face às necessidades das crianças e jovens, bem como estratégias adequadas de regulação emocional para prevenir o desgaste emocional e o declínio da qualidade da prestação de cuidados (NCTSN, 2016; van Gink et al., 2018; Winstanley & Hales, 2015).

6. A eficácia dos programas para cuidadores das casas de acolhimento residencial: Contributos de estudos de revisão sistemática

6.1 Carências na formação especializada

Sendo o acolhimento residencial uma medida para salvaguardar a proteção das crianças e promover os seus direitos, é fundamental que as CAR ofereçam um serviço de qualidade, que assegure cuidados adequados e que promovam interações positivas necessárias ao desenvolvimento das crianças e dos jovens (Pereira, 2009). A elevada prevalência de problemas de vinculação, trauma complexo e problemas de saúde mental entre as crianças e jovens acolhidos, implica que lhes sejam prestados cuidados especializados e intervenções específicas, sendo importante ajudar os cuidadores a atender às necessidades complexas destas crianças (Luke et al., 2014).

Em alguns países, incluindo Portugal, a maioria dos profissionais das equipas educativas possui baixas habilitações escolares e ausência de treino para o desenvolvimento das suas funções (Rodrigues & Barbosa-Ducharne, 2017; Seti, 2008; Steels & Simpson, 2017). Este fator é especialmente preocupante, considerando que estes profissionais são aqueles que normalmente prestam cuidados diretos às crianças e jovens e que passam mais tempo em contacto com os mesmos (Sellers et al., 2020). Não obstante, de modo a não comprometer a prestação de cuidados e a assegurar o funcionamento contínuo das CAR, os membros das equipas educativas são frequentemente impedidos de participar em formações (Brown et al., 2013; James et al., 2017).

A qualidade da prestação de cuidados e os resultados da medida de acolhimento, encontram-se, em parte, associadas ao nível de formação dos profissionais das CAR (Boel-Studt & Tobia, 2016; De Swart et al., 2012; Farmer et al., 2017a; Furnival, 2011; Knorth et al., 2010). Segundo orientações internacionais (FICE et al., 2007; NICE, 2015; ONU, 2010), para garantir a qualidade do processo de acolhimento, os profissionais devem estar qualificados e beneficiar de condições laborais adequadas, devendo receber treino e suporte que facilite e assegure uma ligação afetiva e responsiva às necessidades da criança ou do jovem. Neste campo, a investigação indica que formações/treinos destinadas à promoção de práticas coerentes entre os profissionais de todas as equipas das CAR apresentam melhores resultados, comparativamente a treinos dirigidos a profissionais de categorias específicas (Bunting et al., 2019). Todos os profissionais (incluindo os diretores técnicos), independentemente da sua função, deveriam partilhar do mesmo modelo compreensivo de prestação de cuidados, incluindo assunções sobre os fatores subjacentes ao comportamento da criança e ao trauma, fatores precipitantes de comportamentos agressivos ou de episódios de crise, de forma a prevenir o uso de estratégias repressivas de gestão comportamental, como a contenção física, e a atender adequadamente às necessidades emocionais e sociais das crianças e jovens (Greene et al., 2006; Schmid et al., 2020). Por outro lado, dadas as exigências relativas ao trabalho com esta população específica, é fundamental que os cuidadores possam regular as suas emoções de um modo saudável, não só para conseguirem empatizar e cuidar adequadamente das crianças e jovens, mas sobretudo para poderem manter o seu próprio bem-estar (NCTSN, 2016).

6.2 Contributos da investigação e de revisões sistemáticas prévias

A investigação tem alertado para a necessidade de desenvolver ou adaptar programas de treino/intervenção, que promovam não só competências profissionais e relacionais dos cuidadores, mas também a sua saúde mental (Hermenau et al., 2017; Lizano & Mor Barak, 2012;

Steels & Simpson, 2017; Vashchenko et al., 2010; van Gink et al., 2018). Para responder a estas necessidades, têm sido desenvolvidos programas dirigidos a profissionais com os seguintes objetivos: (i) facilitar a gestão do stress, emoções e exigências associadas à prestação de cuidados; (ii) melhorar o comportamento, desenvolvimento e saúde mental das crianças e jovens abrangidas pelo sistema de proteção; e (iii) fomentar mudanças sistémicas na intervenção das organizações dirigidas a crianças em risco.

Com o objetivo de facilitar o *coping* com o stress e com as exigências associadas à prestação de cuidados, têm sido desenvolvidos e adaptados programas destinados a profissionais de diferentes áreas (e.g., Dunn et al., 2007; Vieira Santos, 2004). Perry e colaboradores (2020) realizaram uma *scoping review* para sintetizar a evidência em torno das intervenções destinadas a promover inteligência emocional em profissionais dos serviços de proteção de crianças e jovens. Esta revisão integrou 18 estudos (publicados entre 2003 e 2018). Os autores concluíram que, apesar das intervenções integrarem componentes que aparentam ser eficazes (e.g., treino de mindfulness), os estudos foram maioritariamente conduzidos apenas com estudantes, e não com profissionais a exercer prática profissional (Perry et al., 2020).

Noutro eixo, têm sido desenvolvidos programas com o objetivo de ajudar os profissionais de diferentes respostas sociais do sistema de proteção da infância e juventude a responder de forma adequada aos comportamentos da criança e a melhorar a saúde mental da mesma (e.g., Vanschoonlandt et al., 2012). Revisões sistemáticas indicam que grande parte dos programas existentes são dirigidos para cuidadores da área do acolhimento familiar ou membros da família alargada (Everson-Hock et al., 2011; Fergeus et al., 2017; Kerr & Cossar, 2014; Kinsey & Schlosser, 2012). Os resultados reportados por estas revisões sistemáticas foram inconsistentes. A revisão sistemática conduzida por Fergeus e colaboradores (2017) incluiu 82 estudos e concluiu que os programas dirigidos a cuidadores apresentam resultados promissores. A revisão sistemática conduzida por Kerr & Cossar (2014) integrou 10 estudos e indicou que existe alguma evidência associada a melhorias comportamentais apenas em crianças mais novas. Outras duas revisões sistemáticas, uma com 6 estudos (Everson-Hock et al., 2011) e outra com 30 (Kinsey & Schlosser, 2012), indicaram que o treino de cuidadores tem um impacto limitado no comportamento, bem-estar e saúde mental das crianças.

No que diz respeito a programas de treino/intervenção dirigidos a profissionais que trabalham em contexto de acolhimento residencial, foram conduzidas três revisões sistemáticas com o objetivo de sintetizar e avaliar a eficácia dos programas existentes (Eenshuistra et al., 2019; Hermenau et al., 2017; Morison, 2018). Hermenau e colaboradores (2017) pretenderam avaliar a eficácia das intervenções que incluem mudanças estruturais na instituição (e.g., rácio

de crianças por cuidador) e treino aos cuidadores relativamente a indicadores de desenvolvimento da criança. Esta revisão sistemática integrou 24 estudos (publicados entre 1956 e 2014), conduzidos com crianças institucionalizadas, com idades compreendidas entre as 4 semanas e os 16 anos. Os resultados indicaram que apenas sete estudos apresentavam um modelo teórico de base, sendo a teoria da vinculação o modelo mais recorrente. Apenas três intervenções dispunham de um manual e apenas dois estudos conduziram ensaios clínicos aleatorizados. Apesar das limitações metodológicas dos estudos, os autores concluíram que o treino dos cuidadores, juntamente com mudanças estruturais e ambientes estimulantes na CAR, têm potencial para melhorar as condições de vida das crianças em acolhimento e apresentam benefícios para o seu desenvolvimento. A maioria dos estudos foi, no entanto, conduzido com bebés ou crianças até aos 8 anos e poucos estudos avaliaram o impacto das intervenções ao nível da relação entre cuidadores e crianças e no clima da instituição (Hermenau et al., 2017).

A revisão sistemática conduzida por Eenshuistra e colaboradores (2019) pretendeu explorar o impacto dos programas nas competências dos cuidadores. Incluiu 12 estudos (publicados entre 1988 e 2015), dos quais constavam nove programas de treino/intervenção para cuidadores. A maioria dos programas tinha como objetivo treinar competências e incrementar conhecimento. Apenas um estudo apresentou um desenho experimental, e a maioria utilizou um desenho pré-pós intervenção, sem grupo de controlo. A maioria dos estudos pretendeu promover competências gerais dos cuidadores (e.g., atitudes, conhecimento, confiança), e apenas três reportaram resultados ao nível do ambiente de trabalho (e.g., satisfação com o trabalho e suporte). Apesar de alguns programas terem revelado efeitos positivos ao nível de características profissionais dos cuidadores e no ambiente de trabalho, os autores concluíram que a evidência em torno dos mesmos era limitada (Eenshuistra et al., 2019).

A revisão sistemática conduzida por Morison (2018) pretendeu sintetizar e examinar a eficácia dos programas em indicadores psicossociais dos cuidadores e dos jovens em acolhimento. Foram incluídos estudos conduzidos em países em desenvolvimento, com metodologia quantitativa, tendo sido analisados 18 estudos (publicados entre 1975 e 2016). Os resultados indicaram que a maioria dos estudos incluiu uma intervenção manualizada, mas apenas um estudo conduziu um estudo experimental. Nove estudos focaram-se em resultados dos cuidadores, dois em resultados dos jovens e sete estudos incluíram resultados de cuidadores e dos jovens. Os resultados mostraram que os programas apresentavam objetivos heterogéneos e que a avaliação dos efeitos dos mesmos se focava maioritariamente em competências (e.g., comunicação, resolução e problemas e conflitos), conhecimento (e.g., trauma), e atitudes (e.g., confiança, segurança) dos cuidadores e nos problemas de comportamento das crianças. A

autora concluiu que a eficácia dos programas era dúbia, devido às limitações metodológicas dos estudos.

Ainda no âmbito dos programas de treino para profissionais das casas de acolhimento, face às extensas críticas e consequências desenvolvimentais associadas à colocação de bebés e crianças em orfanatos (McCall & Groark, 2015), têm sido adaptados programas de competências parentais, com o objetivo de fomentar a ligação emocional entre crianças e cuidadores e uma prestação de cuidados individualizada (e.g., Programa Desenvolver a Sorrir; Pereira, 2009), bem como para reduzir problemas de comportamento das crianças (e.g., Anos Incríveis; Silva, 2013). Um outro estudo adicionou uma componente de suporte emocional a cuidadores, que revelou indicadores positivos para o funcionamento psicológico dos mesmos e desenvolvimento e comportamento das crianças (Çatay & Koloğlugil, 2017). Na sua globalidade, apesar de revelarem resultados positivos em termos de parentalidade positiva, desenvolvimento infantil e decréscimo nos comportamentos de desobediência, estes programas procuram atender às necessidades de bebés e crianças (0 aos 12 anos), não englobando as necessidades desenvolvimentais dos adolescentes e dos desafios colocados a quem deles cuida.

Numa perspetiva de intervenção organizacional, foram desenvolvidos programas que pretendem promover mudanças sistémicas em vários níveis da organização (Bailey et al., 2019; James et al., 2017). Apesar destas intervenções apresentarem filosofias de base e princípios orientadores diversos, são abordagens maioritariamente focadas na redução do trauma (e.g., The Sanctuary Model, Bloom, 2005; Attachment, Self-Regulation and Competency Framework - ARC, Kinniburgh et al., 2005; Children and Residential Experiences – CARE, Izzo et al., 2016), dirigidas para todos os agentes das organizações (e.g., administradores, psicólogos, monitores, professores). Estes programas são normalmente compostos por componentes diversas, aplicadas em diferentes níveis/sistemas (e.g., treino dos colaboradores, avaliação dos casos, políticas da organização, liderança; Hodgdon et al., 2013). Dada a multiplicidade de componentes que fazem aumentar a complexidade destes programas, a sua implementação em contexto ecológico das CAR e respetiva avaliação, via ensaios clínicos aleatorizados, tem-se revelado de difícil execução, comprometendo a evidência em torno da eficácia dos mesmos (Esaki et al., 2013; James, 2017; Raymond, 2020). De facto, várias revisões sistemáticas que procuraram analisar a evidência empírica destes programas em diferentes respostas sociais de proteção de crianças e jovens, concluíram que, apesar dos estudos sugerirem resultados positivos em indicadores das crianças (Bailey et al., 2019), conhecimento, atitudes e comportamento dos cuidadores (Purtle, 2020) e saúde mental e emocional das crianças e

redução do stress dos cuidadores (Bunting et al., 2019), a evidência científica em torno destes programas é limitada, devido à fraca robustez das metodologias de investigação utilizadas.

Face ao exposto, apesar de existirem vários programas disponíveis para profissionais dos serviços de proteção de crianças e jovens, ainda é pouco o que se sabe acerca da eficácia de programas de treino especificamente dirigidos aos profissionais das CAR, que tenham como objetivo promover saúde mental e emocional no acolhimento e nos seus agentes (jovens e cuidadores).

6.3 Revisão sistemática da literatura sobre programas dirigidos a cuidadores e destinados à promoção da saúde emocional e mental nas casas de acolhimento residencial

Como já foi salientado acima, os profissionais das CAR carecem de treino para intervir e cuidar de crianças e jovens que experienciaram acontecimentos traumáticas e que, por isso, apresentam problemas graves de saúde mental (Steels & Simpson, 2017). Paralelamente, dada a exigência emocional deste trabalho, para cuidar destas crianças e jovens, os cuidadores deveriam também ser cuidados (Krueger, 2007). Por esse motivo, os profissionais deveriam receber treino que lhes forneça estratégias de regulação emocional (Garcia Quiroga & Hamilton-Giachritsis, 2017). Por último, o clima da CAR poderá ser melhorado com intervenções que envolvam todos os profissionais da CAR e otimizem as relações entre eles (Brown et al., 2013; Glisson, 2007). A combinação destas vertentes poderá facilitar a qualidade dos cuidados interativos, e otimizar a responsividade dos cuidadores, a fim de responder adequadamente às necessidades das crianças e jovens em acolhimento e otimizar a qualidade da resposta de acolhimento (Garcia Quiroga & Hamilton-Giachritsis, 2016).

Para conhecer e analisar os programas de intervenção/treino disponíveis para profissionais destas instituições, cujo objetivo se direcione para a promoção da saúde emocional e mental nas CAR, foi realizada uma revisão sistemática da literatura no âmbito da presente tese (Capítulo 4 desta tese; Santos et al., 2023c).

Esta revisão sistemática focou-se em programas de treino/intervenção que tivessem como objetivo promover saúde emocional ou mental diretamente nos cuidadores ou indiretamente nas crianças e jovens em acolhimento. Apesar de existirem revisões sistemáticas prévias, as mesmas debruçaram-se sobre outros indicadores (e.g., competências profissionais, conhecimentos) e apresentam limitações metodológicas (e.g., incluem várias respostas do sistema de proteção, incluem apenas estudos com metodologia quantitativa e programas desenvolvidos em países desenvolvidos; Eenshuistra et al., 2019; Everson-Hock et al., 2011; Fergeus et al., 2017; Morison, 2018; Perry et al., 2020; Purtle, 2020), podendo por isso excluir

potenciais estudos de relevo nesta área. Para permitir a comparação de estudos, a presente revisão sistemática excluiu programas organizacionais com múltiplos componentes, uma vez que seria difícil discriminar se a sua eficácia se deveria exclusivamente ao treino dos cuidadores (Purtle, 2020). Foram também excluídos estudos conduzidos em casas destinadas ao acolhimento de bebés e crianças pequenas, devido às especificidades desenvolvimentais dessa população. A descrição detalhada da metodologia e dos resultados desta revisão sistemática pode ser consultada nos capítulos 3 e 4, respetivamente.

Esta revisão sistemática incluiu 17 estudos publicados entre 2003 e 2021. Os estudos incluídos são heterogéneos no que respeita as abordagens e objetivos dos programas, desenhos de investigação, medidas e resultados obtidos.

A maioria dos programas tinha como objetivo desenvolver competências dos cuidadores para: (i) compreender e responder às necessidades dos jovens (Cameron & Das, 2019; Griffing et al., 2021; Hidalgo et al., 2016; Nunno et al., 2003; Schmid et al., 2020); (ii) funcionar como agentes terapêuticos (Donald, 2015); (iii) aprender estratégias de gestão comportamental (Barnett et al., 2018; Hurley et al., 2006; Nunno et al., 2003); (iv) reduzir sintomatologia e tentativas de suicídio dos jovens (Hermenau et al., 2015; Osteen et al., 2018; Silva & Gaspar, 2014). Paralelamente, alguns programas pretendiam dar suporte aos cuidadores (Barnett et al., 2018; Griffing et al., 2021) e melhorar a sua regulação emocional e bem-estar (Hidalgo et al., 2016; Schmid et al., 2020; Turner, 2017; Vallejos et al., 2016). Alguns dos programas pretendiam ainda melhorar as dinâmicas socias, incluindo a relação entre cuidadores e crianças ou entre membros das equipas (Hidalgo et al., 2016; Izzo et al., 2016; van Gink et al., 2018; Wahl, 2011), e melhorar a qualidade da prestação de cuidados (Hermenau et al., 2015).

Poucos estudos mencionaram, de forma clara, o modelo conceptual dos programas. Os modelos mais comumente utilizados foram a Teoria Social Cognitiva (Berridge et al., 2016; Silva & Gaspar, 2014; Turner, 2017) e a Teoria da Vinculação (Barnett et al., 2018; Cameron & Das, 2019, Silva & Gaspar, 2014). Apesar de não apresentarem um modelo teórico de base, vários estudos abrangiam princípios focados no trauma (Barnett et al., 2018; Cameron & Das, 2019; Griffing et al., 2021; Hidalgo et al., 2016; Izzo et al., 2016; Schmid et al., 2020). As seguintes abordagens ou técnicas foram incluídas em alguns programas: (i) técnicas comportamentais (Berridge et al., 2016; Hurley et al., 2006; Nunno et al., 2003; Silva & Gaspar, 2014; van Gink et al., 2018); (ii) mindfulness ou exercícios de meditação (Griffing et al., 2021; Schmid et al., 2020; Turner, 2017; Vallejos et al., 2016); (iii) psicologia positiva (Wahl, 2011); (iv) abordagem lúdica (Donald, 2015; Hidalgo et al., 2016).

Os programas incluídos foram aplicados, na maioria, em formato de grupo, e o número de sessões variou entre três (Osteen et al., 2018) e 20 sessões (Vallejos et al., 2016). A duração dos programas variou entre três dias (Osteen et al., 2018) e um ano (Cameron & Das, 2019). Apenas sete estudos reportaram usar um programa manualizado (Donald, 2015; Griffing et al., 2021; Hermenau et al., 2015; Izzo et al., 2016; Nunno et al., 2003; Silva & Gaspar, 2014; Turner, 2017), dificultando a reprodução desses estudos por outros investigadores e comprometendo a integridade do tratamento.

Relativamente ao desenho de investigação, nenhum estudo conduziu um ensaio clínico aleatorizado. A maioria dos estudos (76.47%) não incluiu grupo de controlo e apenas sete incluíram avaliação de *follow-up*, que variou entre seis semanas (Donald, 2015) e 36 meses (Schmid et al., 2020). No que diz respeito à amostra, a maioria dos estudos incluiu apenas autorrelato de cuidadores. Poucos estudos integraram os jovens como informantes (Berridge et al., 2016; Hermenau et al., 2015; Vallejos et al., 2016). Mais de metade dos estudos apresentou amostras reduzidas ($n < 50$), dificultando o recurso a métodos estatísticos robustos. Uma parte dos estudos procurou integrar métodos de avaliação quantitativos e qualitativos. No entanto, algumas medidas não se encontravam validadas ou eram pouco fiáveis (Barnett et al., 2018; Berridge et al., 2016; Cameron & Das, 2019; Griffing et al., 2021; Nunno et al., 2003; Schmid et al., 2020) e o método de análise de dados qualitativos não se encontrava devidamente descrito (Barnett et al., 2018; Berridge et al., 2016; Griffing et al., 2021; Hermenau et al., 2015; Nunno et al., 2003), dificultando a compreensão do tratamento de dados e a fiabilidade dos resultados obtidos.

Tal como em outras revisões sistemáticas de programas com profissionais do sistema de proteção (Everson-Hock et al., 2011; Morison, 2018; Perry et al., 2020), os resultados sugerem a existência de evidência limitada relativamente à eficácia dos programas avaliados.

Relativamente aos resultados dos estudos focados em indicadores dos cuidadores, alguns programas evidenciaram efeitos positivos no stress e condições psicológicas associadas (Hidalgo et al., 2016; Schmid et al., 2020; Turner, 2017; van Gink et al., 2018), empatia (Donald, 2015; Silva & Gaspar, 2014), confiança (Berridge et al., 2016; Nunno et al., 2003) e autoeficácia (Osteen et al., 2018). Os poucos estudos que testaram a manutenção dos efeitos ao longo do tempo reportaram manutenção e melhorias relativas: (i) ao desempenho do papel de gestor de caso (Osteen et al., 2018) e em competências de empatia (Silva & Gaspar, 2014) 6 meses após a intervenção; (ii) trauma vicariante e saúde mental, 12 meses após a intervenção (Hidalgo et al., 2016); (iii) nível psicofisiológico de stress, 36 meses após a intervenção (Schmid et al., 2020).

Relativamente aos estudos que se focaram em indicadores dos jovens, a maioria centrou-se na ocorrência de incidentes críticos (Barnett et al., 2018; Hidalgo et al., 2016; Hurley et al., 2006; Izzo et al., 2016; Nunno et al., 2003; Schmid et al., 2020; Wahl, 2011) ou no comportamento dos jovens (Berridge et al., 2016; Donald, 2015; Hermenau et al., 2015). Estes indicadores aparentemente diminuíram durante a implementação do programa e mantiveram essa tendência 12 (Barnett et al., 2018; Hidalgo et al., 2016) e 36 meses (Schmid et al., 2020) após a intervenção dirigida aos cuidadores. Apenas três estudos incluíram indicadores referentes a problemas de internalização ou de bem-estar dos jovens (Cameron & Das, 2019; Hermenau et al., 2015; Vallejos et al., 2016). O estudo conduzido por Hermenau e colaboradores (2015) parece ser o mais completo e promissor, indicando que os problemas de externalização e internalização dos jovens reduziram passados três meses da intervenção dirigida aos cuidadores.

Indicadores organizacionais, como o clima (organizacional, social ou emocional), não foram reportados em nenhum dos estudos. Outras revisões sistemáticas reportaram também a escassa atenção dada a este tipo de variáveis (Hermenau et al., 2017; Perry et al., 2020). Alguns dos estudos incluídos na presente revisão sistemática analisaram a qualidade das relações, indicando melhorias na relação entre cuidadores e crianças/jovens (Berridge et al., 2016; Cameron & Das, 2019; Donald, 2015; Hermenau et al., 2015; Hidalgo et al., 2016; Vallejos et al., 2016) e entre colegas de trabalho (Berridge et al., 2016; Griffing et al., 2021; van Gink et al., 2018). Porém, estudos com métodos mistos reportaram inconsistência entre os resultados qualitativos e quantitativos (Berridge et al., 2016; Donald, 2015; Vallejos et al., 2016).

Na leitura destes resultados é importante considerar que, tal como em outras revisões sistemáticas de programas conduzidos no contexto do sistema de proteção (Bailey et al., 2019; Bunting et al., 2019; Eenshuistra et al., 2019; Everson-Hock et al., 2011; Hermenau et al., 2017; Morison, 2018; Purtle, 2020), a maioria dos estudos incluídos nesta revisão sistemática apresenta limitações metodológicas, que podem enviesar os resultados e limitar a sua generalização (CRD, 2009; Kazdin, 2003). Entre as principais limitações destaca-se: (i) escassez de intervenções manualizadas; (ii) indefinição do modelo conceptual ou modelos teóricos comportamentais; (iii) o uso de desenhos de investigação pouco robustos, sem grupo de controlo, nem aletorização ou avaliação em *follow-up*; (iv) uso de medidas de avaliação não validadas ou pouco fiáveis; (v) ausência de medidas de autorrelato dos jovens, bem como de variáveis interpessoais e sobre o clima da CAR. Todas estas limitações tornam difícil retirar conclusões robustas sobre a eficácia dos programas avaliados.

Em conclusão, apesar de ser um contexto direcionado para a prestação de cuidados a crianças e jovens vulneráveis, que apresentam necessidades complexas, as disparidades entre as práticas utilizadas e a investigação são recorrentes, levantando questões éticas não negligenciáveis (James et al., 2017; Morison, 2018). Programas baseados em evidência desenvolvidos com o objetivo de atender às necessidades emocionais não só dos jovens, como dos próprios cuidadores, continuam a ser escassos. É por isso necessário que sejam desenvolvidos programas manualizados, especificamente desenhados para o contexto de acolhimento residencial (Daly et al., 2018). Os futuros programas devem estabelecer uma ligação clara entre modelos teóricos e a prática, de modo a facilitar a reflexão das equipas com base num modelo empiricamente testado (Morison, 2018). A eficácia dos programas deverá ser testada via ensaios clínicos aleatorizados, que incluam múltiplos informantes e variáveis individuais, relacionais e organizacionais, recolhidas ao longo do tempo (i.e., *follow-up*) (Bailey et al., 2016; Brown et al., 2012; Eenshuistra et al., 2019; Perry et al., 2020; Purtle, 2020).

7. Síntese

Face a crises sociais e políticas em todo o mundo, um número significativo de crianças e jovens carecem de cuidados alternativos que assegurem a sua proteção, desenvolvimento integral e bem-estar (Briggs et al., 2012; Collin-Vézina et al., 2011; Garcia Quiroga & Hamilton-Giachritsis, 2016). O acolhimento residencial é uma das medidas de proteção e promoção do sistema de proteção de crianças e jovens em perigo (Guerra, 2022). Apesar do acolhimento residencial ser considerado uma medida de último recurso, a mesma continua a ser globalmente executada (Boel-Studt & Tobia, 2016; Jackson et al., 2019; James, 2017; McCall & Groark, 2015; UNICEF, 2010; Vashchenko et al., 2010; Wright et al., 2019).

Devido à alteração do perfil de crianças e jovens em acolhimento e às necessidades múltiplas e complexas evidenciadas pelas mesmas, as normas internacionais em torno da qualidade dos cuidados alternativos têm recomendado que as CAR disponibilizem ambientes terapêuticos complementares às intervenções psicológicas (Whittaker et al., 2016).

Neste contexto, os profissionais das CAR são considerados agentes ativos no processo de mudança (Holmes et al., 2018; Li & Julian, 2012). Enquanto figuras de referência, podem modelar dinâmicas relacionais e estratégias de regulação emocional saudáveis (Huefner & Ainsworth, 2021). Isto pressupõe que sejam capazes de identificar adequadamente as necessidades das crianças e jovens, de ter uma visão compreensiva das suas experiências de vida e do modo como as mesmas afetam a sua resposta emocional e comportamental. Todavia, as exigências de trabalho deste contexto específico, aliadas à falta de formação especializada

dos profissionais, podem comprometer não só a qualidade da prestação de cuidados, bem como o bem-estar e qualidade de vida profissional dos cuidadores, acarretando efeitos negativos para os próprios e para o funcionamento e resultados das CAR (Bürgin et al., 2020; Middleton & Potter, 2015).

Para colmatar estas dificuldades, tem sido recomendado que as organizações disponibilizem formação contínua e treino aos seus colaboradores, a fim de responderem adequadamente às necessidades expressas pelas crianças e jovens e de atender simultaneamente às necessidades de saúde mental do próprio cuidador (NCTSN, 2016). Revisões sistemáticas da literatura sobre a eficácia de programas dirigidos a cuidadores das CAR revelam que os programas existentes são maioritariamente dirigidos ao treino de competências gerais dos cuidadores (Eenshuistra et al., 2019; Morison, 2018). A revisão sistemática conduzida no âmbito desta tese (Santos et al., 2023c) indica que os programas especificamente dirigidos para o autocuidado dos cuidadores continuam a ser escassos. A maioria dos programas existentes com preocupações ao nível da promoção e manutenção da saúde emocional e mental nas CAR, direciona-se para a melhoria de comportamento dos jovens, não englobando as necessidades complexas manifestadas pelos mesmos. Em conclusão, as revisões sistemáticas da literatura indicam que os programas existentes não cobrem as necessidades expressas na literatura da área e apresentam limitações metodológicas consideráveis (Eenshuistra et al., 2019; Morison, 2018; Santos et al., 2023c). Para colmatar esta lacuna, este trabalho de investigação propôs desenvolver e testar, através de um ensaio clínico aleatorizado por clusters, um treino destinado a cuidadores que constitua uma nova abordagem na prestação de cuidados das CAR baseada na afiliação e na compaixão.

Capítulo 2

O Programa de Treino da Mente Compassiva para Cuidadores: Bases conceptuais, estrutura e conteúdos

1. Introdução

O processo de evolução da espécie humana, retratado por Charles Darwin no livro "A Origem das Espécies" (1859), foi durante muito tempo interpretado e absorvido pela consciência coletiva popular sob o paradigma da sobrevivência do mais forte. Esta interpretação influenciou vários movimentos sociais e corporativistas ao longo do último século e meio. No entanto, sabe-se hoje que ocupar um lugar hierárquico de topo acarreta consequências indesejáveis (Hare & Woods, 2020). Por exemplo, a investigação animal indica que estar no topo da hierarquia se encontra associado a maior stress, pior funcionamento do sistema imunitário e a piores níveis de saúde (Sapolsky, 2005). O comportamento agressivo apresenta também custos associados, uma vez que a resposta comportamental de luta aumenta a probabilidade de se ser ferido ou morto. Por outras palavras, ser o mais forte pode implicar ter uma vida desagradável, conflituosa e mais curta (Gesquiere et al., 2011).

À luz das interpretações modernas da obra de Darwin, compreende-se hoje que o autor se referia não à seleção natural do mais forte, mas do mais apto para garantir a descendência e assegurar a sobrevivência da espécie (Kurzban et al., 2015). Na verdade, nos seus relatos, Darwin revelava-se constantemente impressionado com manifestações de cooperação observadas na natureza, tendo escrito que as comunidades compostas por membros simpáticos tenderiam a florescer e a criar maior número de descendentes (Darwin, 1871). Muitos dos seus seguidores documentaram a importância da amabilidade e cooperação para o florescimento e sobrevivência da espécie humana (Hare, 2017; Kurzban et al., 2015). De facto, para os nossos antepassados, a integração numa rede social coesa foi crucial para a sua sobrevivência (e.g., caçar em grupo, defender contra predador, prestar cuidados; Spikins et al., 2010). Decorrente do processo evolutivo, na atualidade, a ligação aos outros faz-nos sentir seguros, sendo a afiliação um comportamento inato derivado do nosso instinto de sobrevivência (Sieff, 2017).

A investigação contemporânea sugere que o sucesso da evolução da espécie humana poderá ser atribuído às competências pró-sociais únicas do ser humano, como a cooperação, reciprocidade, empatia, compaixão, que permitiram ao *Homo Sapiens* e seus antepassados viver em grupo (Hare, 2017; Hare & Woods, 2020; Spikins et al., 2010). Estas competências fazem de nós, uma espécie altamente social e dependente dos outros (Singer & Klimecki, 2014). Por exemplo, as crias humanas nascem neurobiologicamente imaturas e totalmente dependentes de um cuidador, que as nutra e proteja (Kurzban et al., 2015; Perry et al., 1995; Sieff, 2017). A necessidade de cuidar de uma cria vulnerável terá conduzido a várias adaptações no processo evolutivo dos mamíferos e, particularmente, no ser humano. Os progenitores desenvolveram comportamentos de proximidade às crias, com a atenção dirigida para manifestações de stress

e necessidades das mesmas, protegendo-as, alimentando-as, acalmando-as e confortando-as (Gilbert, 2015b). No curso da evolução, os mecanismos por detrás da prestação de cuidados foram estendidos a outros relacionamentos sociais, sobre a forma de estabelecimento de alianças com membros do grupo e com estranhos (Hare & Woods, 2020). Para além disso, e contrariamente aos outros animais, ao longo da vida o ser humano continua a carecer de cuidados de terceiros para poder prosperar e sobreviver, como por exemplo quando adoece ou envelhece (Spikins et al., 2010). A compaixão apresenta assim uma base evolucionária, cuja função passa pela proteção dos mais fracos ou dos que se encontrem em sofrimento (Goetz et al., 2010). Deste modo, desde o dia em que nascemos até ao dia em que morremos, o estabelecimento de vínculos sociais, a compaixão e a prestação de cuidados são requisitos essenciais para a sobrevivência humana (Gilbert, 2015a).

É sob a lente das abordagens evolucionárias, integrada com conhecimentos de diferentes disciplinas (neurociência, vinculação, teoria das mentalidades sociais e a filosofia budista), que Paul Gilbert, desenvolve a Terapia Focada na Compaixão (TFC, Gilbert, 2010a, 2014). No modelo subjacente à TFC, a compaixão é entendida como uma motivação evolutiva para lidar com o sofrimento humano. Sofrimento refere-se a uma experiência dolorosa de outra pessoa ou a uma dificuldade experienciada pelo próprio (Gilbert, 2015b, 2017a). De acordo com o autor, o sofrimento humano deriva de fatores biopsicossociais associados ao funcionamento evolutivo do cérebro humano, à genética e ao meio onde o indivíduo se insere (Gilbert, 2017a).

Segundo esta perspetiva, o cérebro humano é produto de um longo processo evolutivo. Tendo em vista a sobrevivência e prosperidade da espécie, o cérebro humano encontra-se equipado para responder a potenciais ameaças (Gilbert, 2017a). De acordo com a teoria evolutiva proposta por MacLean (1990), o cérebro humano pode ser dividido em três partes que exibem diferentes funções evolutivas. O cérebro reptiliano (composto pelo tronco cerebral e cerebelo), o cérebro paleomamífero (correspondente ao sistema límbico) e o cérebro neomamífero (relativo ao neocórtex). O cérebro reptiliano e o paleomamífero compõem o cérebro velho, e o cérebro neomamífero é denominado por cérebro novo (Gilbert, 2010a; MacLean, 1990).

As estruturas mais primitivas do cérebro velho, correspondentes ao cérebro reptiliano, são comuns a várias espécies, incluindo o ser humano. Estas estruturas cerebrais ativam reações e comportamentos automáticos, universais e instintivos face a potenciais ameaças. Mecanismos de sobrevivência associados a estas estruturas cerebrais, como comportamentos defensivos, reprodutivos e de aquisição de recursos, são fundamentais para a preservação das espécies (Gilbert, 2010a; MacLean, 1990). O cérebro velho integra também componentes do cérebro

paleomamífero, que surgiu e coevoluiu há cerca de 120 milhões de anos juntamente com os mamíferos. Estas estruturas mais arcaicas facilitam comportamentos sociais de prestação de cuidados e de formação de alianças, fundamentais para a sobrevivência de espécies que nascem imaturas e carecem de cuidados de terceiros, da qual é exemplo particular a cria humana (Gilbert, 2010a; Kurzban et al., 2015; Perry et al., 1995). A integração da prestação de cuidados acarretou alterações profundas no sistema nervoso, que adaptaram a regulação de repostas de luta ou de fuga à proximidade aos outros. Deste modo, as relações sociais conquistaram um papel evolutivamente relevante no processo de regulação emocional do ser humano (Depue & Morrone-Strupinsky, 2005).

O neocórtex refere-se à camada cerebral mais recentemente desenvolvida no curso da evolução (cérebro novo), sendo característica específica do ser humano e de alguns mamíferos, como os primatas. O cérebro novo é sofisticado e anatomicamente complexo. É responsável por competências intelectuais e de inteligência social e emocional, únicas ao ser humano, tais como a autoconsciência, a capacidade de raciocínio abstrato, de imaginação, planeamento, empatia, metacognição, bem como de ruminação, antecipação de dificuldades, autocrítica e emoções autoconscientes (e.g., vergonha, culpa; Gilbert, 2014, 2017b).

Apesar do ser humano possuir competências intelectuais complexas, associadas ao cérebro novo, a mente humana continua também conectada ao instinto de sobrevivência do cérebro velho. Este incentiva-nos a evitar potenciais perigos, a procurar recursos (e.g., comida e abrigo), a formar relações de vinculação com os progenitores, a desenvolver alianças com amigos e a integrar grupos, bem como a competir por estatuto social e por parceiros sexuais (Gilbert, 2017a). Reações a potenciais ameaças externas (e.g., rejeição, exclusão social) e/ou internas (e.g., autocrítica) podem espoletar ciclos de pensamentos-emoções (*loops*) derivadas de conflitos entre o cérebro velho (emoção) e o cérebro novo (lógica; Gilbert, 2010a, 2014; MacLean, 1990). Estes ciclos podem conduzir à perpetuação de estados de stress ou de sofrimento psicológico (Gilbert, 2010a, 2020).

Adicionalmente aos fatores evolucionários acima descritos, e de acordo com esta perspetiva, o funcionamento psicológico do indivíduo resulta de interações genéticas (i.e., genótipo) e ecológicas (Gilbert, 2010b, 2017a). Ao integrar conhecimentos da teoria da vinculação (Bowlby, 1982), este modelo reconhece que a relação estabelecida com o cuidador primário (i.e., mãe ou outra figura de vinculação) nos primeiros anos de vida influenciará o neurodesenvolvimento e o fenótipo do indivíduo (Gilbert, 2010b, 2017a). Por exemplo, indivíduos que tenham crescido num ambiente seguro e estável, nutridos com cuidados e amor, tendem a ser mais abertos, cooperantes, a confiar nos outros e a apresentar melhores índices

de saúde mental e de bem-estar. Indivíduos que tenham crescido em ambientes hostis, pautados por episódios de abuso e negligência, tendem a desenvolver fenótipos defensivos e focados na ameaça, que influenciam a forma como os mesmos percecionam e respondem ao meio (Gilbert, 2017a). Crianças que não tenham tido oportunidade de experienciar relações seguras e de suporte face à adversidade, tendem a ativar recursos inatos para assegurar a sua sobrevivência. Se as redes neuronais responsáveis pelos mecanismos de sobrevivência foram consistentemente ativadas nos primeiros tempos de vida, tendem a tornar-se hipersensíveis, comparativamente a outras áreas do cérebro, como o córtex pré-frontal, que medeia as funções executivas responsáveis pela capacidade de gerir pensamentos, emoções e comportamentos (Jackson et al., 2019). Deste modo, diversos quadros de psicopatologia poderão ser compreendidos como reações adaptativas e naturais a determinados fatores ambientais a que o indivíduo foi exposto ao longo dos primeiros anos de vida (Gilbert, 2017a).

O racional sobre a interação entre estes fatores biopsicossociais integra a psicoeducação na TFC, de forma a que o indivíduo compreenda que o sofrimento faz parte da condição humana e que o mesmo deriva de fatores inerentes a essa condição, não sendo esse sofrimento "culpa sua". Considerando que a mente humana passou por um longo processo evolutivo, no qual se adaptou para ser regulada através da afiliação, a TFC procura estimular os sistemas afiliativos para ajudar o indivíduo a apaziguar o sofrimento psicológico, seu e dos outros (Gilbert, 2010a, 2017a).

Neste capítulo serão apresentadas as bases conceptuais e conceitos chave na abordagem proposta pela TFC, da qual deriva o Treino da Mente Compassiva para Cuidadores (TMC-C). É sucintamente descrita e explanada a aplicação de abordagens baseadas na compaixão em contextos clínicos e laborais. Por fim, é fundamentado o desenvolvimento de um programa de treino da mente compassiva para o contexto de acolhimento residencial e feita uma breve descrição da finalidade, estrutura e conteúdos do programa desenvolvido no âmbito deste trabalho de investigação.

2. A Teoria das Mentalidades Sociais: A importância da Mentalidade Afiliativa

Devido à necessidade da integração do ser humano em grupos, no decorrer do processo de evolução, a mente humana integra diferentes motivos sociais (e.g., sexual, competitivo, colaborativo, prestação de cuidados) que operam através de padrões dinâmicos de interação recíproca e que têm sido denominados de mentalidades sociais (Gilbert, 2014, 2015b, 2017a). A Teoria das Mentalidades Sociais foi proposta por Gilbert (2010a), com base na teoria junguiana dos arquétipos e em conhecimentos da psicologia evolucionária, social e do desenvolvimento.

Mentalidades sociais são sistemas internos que geram padrões de atenção, emoção, cognição e comportamento, que orientam o indivíduo para estabelecer e manter papéis inatos e específicos de relacionamento interpessoal essenciais à sua sobrevivência, tais como procurar cuidados e proteção, cuidar, cooperar, copular e competir (Gilbert, 2017b). Especificamente, estas mentalidades organizam a mente do indivíduo e guiam o mesmo para criar determinados papéis sociais (e.g., a criança procura conforto e proteção junto da figura de vinculação, os adultos procuram relações de afiliação junto de amigos e relações de dominância junto de rivais), facilitam a interpretação dos papéis sociais que os outros estabelecem com o indivíduo (e.g., os outros são prestativos, amigáveis, competitivos) e orientam as respostas afetivas e comportamentais emitidas pelo indivíduo nas suas interações sociais (e.g., se os outros são amigáveis, aproximamo-nos, se os outros são hostis, evitamo-los ou atacamo-los; Gilbert, 2010b).

Cada mentalidade social organiza a mente humana para estabelecer um determinado papel social. As mentalidades sociais coevoluíram de forma a regularem-se mutuamente, desencadeando comportamentos de reciprocidade. No entanto, diferentes mentalidades sociais podem também entrar em conflito e inibirem-se mutuamente (Gilbert, 2021).

Das mentalidades sociais que têm sido descritas, interessam-nos particularmente, no âmbito deste trabalho de investigação as mentalidades associadas à prestação de cuidados e ao trabalho em equipa.

A mentalidade social afiliativa aglomera a prestação de cuidados e de suporte, ou seja, comportamentos responsivos às necessidades dos outros, encontrando-se associada à mentalidade social de procura de cuidados/proteção (Gilbert, 2021). Ambas têm sido analisadas à luz da teoria da vinculação (Bowlby, 1982). Enquadrada nesta teoria, a mentalidade de procura de cuidados envolve motivação e comportamentos dirigidos para procurar proteção e afeto, com o objetivo de assegurar a manutenção de uma relação de proximidade com alguém que proteja e apoie o indivíduo. Espoleta comportamentos que permitem expressar o desconforto (e.g., vocalizações, choro) de forma a ativar comportamentos compassivos no cuidador, bem como comportamentos responsivos aos sinais de necessidade de cuidados. Complementarmente, a mentalidade afiliativa permite ao(s) outro(s) proteger e dar apoio ao indivíduo que expressa essa necessidade. Envolve competências de investimento, atenção às necessidades dos outros, empatia, afeto e responsividade a essas mesmas necessidades (Gilbert, 2010a). A prestação de cuidados pode ser instrumental, com o objetivo de proteção (e.g., manter livre de perigo) e de provisão de recursos (e.g., comida, higiene), ou emocional, com o objetivo de dar suporte emocional, calor e conforto (Gilbert, 2010b). Uma prestação de

cuidados emocional inclui acalmar, estimular, mediar, socializar e validar a criança (Gilbert, 2010a). Assim, a mentalidade afiliativa ou de prestação de cuidados direciona a atenção do indivíduo para as necessidades dos outros, e os seus pensamentos (e.g., como posso ajudar?), sentimentos (e.g., simpatia, empatia, bondade) e comportamentos (e.g., acariciar, abraçar) são orientados para aliviar o sofrimento ou ajudar o outro (Gilbert, 2010b).

Para sobreviver e prosperar em sociedade, o ser humano precisou de aprender não apenas a cooperar com os outros, mas também a competir por recursos, parceiros e estatuto (Gilbert, 2017a, 2021). Enquanto a mentalidade cooperativa e de formação de alianças inclui a inibição da agressão, competências de partilha e de vida em grupo e comportamentos altruístas, a mentalidade competitiva envolve preocupações com o estatuto social, hierarquia e controlo. A mentalidade competitiva orienta a atenção do indivíduo para a posição social, o pensamento para a comparação social e o comportamento para reagir de acordo com o lugar que ocupa na hierarquia social (e.g., competir, impressionar, submeter, desistir). Quando se encontra sob influência desta mentalidade, o indivíduo tende a demonstrar emoções e comportamentos defensivos relativamente aos outros (e.g., atacar o adversário, impor a sua posição sobre um assunto), inibindo comportamentos de afiliação e de cooperação (Gilbert, 2010b).

O potencial inato destas mentalidades é estimulado pelas experiências culturais e sociais de cada indivíduo (Gilbert, 2017b; Hermanto & Zuroff, 2016). O meio onde o indivíduo cresce influencia os seus motivos, organizando a sua mente de diferentes formas. Por exemplo, quando a procura de cuidados é correspondida e atendida de forma adequada, esse comportamento é reforçado e mantido futuramente na busca de conforto. No entanto, esta dependência do cuidado de terceiros pode tornar o indivíduo vulnerável quando enfrenta negligência e maus-tratos, sendo permeável a condicionamento (Gilbert, 2010b). Para crianças que cresçam num meio hostil, solicitar cuidados e pedir ajuda poderá não ser profícuo ou revelar-se mesmo um comportamento perigoso. Neste caso, a mentalidade social de procura de cuidados pode originar sentimentos de solidão, desconexão, abandono ou insegurança (Gilbert, 2010a). Quando a criança se sente insegura, tende a ativar uma mentalidade focada na ameaça e em dinâmicas competitivas (i.e., mentalidade competitiva). Esta mentalidade social orienta a mente do indivíduo para estar hipervigilante a potenciais ameaças e é focada na comparação social, bem como na emissão de comportamentos defensivos de dominância ou de submissão (Gilbert, 2021; Irons & Gilbert, 2005).

Por sua vez, a mentalidade afiliativa pode encontrar-se limitada devido a stress, fadiga, medo, raiva ou devido a hiperativação de outras mentalidades sociais. A mentalidade

competitiva, autofocada na hierarquia social, tende a diminuir a sensibilidade, preocupação e empatia pelo outro e a inibir o funcionamento da mentalidade afiliativa (Gilbert, 2010a; 2015b).

É de salientar que, derivado às competências humanas associadas ao cérebro novo, estas mentalidades sociais podem ser ativadas não só em relações interpessoais, como também na relação intrapessoal (e.g., como atendo às minhas necessidades, na forma como me trato em situações difíceis; Gilbert, 2017b; Hermanto & Zuroff, 2016). Revelar compacidade de ajustar a mentalidade social consoante as necessidades presentes num contexto específico revela-se um indicador de ajustamento psicológico e de saúde mental (Gilbert, 2010a).

3. A Compaixão: Definição, fluxos e inibidores

A sensibilidade ao sofrimento e a capacidade do ser humano para aprender competências que lhe permitam apaziguar o mesmo são fatores evolucionários fundamentais para a prestação de cuidados. A compaixão emerge da combinação da motivação mamífera para prestar cuidados com as competências cognitivas complexas associadas ao cérebro novo, que permitem ao ser humano compreender e intuir a mente dos outros (Gilbert, 2015b; 2017a, 2019).

Etimologicamente, a palavra compaixão advém da palavra *compati*, em latim, que significa "sofrer com" (Gilbert, 2010a; Strauss et al., 2016). Na literatura moderna, no entanto, a definição de compaixão não é consensual (Mascaro et al., 2020; Strauss et al., 2016). Se, por um lado, subsiste uma confusão conceptual com conceitos como empatia, pena, altruísmo ou bondade (Gilbert, 2015b; Goetz et al., 2010), por outro lado, a definição de compaixão diverge de acordo com a perspetiva teórica adotada (Mascaro et al., 2020).

O conhecimento proveniente de diferentes áreas de estudo permite proceder a uma distinção conceptual. Investigação na área das neurociências indica que a expressão de empatia e de compaixão ativam estruturas cerebrais distintas (Klimeck et al., 2014). A etimologia indica que empatia provem da palavra grega *empatheria,* que significa entrar na experiência do outro (Gilbert, 2015b). Assim, sentir empatia, seja cognitiva ou emocionalmente, não implica um ato intencional de ajuda. Ademais, a empatia não é sentida exclusivamente face a situações que envolvem sofrimento (Pommier, 2011; Strauss et al., 2016). Sentir pena envolve condescendência (Fiske et al., 2002), o que colide com o reconhecimento da universalidade do sofrimento na condição humana, tal como conceptualizado em várias definições de compaixão (Neff, 2003b; Pommier, 2011). O altruísmo e a bondade envolvem ações que englobam um espectro amplo de motivações (Strauss et al., 2016). Para mais, a bondade não se restringe a

situações que implicam sofrimento e um ato compassivo pode não ser gentil e amoroso, mas exigir coragem e força (Gilbert, 2015b).

A literatura é ampla e diversificada no que diz respeito à própria definição do conceito de compaixão (Mascaro et al., 2020). Alguns autores conceptualizam a compaixão como uma atitude (Sprecher & Fehr, 2005), uma emoção (Goetz et al., 2010), uma motivação (Gilbert, 2014) ou como um construto multidimensional (e.g., com facetas cognitivas, afetivas, comportamentais e motivacionais; Jazaieri et al., 2013b; Strauss et al., 2016). A perspetiva Budista define compaixão (em sânscrito, Karunã) como uma qualidade humana que implica sensibilidade ao sofrimento do próprio e dos outros, combinada com um compromisso para o aliviar e prevenir (Dalai Lama, 1995). Esta definição foi adotada pela abordagem evolucionária proposta por Gilbert (2015b, 2017a, 2020), que perspetiva a compaixão como um sistema motivacional enraizado na mentalidade social de prestação de cuidados, também designada por mentalidade afiliativa.

De acordo com esta perspetiva, a compaixão envolve dois processos/componentes psicológicos (Gilbert, 2010b). O primeiro inclui a motivação para se envolver com o sofrimento, implicando estar consciente e abordar o mesmo em vez de o evitar. Este processo envolve seis atributos diferenciados. A motivação para cuidar é o atributo basilar deste processo, sendo interdependente de atributos como a sensibilidade e tolerância ao sofrimento, caracterizados como a capacidade de percecionar a existência de sofrimento e de estar em contacto com o mesmo sem se sentir sobrecarregado ou sobreidentificado. Além disso, ao estar em contacto com o sofrimento, o indivíduo pode sentir-se tocado e comovido (i.e., sentir simpatia) e utilizar competências de empatia, como a tomada de perspetiva ou a mentalização, para tentar compreender a natureza do sofrimento e as suas causas. Por último, o não julgamento implica adotar uma atitude de tolerância, não condenatória do indivíduo em sofrimento (Gilbert, 2015b).

O segundo processo é focado na ação compassiva. Compreende motivação para ser responsivo ao sofrimento, implicando sabedoria e aquisição de competências para poder aliviar e prevenir o mesmo (Gilbert, 2010b). Este processo requer o desenvolvimento de competências compassivas, mais concretamente ao nível da atenção compassiva (e.g., mindfulness), imagética compassiva (e.g., lugar seguro), estimulação de processos psicofisiológicos para ativar sensações e emoções compassivas (e.g., respiração tranquila), pensamento compassivo (e.g., discurso interno autocompassivo) e comportamento compassivo (e.g., ações passivas como acalmar, dar calor e afeto, ou ativas como proteger, cuidar, impedir que faça algo prejudicial; Gilbert, 2015b).

A intenção de aprender competências para aliviar o sofrimento e poder ajudar os outros é específica do ser humano (Gilbert, 2017a).

A compaixão é expressa através de um processo dinâmico sociointerativo que flui em três orientações ou fluxos interdependentes: compaixão em relação aos outros, receber compaixão dos outros e autocompaixão (Gilbert, 2014, 2017a, 2020). De acordo com Neff (2003b), a autocompaixão implica estar aberto ao próprio sofrimento e dirigir sentimentos de calor, bondade e de cuidado ao próprio, numa atitude de compreensão e de não julgamento face aos seus erros e inadequações, reconhecendo simultaneamente essas experiências como parte da condição humana. Segundo a mesma autora (Neff, 2003b, 2009), a autocompaixão engloba três componentes interativas: (i) ser bondoso e compreensivo com o próprio, em vez de autocrítico; ii) perspetivar as dificuldades do próprio como parte da condição humana, em vez de se isolar; e (iii) estar consciente (*mindful*) da experiência e dificuldades do próprio no momento presente, em vez de suprimir, evitar ou se identificar excessivamente com as mesmas.

Dada a natureza e dinâmica e interpessoal da compaixão, diversos estudos têm sugerido que os três fluxos da compaixão podem influenciar-se mutuamente (Gilbert, 2005; Hermanto & Zuroff, 2016). O estudo conduzido por Hermanto & Zuroff (2016) indica que indivíduos que apresentam níveis elevados de compaixão em relação aos outros e maior abertura para receber compaixão dos outros, apresentam igualmente níveis mais elevados de autocompaixão. Os autores concluíram ainda que indivíduos que prestam cuidados a outros, mas que não procuram ou aceitam cuidados dos outros, apresentam níveis deficitários de autocompaixão. Este padrão é consistente com o conceito de prestação compulsiva de cuidados proposto por Bowlby (1977). Outros estudos sugerem que ativar uma motivação compassiva em relação aos outros aumenta os níveis de autocompaixão (Breines & Chen, 2013), sendo o contrário também verdade (Gustin & Wagner, 2013; Neff & Pommier, 2013; Welp & Brown, 2014). Estes resultados são reforçados por estudos na área das neurociências que indicam que, de facto, dirigir compaixão aos outros e ao próprio, ativa circuitos cerebrais semelhantes (Longe et al., 2010).

Apesar da interdependência entre os diferentes fluxos, cada fluxo pode apresentar medos, bloqueios e resistências específicas que inibem a ativação e expressão da compaixão (Gilbert, 2017a; Gilbert et al., 2011; Kirby et al., 2019). Os medos, bloqueios e resistências à compaixão podem ser derivados de limites evolucionários relativos à prestação de cuidados (e.g., discriminação entre familiares/amigos e estranhos/inimigos) ou do próprio contexto social onde o indivíduo se insere (e.g., contexto hostil; Gilbert, 2017a; Hare & Woods, 2020). Medos da compaixão dizem respeito a evitamento ou receio da resposta dos indivíduos à compaixão. Constrangimentos intrapessoais, como o stress ou *burnout*, constrangimentos do meio (e.g.,

falta de tempo, excesso de trabalho, poucos recursos nas organizações, ambientes organizacionais de ameaça) ou falta de conhecimento sobre as causas do sofrimento, são exemplos de bloqueios que inibem a motivação compassiva (Crawford et al., 2014; Dev et al., 2018; Henshall et al., 2018). A resistência à compaixão ocorre quando o indivíduo escolhe não ser compassivo, como por exemplo, por estar focado em motivos competitivos (Beaumont et al., 2016b; Dutton et al., 2014; Kirby et al., 2019).

Cada fluxo da compaixão pode envolver medos específicos. O medo de dar compaixão aos outros envolve dificuldades em expressar uma atitude compassiva em relação aos outros. Este fluxo da compaixão pode ser inibido devido a sentimentos de desprezo em relação ao outro, desconforto ou perceção de incapacidade para lidar com o sofrimento, receio de ser rejeitado, de ser incapaz de ajudar ou receio de aproveitamento por parte de quem seria ajudado (Gilbert et al., 2011; Goetz et al., 2010). Adicionalmente, quando o indivíduo sente que não tem recursos para lidar com o sofrimento dos outros, pode sentir-se stressado e assoberbado. Ocorrências que diminuam a capacidade de regulação emocional do indivíduo, como a fadiga física ou emocional, poderão aumentar a experiência de stress empático face ao sofrimento dos outros (Goetz et al., 2010). Como foi descrito no capítulo anterior, o stress empático caracteriza-se por um sentimento aversivo face ao sofrimento expresso pelo outro, que apresenta uma componente de elevada ativação emocional e preocupações autofocadas (Klimecki et al., 2014). O stress empático pode suscitar evitamento ao sofrimento e, por isso, comprometer a compaixão (Condon & Makransky, 2020).

Medo de receber compaixão dos outros envolve desconforto ou dificuldade de receber cuidados ou apoio de outras pessoas em momentos de dificuldade, podendo ser causado por diferentes motivos (Gilbert et al., 2011). Receber compaixão dos outros pode ser percecionado como uma fraqueza, alguns indivíduos podem achar que não são merecedores de cuidados dos outros, ou recear ficarem dependentes desses cuidados (Gilbert & Procter, 2006). Indivíduos previamente expostos a situações de negligência podem ativar memórias aversivas associadas à falta de cuidados e afeto, que se encontram condicionadas a sentimentos de solidão ou vergonha e responder com uma atitude agressiva, resistência ou evitamento quando são objeto de compaixão dos outros (Gilbert et al., 2011; Gilbert & Procter, 2006; Kirby et al., 2019). O medo de receber compaixão dos outros aparenta estar fortemente relacionado com o medo e resistência à autocompaixão (Gilbert et al., 2011), sendo os fluxos mais suscetíveis de apresentar respostas de medo e evitamento (Gilbert, 2010a).

Medo da autocompaixão envolve dificuldade em expressar uma atitude compassiva em relação ao próprio, em situações que envolvam sofrimento. O medo de se tornar

autocompassivo pode dever-se à crença de não se ser merecedor, ao receio de se sentir sobrecarregado ou de isso levar a baixar as suas exigências e padrões autoimpostos (Gilbert et al., 2011). Pode também estar associado a níveis elevados de autocriticismo e vergonha (Gilbert & Irons, 2004; Gilbert & Procter, 2006; Naismith et al., 2019b). O autocriticismo é uma atitude interna condenatória, dura, hostil e punitiva utilizada em situações de falha e desapontamento pessoal, supostamente com uma função de autoaperfeiçoamento, autodisciplina ou autocorreção (i.e., para manter os padrões do próprio), ou ainda como uma forma de castigar o próprio face às inadequações percecionadas (i.e., autoperseguição/autoataque; Gilbert et al., 2004). O autocriticismo encontra-se relacionado com a emoção autoconsciente de vergonha (Hermanto et al., 2016), que engloba uma avaliação negativa do Eu como inferior, inadequado e indesejável, acompanhada pelo desejo de fugir ou esconder-se (Gilbert, 2010a; Tangney & Tracy, 2012). A vergonha encontra-se associada a medo de intimidade e proximidade com os outros (Lutwak et al., 2003). O autocriticismo e a vergonha têm sido apontados como fatores transdiagnósticos para o desenvolvimento e manutenção de diversas dificuldades psicológicas (Castilho et al., 2010; Hermanto et al., 2016). Particularmente, o autocriticismo tem sido apontado como preditor de piores resultados em diversas terapias (Blatt & Zuroff, 2005; Rector et al., 2000).

Fatores sociodemográficos, como o sexo do indivíduo, podem também influenciar a expressão dos fluxos da compaixão (Dutton et al., 2014). Enquanto os elementos do sexo feminino tendem a ser mais compassivos em relação aos outros (Henshall et al., 2018; Lopez et al., 2018; Pommier, 2011), os elementos do sexo masculino tendem a revelar mais autocompaixão (Yarnell et al., 2015).

Medos da compaixão limitam a capacidade do indivíduo para utilizar os mecanismos de regulação emocional evolutivamente associados à proximidade e ligação aos outros, tornando-o vulnerável ao desenvolvimento de dificuldades psicológicas e problemas de saúde mental (Gilbert, 2010a; Kirby et al., 2019).

4. Contributos da Compaixão para a regulação do afeto, relacionamento interpessoal e saúde mental

Devido aos processos psicofisiológicos envolvidos no comportamento evolutivo de prestação de cuidados, a compaixão apresenta um papel fundamental na regulação do afeto e comportamento social do ser humano (Carter, 2014; Depue & Morrone-Strupinsky, 2005). Gilbert (2015a, 2017a, 2020) propõe um modelo de regulação emocional baseado em conhecimentos da psicologia evolucionária e das neurociências, que inclui o desenvolvimento,

funcionamento e interação de três sistemas de regulação do afeto (i.e., ameaça, procura de recursos, afiliação/apaziguamento), que coevoluíram para assegurar a sobrevivência e prosperidade da espécie humana. Apesar de deterem uma função adaptativa, quando a ativação destes sistemas não se encontra regulada/equilibrada poderá originar dificuldades psicológicas e relacionais (Gilbert, 2015a, 2017a, 2020).

O sistema de ameaça (i.e., *threat system*) tem a função de defesa, proteção e procura de segurança, encontrando-se associado à ativação do sistema nervoso simpático. É responsável pela deteção, processamento e resposta a potenciais ameaças. É sensível a sinais de ameaça (reais ou imaginados), que desencadeiam uma resposta automática de afeto negativo (e.g., medo, raiva, nojo) e um reportório de comportamentos defensivos ativadores (e.g., lutar, fugir, expelir) ou inibidores (e.g., paralisar, submeter-se; LeDoux, 1998). Este sistema é facilmente condicionado, tornando-se hiperativo, sendo capaz de desligar o afeto positivo e capacidades cognitivas associadas à mentalização (e.g., empatia, tomada de perspetiva; Gilbert, 2017a; Klimecki et al., 2014). A ativação excessiva deste sistema encontra-se, por exemplo, associada a sintomatologia ansiosa ou a comportamento agressivo (Gilbert, 2010a).

O sistema de procura de recursos e de recompensas (i.e., *drive system*) motiva o indivíduo para procurar e alcançar os recursos necessários para a sua sobrevivência e prosperidade (e.g., procura de comida, abrigo, relações sociais, parceiros sexuais), sendo mediado pelos sistemas dopaminérgicos. Este sistema é sensível a recursos vantajosos, recompensas e estatuto, emitindo afeto positivo ativador/energizante (e.g., excitação, euforia, prazer, orgulho) e comportamentos de procura, de modo a alcançar e/ou manter esses recursos ou estatuto (Depue & Morrone-Strupinsky, 2005). Quando alcançados os recursos ou estatutos vantajosos, e porque o afeto positivo emitido pela ativação deste sistema tende a ser de curta duração, podem gerar-se comportamentos contínuos e aditivos de procura (Gilbert, 2017a). O sistema de procura pode ser também recorrentemente ativado como estratégia de regulação de afeto negativo associado ao sistema de ameaça, o que poderá causar e manter dificuldades psicológicas ou comportamentais (e.g., perfecionismo, trabalho em excesso, anorexia; Veale et al., 2015). Gilbert (2014) enfatiza ainda que os indivíduos podem ficar presos a ciclos de interação entre os sistemas de ameaça e de procura, que espoletam sentimentos de fracasso, vergonha e autocriticismo. Quando o sistema de procura se encontra subativado, pode conduzir a perdas patológicas de prazer e motivação, tendencialmente associadas a sintomatologia depressiva (Gilbert, 2010b).

O sistema de afiliação/apaziguamento (i.e., *soothing system*) evoluiu juntamente com o sistema de vinculação, encontrando-se associado à ativação do sistema nervoso parassimpático

e à libertação de opiáceos e oxitocina (Carter, 2014; Depue & Morrone-Strupinsky, 2005). Este sistema tem como função regular o afeto negativo e desligar comportamentos de procura quando o indivíduo se encontra a salvo e está saciado (Depue & Morrone-Strupinsky, 2005; Gilbert, 2020). É sensível a sinais verbais e não verbais de cuidados (e.g., abraçar, embalar, tom de voz caloroso, expressão facial amigável) e afiliação. Emite afeto positivo associado a estados de tranquilidade, contentamento, satisfação e bem-estar, decorrentes do sentimento de segurança tranquila (Depue & Morrone-Strupinsky, 2005; Gilbert et al., 2008), uma experiência afetiva de calor e tranquilidade, ativada quando o indivíduo se sente cuidado, serenado e ligado aos outros (Gilbert et al., 2009; Kelly & Dupasquier, 2016). Este sentimento facilita capacidades cognitivas do córtex pré-frontal e de mentalização (Klimecki et al., 2014) e encontra-se associado tanto a comportamentos passivos de relaxamento e de não procura, como a comportamentos ativos de exploração do meio e desenvolvimento (Porges, 2007), ativando, neste caso, o sistema de procura de forma equilibrada.

Os sistemas de regulação do afeto funcionam de forma integrada e interdependente, e a sua maturação e equilíbrio parecem encontrar-se relacionados com condições genéticas e ecológicas (Gilbert, 2010b; Perry et al., 1995). Segundo a literatura, as experiências dos primeiros anos de vida do indivíduo organizam o funcionamento destes sistemas. Comportamentos parentais responsivos, afetuosos e consistentes têm um papel estruturante no desenvolvimento e maturação do sistema de afiliação/apaziguamento (Gilbert, 2017a; Gilbert et al., 2008; Gilbert & Procter, 2006). Relações seguras contribuem para a criação de memórias emocionais de calor e segurança que se ativam em situações de stress e facilitam o autoapaziguamento e a autocompaixão (Boykin et al., 2018; Naismith et al., 2019b; Neff, 2009; Richter et al., 2009). No sentido oposto, indivíduos que não tenham recebido cuidados responsivos e consistentes tendem a apresentar um sistema de tranquilidade subdesenvolvido e um sistema de ameaça proeminente, comprometendo a sua capacidade de autoapaziguamento (Gilbert, 2010b, 2017a; Naismith et al., 2019b; Perry et al., 1995). Consequentemente, tendem a manifestar dificuldades pessoais e interpessoais, bem como dificuldade em sentirem-se seguros nas suas relações atuais e futuras (Gilbert, 2010b, 2015a).

A ativação destes sistemas é sensível a estímulos do contexto ecológico do indivíduo. Deste modo, comportamentos compassivos expressos pelos outros ou pelo próprio têm capacidade de regular/equilibrar estes sistemas (Hermanto & Zuroff, 2016). Por outras palavras, a resposta compassiva de um indivíduo face ao desconforto manifestado por outro pode estimular o sistema de afiliação/apaziguamento, permitindo que o indivíduo se acalme e se sinta seguro (Gilbert, 2017a). No mesmo sentido, uma motivação autocompassiva facilita que o

próprio indivíduo, quando confrontado com acontecimentos difíceis, possa dirigir calor e cuidados a si próprio e ativar o seu sistema de afiliação/apaziguamento, com o intuito de restabelecer o equilíbrio emocional. Deste modo, a autocompaixão pode diminuir estratégias de regulação emocional menos adaptativas tais como a supressão, uma vez que encoraja o envolvimento com as emoções desconfortáveis em vez do evitamento das mesmas (Jazaieri et al., 2013b).

De acordo com o que temos vindo a descrever, a compaixão, nos seus diversos fluxos, tem sido reconhecida como uma estratégia de regulação emocional com benefícios ao nível do bem-estar e da saúde mental (Hermanto et al., 2016; Kelly & Dupasquier, 2016; MacBeth & Gumley, 2012). É notório, na literatura, que ser compassivo com os outros melhora o bem-estar psicológico e a saúde física e mental do próprio indivíduo (Austin et al., 2021; Jazaieri et al., 2013b; Mongrain et al., 2011; Klimecki et al., 2014). A compaixão pode também exercer um papel protetor face ao stress (Pace et al., 2010; Vachon, 2016) e promover afeto positivo (Hutcherson et al., 2008). A investigação indica que indivíduos que exibem níveis mais elevados de compaixão exibem mais comportamentos pró-sociais de ajuda, recompensa, conexão e perdão. Deste modo, a compaixão desempenha um papel importante nas relações de ajuda e cooperação, encontrando-se associada a sentimentos de proximidade e de ligação aos outros, bem como a padrões de relacionamento interpessoal mais saudáveis (Crocker & Canevello, 2017; Hutcherson et al., 2008; Klimecki, 2015). Considerando a dinâmica mútua da compaixão, indivíduos que experienciam receber compaixão dos outros tendem a sentir-se mais seguros para lidar com circunstâncias difíceis (Coan et al., 2013; Cosley et al., 2010) e a revelar melhores indicadores de saúde física e mental (Krokavcova et al., 2008; Smith & Howard, 2008). Já níveis elevados de autocompaixão têm sido sistematicamente associados a menores níveis de stress, ansiedade, depressão e *burnout*, maior bem-estar psicológico e qualidade de vida, bem como a menos problemas interpessoais (Barnard & Curry, 2011; Dev et al., 2018; Kelly et al., 2009; MacBeth & Gumley, 2012; Neef, 2009; Neely et al., 2009; Yarnell & Neff, 2013; Zessin et al., 2015).

5. Intervenções baseadas na Compaixão: Contextos de aplicação

A investigação na área das neurociências indica que o funcionamento do cérebro humano pode ser modelado através de treino mental, sugerindo que o treino da compaixão pode aumentar a capacidade de regulação emocional (Hofmeyer et al., 2020; Klimecki, 2015). Nos últimos 20 anos, tem-se assistido a um aumento crescente do desenvolvimento e implementação de intervenções baseadas na compaixão em diferentes contextos, com o intuito

de aliviar o sofrimento inerente à condição humana e promover o bem-estar dos indivíduos (Kirby et al., 2017). Têm sido desenvolvidas distintas intervenções baseadas na compaixão, com a finalidade de cultivar compaixão pelos outros ou pelo próprio (Kirby, 2017).

De acordo com uma revisão da literatura conduzida por Kirby (2017), existem pelo menos seis tipos de intervenções baseadas na compaixão que demonstraram suporte empírico: (i) Terapia Focada na Compaixão (TFC; Gilbert, 2014); (ii) *Mindful Self-Compassion* (MSC; Neff & Germer, 2013); (iii) *Compassion Cultivation Training* (CCT; Jinpa, 2010); (iv) *Cognitively-Based Compassion Training* (CBCT; Ozawa-de Silva & Negi, 2013); (v) *Cultivating Emotional Balance* (CEB; Ekman & Ekman, 2013); (vi) *Loving-Kindness and Compassion Meditations* (Wallmark et al., 2013). Estas intervenções têm sido aplicadas e testadas com populações clínicas (Galante et al., 2014; Gilbert, 2010a; Hoffman et al., 2011), comunitárias (Desbordes et al., 2021; Galante et al., 2014; Jazaieri et al., 2013b; Kemeny et al., 2012; Neff & Germer, 2013) ou populações com necessidades específicas (Reddy et al., 2013).

Apesar de se tratar de abordagens distintas e que incluem diferentes componentes, estas intervenções partilham características em comum (Kirby, 2017). Por norma, todas combinam uma componente psicoeducativa com exercícios experienciais, tendo por base a filosofia budista tibetana sobre o sofrimento humano (Kirby et al., 2017). Por isso, as sessões dos programas incluem práticas de meditação de bondade amorosa (*loving kindness*) e de atenção plena (*mindfulness*), cuja prática diária é incentivada (Kirby, 2017). As práticas de meditação *loving kindness* implicam dirigir e expressar compaixão e boa vontade a si ou aos outros, com o objetivo de promover mudanças cognitivas, emocionais e comportamentais (Hutcherson et al., 2008). As práticas de *mindfulness* são frequentemente introduzidas com o objetivo de estabilizar a mente e de treinar a atenção (Jinpa, 2010). O conceito de *mindfulness* tem sido definido como uma forma particular de prestar atenção no momento presente, de forma intencional e sem julgamento (Kabat-Zinn, 1994). O *mindfulness* pode ser operacionalizado como a autorregulação da atenção para a experiência vivida no momento presente, implicando abordar a experiência com curiosidade, abertura e aceitação (Bishop et al., 2004). Algumas das componentes destes programas ou intervenções têm sido indicadas como elementos facilitadores para o desenvolvimento da compaixão (Kirby et al., 2019). Neste campo, destaca-se a assiduidade às sessões dos programas (Kirby, 2017; Steindl et al., 2018), a realização de práticas diárias de meditação formal (Galante et al., 2014; Jazaieri et al., 2013a) e a aplicação de competências compassivas na vida diária do indivíduo (e.g., ações compassivas, tom de voz amigável; Kelly et al., 2009; Longe et al., 2010; Steindl et al., 2018).

Entre as abordagens mencionadas, a Terapia Focada na Compaixão (TFC) tem sido a intervenção mais estudada, distinguindo-se das restantes por ser uma psicoterapia integrativa e contributos de várias áreas do conhecimento (Gilbert, 2020; Kirby et al., 2017). A TFC inclui psicoeducação sobre o funcionamento da mente humana e dos sistemas de regulação do afeto segundo uma perspetiva evolucionária, com o intuito de normalizar as dificuldades emocionais experienciadas e compreender as mesmas à luz de uma perspetiva evolucionária e biopsicossocial. Integra também o treino de estratégias que ajudem o indivíduo a lidar com os correlatos derivados da ativação do sistema de ameaça e a equilibrar os sistemas de regulação do afeto, bem como a ultrapassar os medos, bloqueios e resistências à compaixão e a cultivar os diferentes fluxos da compaixão (Gilbert, 2010a, 2019, 2020). A TFC tem sido aplicada em populações clínicas com diferentes diagnósticos, incluindo depressão (Gilbert & Irons, 2004), perturbações alimentares (Gale et al., 2014; Goss, 2014), perturbações da personalidade (Lucre & Corten, 2013), psicoses (Braehler et al., 2013; Laithwaite et al., 2009) ou psicopatia (Ribeiro da Silva et al., 2021; Rijo et al., 2022). Os estudos de revisão sistemática sugerem que a TFC apresenta resultados promissores, nomeadamente em indivíduos com perturbações do humor e de ansiedade (Kirby et al., 2017; Leaviss & Uttley, 2015).

O Treino da Mente Compassiva (TMC) é uma modalidade de intervenção, normalmente aplicada em grupo, que deriva da TFC. Distingue-se da mesma, por não envolver a formulação de casos, não sendo considerado uma psicoterapia (Kirby & Gilbert, 2017). O TMC inclui atividades específicas com o objetivo de desenvolver os atributos e as competências compassivas, conducentes à promoção de uma mentalidade compassiva (Gilbert, 2010a). Envolve normalmente: (i) psicoeducação sobre o funcionamento da mente humana e dos sistemas de regulação do afeto de acordo com uma perspetiva evolucionária; (ii) identificação de estratégias de segurança associadas ao sistema de ameaça e análise funcional do autocriticismo; (iii) desenvolvimento de estratégias atencionais e exercícios de *grounding* (e.g., mindfulness e respiração tranquila); (iv) prática de exercícios de imagética para estimular sensações, emoções e pensamentos compassivos (e.g., desenvolver a imagem do Eu compassivo); (v) treino de comportamentos compassivos (e.g., tom de voz e expressão facial amigável; Kirby & Gilbert, 2017). O TMC foi inicialmente desenvolvido para intervir com indivíduos com níveis elevados de vergonha e autocriticismo, revelando-se eficaz na promoção da capacidade de autoapaziguamento e de tolerância ao stress, bem como na redução de ansiedade, depressão e vergonha (Gilbert & Procter, 2006). Recentemente, tem sido também estendido à população geral, apresentando benefícios para o bem-estar dos indivíduos (Irons & Heriot-Maitland, 2020; Matos et al., 2017).

O desenvolvimento de intervenções manualizadas de TMC e de outras abordagens compassivas tem facilitado a implementação de intervenções baseadas na compaixão em diferentes contextos (e.g., comunitário, saúde, família; Bratt et al., 2019; Dodds et al., 2015; Edbrooke-Childs et al., 2020; Kelly et al., 2010; Kirby, 2017; Poehlmann-Tynan et al., 2020) e culturas (Arimitsu, 2016; Kariyawasam et al., 2023). Neste sentido, nos últimos anos tem-se assistido à expansão das intervenções baseadas na compaixão a contextos laborais, como organizações (Andersson et al., 2022), escolas (Matos et al., 2022a) e diferentes profissões assistencialistas (e.g., profissionais de saúde, Seppala et al., 2014; cuidados paliativos, Halifax, 2013; bombeiros, Beaumont et al., 2016a), com o intuito de promover a saúde mental dos cuidadores/profissionais e uma prestação de cuidados compassiva (*compassionate care*; i.e., ambiente acolhedor que promova comportamentos recíprocos de compaixão, McEwan et al., 2020). No âmbito desta tese, importa destacar a aplicação das abordagens focadas na compaixão em contexto de prestação de cuidados, seja em contexto familiar ou laboral.

As abordagens focadas na compaixão têm sido aplicadas junto de famílias em contexto comunitário, clínico e social (Bratt et al., 2019; Edbrooke-Childs et al., 2020; Poehlmann-Tynan et al., 2020). No estudo conduzido por Poehlmann-Tynan e colaboradores (2020), o CBCT foi aplicado a pais de crianças pequenas com o objetivo de reduzir o stress parental e melhorar indiretamente o bem-estar dos filhos. Os resultados do estudo mencionado indicam que apesar de não terem sido captadas alterações significativas ao nível de stress parental, os níveis de cortisol das crianças reduziram após os pais terem sido intervencionados. Bratt e colaboradores (2019) aplicaram um programa de TFC a pais de adolescentes com problemas de saúde mental. Os resultados indicaram que esta abordagem foi útil para aumentar a confiança dos pais e fortelecer os laços afiliativos entre pais e filhos (Bratt et al., 2019). O projeto SafeCORE (*Compassion, Openness, Relationships and Engagement*) implementado no Reino Unido, desde 2018, aplicou uma abordagem ecológica compassiva junto de famílias socialmente vulneráveis, envolvidas no sistema de proteção devido à ocorrência de episódios de abuso e de violência doméstica (Edbrooke-Childs et al., 2020). Este projeto pretendeu estimular um processo colaborativo de resolução de problemas entre os membros da familia com o objetivo de reduzir ciclos de violência e referênciação ao sistema (Edbrooke-Childs et al., 2020). Os resultados obtidos sugeriram que as famílias envolvidas no projeto concretizaram mais objetivos e demonstraram melhorias em várias áreas problemáticas. Qualitativamente, foram reportadas melhorias ao nível da regulação emocional e da comunicação, que aparentam ter-se refletido na estabilidade do ambiente familiar e bem-estar das crianças. Em conjunto, estes estudos sugerem que a intervenção junto dos pais pode servir de mecanismo para obter efeitos indiretos

no bem-estar e saúde mental das crianças, mesmo que as mesmas não sejam diretamente intervencionadas.

Em contexto laboral, as dificuldades emocionais dos colaboradores acarretam custos humanos (e.g., stress, *burnout*, conflitos interpessoais) e organizacionais (e.g., absentismo, rotatividade de trabalhadores, baixa produtividade; Dutton et al., 2014). Nesta conjuntura, o fomento de uma mentalidade compassiva tem sido percecionado como potencial mais-valia para o bem-estar dos colaboradores, das equipas e das organizações (Lilius et al., 2011), devendo ser adotada em todos os níveis da organização (McEwan et al., 2020). Ao funcionar como um mecanismo de regulação emocional, a compaixão pode ajudar os colaboradores a melhor regularem emoções difíceis e a reduzir o stress e a ansiedade (Andersson et al., 2022; Lilius et al., 2008). A nível interpessoal, a compaixão pode fomentar sentimentos de proximidade e ligação aos outros, melhorar a comunicação, encorajar a cooperação e motivar os colaboradores para alcançarem objetivos comuns, impactando na qualidade relacional da equipa e na perceção de segurança interpessoal (Andersson et al., 2022; Lilius et al., 2008; Pinard et al., 2020). A investigação tem evidenciado também uma associação entre a autocompaixão e melhorias em variáveis individuais, tais como satisfação com o trabalho (Abaci & Ardi, 2013), práticas de autocuidado (Horan & Taylor, 2018), motivação para o autoaperfeiçoamento (Breines & Chen, 2012) e menor intenção de rescisão de contrato (Reizer, 2019). A compaixão e a autocompaixão têm ainda sido associadas a benefícios coletivos organizacionais ao nível do desempenho, uma vez que tendem a contribuir para reduzir a resistência ao reconhecimento de erros, e a facilitar maior comprometimento no trabalho e um clima seguro de aprendizagem (Condon & Makransky, 2020; Guinot et al., 2020; Leary et al., 2007; Lilius et al., 2008; Reizer, 2019). Neste âmbito, são também reconhecidos diferentes fatores relacionais (e.g., semelhanças e proximidade entre colaboradores) e organizacionais (e.g., valores e normas partilhados, rotinas, qualidade das relações e comportamentos dos líderes), como facilitadores da compaixão em contexto organizacional (Dutton et al., 2014).

No que respeita a contextos de trabalho assistencialistas, que implicam cuidar de outros em sofrimento, a motivação compassiva tem sido reconhecida como um ingrediente ativo para garantir a qualidade da prestação de cuidados e o bem-estar do próprio profissional (Bauer-Wu & Fontaine, 2015; Gilbert & Procter, 2006; Seppala et al., 2014). Por um lado, exaltar a motivação compassiva de profissionais com funções assistencialistas (i.e., cuidadores) pode facilitar com que os mesmos se foquem de forma intencional na prestação de cuidados, criando oportunidades de valorizar e reforçar a interação com os utentes e de lhes proporcionar cuidados compassivos e experiências de apaziguamento (Veale et al., 2015). Uma prestação de

cuidados compassiva atende à necessidade de conexão do utente, sendo baseada na escuta atenta e no desejo de compreender a perspetiva do utente (Lown, 2014). Por outro lado, enquanto estratégia de regulação emocional adaptativa (Preckel et al., 2018), a compaixão é essencial para manter a distinção "eu-outro" e não absorver o sofrimento do utente (Klimecki, 2015; Vachon, 2016), a fim de prevenir o *burnout* e stress empático por parte do profissional (Duarte & Pinto-Gouveia, 2017). A motivação compassiva perspetiva o sofrimento como parte da condição humana, facilitando a aceitação da vulnerabilidade do próprio e fomentando a coragem para cuidar e ser cuidado (Gustin & Wagner, 2013). A investigação indica ainda que estar motivado para atender às próprias necessidades, dispor de estratégias de autocuidado (i.e., para promover o equilíbrio pessoal, profissional, emocional, físico e espiritual; Collins, 2005) e de regulação emocional, são competências essenciais para assegurar o bem-estar do cuidador e a qualidade da prestação cuidados (Gilbert, 2005; McGarrigle & Walsh, 2011; Singer & Klimecki, 2014; Vachon, 2016). Neste sentido, o desenvolvimento da compaixão em relação aos outros e da autocompaixão afiguram-se fundamentais para prevenir dificuldades emocionais dos profissionais e promover cuidados compassivos e satisfação por compaixão, facilitando um contacto de proximidade entre cuidadores e utentes (Duarte & Pinto-Gouveia, 2017; Gustin & Wagner, 2013; Hermanto & Zuroff, 2016). Não obstante, e contrariamente ao expectável, os níveis de compaixão reportados por profissionais assistencialistas aparentam ser menores, quando comparados a outros profissionais (e.g., administrativos), o que levanta questões sobre o papel das organizações enquanto facilitadores ou inibidores da compaixão (Lilius et al., 2008).

Reconhecendo as dificuldades inerentes aos serviços assistencialistas e os benefícios associados à compaixão, têm sido desenvolvidos e aplicados vários programas baseados na compaixão junto de diferentes profissionais de saúde (Beaumont et al., 2016b; Delaney, 2018; Johansson et al., 2022; McEwan et al., 2020; McVicar et al., 2021; Orellana-Rios et al., 2017; Scarlet et al., 2017; Seppala et al., 2014). A nível pessoal, estes programas têm revelado resultados promissores no desenvolvimento da autocompaixão (Beaumont et al., 2016b; Johansson et al., 2022; McEwan et al., 2020; Scarlet et al., 2017), bem como na redução dos medos da compaixão (McVicar et al., 2021), de sintomas de ansidedade (Orellana-Rios et al., 2017), de stress traumático secundário (Delaney, 2018; Johansson et al., 2022) e de *burnout* (Delaney, 2018; Orellana-Rios et al., 2017). A nível interpessoal, estes programas têm demonstrado capacidade de reduzir conflitos interpessoais (Scarlet et al., 2017) e facilitar maior conexão e ligação aos outros (Seppala et al., 2014). Particularmente, o desenvolvimento da compaixão em relação aos outros aparenta contribuir não só para o bem-estar dos próprios

profissionais, como para a melhoria dos serviços, níveis de satisfação e melhores indicadores clínicos dos utentes (Bauer-Wu & Fontaine, 2015; Lown, 2014; Orellana-Rios et al., 2017; Patel et al., 2019; Seppala et al., 2014). Já a autocompaixão parece facilitar o *coping* dos profissionais com situações difíceis e incertas, associando-se ao aumento da satisfação com o trabalho e do bem-estar profissional e na redução do *burnout* e stress traumático secundário (Babenko et al., 2019; Delaney, 2018; Kemper et al., 2019). Em última instância, a compaixão e a autocompaixão parecem contribuir para a melhoria da qualidade da prestação de cuidados em contextos de saúde (Raab, 2014). A literatura sugere ainda que ao facultar treino desta natureza aos profissionais e às direções, as organizações assistencialistas poderão criar ambientes organizacionais acolhedores e de suporte (Crawford et al., 2014; McEwan et al., 2020).

Devido à crise no ensino sentida em diversos países, têm sido também desenvolvidas diversas intervenções desta natureza para o contexto escolar. A iniciativa "Escolas compassivas" juntou investigadores de Portugal e do Reino Unido no desenvolvimento, aplicação e estudo de eficácia de um programa de Treino da Mente Compassiva para Professores (Matos et al., 2022c). Este programa apresenta 8 sessões de grupo, onde se propõe incrementar os fluxos da compaixão e reduzir os medos da compaixão e o autocriticismo, com a finalidade de promover afeto positivo e satisfação com o trabalho, assim como reduzir sintomas de ansiedade, depressão, stress e *burnout*. Os diversos estudos conduzidos até ao momento indicaram que o programa foi bem acolhido em ambos os países (Maratos et al., 2019; Matos et al., 2022c) e que se revelou eficaz na promoção da compaixão e da autocompaixão, bem-estar e regulação emocional dos profissionais, bem como na redução de indicadores psicofisiológicos de stress (Matos et al., 2022a).

Apesar dos inúmeros benefícios reportados na literatura relativos às intervenções baseadas na compaixão em contexto de trabalho (e.g., Andersson et al., 2022; Matos et al., 2022a), e nomeadamente junto de cuidadores formais (Orellana-Rios et al., 2017; Scarlet et al., 2017) e informais (Bratt et al., 2019; Poehlmann-Tynan et al., 2020), à data do início deste trabalho de investigação, esta abordagem não havia ainda sido implementada e testada em contexto de acolhimento residencial de crianças e jovens em perigo.

6. Fundamentos para a elaboração do programa de Treino da Mente Compassiva para Cuidadores

Enquanto motivação evolucionária para cuidar, a compaixão revela-se fundamental para assegurar a qualidade da prestação de cuidados junto de populações vulneráveis e em sofrimento (Adams et al., 2006; Gilbert, 2010b). Com base na revisão da investigação e da

literatura, este trabalho de investigação propôs-se promover uma mentalidade afiliativa nas Casas de Acolhimento Residencial (CAR) de crianças e jovens em perigo, com a finalidade de facilitar uma prestação de cuidados compassiva, sustentada no estabelecimento de relações afiliativas e num clima emocional seguro, sem negligenciar as necessidades emocionais dos próprios cuidadores. Os argumentos que motivaram o desenvolvimento deste trabalho de investigação serão descritos em seguida.

Em primeiro lugar, assume-se a premissa de que cuidar de forma responsiva de outros em sofrimento, requer autocompaixão por parte de quem cuida (Gilbert, 2005). Face às elevadas exigências deste contexto particular de prestação de cuidados (Eenshuistra et al., 2019; Wilke et al., 2020), é natural que sentimentos como a frustração, a ansiedade, a raiva ou o cansaço possam surgir na rotina diária dos profissionais das CAR. Neste sentido, atender à própria necessidade de apaziguamento e regulação emocional é um pré-requisito importante para prestar cuidados compassivos e efetivos (Gustin & Wagner, 2013). Por este motivo, os cuidadores necessitam de possuir estratégias de regulação emocional adaptativas, que lhes permitam regular não só a ativação do sistema de ameaça das crianças e jovens, como gerir as suas próprias emoções durante e após o processo de prestação de cuidados. Quando o sistema de ameaça dos cuidadores se ativa, capacidades cognitivas como a empatia e a tomada de perspetiva, necessárias para compreender as necessidades do outro e estabelecer uma ligação afetiva, encontram-se menos disponíveis, sendo automaticamente utilizados comportamentos reativos de defesa e proteção (e.g., atacar, ameaçar, envergonhar, criticar), que podem aumentar a desregulação do jovem e motivar uma escalada comportamental (Klimecki et al., 2014). A desregulação emocional dos cuidadores pode ainda comprometer a relação estabelecida com o jovem, relação essa que se assume ser um dos principais veículos de mudança nas intervenções neste contexto (Huefner & Ainsworth, 2021; Li & Julian, 2012).

Em segundo lugar, é importante considerar que a maturação cerebral das crianças e jovens em acolhimento ocorreu num ambiente hostil, de abuso e negligência. Assim, o cérebro destas crianças/jovens encontra-se calibrado para assegurar a sua sobrevivência (Porges, 2015; Sieff, 2017). Consequentemente, para se adaptarem a tais meios hostis, estas crianças e jovens tendem a apresentar um sistema de ameaça hipersensível e hiperreativo, que se ativa facilmente face a estímulos inócuos ou de baixa intensidade, muitas vezes impercetíveis para os cuidadores (Lee & James, 2012; Porges, 2007). Esta hiperativação do sistema de ameaça encontra-se na base da desregulação emocional, reexperienciação de memórias traumáticas, níveis elevados de afeto negativo e comportamentos disruptivos que, conjuntamente, interferem significativamente no funcionamento destas crianças e jovens nos seus diferentes

contextos de vida (Lee & James, 2012). Na tentativa de procurar estarem a salvo e regularem o afeto negativo associado ao sistema de ameaça, estas crianças e jovens tendem a ativar o sistema de procura para alcançar satisfação imediata ou estatuto (e.g., para evitar ser rejeitado; Lucre & Clapton, 2021). Quando este ciclo ameaça-procura é quebrado, pode gerar respostas de ansiedade, frustração ou raiva e potenciar comportamentos agressivos e subsequentes consequências indesejadas (Rijo et al., 2014). Estratégias de regulação emocional menos adaptativas, maioritariamente focadas na procura ou na ameaça, poderão ser recorrentemente utilizadas, uma vez que o sistema de afiliação/apaziguamento destas crianças e jovens tende a encontrar-se subdesenvolvido e, portanto, indisponível (Gilbert, 2014; Lee & James, 2012; Porges, 2007). Crianças que foram vítimas de abuso e negligência, foram privadas de experiências afiliativas que lhes permitissem formar memórias de cuidados, calor e segurança com figuras de vinculação, comprometendo assim o desenvolvimento do sistema de afiliação/apaziguamento e a sua capacidade de autoapaziguamento (Boykin et al., 2018; Naismith et al., 2019b). Ao invés, no seu percurso de vida, estas crianças e jovens aprenderam a recear a aproximação dos outros e cresceram com uma imagem de si pautada por temas de inferioridade e vergonha (Sieff, 2017). Este modo de funcionamento tende a originar e a manter problemas de regulação emocional, problemas interpessoais e um autoconceito negativo (Lee & James, 2012).

Num contexto residencial terapêutico, a intervenção diária deve ser considerada um momento privilegiado de mudança (Huefner & Ainsworth, 2021). Enquanto figuras de referência, os cuidadores poderão facilitar a estimulação do sistema de afiliação/apaziguamento das crianças e jovens, sendo para isso necessário que possuam capacidade de reagir e atuar de forma compassiva. No entanto, as experiências interpessoais prévias das crianças e jovens podem condicionar e limitar a sua abertura a comportamentos de ajuda e suporte, potenciando o medo de receber compaixão dos outros e o medo da autocompaixão (Boykin et al., 2018; Naismith et al., 2019b). Por um lado, a ativação do sistema de afiliação/apaziguamento das crianças e jovens encontra-se limitada, devido ao estilo de vinculação inseguro usualmente desenvolvido (Cicchetti et al., 2006; Cook et al., 2005; Naismith et al., 2019b), e aos comportamentos interpessoais defensivos (e.g., desconexão, afastamento e submissão), derivados da perceção dos outros como fonte de ameaça (o outro pode controlar, magoar ou rejeitar; Boykin et al., 2018; Gilbert, 2014; Gilbert & Procter, 2006). Por outro lado, devido a memórias emocionais aversivas associadas à negligência e ao abuso, o apoio e cuidados prestados pelos outros podem ser percecionados como ameaçadores, uma fraqueza do próprio ou como não merecidos, ativando preocupações acerca de uma possível rejeição, crítica ou

aproveitamento, bem como uma consequente desregulação afetiva e afastamento ou ataque aos cuidadores (Boykin et al., 2018; Gilbert, 2014; Gilbert et al., 2011; Kirby et al., 2019; Naismith et al., 2019b). Deste modo, a regulação do afeto negativo via sistema de afiliação torna-se difícil (Kelly & Dupasquier, 2016; Veale et al., 2015), mantendo a desregulação emocional e comportamental das crianças e jovens em CAR. Conjuntamente, estas dificuldades poderão criar resistências à prestação de cuidados e ao próprio processo de acolhimento.

Face ao referido e de acordo com as recomendações para acolhimento terapêutico (Whittaker et al., 2016), revela-se importante que os cuidadores das várias equipas da CAR partilhem um modelo teórico comum, que lhes permita compreender o funcionamento psicológico subjacente ao trauma, de modo a poderem validar e atender de forma sensitiva e adequada as necessidades emocionais das crianças e jovens e serem capazes de antecipar e prevenir eventuais situações de desregulação. Neste processo, a autorregulação emocional do cuidador revela-se fundamental para reduzir a vulnerabilidade do próprio perante a exposição ao sofrimento manifestado pelas crianças e jovens, e prevenir síndromes psicológicos como o stress empático e o *burnout* (Singer & Klimecki, 2014). A compaixão abre portas à aceitação e tolerância ao sofrimento e incentiva a aprendizagem de técnicas para alívio do mesmo, seja nos outros ou no próprio (Gilbert, 2010a). Promover uma motivação compassiva facilitará que os cuidadores possam validar e regular o afeto negativo e permitirá mover o foco de atenção de preocupações associadas à ativação do sistema de ameaça para o seu papel de cuidador. Deste modo, o cuidador poderá reduzir comportamentos reativos e escolher, de forma intencional e consciente, as estratégias que melhor se adequem para gerir situações diárias desafiantes na CAR.

Considerando a natureza dinâmica e recíproca da compaixão, os colegas e as chefias poderão funcionar como base segura na regulação emocional das equipas (Reizer, 2019). Se os profissionais da CAR se encontrarem mais aptos para regular as próprias emoções e atuarem de forma compassiva entre si, mais facilmente poderão modelar respostas de apaziguamento nos jovens e fomentar um clima de suporte e segurança na CAR (Saxe et al., 2007), capaz de responder não só às necessidades emocionais e vinculativas das crianças e jovens em acolhimento (Steinlin et al., 2017), como também à necessidade de segurança e suporte entre colaboradores (Sedivy et al., 2020). Um clima emocional seguro e afiliativo tende a reduzir estímulos interpessoais potencialmente ativadores do sistema de ameaça, diminuindo a desregulação emocional e deixando o indivíduo mais disponível para investir em comportamentos pró-sociais e de cooperação (Irons & Gilbert, 2005; Saxe et al., 2007). Os jovens poderão processar os seus medos e feridas associadas ao trauma num clima seguro, com recurso

a estratégias mais adaptativas e funcionais. Ao mesmo tempo, um clima emocional seguro proporciona maior coragem e abertura para adquirir novas aprendizagens, podendo encorajar os jovens a investirem nos seus objetivos e projetos de vida com maior segurança, motivação e abertura (Jackson et al., 2019; Mikulincer & Shaver, 2007; Veale et al., 2015).

A proposta apresentada neste trabalho de investigação visa colmatar a crítica frequentemente apontada ao funcionamento das CAR, por se direcionarem maioritariamente para a proteção da criança face a situações de perigo (e.g., abuso, exploração, negligência) e provisão assistencialista de recursos (e.g., abrigo, refeição, higiene, educação; Rodrigues et al., 2013). A promoção de uma mentalidade afiliativa, operacionalizada através da implementação de um programa de Treino da Mente Compassiva para Cuidadores (TMC-C), pretende contribuir para a promoção de um ambiente afiliativo e seguro nas CAR, facilitador da segurança psicológica necessária à recuperação da criança (Sellers et al., 2020; Slaatto et al., 2023). Esta abordagem compassiva poderá disponibilizar um modelo baseado em evidência para criar ambientes terapêuticos nas CAR, tal como preconizado na literatura da área (Whittaker et al., 2016) e na Lei de Proteção de Crianças e Jovens em Perigo. Este modelo permitiria identificar elementos desencadeadores de desregulação emocional dos jovens, bem como as suas necessidades não atendidas, proporcionando estratégias de intervenção baseadas em evidência, que se têm revelado escassas neste contexto (James et al., 2017; Rodrigues & Barbosa-Ducharne, 2017). O TMC-C incorpora também práticas de autorregulação emocional e de autocuidado (Gilbert, 2010a), não descurando o bem-estar daqueles que cuidam (Dalai Lama, 1995).

7. O programa de Treino da Mente Compassiva para Cuidadores

7.1 Finalidade do programa

O Treino da Mente Compassiva para Cuidadores (TMC-C) tem como objetivo o desenvolvimento de motivações e atitudes inerentes aos três fluxos da compaixão descritos por Gilbert (2010b), com a finalidade de promover uma mentalidade afiliativa em cuidadores profissionais de crianças e jovens em acolhimento residencial. Engloba psicoeducação baseada na perspetiva evolucionária da TFC sobre o funcionamento da mente humana, bem como o treino de diferentes práticas experienciais desenhadas para cultivar processos fisiológicos e psicológicos conducentes ao equilíbrio dos sistemas de regulação do afeto e ao bem-estar do cuidador.

7.2 Destinatários

O TMC-C destina-se a cuidadores profissionais das casas de acolhimento residencial de crianças e jovens. Considerando que o funcionamento das CAR é assegurado por equipas multidisciplinares, e que o envolvimento de profissionais com diferentes funções tem sido recomendado nas formações para facilitar a aplicação coletiva das práticas (van Gink et al., 2018), todos os profissionais que prestam serviços regulares e diretos aos jovens em acolhimento são convidados a participar independentemente da sua função. Deste modo, podem participar no TMC-C elementos da equipa técnica (e.g., diretor técnico, psicólogo, assistente social), educativa (e.g., educadores, monitores) e/ou de apoio (e.g., cozinheiro, auxiliar de serviços gerais, etc.). Uma vez que este programa pretende contribuir para um modelo de prestação de cuidados consistente, uniformizado e integrado no funcionamento da CAR, recomenda-se que todos os colabores da CAR possam participar no programa.

7.3 Formato, *setting*, frequência e duração das sessões e do programa

O TMC-C é um programa estruturado, composto por 12 sessões de grupo. O programa encontra-se desenhado para ser aplicado em formato presencial, junto de grupos constituídos por 6 a 10 cuidadores. Considerando o trabalho em equipa nas CAR e a dinâmica interpessoal da compaixão, o formato grupal pareceu-nos ser o mais adequado para facilitar dinâmicas interpessoais compassivas que pudessem ter potencial efeito nas dinâmicas e clima da CAR.

As sessões devem ser efetuadas nas instalações da própria CAR, em espaço cedido pela mesma. O espaço deve ser confortável, fechado e não sujeito a interrupções. No caso da CAR não apresentar um espaço adequado que assegure as condições necessárias, em alternativa, as sessões poderão ser realizadas num espaço próximo da CAR, que seja de fácil acesso para os participantes. Nas sessões, os participantes devem estar sentados em cadeiras dispostas em grande círculo e com espaço disponível para circular e realizar algumas dinâmicas e atividades. Cada sessão tem a duração de duas horas e meia, ocorrendo com frequência semanal, correspondendo a um total de 30 horas de treino e formação. O horário das sessões deve ser agendado de acordo com a disponibilidade mútua dos participantes e do dinamizador. Em casas de maior dimensão, se necessário, podem ser agendados dois horários semanais, para facilitar a participação dos profissionais que trabalhem em turnos rotativos. Prevê-se que a implementação do programa decorra durante aproximadamente três meses.

7.4 Estrutura das sessões

O tema das viagens foi escolhido como uma metáfora para estruturar as sessões e os respetivos conteúdos. O TMC-C é apresentado como uma viagem de grupo pelo mundo, da qual constam diferentes destinos (cada sessão representa um destino diferente), de onde os participantes poderão trazer diferentes lembranças/*souvenirs* (i.e., aprendizagens fundamentais de cada sessão). Recorrendo a esta metáfora, a estrutura das sessões encontra-se dividida em três partes: (1) *Check-in*; (2) Exploração do tema da sessão; (3) *Check-out* (cf. Quadro 1).

Quadro 1. *Estrutura das sessões do programa TMC-C*

Partes da sessão	Tópicos
1) Check-in	– Exercício de aterragem na sessão – Revisão das aprendizagens fundamentais da sessão anterior – Partilha de experiências com o desafio compassivo semanal – Avaliação das práticas semanais
2) Exploração do tema da sessão	– Partilha dos objetivos definidos para a sessão – Psicoeducação e exercícios experienciais para explorar os objetivos da sessão – Partilha de experiências com os exercícios – Discussão em grupo
3) Check-out	– Resumo das aprendizagens fundamentais da sessão – Brainstorming sobre a aplicação prática das aprendizagens em três eixos: cuidador, jovem, dinâmicas da casa – Selecionar as aprendizagens mais relevantes da sessão para o grupo e redigir as mesmas no Muro da Compaixão – Partilha do desafio compassivo semanal e entrega do postal souvenir com o destino da sessão – Avaliação da sessão e escuta da música compassiva – Exercício de descolagem da sessão

As sessões são iniciadas com um exercício de aterragem (i.e., uma prática formal de *mindfulness* ou meditação compassiva). Uma vez que as sessões decorrem no local de trabalho e em horário laboral, o exercício de aterragem na sessão procura estabilizar a mente dos participantes e facilitar o foco na sessão, preparando os participantes para se envolverem em exercícios e estados mentais mais complexos durante a sessão. A fim de manter a continuidade e ligação entre os conteúdos das sessões, no *Check-in* realiza-se uma breve síntese das aprendizagens realizadas na sessão anterior. De acordo com o Modelo Interativo de Planeamento de Programas de Caffarella (2002), encontram-se definidos objetivos específicos

para cada sessão, aprendizagens fundamentais a alcançar e uma tarefa de transferência da aprendizagem que os participantes possam aplicar entre as sessões, denominada de desafio compassivo semanal. Este desafio apresenta os seguintes objetivos: (i) otimizar o treino da mente compassiva através da prática regular de exercícios entre as sessões; (ii) transferir e integrar as aprendizagens da sessão nas práticas de acolhimento e/ou na rotina pessoal dos participantes; (iii) facilitar o estabelecimento de uma rotina diária de autocuidado. Este desafio inclui a realização de uma tarefa prática para ser aplicada em contexto de vida real, que os cuidadores podem aplicar em contexto pessoal e/ou profissional. No âmbito deste desafio, os participantes são ainda convidados a integrar na sua rotina diária a prática de meditações formais realizadas nas sessões (disponibilizadas em formato áudio via *whatsapp* ou email após cada sessão). A partilha das experiências e dificuldades com o desafio compassivo semanal é efetuada no *Check-in* de cada sessão. A realização deste desafio é voluntária, devendo, no entanto, ser incentivada. A frequência das tarefas e práticas compassivas é avaliada através do preenchimento do Formulário de *Check-in* (anónimo; Anexo B).

A Exploração do Tema da sessão envolve uma componente psicoeducativa e práticas experienciais (e.g., imagética compassiva, role-play) que pretendem facilitar a aquisição das aprendizagens fundamentais e treino das competências alinhadas com os objetivos específicos definidos para cada sessão. Estes exercícios permitem que os participantes ganhem conhecimento e consciência acerca do funcionamento da mente humana e dos sistemas de regulação do afeto. São realizadas práticas experienciais que incluem componentes como a respiração tranquila, expressões faciais e tom de voz amigável, a fim de ativar determinados estados emocionais associados ao sistema nervoso parassimpático. São também realizados exercícios para treinar pensamentos e comportamentos compassivos. Dependendo do objetivo, os exercícios podem ser realizados individualmente, em pares ou em grupo. Após cada exercício, abre-se espaço para efetuar a partilha de experiências e dificuldades sentidas. Conduz-se uma discussão em grupo, com recurso à técnica da descoberta guiada, para extrair as principais conclusões em torno de cada exercício. A participação e partilha são voluntárias; no entanto, todos os membros do grupo devem ser encorajados a participar.

No *Check-out*, os participantes são convidados a realizar uma síntese das aprendizagens fundamentais da sessão, bem como uma reflexão sobre a aplicação das mesmas a três níveis: o cuidador, o jovem e as dinâmicas da casa de acolhimento. Ao nível do cuidador, os participantes são convidados a refletir como as aprendizagens podem ser aplicadas, por exemplo, para atender e regular as próprias emoções ou para desenvolver comportamentos de autocuidado. Ao nível do jovem, as aprendizagens do TMC-C podem, por exemplo, facilitar a leitura do

comportamento do jovem, facilitar o estabelecimento de uma relação compassiva, ou apaziguar o sofrimento do jovem. Por último, os cuidadores são convidados a refletir como as aprendizagens poderão ser aplicadas no contexto da CAR, por exemplo, ao nível do relacionamento interpessoal com colegas e chefias, ou nas práticas de acolhimento. Este tópico é encerrado com a seleção por todos de uma ou duas aprendizagens fundamentais da sessão e a sua redação no Muro da Compaixão. O Muro da Compaixão é um mural (em papel cenário) afixado no espaço onde decorrem as sessões, onde são registadas as ideias-chave mais relevantes para o grupo. No final do programa, o Muro da Compaixão constituirá um produto produzido pelo grupo, capaz de resumir as aprendizagens realizadas no TMC-C e possíveis aplicações práticas na casa de acolhimento (Anexo C). Este mural fica para a CAR após a conclusão do programa, devendo ser exposto num lugar acessível a todos, de modo a funcionar como lembrete das aprendizagens efetuadas no programa. No *Check-out*, é entregue a cada participante um postal souvenir da sessão (postal com fotografia do destino da sessão) e revelado o destino da viagem (relacionado com as aprendizagens da sessão; e.g., Tóquio na sessão 5; Bali na sessão 11). A entrega do postal corresponde ao momento de revelação do desafio compassivo semanal, que se encontra registado no verso do postal, juntamente com as aprendizagens fundamentais da sessão. Pretende-se que o postal funcione como um lembrete para a prática e transferência das aprendizagens. A concretização do desafio compassivo semanal apresenta carácter voluntário. No entanto, os participantes devem ser sensibilizados para a relevância deste desafio para promover uma mentalidade afiliativa e mudança comportamental. De seguida, a sessão é avaliada pelos participantes através do preenchimento de uma ficha anónima de avaliação da satisfação, interação e desempenho (Formulário de *Check-out;* Anexo B). Este formulário é preenchido ao som da música compassiva de um dos participantes, que é convidado a partilhar com o grupo o significado e função que aquela música tem para si. A sessão termina com uma prática formal de meditação (i.e., exercício de descolagem).

7.5 Módulos e conteúdos do programa

As 12 sessões do TMC-C encontram-se divididas em três módulos sequenciais (Quadro 2). O primeiro módulo denomina-se "A nossa mente de acordo com uma abordagem baseada na compaixão" e engloba as primeiras seis sessões do programa. Este módulo pretende introduzir os conceitos-chave do programa (e.g., compaixão, autocompaixão, humanidade comum) e familiarizar os participantes com a abordagem evolucionária do funcionamento da mente humana e o modelo dos três sistemas de regulação do afeto (valor adaptativo, *inputs* e

outputs de cada sistema). A primeira sessão apresenta uma estrutura ligeiramente diferente das restantes. É iniciada com um exercício de apresentação, seguido de um exercício de grupo para partilha de motivações e expetativas acerca do programa e da participação no mesmo. Na mesma sessão, estabelecem-se ainda as regras de funcionamento do grupo, que devem contribuir para fomentar um clima de segurança e partilha entre os participantes (e.g., participação voluntária, não julgamento). Nesta sessão, é explorada a perceção dos participantes sobre a definição de compaixão, a fim de clarificar os objetivos do programa e diminuir eventuais medos e resistências (Kirby et al., 2019).

O segundo módulo é composto por cinco sessões (da sessão 7 à sessão 11), especificamente direcionadas para o treino da mente compassiva. Apesar de este treino ser gradualmente introduzido desde a primeira sessão, no segundo módulo, as sessões são especificamente direcionadas para o treino dos atributos e competências da compaixão, de forma a estimular o desenvolvimento dos três fluxos da compaixão e identificar e atenuar os medos, bloqueios e resistências que podem estar relacionadas com cada um dos fluxos. No segundo módulo, recorre-se com maior frequência a exercícios de imaginação compassiva (e.g., Eu cuidador e compassivo, Amigo compassivo) e de *role-play*, para treino do pensamento e comportamento compassivos.

Por fim, o último módulo é composto pela sessão final que, tal como a primeira sessão, apresenta uma estrutura ligeiramente diferente das restantes sessões do programa. Esta sessão não pretende introduzir novas aprendizagens, mas antes sistematizar e sintetizar os conteúdos aprendidos, compreender o progresso dos participantes e reforçar a transferência das aprendizagens e práticas para a casa de acolhimento.

Quadro 2. *Módulos, sessões e objetivos do programa TMC-C*

Módulo	Nº	Sessão	Objetivos
i) A nossa mente de acordo com uma abordagem baseada na compaixão	1	Humanidade comum	– Conhecer a estrutura das sessões e objetivos do programa – Definir regras de grupo para a criação de um ambiente seguro – Reconhecer a universalidade do sofrimento humano – Definir compaixão – Reconhecer as causas e impacto do stress empático

2	Uma mente evolucionariamente determinada	– Iniciar a prática de mindfulness – Reconhecer o funcionamento do cérebro como resultado de fatores evolucionários e biopsicossociais – Identificar as funções do cérebro velho e do cérebro novo – Reconhecer as dificuldades associadas ao conflito entre cérebro velho e cérebro novo – Compreender o princípio "Não tenho culpa, mas tenho responsabilidade"
3	Modelo dos Sistemas de Regulação do Afeto	– Compreender o funcionamento dos três sistemas de regulação do afeto – Aplicar o modelo de regulação do afeto ao próprio e ao contexto de trabalho – Perceber as dificuldades associadas ao desequilíbrio entre os sistemas de regulação do afeto
4	Sistema de Ameaça	– Compreender o funcionamento e *outputs* do sistema de Ameaça – Distinguir ameaças internas de ameaças externas – Identificar ameaças existentes na rotina da casa de acolhimento para os colaboradores e para os jovens – Identificar as funções e consequências do autocriticismo – Analisar as estratégias de *coping* com a ameaça no local de trabalho
5	Sistema de Procura	– Compreender o funcionamento e *outputs* do Sistema de Procura – Identificar os "perigos" do Sistema de Procura – Reconhecer as características e consequências associadas à Mentalidade Competitiva – Distinguir vergonha de culpa
6	Sistema de Tranquilidade	– Compreender o funcionamento e *outputs* do Sistema de Tranquilidade – Compreender a relação entre a vinculação e o Sistema de Tranquilidade – Identificar estratégias de ativação do Sistema de Tranquilidade – Estimular a imagem do Lugar Seguro – Reconhecer a importância da Mentalidade Afiliativa no sistema de acolhimento – Reconhecer as necessidades de calor e segurança das crianças e jovens
7	A Compaixão	– Identificar os fluxos da compaixão

ii) Treino da mente compassiva			– Descrever os atributos da compaixão – Treinar as competências da compaixão
	8	Medos, Bloqueios e Resistências à Compaixão	– Reconhecer os medos, bloqueios e resistências associados a cada fluxo da compaixão – Analisar as funções do autocriticismo – Identificar medos, bloqueios e resistências à compaixão no funcionamento da casa de acolhimento
	9	Desenvolver Compaixão pelo Outro	– Identificar as qualidades do Eu Cuidador e Compassivo – Estimular o Eu Cuidador e Compassivo – Treinar a atitude compassiva para com o outro
	10	Receber Compaixão dos Outros	– Reconhecer a necessidade de receber compaixão dos outros – Estimular a imagem do Amigo Compassivo – Praticar receber compaixão dos outros
	11	Desenvolver Autocompaixão	– Comparar o funcionamento autocrítico ao funcionamento autocompassivo – Reconhecer a existência de Múltiplos Eus – Praticar dar autocompaixão
iii) Sessão final	12	Construir uma Casa de Acolhimento Compassiva	– Sintetizar as aprendizagens realizadas ao longo do programa de TMC-C – Rever as conclusões redigidas no Muro da Compaixão – Avaliar o progresso na regulação dos sistemas de afeto dos cuidadores – Definir estratégias para promover um ambiente compassivo na casa de acolhimento

7.6 Dinamização e aplicação manualizada do programa

O programa poderá ser dinamizado por um ou dois dinamizadores. Ambos devem ser psicólogos e possuir um conhecimento sólido dos pressupostos teóricos da TFC, bem como dos desafios e exigências do trabalho em contexto de acolhimento residencial (e.g., trauma, desenvolvimento infanto-juvenil, funcionamento das CAR). Devem ainda ter formação prévia no âmbito do programa para poder proceder à sua aplicação.

Considerando a natureza do TMC-C, para além dos conhecimentos teóricos, o dinamizador deverá também possuir determinadas competências clínicas e interpessoais (e.g., empatia, sensibilidade ao sofrimento, capacidade de escuta ativa) que lhe permita modelar

comportamentos e atitudes baseadas na compaixão. O dinamizador deve promover um ambiente seguro e compassivo no grupo, que facilite que os participantes se relacionem entre si e consigo próprios de forma compassiva. Por isso, é necessário que o dinamizador cultive uma mente compassiva, sendo recomendada a prática pessoal de exercícios de meditação (preferencialmente Mindfulness e/ou Compaixão). O papel de modelo compassivo deve ser combinado com o papel de membro ativo do grupo. O dinamizador deve integrar os exercícios sempre que possível e partilhar experiências pessoais, quando apropriado.

O TMC-C é um programa estruturado, encontrando-se manualizado. Do manual consta um breve enquadramento conceptual do programa, a descrição detalhada das sessões e respetivas instruções. Constam ainda materiais de apoio às sessões, por exemplo: *powerpoints* com imagens e vídeos, cartão de embarque (sessão 1), 12 postais *souvenir*, mapa da compaixão (sessão 7), mala de mão compassiva (sessão 12), áudios das práticas de meditação, certificado de participação. O dinamizador deverá orientar as sessões de acordo com as instruções sugeridas no manual, podendo adaptar as mesmas para responder às necessidades e características do grupo, devendo, no entanto, assegurar que os objetivos e conteúdos da sessão são mantidos.

O logótipo e manual do TMC-C encontram-se registados como marca da Universidade de Coimbra. O logótipo (Figuras 1 e 2) e a edição gráfica do manual foram realizados pelo designer Nuno Barros. A imagem do logótipo representa um toque caloroso e compassivo que afaga e protege o coração, sendo uma metáfora da atitude autocompassiva treinada no programa. Poderá ser consultada no Anexo A uma sessão integral do programa.

Figura 1. *Logotipo do programa (versão em português)*

Figura 2. *Logotipo do programa (versão em inglês)*

8. Síntese

A espécie humana é uma espécie altamente social, dependendo dos outros para sobreviver e prosperar (Singer & Klimecki, 2014). Evolucionariamente, a vinculação, a prestação

de cuidados e as relações de proximidade aos outros contribuem não só para proteger, como para regular fisiológica e emocionalmente os indivíduos (Gilbert, 2021). Para viver em sociedade, o ser humano dispõe de diferentes mentalidades sociais que o orientam para estabelecer e manter diferentes papéis sociais (Gilbert, 2015b). Alinhada com a função do sistema de vinculação, a mentalidade afiliativa orienta a mente do ser humano para detetar sinais de desconforto/sofrimento expressos pelos outros e emitir comportamentos que respondam às necessidades manifestadas (Gilbert, 2014, 2017a). A compaixão representa uma motivação aninhada na mentalidade afiliativa, definida como a sensibilidade ao sofrimento do eu e do outro, com um compromisso para o aliviar e prevenir (Dalai Lama, 1995; Gilbert, 2010b). Segundo Gilbert (2020), a compaixão pode ser dirigida aos outros, pode vir dos outros em direção ao próprio, ou pode fluir do próprio para si mesmo (i.e., autocompaixão).

Durante as últimas décadas, verificou-se um aumento substancial de estudos empíricos em torno da compaixão (Mascaro et al., 2020). A investigação indica que a compaixão, nos seus três fluxos, apresenta inúmeros benefícios para o próprio e para os outros, incluindo benefícios ao nível da regulação emocional, relacionamento interpessoal, saúde física e bem-estar psicológico (Crocker & Canevello, 2017; Galante et al., 2014; Mongrain et al., 2011).

De acordo com estudos das neurociências, a compaixão pode ser estimulada e treinada (Klimecki et al., 2014). Com base neste pressuposto, têm vindo a ser desenvolvidos e testados diversos programas baseados na compaixão, aplicados em diversos contextos, incluindo populações clínicas, famílias, escolas, organizações ou profissionais assistencialistas (e.g., Andersson et al., 2022; Bratt et al., 2019; Condon & Makransky, 2020; Gilbert, 2014; Gilbert & Procter, 2006; Jazaieri et al., 2013a; Matos et al., 2022a; Neff & Germer, 2013).

Particularmente nos contextos de trabalho assistencialistas, que implicam cuidar de pessoas em sofrimento, a motivação compassiva tem sido reconhecida como um ingrediente ativo para garantir a qualidade da prestação de cuidados e promover o bem-estar dos profissionais (Bauer-Wu & Fontaine, 2015; Gilbert & Procter, 2006; Seppala et al., 2014). Apesar dos programas baseados na compaixão revelarem resultados promissores junto de quem dá compaixão e daqueles que a recebem em contextos assistencialista (Beaumont et al., 2016b; Delaney, 2018; Matos et al., 2022a; Orellana-Rios et al., 2017), esta abordagem não tinha ainda sido implementada nem testada em casas de acolhimento residencial de crianças e jovens com medidas de promoção e proteção.

Numa tentativa de colmatar as necessidades sentidas e reportadas nas CAR, este trabalho de investigação teve como principal objetivo desenvolver e estudar a eficácia de um programa de Treino da Mente Compassiva para Cuidadores (TMC-C). O TMC-C é um programa

estruturado, composto por 12 sessões de grupo. Deriva da TFC (Gilbert, 2010a) e foca-se no desenvolvimento de motivações e atitudes compassivas nos cuidadores, com o objetivo de promover e cultivar uma mentalidade afiliativa nas CAR.

Uma mentalidade afiliativa abre portas à aceitação e tolerância ao sofrimento e incentiva a aprendizagem de técnicas para alívio do mesmo, seja nos outros ou no próprio (Gilbert, 2010b). Esta abordagem pareceu-nos, por isso, útil e adequada para ajudar os cuidadores a compreenderem e a responderem de forma compassiva às necessidades complexas das crianças e jovens em acolhimento e, simultaneamente, ajudar os mesmos a acolherem e a serem capazes de apaziguar o sofrimento que a prestação de cuidados a estas crianças e jovens poderá espoletar em si. Deste modo, esta abordagem poderá contribuir para establecer um ambiente relacional seguro e de apoio nas CAR, capaz de responder não só às necessidades emocionais e vinculativas das crianças e jovens (Steinlin et al., 2017), mas também à necessidade de segurança e apoio entre colaboradores no local de trabalho (Sedivy et al., 2020). Ao promover uma mentalidade afiliativa, pretende-se contribur para a criação de ambientes terapêuticos que facilitem às crianças e jovens em acolhimento experiências reparadoras, sem descurar o bem-estar dos seus cuidadores.

PARTE II

METODOLOGIA

CAPÍTULO 3

METODOLOGIA GERAL E OBJETIVOS DE INVESTIGAÇÃO

1. Apresentação do projeto de investigação

Este projeto de doutoramento emergiu da experiência profissional da doutoranda em contexto de acolhimento residencial de crianças e jovens, no âmbito do sistema de promoção e proteção. Durante cinco anos, a doutoranda integrou a equipa técnica da Casa do Canto (APDMF-CrescerSer) e colaborou no desenvolvimento, implementação e avaliação de um projeto destinado a promover a autonomia das crianças e jovens (Projet'Ar-te: Desafios para a mudança no Sistema de Acolhimento, financiado pela Fundação Calouste Gulbenkian; Pinheiro et al., 2015, 2018). O Projet'Ar-te articulou um programa de promoção de competências de regulação emocional com um programa de desenvolvimento de competências pessoais e sociais dirigido aos jovens, bem como a criação de uma estrutura de apoio e acompanhamento de jovens após a sua saída do acolhimento, propondo melhorias dos processos de acolhimento residencial, de finalização do acolhimento e de apoio e acompanhamento do projeto de vida pós-acolhimento (Pinheiro et al., 2018). O exercício profissional como técnica de referência de jovens e como investigadora, permitiu à autora, por um lado constatar o hiato entre as práticas nas CAR e o conhecimento científico, e por outro identificar a necessidade de cuidar dos cuidadores. No exercício das suas funções, a autora contactou, observou e sentiu o desgaste e as dificuldades psicológicas e de regulação emocional recorrentes nos profissionais que trabalham nestas casas. Quando experienciadas de forma persistente em vários elementos das equipas, estas dificuldades refletiam-se negativamente nas práticas de acolhimento e, consequentemente, nos resultados obtidos. As mesmas dificuldades eram igualmente reportadas na investigação da área. Alinhadas com este problema estavam as necessidades reportadas na literatura ao nível da carência de programas que facilitassem treino especializado a estes profissionais que, apesar de trabalharem "de coração", sentem-se frequentemente angustiados e frustrados por não serem capazes de ajudar os jovens de quem cuidam. A experiência profissional e a sensibilidade pessoal da doutoranda para estes assuntos, aliada à necessidade evidenciada na investigação em torno dos mesmos, motivaram o desenvolvimento e prossecução do projeto de doutoramento "Mentalidade afiliativa no acolhimento residencial de jovens: Implementação e estudos de eficácia de um programa de treino da mente compassiva com cuidadores", financiado pela Fundação para a Ciência e a Tecnologia (FCT) com uma Bolsa Individual de Doutoramento (SFRH/BD/132327/2017). O projeto foi acolhido, em 2018, no grupo de investigação *Cognitive and Behavioural Processes and Change*, do Centro de Investigação em Neuropsicologia e Intervenção Cognitivo-Comportamental (CINEICC, Unidade I&D) da Faculdade de Psicologia e de Ciências da Educação da Universidade de Coimbra (FPCE-UC).

A eclosão da pandemia de Covid- 19, em março de 2020, coincidiu com a execução do ensaio clínico incluído no projeto de doutoramento. As medidas sanitárias decretadas pelo governo de Portugal para mitigação dos efeitos e controlo da pandemia tiveram um impacto significativo nas atividades de investigação, afetando consideravelmente a prossecução do plano de trabalhos inicialmente aprovado. Mais concretamente, em março de 2020, o ensaio clínico encontrava-se a decorrer, quando foi promulgado o primeiro confinamento geral. Consequentemente, o acesso às CAR foi vedado a terceiros e a organização e rotina das mesmas foi completamente alterada (e.g., os profissionais passaram a trabalhar em semanas revezadas, com equipas desencontradas), o que exigiu consecutivas adaptações do cronograma inicial do projeto. Por esse motivo, este doutoramento beneficiou também de uma bolsa excecional financiada pela FCT para mitigação de impacto da pandemia da COVID-19 nas atividades de investigação (COVID/BD/152441/2022).

A componente empírica desta tese integra sete estudos empíricos e uma revisão sistemática da literatura, que foram desenhados para responder a questões de investigação e objetivos específicos. Sete destes estudos encontram-se publicados em revistas internacionais com revisão por pares (Revisão sistemática e Estudos I, II, III, IV, VI, VII). O Estudo V encontra-se em processo de revisão. Foi ainda conduzido um estudo de viabilidade, que foi apresentado numa comunicação em formato poster nas Jornadas de Mindfulness e Compaixão, em Coimbra, em fevereiro de 2020. Os estudos empíricos encontram-se na Parte III desta tese, onde é feita uma exposição detalhada dos seus objetivos, metodologia (e.g., participantes e procedimentos, instrumentos e análise de dados) e resultados obtidos. O estudo de viabilidade encontra-se descrito sucintamente na Parte II, sendo descrito o processo de desenvolvimento e adaptação do programa, que culminou na versão final do manual do TMC-C. Encontra-se ainda, em anexo, um estudo empírico com coautoria da doutoranda, referente à adaptação e validação da Escala de Proximidade e Ligação aos Outros para Adolescentes (SSPS-A; Anexo D), que foi utilizada como medida de resultado da intervenção no Estudo empírico VI.

O programa desenvolvido no âmbito deste doutoramento encontra-se descrito na Parte I desta tese. A título ilustrativo, encontram-se disponíveis, em anexo, uma sessão integral do programa, os formulários desenvolvidos para avaliar componentes do programa e exemplos ilustrativos do Muro da Compaixão desenvolvido durante a aplicação do programa nas CAR (Anexo A, B e C, respetivamente).

No presente capítulo é apresentada uma visão global do projeto de investigação, dos seus objetivos gerais e específicos, bem como das opções metodológicas inerentes à sua concretização.

2. Objetivos

Esta tese tem como objetivo geral promover uma mentalidade afiliativa nas casas de acolhimento residencial de crianças e jovens, através do desenvolvimento, implementação e estudos de eficácia de um programa estruturado de Treino da Mente Compassiva para Cuidadores (TMC-C). Para alcançar a finalidade proposta, foram definidos os seguintes objetivos específicos:

1) Rever, de forma sistemática, os programas de treino/intervenção existentes, dirigidos a profissionais das casas de acolhimento e que tenham como objetivo promover a saúde emocional e mental no acolhimento residencial, e avaliar o efeito dos mesmos nos cuidadores, nos jovens, e nas relações interpessoais e/ou clima das casas de acolhimento [Revisão Sistemática da Literatura].
2) Adaptar e validar medidas de autorrelato dirigidas a adolescentes que avaliem construtos psicológicos associados ao modelo teórico da Terapia Focada na Compaixão [Estudos Empíricos I e II].
3) Compreender o papel das experiências de cuidados e segurança com os outros (passadas e correntes) no desenvolvimento de sintomatologia de ansiedade e depressão na adolescência [Estudo Empírico III].
4) Desenvolver um programa estruturado e manualizado de Treino da Mente Compassiva para Cuidadores (TMC-C) e testar a sua viabilidade em contexto do acolhimento residencial [Estudo de viabilidade do TMC-C].
5) Avaliar a capacidade do TMC-C para:
    a. Desenvolver uma mentalidade afiliativa nos cuidadores das casas de acolhimento residencial [Estudos Empíricos IV, V];
    b. Melhorar a qualidade de vida profissional e saúde mental dos cuidadores [Estudos Empíricos V e VII];
    c. Promover a ligação aos outros e relações de proximidade e segurança nos cuidadores e, indiretamente, nos jovens em acolhimento [Estudo Empírico VI];
    d. Melhorar o clima emocional das casas de acolhimento para os cuidadores e para os jovens em acolhimento [Estudo Empírico VI].
6) Avaliar a manutenção de ganhos alcançados com o TMC-C ao longo do tempo, percecionados pelos cuidadores e pelos jovens em acolhimento residencial [Estudos Empíricos VI e VII].

Para alcançar os objetivos propostos, foram concretizados diversos estudos, recorrendo a diferentes metodologias. Antes de procedermos à sua descrição, importa referir que os constrangimentos associados à pandemia (i.e., limitação no acesso às CAR e reajustamento do cronograma) que afetaram a execução do ensaio clínico, permitiram iniciar estudos, durante o tempo de confinamento, não incluídos no plano de trabalhos inicialmente proposto (i.e., revisão sistemática da literatura "Fostering emotional and mental health in residential youth care facilities: A systematic review of programs targeted to care workers" e estudo empírico III "Impact of early memories and current experiences of warmth and safeness on adolescents' psychological distress"). Esses estudos contribuíram para incrementar o conhecimento científico da área em estudo e para melhor sustentar, teórica e empiricamente, o programa proposto nesta tese.

Para sustentar o desenvolvimento do programa, foi conduzida a revisão sistemática da literatura "Fostering emotional and mental health in residential youth care facilities: A systematic review of programs targeted to care workers" com o intuito de identificar as respostas existentes na literatura relativamente aos programas disponíveis para cuidadores das CAR, que tivessem como objetivo promover a saúde emocional e mental dos jovens e/ou do próprio cuidador. Este estudo pretendeu também identificar os desenhos de investigação e metodologias utilizadas, bem como avaliar sistematicamente os efeitos dos programas em variáveis de saúde mental e emocional dos cuidadores e dos jovens e em variáveis associadas à qualidade das relações interpessoais e do clima na CAR. A revisão sistemática reforçou, não só a necessidade de desenvolvimento do programa, como permitiu ainda obter uma visão compreensiva das dificuldades práticas e metodológicas reportadas por outros estudos empíricos conduzidos neste contexto específico.

Tendo em conta as especificidades das populações em estudo neste trabalho de investigação, considerou-se ser também relevante estudar o papel das relações de cuidado na recuperação psicológica de jovens em acolhimento. De acordo com a investigação disponível, as crianças e jovens em acolhimento são um grupo particularmente vulnerável devido às experiências potencialmente traumáticas a que foram expostas ao longo do seu desenvolvimento (Fischer et al., 2016). A investigação nesta área tem-se centrado, maioritariamente, em torno das experiências de vida adversas experienciadas por estes jovens, durante a sua infância e início da adolescência, como os maus-tratos (Indias et al., 2019). Apesar de ser reconhecida a importância das relações interpessoais durante a adolescência, o papel das relações de suporte, pautadas por calor e segurança, entre cuidadores das CAR e jovens em

acolhimento tem sido pouco explorado enquanto fator de proteção (De Bellis & Zisk, 2014; James et al., 2017). Nesse sentido, o estudo empírico III (Impact of early memories and current experiences of warmth and safeness on adolescents' psychological distress) foi conduzido com o objetivo de investigar o papel das experiências atuais de cuidado e segurança na relação entre a presença/ausência de memórias de experiências precoces de calor e segurança e sintomatologia atual de ansiedade e depressão, em adolescentes da comunidade e em acolhimento. Este estudo combinou a análise de trajetórias e a análise de perfis latentes para compreender se as experiências atuais de cuidados e segurança poderão ser consideradas eventuais fatores protetores face a sintomatologia depressiva e ansiosa, prevalente em adolescentes da comunidade e em acolhimento (Bronsard et al., 2011; Jozefiak et al., 2016; Polanczyk et al., 2016).

Os dois estudos acima mencionados, juntamente com evidência fornecida pela literatura atual (Eenshuistra et al., 2019) e a necessidade evidente no terreno, apoiaram o desenvolvimento do programa proposto. Apesar da necessidade evidenciada para desenvolver e testar um programa desta natureza, revelou-se inicialmente necessário compreender se tal programa seria bem aceite e se a sua aplicação seria viável num contexto exigente e com necessidades específicas, como é o caso do acolhimento residencial de crianças e jovens. Neste sentido, foi realizado um estudo de viabilidade para testar: (i) a aceitabilidade da versão experimental do manual de TMC-C para o contexto de acolhimento residencial de crianças e jovens; (ii) a viabilidade dos procedimentos do ensaio clínico em contexto de vida real. Este estudo foi conduzido numa casa de acolhimento, com recurso a uma metodologia mista. A combinação de métodos qualitativos e quantitativos permitiu testar procedimentos de execução e de avaliação do ensaio clínico e otimizar o programa de intervenção (O'Cathain et al., 2013). Este estudo culminou na redação da versão final do manual do programa de TMC-C, um dos principais produtos desta tese. Este estudo permitiu avançar para a execução do ensaio clínico.

Para estudar o efeito dos fluxos da compaixão nos diferentes agentes das CAR, os estudos realizados no âmbito do ensaio clínico integraram a experiência de dar e receber compaixão na primeira e na segunda pessoa, com recurso a métodos quantitativos e qualitativos (Mascaro et al., 2020). Para esse efeito, o ensaio clínico aleatorizado por *clusters* apresentou um desenho longitudinal, composto por quatro medidas repetidas. Foram incluídas duas amostras, uma de cuidadores e outra de jovens em acolhimento residencial, recolhidas em 12 CAR. Para tornar este estudo exequível, as casas foram consideradas como unidade de aleatorização, tendo sido distribuídas por duas condições experimentais (intervenção e controlo; cf. Opções

metodológicas). Para estabelecer a eficácia inicial do programa em variáveis como a compaixão, afiliação e clima emocional da CAR, foi utilizado um desenho pré-pós-intervenção, com grupo de controlo, centrado no autorrelato dos cuidadores (Estudo empírico IV "Compassionate mind training for caregivers of residential youth care: Early findings of a cluster randomized trial").

Reconhecendo as limitações associadas aos questionários de autorrelato e o valor de abordagens multimodais (Van Dam et al., 2018), foi integrado um estudo qualitativo no ensaio clínico. Adicionalmente, a escolha desta abordagem baseou-se na possibilidade de poder complementar, contextualizar e facilitar a interpretação dos dados quantitativos (Drabble et al., 2014; Mascaro et al., 2020). Esse estudo foi realizado com uma amostra de cuidadores, após a sua participação no programa, recorrendo ao método do grupo focal para recolha de dados (Estudo V "Compassionate Mind Training for caregivers in residential youth care: Investigating their experiences through a thematic analysis"). O estudo empírico V pretendeu compreender as experiências de participação no TMC-C e o valor de uma abordagem focada na compaixão neste contexto específico de prestação de cuidados. Dadas as dificuldades de transferência das aprendizagens dos programas para as práticas de acolhimento reportadas na investigação (Liu & Smith, 2011; Morison, 2018), este estudo pretendeu compreender de que modo os cuidadores transferiram as aprendizagens e práticas do TMC-C para contexto de vida real, bem como a sua perceção de mudança a nível individual, da equipa e da organização. Incluiu ainda a perspetiva dos cuidadores relativamente a eventuais mudanças indiretas nos jovens decorrentes da sua participação no TMC-C.

Paralelamente às variáveis associadas à compaixão, foram testados os efeitos do TMC-C na qualidade de vida profissional e na saúde mental dos cuidadores (Estudo empírico VII "The effects of the Compassionate Mind Training for Caregivers on professional quality of life and mental health over time: A cluster randomized trial in residential youth care"), e em variáveis afiliativas (e.g., proximidade e ligação aos outros) e organizacionais (e.g., clima emocional percecionado na CAR) autorrelatadas por cuidadores e por jovens (Estudo empírico VI "Fostering an affiliative environment in residential youth care: A cluster randomized trial of a compassionate mind training program for caregivers enrolling youth and their caregivers"). O estudo empírico VI procurou testar o efeito do TMC-C, quer na qualidade das relações estabelecidas entre cuidadores e jovens, quer no clima emocional das CAR, tendo sido recolhida para esse efeito, uma amostra de jovens em acolhimento residencial. Os estudos empíricos VI e VII avaliam ainda a estabilidade das mudanças, seis meses após a conclusão do programa.

Considerando que a pandemia impactou a sociedade em geral, e em particular o funcionamento das CAR, no estudo empírico VII (The effects of the Compassionate Mind

Training for Caregivers on professional quality of life and mental health over time: A cluster randomized trial in residential youth care) procurou-se explorar, ainda que de forma preliminar, o efeito do TMC-C e da pandemia na qualidade de vida e saúde mental dos profissionais das CAR.

Para testar a eficácia do programa foi necessário adaptar e validar três instrumentos de autorresposta dirigidos a jovens em acolhimento, que permitissem avaliar variáveis de relevo tendo em conta o modelo conceptual do programa.

A qualidade das relações estabelecidas entre jovens e cuidadores é central neste trabalho de investigação. No entanto, a avaliação desta variável em contexto de acolhimento residencial é complexa, uma vez que os jovens têm múltiplos cuidadores, que trabalham em diferentes turnos, e com quem podem estabelecer diferentes padrões de interação (Izzo et al., 2020). Uma vez que os cuidadores trabalham em equipas e que nem todas as CAR funcionam com base no modelo de adulto de referência, não se revelou adequado avaliar a qualidade das relações interpessoais por díades. De acordo com recomendações fornecidas pela investigação, foi realizada uma avaliação das experiências subjetivas do jovem com os cuidadores das casas (Howes & Spieker, 2016), em relação à perceção de cuidado, calor e segurança com os outros, associada à ativação do sistema de afiliação/apaziguamento. Estas variáveis encontram-se alinhadas com o modelo conceptual do programa e com indicadores positivos de desenvolvimento e de saúde mental em adolescentes (Gilbert, 2010a; Marta-Simões et al., 2020).

Neste sentido, foram conduzidos os estudos de adaptação e validação da Escala de Avaliação do Clima Emocional para Jovens em Acolhimento Residencial (ECRC-Y; Estudo empírico I "Emotional Climate in Residential Care Scale for Youth: Psychometric properties and measurement invariance"), da Escala de Experiências Atuais de Cuidados e Segurança para Adolescentes (CEWSS-A; Estudo empírico II "Development and validation of the Current Experiences of Warmth and Safeness Scale in community and residential care adolescents"), e da Escala de Proximidade e Ligação aos Outros para Adolescentes (SSPS-A; Anexo D "Dimensionality and measurement invariance of the Social Safeness and Pleasure Scale in adolescents from community and residential youth care"). Nestes estudos, foram analisadas as propriedades psicométricas das escalas, testada a sua dimensionalidade e invariância do modelo de medida entre rapazes e raparigas. Na validação da CEWSS-A e da SSPS-A foram também incluídas amostras de adolescentes da comunidade e testada a invariância do modelo de medida entre adolescentes da comunidade e adolescentes em acolhimento residencial. Os objetivos específicos de cada estudo encontram-se apresentados no Quadro 1.

Quadro 1. *Objetivos específicos dos estudos*

Capítulo	Estudo	Objetivos específicos
4	Revisão sistemática da literatura	– Identificar e sintetizar os programas de treino/intervenção dirigidos a profissionais das casas de acolhimento que tenham como objetivo promover a saúde emocional e mental no acolhimento residencial; – Identificar os desenhos de investigação utilizados; – Avaliar, de forma sistemática, o efeito dos programas nos cuidadores, nos jovens, e nas relações interpessoais e/ou clima organizacional.
5	Estudo empírico I	– Adaptar e validar a Escala de Avaliação do Clima Emocional para Jovens em Acolhimento Residencial; – Analisar a dimensionalidade e as propriedades psicométricas da escala; – Testar a invariância do modelo de medida por sexo.
	Estudo empírico II	– Adaptar e validar a Escala de Experiências Atuais de Cuidados e Segurança para adolescentes da comunidade e em acolhimento residencial; – Analisar a dimensionalidade e as propriedades psicométricas da escala; – Testar a invariância do modelo de medida por sexo e grupo.
6	Estudo empírico III	– Explorar o papel das memórias de experiências passadas e das experiências atuais de cuidados e segurança com os outros no desenvolvimento de sintomatologia de ansiedade e depressão na adolescência; – Testar o efeito direto das memórias precoces de calor e segurança na sintomatologia ansiosa e depressiva, bem como o efeito indireto das experiências atuais de cuidados e segurança na relação entre as memórias precoces de cuidados e segurança e sintomatologia ansiosa e depressiva, em adolescentes da comunidade e adolescentes em acolhimento residencial; – Testar a invariância do modelo por sexo e por grupo; – Identificar perfis de jovens em acolhimento com base nas suas memórias de infância e experiências atuais de cuidados e segurança; – Comparar os diferentes perfis relativamente à probabilidade de sintomatologia ansiosa e depressiva na adolescência.
7	Estudo empírico IV	– Testar os efeitos preliminares do programa de TMC-C na promoção de uma mentalidade afiliativa nos cuidadores.
	Estudo empírico V	– Compreender a experiência dos cuidadores com o programa de TMC-C; – Compreender a transferência das aprendizagens do TMC-C para as práticas de acolhimento; – Avaliar o impacto do desenvolvimento de uma motivação e atitude compassiva a nível pessoal, da equipa e da organização; – Analisar o impacto indireto do TMC-C nos jovens em acolhimento residencial.

Estudo empírico VI	– Testar a eficácia do TMC-C na promoção da afiliação e melhoria do clima emocional das casas de acolhimento, através do autorrelato de cuidadores e de jovens em acolhimento; – Avaliar a estabilidade das mudanças reportadas por cuidadores e jovens em acolhimento, 6 meses após a intervenção.
Estudo empírico VII	– Testar a eficácia do TMC-C na melhoria da qualidade de vida profissional e saúde mental dos cuidadores; – Avaliar a estabilidade das mudanças 3 e 6 meses após a intervenção.

3. Opções metodológicas

3.1 Desenho dos estudos e participantes

Os estudos empíricos incluídos nesta tese apresentam desenhos de investigação transversais e longitudinais, tendo também sido realizada uma revisão sistemática da literatura. Os procedimentos metodológicos e resultados do estudo de viabilidade encontram-se descritos no ponto 3.3.1. O Quadro 2 sintetiza o desenho e número de participantes em cada um dos diferentes estudos empíricos.

Quadro 2. *Desenho de investigação e participantes dos estudos empíricos*

Estudos empíricos	Desenho	Participantes		
		Cuidadores	Jovens	
			Acolhimento	Comunidade
Estudo I	Transversal	-	372	-
Estudo II	Transversal	-	319	453
Estudo III	Transversal		293	433
Estudo IV	Longitudinal	114	-	-
Estudo V	Transversal	19	-	-
Estudo VI	Longitudinal	127	154	-
Estudo VII	Longitudinal	127	-	-

O estudo "Fostering emotional and mental health in residential youth care facilities: A systematic review of programs targeted to care workers" é uma revisão sistemática da literatura sobre a existência e respetiva eficácia de programas dirigidos a cuidadores para promover saúde mental e emocional nas CAR.

Os estudos empíricos I (Emotional Climate in Residential Care Scale for Youth: Psychometric properties and measurement invariance) e II (Development and validation of the Current Experiences of Warmth and Safeness Scale in community and residential care adolescents), são estudos transversais de adaptação e validação de escalas de avaliação. O

estudo empírico I incluiu uma amostra de 372 jovens em acolhimento residencial (38.2% rapazes e 61.8% raparigas), com idades compreendidas entre os 12 e os 24 anos. O estudo II envolveu uma amostra de 772 adolescentes (49% rapazes e 51% raparigas), dos 14 aos 18 anos de idade, dos quais 453 eram adolescentes da comunidade e 319 adolescentes em acolhimento residencial.

O estudo empírico III (Impact of early memories and current experiences of warmth and safeness on adolescents' psychological distress) apresenta um desenho transversal. Neste estudo utilizou-se uma amostra composta por 726 adolescentes, com idades compreendidas entre os 14 e os 18 anos, 433 eram adolescentes da comunidade (48.3% rapazes e 51.7% raparigas) e 293 eram adolescentes em acolhimento residencial (48.1% rapazes e 51.9% raparigas).

Os estudos empíricos IV (Compassionate mind training for caregivers of residential youth care: Early findings of a cluster randomized trial), V (Compassionate Mind Training for caregivers in residential youth care: Investigating their experiences through a thematic analysis), VI (Fostering an affiliative environment in residential youth care: A cluster randomized trial of a compassionate mind training program for caregivers enrolling youth and their caregivers) e VII (The effects of the Compassionate Mind Training for Caregivers on professional quality of life and mental health over time: A Cluster randomized trial in residential youth care) foram realizados no âmbito do ensaio clínico. Devido aos diferentes objetivos e variáveis em estudo, bem como aos métodos de análise de dados utilizados, estes estudos apresentam amostras de tamanho variável, partilhando, no entanto, a mesma amostra de base de cuidadores. O estudo empírico VI integra também uma amostra de jovens em acolhimento, residentes nas mesmas CAR onde foi recolhida a amostra de cuidadores. Os estudos empíricos IV (dois momentos de avaliação), VI (três momentos de avaliação) e VII (quatro momentos de avaliação) são longitudinais e utilizam uma metodologia quantitativa, enquanto que o estudo empírico V utiliza uma metodologia qualitativa. De seguida, serão descritos os procedimentos de recrutamento das duas amostras gerais do ensaio clínico (cuidadores e jovens). O número de participantes de cada estudo empírico encontra-se especificado no Quadro 2.

O presente trabalho de investigação integrou um ensaio clínico aleatorizado por *clusters* (Cluster Randomized Trial – CRT), que decorreu em 12 CAR localizadas em Portugal continental. O CRT foi desenhado de acordo com *Consort 2010 statement: extension to cluster randomised trials* (Campbell et al., 2012) e encontra-se registado em ClinicalTrials.gov (Identifier: NCT04512092).

No processo de recrutamento, foram inicialmente contactadas 20 CAR, de acordo com os seguintes critérios de elegibilidade: (i) CAR generalistas; (ii) maioritariamente dirigidas a jovens; (iii) localizadas nos distritos de Coimbra e de Leiria. As CAR especializadas foram excluídas por possuírem modelos socioeducativos e terapêuticos específicos para responder às necessidades da população alvo acolhida (e.g., problemas de conduta, consumo de substâncias). De acordo com o mesmo critério, as CAR maioritariamente dirigidas a crianças, com idade inferior a 12 anos, foram igualmente excluídas, considerando as necessidades específicas de intervenção com bebés e crianças. A seleção geográfica atendeu a critérios práticos e de viabilidade do estudo.

Doze CAR aceitaram participar no CRT. Todos os colaboradores dessas casas, regularmente envolvidos na prestação de cuidados aos jovens, foram convidados a participar de forma voluntária. Foram também convidados a participar voluntariamente os jovens acolhidos nessas casas, abrangidos pelos os seguintes critérios de elegibilidade: (i) idade compreendida entre 12 e 25 anos; (ii) capacidade de compreensão e interpretação da leitura e da escrita; (iii) com previsão de tempo de medida de acolhimento residencial superior a 6 meses. Os critérios i e ii pretendem assegurar a compreensão e interpretação dos instrumentos incluídos na bateria de avaliação e controlar eventuais enviesamentos nas respostas. Neste sentido, de acordo com a informação fornecida pelo psicólogo de cada CAR, jovens com défice cognitivo com interferência significativa na capacidade de compreensão foram excluídos. Jovens com défice cognitivo ligeiro foram incluídos. Nesses casos, a bateria de avaliação foi preenchida, individualmente, em formato de entrevista, a fim de assegurar que o conteúdo dos itens dos questionários fosse devidamente compreendido. Atendendo ao período normativo de desenvolvimento cognitivo e de linguagem, crianças com idade inferior a 12 anos foram também excluídas (Conijn et al., 2020). O limite de 25 anos de idade foi definido de acordo com o estabelecido pela LPCJP (art.º 5º), como idade limite para manter uma medida de colocação em acolhimento residencial. Ainda que o tempo das medidas não possa ser facilmente previsto, jovens cujo tempo expectável de medida fosse inferior à duração do estudo, não foram incluídos.

Participaram no CRT 127 cuidadores e 154 jovens em acolhimento de 12 CAR. As CAR foram aleatoriamente distribuídas por: grupo de intervenção (6 CAR) e grupo de controlo (6 CAR). Os cuidadores eram maioritariamente do sexo feminino (89%) e tinham idades compreendidas entre os 22 e os 62 anos (M = 43.99; DP = 10.96). A maioria dos cuidadores eram casados (69%), 23% solteiros, e 7.9% divorciados. Na data do início do estudo, os participantes encontravam-se, em média, a trabalhar na atual CAR havia 11.95 anos (DP = 8.99; variando de

0 a 39 anos), sendo que 29.4% exerciam funções técnicas (e.g., diretor técnico, psicólogo, assistente social), 63.5% educativas (e.g., educadores) e 7.1% de suporte (e.g., cozinheiro, serviços gerais). Aproximadamente metade dos participantes (52%) reportou trabalhar por turnos. No que diz respeito às habilitações académicas, 44.1% reportou ter um grau académico do ensino superior, 19.7% completou o ensino secundário e 36.2% completou o segundo ou o terceiro ciclo do ensino básico. Dos 127 cuidadores, 66 participantes ficaram alocados no grupo de intervenção e 61 no grupo de controlo.

A amostra de jovens era composta por participantes de ambos os sexos (44.2% rapazes e 55.8% raparigas), com idades compreendidas entre os 12 e os 23 anos de idade (M = 16.19, DP = 2.07). A maioria dos jovens era de nacionalidade portuguesa (97.4%) e vivia, em média, na presente CAR há 40.81 meses (DP = 41.94; variando entre 1 a 216 meses). Para a maioria dos jovens, este era o seu primeiro acolhimento (62.3%). Os principais motivos de acolhimento foram a negligência (46.8%), os maus-tratos (27%), o abandono ou ausência temporária de suporte familiar (10.6%), comportamento desviante (9.7%), e outros motivos (4.5%). Relativamente ao nível de escolaridade, 5.9% dos jovens estava a frequentar o 2º ciclo do ensino básico, 49.3% o 3º ciclo do ensino básico, 38.8% o ensino secundário, e 5.9% o ensino superior. A maioria dos jovens reportou ter pelo menos uma reprovação de ano escolar (74%) e 31.8% reportou usufruir de medidas educativas especiais (31.8%). Dos 154 jovens, 65 participantes ficaram alocados no grupo de intervenção e 89 no grupo de controlo.

Cuidadores e jovens foram avaliados em quatro momentos distintos: antes da intervenção, após a intervenção, 3 e 6 meses após a conclusão da intervenção (avaliação de *follow-up*). Após a primeira avaliação, as CAR foram aleatoriamente distribuídas pelas duas condições (grupo de intervenção e grupo de controlo). Os cuidadores das CAR alocadas no grupo de intervenção receberam as 12 sessões do TMC-C, em formato presencial. Os períodos de avaliação *follow-up* decorreram durante a pandemia. Por esse motivo, os procedimentos de recolha de dados foram adaptados. O primeiro *follow-up* decorreu durante um período de confinamento geral, o que motivou o fecho das CAR a elementos externos. Consequentemente, os dados desse momento de *follow-up* não foram recolhidos presencialmente. Ainda decorrente da pandemia e respetivo confinamento geral, no primeiro momento de *follow-up,* registaram-se perdas amostrais acrescidas, devido a baixas médicas e de apoio à família e a transferências de profissionais para outras respostas sociais das IPSS. Relativamente aos jovens, as CAR e as entidades responsáveis pela tomada de decisão nos processos de promoção e proteção, foram forçadas a executar medidas extraordinárias tendo em vista a diminuição do número de utentes nas CAR. Deste modo, assistiu-se a cessações de medidas antecipadas ou inicialmente não

programadas, e a períodos prolongados de ausência das CAR. O segundo momento de *follow-up* correspondeu a uma fase mais estável da pandemia. Nesta fase, as CAR já se começavam a reorganizar em termos de procedimento e gestão de recursos humanos, e os jovens começavam a reintegrar novamente as CAR. Para lidar com a perda amostral, optou-se por recolher os dados dos participantes no segundo momento de *follow-up*, mesmo que os não tivessem preenchido o primeiro.

Relativamente à amostra de cuidadores, dos 66 participantes que ficaram alocados ao grupo de intervenção e que completaram a avaliação em pré-intervenção, sete (10.61%) não concluíram o programa, três devido a baixa médica prolongada, dois devido a rescisão de contrato, e dois desistiram do programa. Cinquenta e nove (89.39%) participantes concluíram o programa, 57 (86.36%) completaram a avaliação após a intervenção, 52 (72.79%) a avaliação 3 meses após a intervenção, e 48 (72.73%) a avaliação 6 meses após a intervenção. A perda amostral deveu-se a rescisão de contrato (n = 4), protocolos inválidos (n = 3), baixa médica ou de apoio à família (n = 3), transferência de recursos humanos para outras respostas sociais das IPSS durante a pandemia (n = 1), e desistência do estudo (n = 1). Os cuidadores frequentaram, em média, 10 sessões (M = 9.52; DP = 1.99) do programa, variando o número de sessões frequentadas entre 5 e 12 sessões. As ausências registadas foram devidas a dias de folga, férias, baixa médica ou diligência profissional.

Dos 61 cuidadores que ficaram alocados ao grupo de controlo, 51 (83.61%) completaram a avaliação após a intervenção, 42 (68.85%) a avaliação 3 meses após a intervenção, e 43 (70.49%) a avaliação 6 meses após a intervenção. No grupo de controlo os motivos que conduziram a perda amostral foram a desistência do estudo (n = 11), baixa médica (n = 5), rescisão de contrato (n = 5) e transferência de recursos humanos para outras respostas sociais das IPSS durante a pandemia (n = 2). Devido à pandemia, quatro participantes foram avaliados apenas no segundo momento de *follow-up*.

Relativamente à amostra de jovens, dos 65 participantes que ficaram alocados ao grupo de intervenção e que completaram a avaliação em pré-intervenção, 55 (84.62%) completaram a avaliação após a intervenção, 46 (70.77%) a avaliação 3 meses após a intervenção, e 47 (72.31%) a avaliação 6 meses após a intervenção. Os motivos que conduziram a perda amostral foram a cessação de medida (n = 11), serviço militar (N = 1), férias (n = 1), desistência do estudo (n = 3). Dos 89 jovens alocados ao grupo de controlo, 78 (87.64%) completaram a avaliação após a intervenção, 64 (71.91%) a avaliação 3 meses após a intervenção, e 62 (69.66%) a avaliação 6 meses após a intervenção. Os motivos que conduziram a perda amostral no grupo de controlo foram a cessação de medida (n = 18), fuga (n = 2), transferência de instituição (n = 2), protocolo

inválido (n = 2), desistência do estudo (n = 12). Devido à pandemia sete jovens foram avaliados apenas no segundo momento de *follow-up*.

Para lidar com as perdas amostrais associadas à pandemia, foram recrutadas mais casas para aplicação do programa. Duas casas iniciaram o programa, contudo o mesmo não foi concluído, devido a novo confinamento geral.

A Figura 1 apresenta o fluxograma da participação de cuidadores e jovens das CAR recrutadas, ao longo dos quatro momentos de avaliação do CRT.

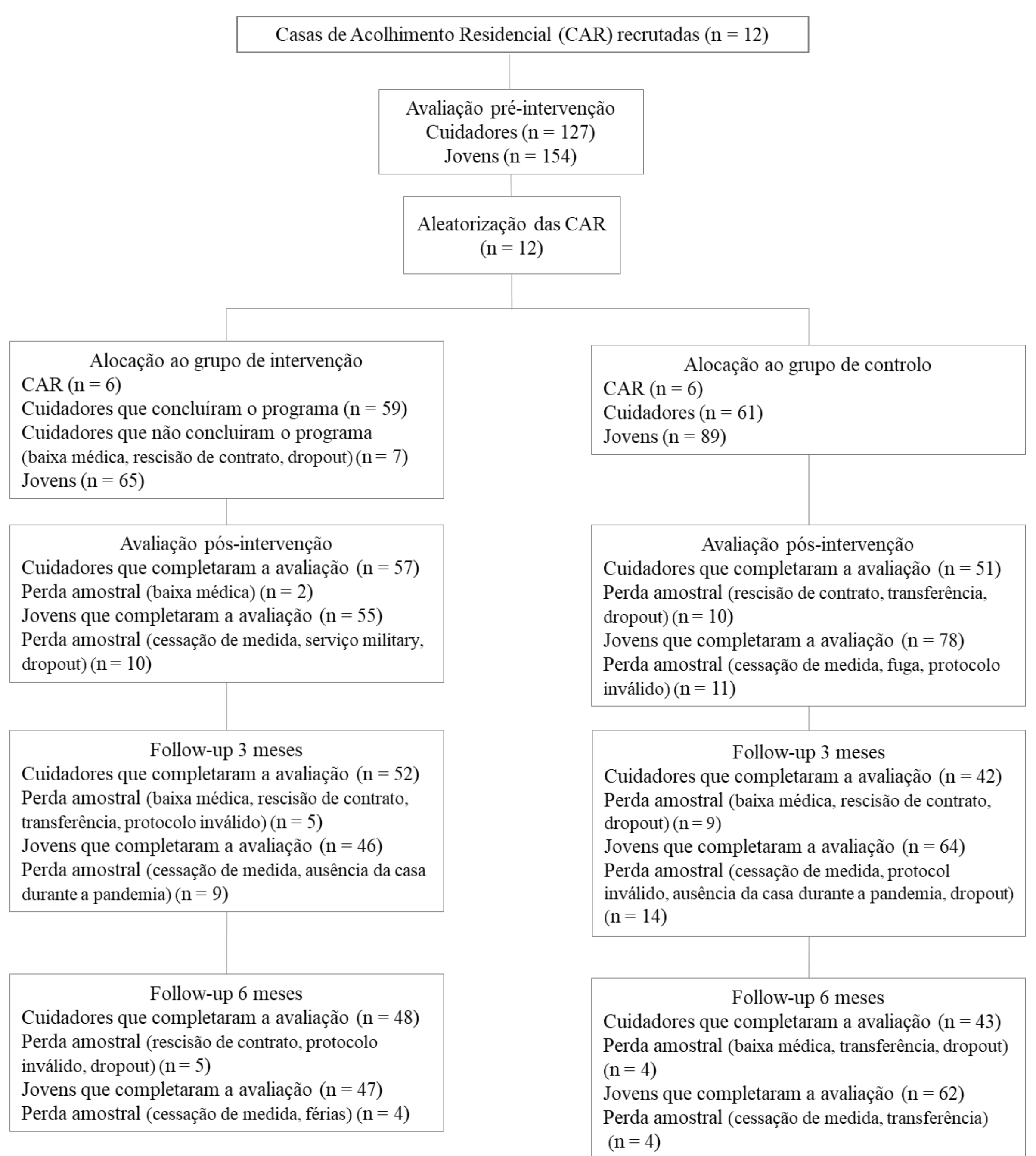

Figura 1. *Fluxograma dos participantes no CRT*

No estudo empírico VI (Fostering an affiliative environment in residential youth care: A cluster randomized trial of a compassionate mind training program for caregivers enrolling youth and their caregivers), que integrou a amostra de cuidadores e de jovens, optou-se por incluir apenas os dados do *follow-up* de seis meses. Esta escolha deveu-se ao facto de os dados do *follow-up* de 3 meses terem sido recolhidos durante o primeiro confinamento geral, que provocou as dificuldades mencionadas de acesso às CAR e respetivos constrangimentos na recolha de dados. Os constrangimentos acima mencionados impactaram no número de protocolos recolhidos, bem como na confiança na fiabilidade dos dados. Deste modo optou-se por incluir apenas o *follow-up* de seis meses, num período de maior estabilidade pandémica. No estudo empírico VII (The effects of the Compassionate Mind Training for Caregivers on professional quality of life and mental health over time: A cluster randomized trial in residential youth care) incluíram-se os dois momentos de *follow-up*, uma vez que foi integrada unicamente a amostra de cuidadores (preenchimento autónomo dos questionários) e explorado o potencial efeito da pandemia.

Ainda dentro do CRT, o estudo empírico V (Compassionate Mind Training for caregivers in residential youth care: Investigating their experiences through a thematic analysis), conduzido com recurso a metodologia qualitativa, incluiu uma amostra de 19 cuidadores do grupo de intervenção (89.47% do sexo feminino), que se voluntariaram a participar num grupo focal, após a conclusão do programa. Esta amostra incluiu nove profissionais com funções técnicas e 10 profissionais com funções educativas. Devido aos constrangimentos de acesso às CAR e reorganização organizacional durante a pandemia, neste estudo participaram apenas as primeiras três primeiras CAR que concluíram o TMC-C.

3.2 Instrumentos

Nos estudos que compõem esta tese foram utilizadas metodologias de avaliação quantitativas e qualitativas. Nos estudos transversais e longitudinais, os participantes (cuidadores e jovens) responderam a uma bateria de questionários de autorresposta. Para os estudos com metodologia qualitativa foram construídos guiões de discussão, de acordo com os objetivos dos respetivos estudos. Foram ainda desenvolvidas fichas de avaliação processual das sessões do TMC-C. Os instrumentos utilizados encontram-se sucintamente descritos em seguida. O Quadro 3 indica que instrumentos foram utilizados nos diferentes estudos empíricos que compõem esta tese.

Quadro 3. *Instrumentos de avaliação e variáveis avaliadas nos estudos empíricos*

Variáveis		Instrumentos	Estudos empíricos						
			I	II	III	IV	V	VI	VII
Informação sociodemográfica, processual, e relacionada com a pandemia de COVID-19	Dados sociodemográficos	Ficha de dados sociodemográficos	v	v	v	v	v	v	v
	Dados processuais	Ficha de dados processuais	v	-	-	-	-	v	-
	Coping com a pandemia	Ficha de informação relacionada com a pandemia	-	-	-	-	-	v	v
Compaixão	Compaixão pelos outros	CS	-	-	-	v	-	v	-
		CS-A	-	v	-	-	-	-	-
	Autocompaixão	SELFCS	-	-	-	v	-	v	v
	Medos da compaixão	FCS	-	-	-	v	-	-	-
Afiliação	Proximidade e ligação aos outros	SSPS	-	-	-	v	-	v	-
		SSPS-A	-	-	-	-	-	v	-
	Clima emocional da CAR	EACELT	-	-	-	v	-	v	-
		ECRC-Y	v	-	-	-	-	v	-
	Experiências atuais de cuidados e segurança	CEWSS-A	v	v	v	-	-	v	-
	Memórias Precoces de Calor e Segurança	EMWSS-A	-	v	v	-	-	-	-
Funcionamento psicológico	Satisfação por compaixão, *burnout*, STS	ProQOL-5	-	-	-	-	-	v	v
	Depressão, ansiedade e stress	DASS-21	-	v	v	-	-	-	v
	Afeto positivo e afeto negativo	PANAS	v	v	-	-	-	-	-
	Comportamento agressivo	PCS	-	v	-	-	-	-	-
	Problemas internalizantes e externalizantes	SDQ	v	-	-	-	-	-	-
Aceitabilidade e utilidade do TMC-C	Experiências de participação no TMC-C e efeitos do programa	Guião de discussão	-	-	-	-	v	-	-

3.2.1 Fichas de dados sociodemográficos e processuais

Foram construídas fichas de dados sociodemográficos para obter informações relevantes sobre os participantes para os diferentes estudos. Foi ainda construída uma ficha para recolha de informação processual sobre os jovens em acolhimento.

Foram construídas três versões da ficha de recolha de dados sociodemográficos. Versão para: (1) cuidadores; (2) jovens em acolhimento; (3) adolescentes da população geral. Estas fichas foram preenchidas pelos próprios participantes e incluíam questões gerais como a idade e o sexo, e questões específicas relacionadas com a amostra de pertença. Para os cuidadores, foi recolhida informação acerca do estado civil, número de anos de serviço, habilitações académicas e função desempenhada na casa. Foi também avaliada a existência de trabalho por turnos, outro emprego, apoio psicológico e/ou psiquiátrico, consumo de psicofármacos, formação prévia especifica em acolhimento, formação prévia em abordagens focadas na compaixão, e prática prévia de meditação. Em relação aos jovens em acolhimento, a ficha recolhia dois tipos de informação. A primeira parte destinava-se a recolher informação geral, igualmente recolhida na amostra de adolescentes da comunidade, respetiva à nacionalidade, ano escolar, número de reprovações, existência de necessidades educativas especiais, apoio psicológico e/ou pedopsiquiátrico ou consumo de psicofármacos, e Nível Socioeconómico (NSE). O NSE foi classificado como baixo, médio ou elevado, de acordo com as profissões do agregado familiar (anterior ao acolhimento), segundo o Instituto Nacional de Estatística (2011). A segunda parte da ficha destinava-se a recolher informação relativa ao processo de acolhimento, nomeadamente, se existiam acolhimentos prévios e tempo de acolhimento na casa atual. Informação sensível, associada aos motivos de acolhimento, foi recolhida através de uma ficha processual dirigida aos psicólogos de cada CAR.

3.2.2 Ficha de informação relacionada com a pandemia

Uma vez que a pandemia surgiu durante o ensaio clínico, foi adicionada à bateria de avaliação dos cuidadores, uma ficha com perguntas destinadas a avaliar o nível de ansiedade provocado pela pandemia. Desta ficha constavam perguntas de resposta única como: “De 0 a 10, em que 0 corresponde a “nada” e 10 a “extremamente”, por favor indique o nível de ansiedade que o panorama atual do COVID-19 lhe causa”. No grupo de intervenção, esta ficha apresentava questões adicionais relacionadas com a utilidade do TMC-C para lidar com as exigências associadas à pandemia (“De 0 a 10, em que 0 corresponde a “nada” e 10 a “extremamente”, por favor indique em que medida o TMC-C é útil para o ajudar a lidar com o panorama atual do COVID-19, por exemplo, medo, ansiedade, alteração de rotinas e de hábitos,

isolamento social, incerteza relativa ao futuro") e com as crianças e jovens em acolhimento durante os períodos de confinamento (De 0 a 10, em que 0 corresponde a "nada" e 10 a "extremamente", por favor indique em que medida o TMC é útil para o ajudar a lidar com as crianças e jovens em acolhimento durante a atual pandemia do COVID-19").

3.2.3 Questionários de autorresposta para cuidadores

3.2.3.1 CS - Compassion Scale/Escala da Compaixão

A Escala da Compaixão (Pommier, 2011; versão portuguesa de Sousa et al., 2017) é um instrumento de autorresposta, composto por 24 itens, destinado a avaliar a compaixão pelos outros. Originalmente, o instrumento está organizado em seis fatores: bondade (4 itens, e.g., "Se vejo alguém a passar por um momento difícil, tento ser atencioso e caloroso com essa pessoa"), humanidade comum (4 itens, e.g., "Toda a gente se sente triste por vezes; faz parte de ser-se humano"), mindfulness (4 itens, e.g., "Presto muita atenção quando as pessoas falam comigo"), indiferença (4 itens, e.g., "Por vezes quando as pessoas falam sobre os seus problemas, sinto que não me importo"), desligamento (4 itens, e.g., "Não me sinto emocionalmente ligado a pessoas que estão em sofrimento") e o não envolvimento (4 itens, e.g., "Quando as pessoas choram à minha frente, a maior parte das vezes, não sinto nada"). Os participantes são instruídos a referir a frequência com que se comportam em relação aos outros, recorrendo a uma escala de cinco pontos (1 = quase nunca a 5 = quase sempre).

No estudo original, o instrumento revelou um excelente indicador de consistência interna para o total da escala ($\alpha = .90$) e níveis pobres a aceitáveis para as subescalas, que variam entre .57 (não envolvimento) e .77 (bondade; Pommier, 2011). No presente estudo, foi utilizado o modelo bifatorial encontrado na versão portuguesa, que agrupa as subescalas em dois fatores de ordem superior: compaixão (bondade, humanidade comum e mindfulness) e desconexão (indiferença, desligamento e não envolvimento). Ambos revelaram excelentes indicadores de consistência interna (.91 e .92, respetivamente; Sousa et al., 2017). Na amostra do presente CRT, os valores do alfa de *Cronbach* foram de .79 para a compaixão e .85 para desconexão.

3.2.3.2 SELFCS - Self-Compassion Scale/Escala de Autocompaixão

A Escala de Autocompaixão (Neff, 2003a; versão portuguesa de Castilho et al., 2015) é um instrumento de autorresposta, composto por 26 itens, distribuídos por seis subescalas: bondade (5 itens, e.g., "Tento ser carinhoso comigo próprio quando estou a sofrer emocionalmente"), humanidade comum (4 itens, e.g., "Tento ver os meus erros e falhas como parte da condição humana"), mindfulness (4 itens, e.g., "Quando alguma coisa dolorosa

acontece tento ter uma visão equilibrada da situação") autocrítica (5 itens, e.g., "Desaprovo-me e faço julgamentos acerca dos meus erros e inadequações"), isolamento (4 itens, e.g., "Quando falho nalguma coisa importante para mim tendo a sentir-me sozinho no meu fracasso") e sobre identificação (4 itens, e.g., "Quando alguma coisa dolorosa acontece tendo a exagerar a sua importância"). Cada item é respondido de acordo com uma escala de cinco pontos (1 = quase nunca a 5 = quase sempre). O total da escala pode ser calculado através do somatório das pontuações das subescalas (após inverter os itens das subescalas negativas).

No estudo original, o instrumento apresentou bons indicadores de consistência interna para o total da escala (α = .92) e para as subescalas, que variam entre .75 (mindfulness) a .81 (sobre identificação). Apresentou também bons níveis de estabilidade temporal (r = .93; Neff, 2003a). A versão portuguesa obteve bons níveis de consistência interna, que variaram entre .85 (humanidade comum e mindfulness) e .93 (autocrítica). A estabilidade temporal foi aceitável (r = .78; Castilho et al., 2015). No presente estudo, foi utilizado o modelo bifatorial encontrado num estudo com a versão portuguesa (Costa et al., 2015), que agrupa as subescalas em dois fatores de segunda ordem: atitude autocompassiva (bondade, humanidade comum e mindfulness) e atitude autocrítica (autocrítica, isolamento e sobre identificação). Ambos revelaram bons indicadores de consistência interna (.91 e .89, respetivamente). Na amostra deste CRT, os valores do alfa de *Cronbach* foram de .87 para atitude autocompassiva e .88 para atitude autocrítica.

3.2.3.3 FCS - Fears of Compassion Scales/Escala dos Medos da Compaixão

A Escala dos Medos da Compaixão (Gilbert et al., 2010; tradução e adaptação de Matos et al., 2011) é um instrumento de autorresposta que compreende três subescalas. Cada subescala avalia, respetivamente, o medo de desenvolver compaixão pelos outros (10 itens, 9 na versão portuguesa, e.g., "Existem pessoas na vida que não merecem a nossa compaixão"), medo de receber compaixão por parte dos outros (13 itens, e.g., "Fico algo assustado com sentimentos de amabilidade por parte dos outros") e medo da autocompaixão (15 itens, e.g., "Na vida tem de se ser duro e não compassivo"). Cada item é respondido de acordo com uma escala de cinco pontos (0 = discordo totalmente a 4 = concordo totalmente).

No estudo original, foram encontrados valores de alfa de *Cronbach* de .72 para a subescala do medo de dar compaixão, .80 para o medo de receber compaixão e .83 para o medo da autocompaixão (Gilbert et al., 2011). A versão portuguesa revelou bons indicadores de consistência interna, com valores de alfa de *Cronbach* de .88 para a subescala do medo de dar compaixão, .91 para a subescala do medo de receber compaixão e de .94 para a subescala do

medo da autocompaixão (Simões, 2012). Na amostra deste CRT, as consistências internas encontradas foram de .91 para a subescala do medo de dar compaixão, .95 para a subescala do medo de receber compaixão e .96 para a subescala de medo da autocompaixão.

3.2.3.4 SSPS - Social Safeness and Pleasure Scale/Escala de Proximidade e Ligação aos Outros

A Escala de Proximidade e Ligação aos Outros (Gilbert et al., 2009; tradução e adaptação de Dinis et al., 2008) é um instrumento de autorresposta composto por 11 itens, que avalia a forma como as pessoas experienciam sentimentos e emoções positivas em situações sociais (e.g., "Sinto-me satisfeito nas minhas relações com os outros."). Cada item é respondido numa escala de cinco pontos (1 = quase nunca a 5 = quase sempre). No estudo original, a escala revelou um excelente nível de consistência interna (α = .91; Gilbert et al., 2009). Na amostra do presente CRT, o alfa de Cronbach foi de .88.

3.2.3.5 EACELT- Escala de Avaliação do Clima Emocional no Local de Trabalho

A Escala de Avaliação do Clima Emocional no Local de Trabalho (Albuquerque et al., 2020) é um instrumento de autorresposta, composto por 30 itens, que avalia como os trabalhadores se sentiram no local de trabalho nas últimas duas semanas. O instrumento divide-se em duas partes: a primeira avalia as emoções sentidas no local de trabalho (15 itens), e a segunda avalia os motivos/motivações que levaram o trabalhador a comportar-se de determinada forma (15 itens). Os itens de ambas as partes agrupam-se em subfactores referentes aos três sistemas de regulação do afeto propostos por Gilbert (2010a): sistema de ameaça (5 itens, e.g., "irritado"), sistema de procura (5 itens, e.g., "com vivacidade") e sistema de afiliação/apaziguamento (5 itens, e.g., "calmo"). Cada item é respondido numa escala de cinco pontos (0 = nunca a 4 = sempre), de acordo com a frequência com que foi experienciado no local de trabalho nas últimas duas semanas.

Originalmente portuguesa, esta escala apresentou indicadores de consistência interna que variaram entre níveis aceitáveis a bons, para a primeira parte (emoções sentidas no local de trabalho), com um alfa de *Cronbach* de .75 para o sistema de ameaça, .86 para o sistema de procura, e .83 para o sistema de afiliação/apaziguamento; e para a segunda parte (motivos que levaram o trabalhador a comportar-se de determinada forma), com valores de alfa de *Cronbach* de .82 para o sistema de ameaça, .78 para o sistema de procura, e .64 para o sistema de afiliação/apaziguamento. No presente CRT, foi incluída apenas a primeira parte da escala, tendo

sido encontrados valores de consistência interna de .72 para ameaça, .80 para procura e .72 para afiliação/apaziguamento.

3.2.3.6 ProQOL-5 - Professional Quality of Life Scale, version 5/Escala de Qualidade de Vida Profissional, versão 5

A Escala de Qualidade de Vida Profissional (Stamm, 2010; tradução e adaptação de Carvalho & Sá, 2011) é um instrumento de autorresposta, composto por 30 itens, divididos em três subescalas: satisfação por compaixão (10 itens, e.g., "Eu fico satisfeito ao poder ajudar os outros"), *burnout* (10 itens, e.g., "Eu sinto-me encurralado no meu trabalho como cuidador") e Stress Traumático Secundário (STS; 10 itens, e.g., "Eu salto ou assusto-me com sons inesperados"). Cada item é respondido numa escala de cinco pontos (1 = nunca a 5 = muito frequentemente), de acordo com a frequência com que foi experienciado no local de trabalho nos últimos 30 dias.

No estudo original foram encontrados bons indicadores de consistência interna, com valores de alfa de *Cronbach* de .88 para satisfação por compaixão, .75 para *burnout* e .81 para STS (Stamm, 2010). A versão portuguesa revelou também bons indicadores de consistência interna, apresentando valores de alfa de *Cronbach* de .86 para satisfação por compaixão, .71 para *burnout* e .83 para STS (Carvalho, 2011). Neste CRT, foram encontrados valores de consistência interna de .81 para satisfação por compaixão, .64 para *burnout* e .67 para stress traumático secundário. As subescalas de *burnout* e STS revelaram valores aceitáveis, devendo por isso ser interpretados com precaução (DeVellis, 1991; Nunnally & Bernstein, 1994).

3.2.3.7 DASS-21- Depression, Anxiety and Stress Scales/Escala de Ansiedade, Depressão e Stress

A Escala de Ansiedade, Depressão e Stress-21 (Lovibond & Lovibond, 1995; versão portuguesa de Pais-Ribeiro et al., 2004) é um instrumento de autorresposta, composto por 21 itens, que avaliam três dimensões de sintomas psicopatológicos: depressão (7 itens, e.g., "Senti-me desanimado e melancólico"), ansiedade (7 itens, e.g., "Senti dificuldades em respirar") e stress (7 itens, e.g., "Dei por mim a ficar agitado"). Cada item é respondido numa escala de quatro pontos (0 = não se aplicou nada a mim a 3 = aplicou-se a mim a maior parte das vezes), de acordo com a frequência com que foi experienciado na semana anterior.

A versão original apresentou bons indicadores de consistência interna, com valores de alfa de *Cronbach* de .91 para a depressão, .84 para a ansiedade, e .90 para o stress (Lovibond & Lovibond, 1995). A versão portuguesa revelou também bons indicadores de consistência

interna, apresentando valores de alfa de *Cronbach* de .85 para a depressão, .74 para a ansiedade e .81 para o stress (Pais-Ribeiro et al., 2004). Neste CRT, os valores do alfa de *Cronbach* foram de .87 para a depressão, .86 para a ansiedade e .87 para o stress.

3.2.4 Questionários de autorresposta para jovens

3.2.4.1 ECRC-Y - Emotional Climate in Residential Care – Youths/Escala de Avaliação do Clima Emocional para Jovens em Acolhimento Residencial

A Escala de Avaliação do Clima Emocional para Jovens em Acolhimento Residencial (Albuquerque et al., 2021; adaptado por Santos et al., 2023b) é um instrumento de autorresposta, composto por 14 itens, que avalia o clima emocional da casa de acolhimento, tal como é percecionado pelos jovens que lá residem. O questionário compreende três subescalas, que descrevem diferentes estados emocionais associados aos sistemas de regulação do afeto propostos por Gilbert (2010a): o sistema de ameaça (4 itens, e.g., "stressado"), o sistema de procura (5 itens, e.g., "ativo"), e o sistema de afiliação/apaziguamento (5 itens, e.g., "seguro"). Cada item é respondido numa escala de cinco pontos (0 = nunca a 4 = sempre), de acordo com a frequência com que foi experienciado na casa de acolhimento durante as últimas duas semanas.

A versão original, destinada a avaliar o clima emocional da sala de aula, apresentou níveis de consistência interna que variaram entre valores aceitáveis a bons, com valores de alfa de *Cronbach* de .70 para a subescala das emoções do sistema de ameaça, .86 para o sistema de procura e .73 para o sistema de afiliação/apaziguamento. Os valores de estabilidade temporal variaram entre .61 (sistema de afiliação/apaziguamento) e .77 (sistema de procura; Albuquerque et al., 2021). A ECRC-Y revelou também níveis de consistência interna que variaram entre valores apropriados a bons, com valores de alfa de *Cronbach* de .71 para sistema de ameaça, .89 para o sistema de procura e .82 para o sistema de afiliação/apaziguamento. O modelo de medida provou ser invariante relativamente ao sexo (Santos et al., 2023b). Na amostra de adolescentes do CRT, os valores de consistência interna foram de .71 para as emoções do sistema de ameaça, .90 para o sistema de procura e .87 para o sistema de afiliação/apaziguamento.

3.2.4.2 CEWSS-A - Current Experiences of Warmth and Safeness Scale for Adolescents/ Escala de Experiências Atuais de Cuidados e Segurança para Adolescentes

A Escala de Experiências Atuais de Cuidados e Segurança para Adolescentes (Richter et al., 2009; adaptado por Santos et al., 2021) é um instrumento de autorresposta, composto por

12 itens, que se agrupam numa única dimensão. O instrumento pretende avaliar a frequência de experiências emocionais de cuidados e segurança com os outros (e.g., "Senti-me aconchegado pelas pessoas à minha volta"). Cada item é respondido numa escala de cinco pontos (0 = não, nunca a 4 = sim, a maior parte do tempo), de acordo com a frequência com que foi experienciado nas últimas duas semanas.

A CEWSS-A foi adaptada a partir da Escala de Memórias Precoces de Calor e Segurança para Adolescentes, a seguir descrita. A CEWSS-A foi validada para adolescentes da comunidade e em acolhimento residencial. Revelou excelentes indicadores de consistência interna nas duas amostras (α = .94) e estabilidade temporal aceitável na amostra comunitária (r = .62) e na amostra de acolhimento residencial (r = .77). O modelo de medida provou ser invariante por sexo e por grupo (i.e., comunitário e acolhimento residencial; Santos et al., 2021). Nos estudos empíricos I e III, o valor de consistência interna encontrado foi superior a .90 na amostra comunitária e de adolescentes em CAR. Na amostra de adolescentes do CRT, o valor de consistência interna foi de .96.

3.2.4.3 SSPS-A - Social Safeness and Pleasure Scale for Adolescents/ Escala de Proximidade e Ligação aos Outros para Adolescentes

A Escala de Proximidade e Ligação aos Outros para Adolescentes (Gilbert et al., 2009; versão portuguesa para adolescentes de Miguel et al., 2022) é um instrumento de autorresposta, constituído por 12 itens, que se agrupam numa única dimensão. Pretende avaliar em que medida os adolescentes experienciam emoções e sentimentos positivos em diferentes situações sociais (e.g., "Sinto-me satisfeito nas minhas relações com os outros"). Cada item é respondido numa escala de cinco pontos (1 = quase nunca a 5 = quase sempre).

No estudo original, a escala obteve um excelente valor de consistência interna (α = .91; Gilbert et al., 2009). A versão portuguesa encontra-se validada para adolescentes da comunidade e em acolhimento residencial. A SSPS-A revelou uma consistência interna excelente nas duas amostras (α = .94) e o modelo de medida provou ser invariante por sexo e por grupo (i.e., comunitário e acolhimento residencial; Miguel et al., 2022). Na amostra de adolescentes deste CRT, o valor do alfa de *Cronbach* foi de .96.

3.2.4.4 EMWSS-A - Early Memories of Warmth and Safeness Scale – Adolescents/ Escala de Memórias Precoces de Calor e Segurança para Adolescentes

A Escala de Memórias Precoces de Calor e Segurança para Adolescentes (Richter et al., 2009; versão portuguesa para adolescentes de Cunha et al., 2014) é um instrumento de

autorresposta, composto por 21 itens, agrupados num único fator. Este questionário pretende avaliar memórias de experiências emocionais positivas com os outros, especificamente memórias de calor, segurança, aceitação e cuidados prestados na infância (e.g., "Sentia que era um membro querido da minha família"). Cada item é respondido numa escala de cinco pontos (0 = não, nunca a 4 = sim, a maior parte do tempo), de acordo com a frequência com que cada afirmação se aplica à infância do participante.

A versão original apresentou níveis excelentes de consistência interna (α = .97) e de estabilidade temporal (r = .91; Richter et al., 2009). A versão portuguesa para adolescentes apresentou igualmente excelentes indicadores de consistência interna (α = .95) e de estabilidade temporal (r = .92; Cunha et al., 2014). O modelo de medida provou ser invariante por sexo e por grupo (i.e., comunitário, acolhimento residencial e justiça juvenil; Vagos et al., 2017). Nos estudos empíricos II e III, o valor do alfa de *Cronbach* foi de .96 para a amostra comunitária e de .98 para a amostra de adolescentes em CAR.

3.2.4.5 CS-A - Compassion Scale – Adolescents/ Escala da Compaixão - Adolescentes

Este instrumento (Pommier, 2011; versão portuguesa para adolescentes de Sousa et al., 2022) corresponde à versão para adolescentes da Escala da Compaixão (Pommier, 2011; versão portuguesa de Sousa et al., 2017) anteriormente descrita. A versão para adolescentes é composta por 24 itens, podendo os mesmos ser igualmente agrupados em dois fatores de segunda ordem: compaixão (bondade, humanidade comum e mindfulness) e desconexão (indiferença, desligamento e não envolvimento). Cada item é respondido numa escala de cinco pontos (1 = quase nunca a 5 = quase sempre).

Na versão portuguesa para adolescentes, os dois fatores de segunda ordem revelaram bons níveis de consistência interna, com valores de alfa de *Cronbach* de .90 (compaixão) e .87 (desconexão; Sousa et al., 2022). No estudo empírico II, os valores do alfa de *Cronbach* para as subescalas de compaixão e desconexão foram, respetivamente, de .84 e .85 na amostra de adolescentes da comunidade, e de .88 e .84 na amostra de adolescentes das CAR.

3.2.4.6 PANAS - Positive and Negative Affect Schedule/ Escala do Afeto Positivo e Negativo

A Escala do Afeto Positivo e Negativo (Watson et al., 1998; versão portuguesa de Galinha & Pais-Ribeiro, 2005) é um instrumento de autorresposta, composto por 20 itens, que avalia emoções e sentimentos associados a dois tipos de afeto. Os itens encontram-se agrupados em duas dimensões: afeto positivo (10 itens, e.g., "Entusiasmado") e afeto negativo (10 itens, e.g.,

"Perturbado"). Cada item é respondido numa escala de cinco pontos (1 = nada ou muito ligeiramente a 5 = extremamente), de acordo com a frequência e severidade com que foi experienciado nas últimas semanas.

A versão original apresentou bons indicadores de consistência interna, com valores de alfa de *Cronbach* de .88 para o afeto positivo e de .87 para o afeto negativo (Watson et al., 1998). A versão portuguesa revelou igualmente bons indicadores de consistência interna, com valores de alfa de *Cronbach* de .86 para afeto positivo e de .89 para afeto negativo (Galinha & Pais-Ribeiro, 2005). No estudo empírico I, os valores do alfa de *Cronbach* foram de .90 para o afeto positivo e de .88 para o afeto negativo. No estudo empírico II, os valores de consistência interna para o afeto positivo e afeto negativo foram, respetivamente, de .86 e .89 na amostra de adolescentes da comunidade, e de .87 e .88 na amostra de adolescentes em CAR.

3.2.4.7 DASS-21 - Depression Anxiety and Stress Scales/ Escala de Ansiedade, Depressão e Stress

A Escala de Ansiedade, Depressão e Stress-21 (Lovibond & Lovibond, 1995; versão portuguesa de Pais-Ribeiro et al., 2004) foi descrita no ponto 3.2.3.7.

Nos estudos empíricos II e III, os valores do alfa de *Cronbach* para a depressão, ansiedade e stress foram, respetivamente, de .88, .82 e .88 na amostra de adolescentes da comunidade, e de .86, .84 e .84 na amostra de adolescentes em CAR.

3.2.4.8 PCS - Peer Conflict Scale/ Escala de Conflito entre Pares

A Escala de Conflito entre Pares (Marsee et al. 2011; versão portuguesa de Vagos et al., 2014) é um instrumento de autorresposta, composto por 40 itens, que avalia comportamentos agressivos. Os itens agrupam-se em quatro subescalas, que distinguem quatro tipos de comportamentos agressivos: agressividade reativa aberta (10 itens, e.g., "Já ameacei alguém que me fez alguma coisa de mal"), agressividade proativa aberta (10 itens, e.g., "Já comecei uma luta para conseguir o que quero"), agressividade reativa relacional (10 itens, e.g., "Quando alguém me faz ficar zangado, sou capaz de falar mal dessa pessoa") e agressividade proativa relacional (10 itens, e.g., "Já aconteceu espalhar boatos e mentiras sobre alguém para conseguir o que quero"). As subescalas podem ser agrupadas de acordo com a função da agressividade em: agressividade reativa, que diz respeito a uma reação de raiva defensiva face a uma provocação (composta pelas subescalas de agressividade reativa aberto e reativa relacional) e agressividade proativa, que parte do agressor como forma de estabelecer dominância ou para conseguir algo que deseja (composta pelas subescalas de agressividade proativa aberta e

proativa relacional; Marsee et al. 2011). Cada item é respondido numa escala de cinco pontos (0 = tem pouco a ver comigo a 4 = tem tudo a ver comigo).

O estudo original apresentou bons indicadores de consistência interna, com valores de alfa de *Cronbach,* que variaram entre .79 (agressividade reativa relacional) a .89 (agressividade reativa aberta; Marsee et al. 2011). A versão portuguesa revelou igualmente bons indicadores de consistência interna (reativo aberto α = .91; proativo aberto α = .90; reativo relacional α = .87; proativo relacional α = .89; Vagos et al., 2014). No estudo empírico II, foram utilizadas as duas funções da agressividade. Os valores de consistência interna em ambas as amostras foram de .91 para agressividade reativa e de .90 para agressividade proativa.

3.2.4.9 SDQ - Strengths and Difficulties Questionnaire/ Questionário de Capacidades e Dificuldades

O Questionário de Capacidades e Dificuldades (Goodman et al, 2010; tradução e adaptação de Fleitlich et al., 2005) é um instrumento de autorresposta, composto por 25 itens, que avalia comportamentos sociais e problemas socioemocionais. Os itens encontram-se agrupados em cinco subescalas, uma destinada a avaliar comportamentos pró-sociais (5 itens, e.g., "Tento ser simpático/a com as outras pessoas. Preocupo-me com o que sentem") e quatro desenhadas para avaliar indicadores de dificuldades, nomeadamente problemas emocionais (5 itens, e.g., "Ando muitas vezes triste, desanimado ou a chorar"), problemas de comportamento (5 itens, e.g., "Irrito-me e perco a cabeça muitas vezes"), hiperatividade (5 itens, e.g., "Sou irrequieto, não consigo ficar quieto/a muito tempo") e problemas de relacionamento com os colegas (5 itens, e.g., "As outras crianças ou jovens metem-se comigo, ameaçam-me ou intimidam-me"). A soma das últimas quatro subescalas constituí um índice total de dificuldades. As mesmas podem também ser agrupadas em problemas internalizantes (problemas emocionais e de relacionamento com os colegas) e problemas externalizantes (problemas de comportamento e hiperatividade; Goodman et al., 2010). Cada item é respondido numa escala de três pontos (0 = não é verdade a 2 = é muito verdade).

A versão original apresentou valores de consistência interna que variaram entre níveis aceitáveis a apropriados, com valores de alfa de *Cronbach* de .66 para comportamentos de internalização, .76 para comportamentos de externalização e .66 para a subescala de comportamento pró-social (Goodman et al., 2010). Até ao momento, não existem estudos publicados que testem a estrutura fatorial da escala para a população portuguesa de adolescentes. No entanto, esta escala é recorrentemente utilizada em Portugal (Marzocchi et al., 2004). No estudo empírico I, foram utilizadas as pontuações das subescalas de internalização

e de externalização, que apresentaram, respetivamente, valores de .66 e .71. A subescala de comportamentos de internalização revelou um valor de alfa de *Cronbach* aceitável, devendo por isso ser interpretada com precaução (DeVellis, 1991; Nunnally & Bernstein, 1994).

3.2.5 Guiões de discussão para grupos focais

O estudo empírico V (Compassionate Mind Training for caregivers in residential youth care: Investigating their experiences through a thematic analysis) e o estudo de viabilidade foram concretizados com metodologia qualitativa, com recurso a grupos focais. Esta técnica foi selecionada por questões práticas e de investigação. Primeiro, os grupos focais permitem gerar discussão e reflexão de grupo em torno de uma experiência coletiva, neste caso compreender as experiências de participação num programa de grupo em contexto de acolhimento residencial. Segundo, esta técnica permite recolher uma grande quantidade de informação, num curto período de tempo (Parker & Tritter, 2006), o que permite minimizar as alterações à rotina de funcionamento das CAR.

Para aumentar a fiabilidade da execução dos grupos focais, foram construídos, *a priori*, guiões de discussão para captar informação que respondesse às perguntas de investigação dos respetivos estudos. As perguntas formuladas foram testadas junto de um colaborador de uma casa não intervencionada, para avaliar a sua compreensibilidade (Breen, 2006).

3.2.5.1 Guião do estudo de viabilidade do TMC-C

Este guião é composto por seis secções (i.e., boas-vindas e apresentação dos moderadores e participantes, objetivos do estudo, regras de participação, recolha de consentimento informado para gravação áudio, questões para discussão, resumo e conclusão do grupo focal), que incluem 12 perguntas abertas para discussão. As perguntas abordam temas como a motivação para participar no programa, a aplicação das aprendizagens realizadas, o impacto percecionado, bem como as dificuldades sentidas e sugestões de melhoria do programa. Para concluir, foi ainda explorado um plano de sustentabilidade das aprendizagens na CAR. Para além das perguntas-chave, constavam também do guião perguntas de bolso, para aprofundar um determinado tópico ou compreender se a ideia é partilhada pelo grupo (Breen, 2006).

3.2.5.2 Guião do estudo qualitativo

Este guião é composto por seis secções (i.e., boas-vindas e apresentação dos moderadores e participantes, objetivos do estudo, regras de participação, recolha de consentimento informado para gravação áudio, questões para discussão, resumo e conclusão

do grupo focal), que incluem 12 perguntas abertas para discussão. As perguntas abordam temas como as experiências formativas, a aplicação das aprendizagens realizadas, a perceção de mudança no próprio, o impacto percecionado nas dinâmicas da CAR e nos jovens, bem como um plano de sustentabilidade das aprendizagens na CAR. Tal como no guião anterior, para além das perguntas-chave, constava também do guião, algumas perguntas de bolso para aprofundar um determinado tópico ou compreender se a ideia é partilhada pelo grupo (Breen, 2006). Este guião encontra-se disponível para consulta no Apêndice A do estudo empírico V.

3.2.6 Avaliação processual das sessões do TMC-C

Juntamente com o manual do programa, foram desenvolvidas fichas de avaliação processual para registo de indicadores de qualidade da formação (Kirkpatrick & Kirkpatrick, 2005). Estes documentos encontram-se sucintamente descritos, em seguida, e seus exemplares estão apresentados no Anexo B.

3.2.6.1 Folha de presenças

Ficha desenvolvida para registar a presença de cada participante nas sessões do TMC-C. Esta ficha é passada no início de cada sessão. Permite controlar e avaliar a adesão ao programa. Apresenta ainda espaço próprio para registo de observações por parte do dinamizador (e.g., motivo de ausências, duração das sessões, dificuldades com exercícios).

3.2.6.2 Formulário de Check-in

Ficha composta por 6 itens, que pretendem avaliar: (i) a frequência da transferência das aprendizagens para contexto de vida pessoal e profissional (e.g., "Aplicou na sua rotina profissional as aprendizagens realizadas na última sessão?"); (ii) a frequência de realização das práticas formais e das tarefas práticas entre as sessões (e.g., "Durante a semana realizou a tarefa de aplicação prática?"); (iii) o impacto percebido dessas transferências nos jovens das CAR (e.g., "Sentiu que as suas novas práticas e aprendizagens tiveram impacto nas crianças e jovens?"). Esta ficha é preenchida no início de cada sessão por cada participante, de acordo com uma escala de cinco pontos (0 = nunca a 4 = sempre).

3.2.6.3 Formulário de Check-out

Esta ficha pretende avaliar: (i) a satisfação com a sessão (7 itens; e.g., duração, recursos, exercícios, interação, participação, dinamizador); (ii) relevância e aquisição dos conteúdos da sessão (número de itens varia entre 3 e 7, dependendo dos conteúdos da sessão, e.g., "Fiz aprendizagens relevantes"); (iii) comprometimento com o desafio compassivo semanal (e.g.,

"Sinto-me capaz de aplicar o que aprendi na sessão"). Esta ficha é preenchida por cada participante no final das sessões do TMC-C. Os itens de avaliação da satisfação são preenchidos com uma escala de cinco pontos que varia entre 1 (muito insatisfeito) a 5 (muito satisfeito), os restantes itens variam entre 1 (discordo totalmente) a 5 (concordo totalmente).

3.2.6.4 Grelha de avaliação do dinamizador

Ficha composta por sete itens, desenvolvida para auxiliar o dinamizador a acompanhar o progresso de cada participante relativamente a indicadores de: (i) relacionamento (2 itens); (ii) participação (2 itens); (iii) concretização das aprendizagens (2 itens); (iv) concretização do desafio compassivo semanal (1 item). Esta ficha é preenchida pelo dinamizador, após cada sessão, de acordo com uma escala de cinco ponto (1 = não revela a 5 = revela totalmente).

3.3 Intervenções

3.3.1 O programa de Treino da Mente Compassiva para Cuidadores: Desenvolvimento e estudo de viabilidade do programa

Como foi descrito no Capítulo 2, o TMC-C foi desenhado com base no modelo da Terapia Focada na Compaixão (TFC) e em práticas do Treino da Mente Compassiva (Gilbert, 2010), bem como em práticas de outros programas com abordagens baseadas na compaixão e mindfulness destinados a outras populações (e.g., Compass, Martins et al., 2020; Mindful Self- Compassion, Neff & Germer, 2013; Psycopathy.comp, Ribeiro da Silva et al., 2017). Os exercícios foram desenhados e adaptados com o objetivo de responder às necessidades dos profissionais da área do acolhimento residencial de crianças e jovens. Assim, o programa fornece estratégias de regulação emocional e incentiva comportamentos de autocuidado. O programa fornece também um modelo de leitura e compreensão do funcionamento psicológico e comportamental das crianças e jovens em acolhimento, bem como estratégias de intervenção que respondam de forma adequada às necessidades emocionais e sociais dos mesmos.

Uma vez que o TMC-C era um programa novo, baseado numa abordagem que não tinha sido previamente testada em contexto de acolhimento residencial de crianças e jovens em perigo, foi conduzido um estudo de viabilidade de acordo com as recomendações de Bowen e colaboradores (2010). Este estudo teve como objetivo testar a viabilidade dos procedimentos de avaliação do ensaio clínico e a aceitabilidade da versão experimental do manual do programa de TMC-C, tendo em vista a implementação futura do ensaio clínico planeado no presente trabalho de investigação. O estudo foi conduzido numa CAR, selecionada de acordo com critério de conveniência geográfica. O recrutamento dos participantes foi realizado de acordo com a

indicações da diretora técnica da CAR (de modo a assegurar o funcionamento da CAR) e com os critérios de elegibilidade atrás descritos (ponto 3.1). Foram inicialmente recrutados oito jovens e 10 cuidadores, tendo um cuidador desistido no início da aplicação do programa, devido à dificuldade em conciliar a participação com os seus horários pessoais. O TMC-C foi aplicado pela doutoranda junto de um grupo de nove cuidadores (77.78% do sexo feminino), com idades compreendidas entre os 34 e os 53 anos (*M* = 45.33; *DP* = 7.16) e uma média de 14.33 anos de trabalho em acolhimento residencial (*DP* = 7.43). A maioria dos participantes (66.67%) pertencia à equipa educativa e o nível de habilitações académicas variava entre o 6º ano e o mestrado. Os participantes e oito jovens residentes na CAR (todos do sexo masculino), com idades compreendidas entre os 13 e os 18 anos (*M* = 15.88; *DP* = 1.81), preencheram uma bateria de questionários de autorresposta em pré e pós-intervenção. Durante a aplicação do programa, realizou-se uma avaliação processual com recurso aos formulários de *Check-in* e de *Check-out* (descritos no ponto 3.2.6.2 e 3.2.6.3). Duas semanas após a participação no TMC-C, os cuidadores foram convidados a participar num grupo focal, com o objetivo de avaliar as experiências de participação no programa, a sua aceitabilidade e viabilidade no contexto de acolhimento residencial, bem como seus potenciais efeitos. O grupo focal foi realizado na CAR, junto de um grupo de seis cuidadoras que se voluntariaram para colaborar. O grupo focal foi moderado pela doutoranda e os dois orientadores desta tese, de acordo com um guião de discussão composto por 12 perguntas abertas previamente construído (descrito no ponto 3.2.5.1). A informação foi gravada em formato áudio e posteriormente transcrita, a fim de ser conduzida uma análise temática, de acordo com a abordagem proposta por Braun e Clarke (2013).

Considerando que o teste de hipóteses não é normalmente apropriado em estudos de viabilidade, devido ao reduzido tamanho da amostra e respetivo poder estatístico (Tickle-Degnen, 2013), no presente estudo foi adotada uma metodologia mista, que incluiu análise qualitativa e a estatísticas descritivas dos dados recolhidos através dos formulários de *Check-in* e *Check-out*. A análise de dados procurou responder aos critérios definidos por Bowen e colaboradores (2010) para estudos de viabilidade, nomeadamente, a implementação, praticidade, aceitabilidade, integração, resultados preliminares e adaptação.

Relativamente à implementação e praticidade, as 12 sessões do programa foram implementadas com sucesso, e de acordo com o planeado, em espaço cedido pela CAR, durante o horário escolar dos jovens. O espaço da CAR revelou-se adequado, facilitando a acessibilidade dos colaboradores dentro do seu horário de trabalho, bem como a gestão de eventuais emergências. O horário das sessões (dentro do horário escolar e em horário de troca de turno

do *staff*) facilitou a presenta dos participantes, num período com menor número de solicitações e consequente interrupção das sessões. Os cuidadores participaram, em média, em 9.67 sessões (*DP* = 2.12), variando o número de sessões frequentadas entre 6 e 12. A não comparência nas sessões por parte dos cuidadores deveu-se à realização prévia de turno noturno, ao facto de poderem estar a gozar dia de folga ou férias, ou ainda por terem que efetuar diligências médicas no trabalho ou em contexto de vida pessoal. Como anteriormente mencionado, verificou-se apenas uma desistência. Relativamente aos procedimentos de avaliação, a bateria de avaliação dos jovens revelou-se adequada em termos de compreensão do conteúdo e tempo de preenchimento. Já a bateria de avaliação dos cuidadores revelou-se extensa e cuidadores com um nível de habilitação escolar mais baixa revelaram necessidade de apoio no preenchimento de determinados questionários (e.g., Escala da Compaixão).

Em termos de aceitabilidade, os resultados da análise temática e estatísticas descritivas sugerem que os participantes reagiram positivamente ao programa e reconheceram a sua relevância para este contexto específico de prestação de cuidados. A sua dupla aplicabilidade, ao nível da regulação emocional dos cuidadores e capacitação de estratégias de intervenção com os jovens, foi destacada na análise qualitativa. Os dados quantitativos suportaram os dados qualitativos, indicando que as aprendizagens têm potencial de aplicabilidade, tanto a nível profissional, como a nível pessoal. O formato grupal das sessões e o carácter inovador do programa foram também salientados. De acordo com os dados quantitativos, o nível de satisfação com as sessões variou entre satisfeito e muito satisfeito. As sessões com maior nível de satisfação foram relativas aos temas: Humanidade comum (Sessão 1); Sistema de afiliação/ apaziguamento (Sessão 6); Desenvolver compaixão pelo outro (Sessão 8). Ainda que dentro desta classificação (satisfeitos), as sessões com menos pontuação foram a Sessão 7 - A compaixão, a Sessão 9 - Autocompaixão e a Sessão 10 - Receber compaixão dos outros. Os dados qualitativos permitiram compreender que estes resultados se deveram à utilização de conteúdo mais expositivo e menos interativo (Sessão 7) e exercícios de imagética mais longos (Sessões 9 e 10).

Relativamente ao parâmetro da integração, de acordo com a análise temática, os exercícios do programa pareceram ser aplicados, sobretudo, com a finalidade de regulação emocional do cuidador e para este adotar uma atitude compassiva na intervenção diária com os jovens. Os resultados do formulário de *Check-in* reforçam os dados qualitativos, indicando que as aprendizagens foram aplicadas a nível pessoal e profissional e que as aprendizagens de algumas sessões do primeiro módulo foram ligeiramente mais transferidas para o contexto pessoal. A informação recolhida pelos dois métodos de avaliação indicou que as práticas entre

as sessões foram realizadas com pouca frequência. Não obstante, no grupo focal foram relatados potenciais benefícios do TMC-C para o cuidador, para a relação entre cuidadores e jovens e para as práticas e clima da casa de acolhimento. Ao nível do cuidador, foram percecionados efeitos positivos na sua capacidade de regulação emocional, autocuidado e sentimento geral de bem-estar. Foi percecionada uma maior proximidade entre os jovens e os cuidadores. Na casa de acolhimento, de acordo com as participantes, a intervenção passou a ser realizada de forma mais consciente, sistemática e menos reativa, o ambiente da casa tornou-se mais tranquilo e organizado e a relação entre membros da equipa tornou-se mais assertiva.

Apesar do programa ter sido implementado com sucesso, foram também evidenciadas dificuldades, nomeadamente com determinadas práticas formais, na concretização das tarefas entre sessões, e na duração das sessões e do programa em si. Relacionadas com estas dificuldades, surgiram sugestões de melhoria que permitiram realizar adaptações ao programa ao nível do seu conteúdo, ordem das sessões e metodologia utilizada. A título de exemplo, a ordem de duas sessões foi alterada (e.g., a sessão dos medos da compaixão passou para meio do programa, em vez de ser realizada no final do programa). O conteúdo de algumas sessões foi simplificado, de forma a obter mais tempo para realizar as partilhas e discussão em grupo. Foram introduzidos mais vídeos ilustrativos (e.g., Sessão 7) e reduzido o tempo dos exercícios de imagética e de meditação. Materiais como os postais de *souvenir* e o Muro da Compaixão, e exercícios de *role-play* foram mantidos por terem sido reconhecidos como fatores adjuvantes. Não foi referida nenhuma sugestão alternativa relativamente aos constrangimentos relacionados com o horário e duração das sessões. Este tipo de constrangimentos dificultou a frequência das 12 sessões do programa, mais concretamente por parte dos membros da equipa educativa que trabalham por turnos. Foi um problema de difícil resolução, uma vez que este contexto exige recursos contínuos que assegurem a prestação de cuidados e que deem resposta a diligências frequentes de carácter imprevisível.

Resumidamente, este estudo reforçou a relevância desta abordagem para o contexto de acolhimento residencial e apontou potenciais benefícios do TMC-C para este contexto específico. Permitiu ainda ajustar a estrutura e conteúdo do programa e antecipar eventuais dificuldades na implementação do ensaio clínico, ao nível do tempo necessário para preenchimento dos questionários de avaliação, definição do horário das sessões do programa e utilização de estratégias motivacionais para envolver os participantes na concretização das práticas entre sessões (Steindl et al., 2018). Deste estudo resultou a versão final do programa de TMC-C, que foi aplicada no ensaio clínico, e que se encontra descrita no Capítulo 2 da presente tese.

3.3.1.1 Manual e materiais de apoio ao programa

A versão final do programa de TMC-C apresenta 12 sessões de grupo, que se encontram estruturadas em três módulos sequenciais: 1) A nossa mente de acordo com uma abordagem baseada na compaixão; 2) Treino da mente compassiva; 3) Sessão final (cf., ponto 7.5 do Capítulo 2). As sessões do programa foram aplicadas pela doutoranda, semanalmente, em formato presencial, nas CAR, em grupos constituídos por 6 a 10 participantes. Para facilitar a sua reprodução, o programa encontra-se manualizado. Cada sessão dispõe de materiais de apoio, que se encontram disponíveis no manual. Pode ser consultada em anexo a esta tese uma sessão integral do programa (Anexo A), bem como os formulários de *Check-in* e de *Check-out* aplicados nas sessões (Anexo B) e exemplos ilustrativos do Muro da Compaixão (Anexo C).

3.3.2 Grupo de controlo

Os cuidadores das CAR alocadas no grupo de controlo não receberam nenhum treino grupal de longa duração. De acordo com o normal funcionamento das CAR, formações breves e pontuais dirigidas a determinados profissionais poderão ter ocorrido durante o período do estudo.

3.4 Procedimentos de investigação

O projeto de investigação foi submetido a aprovação da Comissão de Ética e Deontologia da Investigação da Faculdade de Psicologia e de Ciências das Educação da Universidade de Coimbra (CEDI). Os estudos que integram uma amostra comunitária (recolhida em contexto escolar), foram também submetidos a aprovação pela Direção Geral de Educação.

As direções das casas de acolhimento, escolas e associações desportivas e recreativas foram contactadas com o objetivo de formalizar o convite para colaboração nos estudos e explicar seus objetivos e procedimentos.

Após terem sido obtidas as devidas autorizações institucionais, foram explicados os objetivos e procedimentos dos estudos aos sujeitos enquadrados nos critérios de elegibilidade definidos para cada estudo. Os indivíduos foram convidados a participar, de forma voluntária, assegurando a confidencialidade e anonimato das respostas. Para esse efeito, foram facultadas instruções para a criação de um código pessoal, de forma a garantir o emparelhamento das respostas nos diferentes momentos de avaliação. Não foi oferecida nenhuma compensação (e.g., monetária) a fim de incentivar a participação, tendo sido explicitado que os participantes poderiam desistir a qualquer momento, sem qualquer prejuízo para os próprios. Especificamente nas amostras de jovens em acolhimento, foi explicado que a sua decisão não

teria qualquer impacto/interferência na medida de promoção e proteção, e que a informação recolhida não seria partilhada com terceiros.

O consentimento informado foi solicitado a todos os participantes dos estudos que compõem esta tese. Na amostra comunitária, foram enviados formulários de consentimento informado para os encarregados de educação de adolescentes com idade inferior a 18 anos e recolhido o consentimento por escrito de todos os adolescentes, independentemente da sua idade, desde que o encarregado de educação consentisse a sua participação e o mesmo desejasse participar. Foram efetuados os mesmos procedimentos nas amostras de jovens em acolhimento, sendo nesse caso, o consentimento informado do representante legal requerido ao diretor técnico da respetiva CAR. Na amostra do CRT, o consentimento informado foi solicitado ao nível do cluster (i.e., CAR) e do participante (i.e., cuidadores e jovens).

A recolha de dados foi realizada de diferentes formas, consoante a natureza da amostra e as regras de saúde vigentes associadas às diferentes fases da pandemia COVID-19. A recolha de dados quantitativos foi efetuada por alunas do mestrado de psicologia clínica e da saúde da FPCE-UC, sob coordenação e treino da doutoranda. A recolha de dados do estudo qualitativo foi efetuada pela doutoranda em colaboração com a coorientadora da tese e alunos do mestrado de ciências da educação da FPCE-UC.

Considerando que este trabalho de investigação integra diferentes tipos de estudos, que apresentam procedimentos específicos que vão para além dos procedimentos gerais acima descritos, as especificidades inerentes a cada estudo serão reportadas, de forma mais detalhada, em seguida.

3.4.1 Procedimentos específicos para a revisão sistemática da literatura

Os procedimentos da revisão sistemática da literatura (Fostering emotional and mental health in residential youth care facilities: A systematic review of programs targeted to care workers) foram efetuados de acordo com as *Preferred Reporting Items for Systematic Reviews and Meta-Analyses* (PRISMA; Page et al., 2021). Em seguida são brevemente apresentados os procedimentos deste estudo.

Primeiramente, antes de se dar início à revisão sistemática, o protocolo de investigação foi desenhado e registado na *International Prospective Register of Systematic Reviews* (PROSPERO; número de registo CRD42021254783; https://www.crd.york.ac.uk/prospero/display_record.php?ID=CRD42021254783).

Em segundo lugar, foi realizada uma pesquisa compreensiva da literatura nas seguintes bases de dados eletrónicas: PsycINFO (via OVID), PsycARTICLES (via OVID), PsycArticles & Mental

Health (via OVID), Proquest, Web of Science, SocIndex with full text, Medline (via EBSCO), ERIC (via EBSCO), and Scielo (via EBSCO). As pesquisas foram realizadas em inglês com a seguinte combinação de palavras-chave: residential care OR residential youth care OR institutional care OR child care institution OR orphanage OR residential child care OR child welfare OR group homes OR institution* OR residential treatment AND Intervention OR program* OR training OR evidence-based practices OR support OR empower*OR effective* AND caregivers OR staff OR child care staff OR care worker* OR care providers OR caretakers OR carer* OR child care professionals OR professional caregivers OR child care practitioners OR residential care workers AND adolescent* OR child OR children OR youth* OR young people OR teen* OR young* AND well-being OR wellbeing OR mental health OR emotional health OR emotion regulation OR affect regulation OR emotional climate OR organizational climate OR social climate OR social environment OR burnout OR stress OR compassion fatigue OR depression. A pesquisa foi restringida a publicações com revisão por pares, redigidas em inglês, português, francês ou espanhol, e publicadas entre 1980 e 2021.

Foram ainda realizadas as seguintes pesquisas adicionais, através da consulta de: (i) lista de referências bibliográficas de revisões sistemáticas relevantes e de artigos incluídos na análise; (ii) sites de instituições e organizações sociais de relevo (e.g., Better Care Network, National Child Traumatic Stress Network); (iii) um jornal específico da área do acolhimento (i.e., Residential Treatment for Children & Youth).

De seguida, procedeu-se à seleção dos estudos. Para esse efeito, os estudos derivados das pesquisas descritas foram incluídos na aplicação Rayyan (Ouzzani et al., 2016). Depois de removidos os duplicados, duas investigadoras independentes procederam à primeira triagem dos estudos, com base na leitura dos títulos e resumos, de acordo com os critérios de elegibilidade descritos no Quadro 1 do Capítulo 4. Quando os títulos ou resumos não forneciam informação suficiente para determinar a elegibilidade do estudo, o mesmo era incluído na fase seguinte de triagem, baseada na leitura do estudo integral. Esta fase foi realizada de forma independente pelas mesmas duas investigadoras. Quando os estudos não se encontravam disponíveis, foram contactados os respetivos autores, a fim de solicitar o envio do artigo. A ausência de resposta decretava a exclusão do estudo em questão.

Após cada fase de triagem, os artigos selecionados por cada investigadora foram comparados para calcular o nível de concordância da seleção entre investigadoras, através do coeficiente do *Kappa* de Cohen. O nível de concordância foi interpretado de acordo com: $k < .00$ (pobre), $k < .20$ (fraco), $k < .40$ (razoável), $k < .60$ (moderado), $k < .80$ (substancial) e $k > .81$ (quase perfeito; Landis & Koch, 1977). Após calculado o nível de concordância, os desacordos

foram resolvidos através de argumentação entre as investigadoras, não tendo sido necessário envolver um terceiro investigador neste processo.

O procedimento seguinte diz respeito à extração de dados dos estudos incluídos para análise. Este procedimento foi conduzido pelas mesmas duas investigadoras, com base num formulário criado a partir da folha de registo da Cochrane (https://www.cochrane.org/). A extração de informação sobre as intervenções testadas nos estudos incluídos para análise foi realizada através de um formulário desenhado de acordo com o *Template for Intervention Description and Replication* (TIDieR; Hoffmann et al., 2014). Foi recolhida informação sobre os seguintes tópicos: (i) Fonte (título, autores, ano de publicação, país, tipo de publicação); (ii) Método (objetivos, contexto, características sociodemográficas dos participantes, tamanho da amostra, questões éticas, desenho de investigação, tipo de controlo); (iii) Intervenção (objetivo, componentes, base conceptual, manual, dinamizador, formato de aplicação, duração do programa, número de sessões); (iv) Variáveis em estudo e respetivas medidas (para cuidadores e/ou jovens, momentos de avaliação); (v) Principais resultados.

O último procedimento metodológico diz respeito à avaliação da qualidade dos estudos incluídos para análise. Este procedimento foi realizado de forma independente pelas mesmas duas investigadoras, com recurso ao *Mixed Methods Appraisal Tool*, versão de 2018 (MMAT; Hong et al., 2018b). Este instrumento foi escolhido por permitir avaliar a qualidade metodológica de estudos com diferentes metodologias, incluindo estudos quantitativos aleatorizados ou não-aleatorizados, estudos qualitativos e estudos com metodologia mista (Hong et al., 2018a; Hong et al., 2019).

O MMAT inclui duas perguntas de triagem (i.e., "As perguntas de investigação encontram-se claramente definidas?" e "Os dados recolhidos permitem responder à pergunta de investigação?"). A inclusão dos estudos para avaliação encontra-se dependente de resposta afirmativa a estas duas perguntas de triagem. Os estudos incluídos para análise foram avaliados de acordo com os cinco itens fornecidos pelo MMAT para o tipo de metodologia correspondente ao estudo em análise. Cada item deve ser avaliado de acordo com a presença ou ausência dos critérios apresentados. Uma vez que o MMAT não sugere o cálculo de uma pontuação total (Hong et al., 2018a), recorreu-se a um sistema de avaliação utilizado noutra revisão sistemática (Martins et al., 2019) para categorizar a qualidade de cada estudo. Cada estudo foi categorizado com: metodologia forte quando mais de 60% dos critérios foram atendidos; metodologia de qualidade moderada, se 40% a 60% dos critérios foram atendidos; metodologia de qualidade fraca, se menos de 40% dos critérios foram atendidos. Após esta avaliação, os níveis de qualidade de cada estudo, tal como foram avaliados pelas duas investigadoras, foram

comparados de forma a calcular o nível de concordância entre ambas, através do coeficiente do *Kappa* de Cohen (Landis & Koch, 1977). Após calculado o nível de concordância, os desacordos foram resolvidos através de argumentação entre as investigadoras, não tendo sido necessário envolver um terceiro investigador neste processo.

Devido à heterogeneidade de variáveis em estudo e metodologias dos estudos incluídos para análise não foi possível conduzir uma meta análise (CRD, 2009). Por esse motivo foi realizada uma síntese narrativa dos estudos de acordo com as normas fornecidas pelo Centre for Reviews and Dissemination (CRD, 2009).

3.4.2 Procedimentos específicos para estudos transversais com metodologia quantitativa

A amostra do estudo empírico I (Emotional Climate in Residential Care Scale for Youth: Psychometric properties and measurement invariance) foi recolhida em 33 CAR generalistas, localizadas em Portugal continental. Os critérios de inclusão foram: (i) ter idade compreendida entre os 12 e 25 anos; (ii) encontrar-se acolhido há pelo menos um mês na presente CAR (tempo de adaptação). A existência de défice cognitivo que comprometesse a compreensão dos itens dos questionários foi considerado como critério de exclusão. Jovens com défices cognitivos ligeiros foram incluídos, sendo o questionário preenchido individualmente, com o auxílio do psicólogo da CAR, em formato de entrevista. Os jovens que correspondessem aos critérios de elegibilidade definidos, foram identificados pelos psicólogos de cada CAR e convidados a colaborar de forma voluntária.

Face à situação pandémica, à promulgação do estado de emergência e de confinamento geral e aos respetivos planos de contingência, não foi possível efetuar a recolha de dados presencialmente pelas investigadoras. Os questionários e formulários de consentimento informado foram enviados em formato papel para as CAR, tendo a recolha de dados sido assegurada pelo psicólogo de cada CAR, de acordo com as instruções fornecidas pelas investigadoras. Para fins de estudo da estabilidade temporal da ECRC-Y, os jovens das primeiras CAR a concluir a avaliação foram convidados a preencher a escala, num segundo momento (aproximadamente passado um mês da primeira avaliação).

As amostras dos estudos empíricos II (Development and validation of the Current Experiences of Warmth and Safeness Scale in community and residential care adolescents) e III (Impact of early memories and current experiences of warmth and safeness on adolescents' psychological distress) foram recolhidas em oito escolas e quatro clubes desportivos e/ou recreativos da região centro do país, e em 34 CAR generalistas, localizadas em Portugal continental. Os critérios de inclusão dos participantes foram: (i) ter idade compreendida entre

os 14 e 18 anos; (ii) encontrar-se acolhido há pelo menos um mês na presente CAR (amostra recolhida em CAR). A existência de défice cognitivo que comprometesse a compreensão dos itens dos questionários foi considerado como critério de exclusão. Foram incluídos adolescentes das CAR com défices cognitivos ligeiros, sendo o questionário preenchido individualmente, em formato de entrevista, com auxílio das investigadoras. Os adolescentes que correspondessem aos critérios de elegibilidade definidos, foram indicados pelos psicólogos das CAR e das escolas, e convidados a colaborar de forma voluntária.

A amostra comunitária foi recolhida em grupos alargados, durante as aulas (escolas) ou treinos/ensaios (associações desportivas e recreativas), na presença das investigadoras. As amostras de adolescentes em acolhimento foram recolhidas, presencialmente, em pequenos grupos, ou individualmente, em formato de entrevista, caso o jovem tivesse dificuldades na leitura (previamente identificadas pelo psicólogo da CAR). Os dados foram recolhidos após o horário escolar dos jovens ou durante o fim de semana. Devido à semelhança dos itens das escalas EMWSS-A e CEWSS-A, o protocolo de avaliação foi dividido em duas partes (A e B), para evitar que as escalas se influenciassem e/ou que os participantes se desmotivassem. Os dados foram recolhidos, em dois momentos, com uma semana de intervalo.

No âmbito do estudo empírico II, os participantes das primeiras escolas e CAR a concluir a avaliação foram convidados a preencher a CEWSS-A, num segundo momento (aproximadamente um mês depois), para estudo da estabilidade temporal da escala.

3.4.3 Procedimentos específicos para estudos longitudinais com metodologia quantitativa

O CRT foi desenhado de acordo com o *Consort 2010 statement: extension to cluster randomised trials* (Campbell et al., 2012) e encontra-se registado em ClinicalTrials.gov (Identifier: NCT04512092).

Vinte CAR foram convidadas a participar no CRT, de acordo com os critérios de elegibilidade descritos no ponto 3.1. Doze CAR aceitaram participar. Cuidadores e jovens dessas CAR, que apresentavam critérios de elegibilidade (descritos no ponto 3.1) e que aceitaram voluntariamente colaborar no CRT, foram avaliados em quatro momentos (pré-intervenção, pós-intervenção, 3 e 6 meses após a intervenção), com os questionários de autorresposta descritos nos pontos 3.2.3 e 3.2.4. Os participantes foram informados acerca do procedimento de aleatorização e alocação a uma das condições (intervenção ou controlo). Após a primeira avaliação, as CAR foram aleatoriamente distribuídas por duas condições: grupo de intervenção e grupo de controlo. A aleatorização foi realizada por um investigador não envolvido na

avaliação e intervenção, sem conhecimento prévio das CAR, com recurso à aplicação *keamk* (https://www.keamk.com/).

O TMC-C foi aplicado pela doutoranda, de acordo com o manual, nas CAR alocadas no grupo de intervenção. As sessões foram realizadas, semanalmente, em formato presencial, junto de grupos constituídos por 6 a 10 participantes, com uma duração aproximada de três meses. O horário das sessões foi definido pelo diretor técnico de cada CAR, de acordo com o respetivo funcionamento da CAR e em horário escolar dos jovens.

Por questões práticas, não foi possível realizar uma avaliação totalmente cega por investigadores independentes, sendo do conhecimento das investigadoras envolvidas no processo de avaliação, a respetiva alocação dos participantes às condições experimentais. Os dois primeiros momentos de recolha de dados (pré e pós intervenção) foram efetuados na presença das investigadoras. A amostra de cuidadores foi recolhida em reuniões agendadas para esse efeito, de acordo com horários providenciados pelo diretor técnico de cada CAR. A amostra de jovens foi recolhida, em pequenos grupos, ou individualmente, em formato de entrevista, caso o jovem tivesse dificuldades na leitura (previamente identificadas pelo psicólogo da CAR). Os dados desta amostra foram recolhidos após o horário escolar dos jovens ou durante o fim de semana. Devido à pandemia e por questões práticas relacionadas com o trabalho por turnos, nos últimos dois momentos de avaliação (*follow-up*), os questionários foram entregues em formato papel em cada CAR, a fim de serem preenchidos individualmente por cada cuidador. Também devido à pandemia e respetivo confinamento geral, o primeiro *follow-up* da amostra de jovens foi recolhido pelos técnicos das CAR (psicólogo sempre que possível), uma vez que a entrada das investigadoras se encontrava restringida. O segundo momento de *follow-up* foi recolhido, sempre que possível, na presença das investigadoras, assegurando o cumprimento das medidas de higiene pessoal.

3.4.4 Procedimentos específicos para estudo com metodologia qualitativa

O estudo empírico V (Compassionate Mind Training for caregivers in residential youth care: Investigating their experiences through a thematic analysis) foi realizado de acordo com as *Consolidated Criteria for Reporting Qualitative Research* (COREQ; Tong et al., 2007).

Depois da avaliação quantitativa realizada após o término da aplicação do TMC-C, os cuidadores das primeiras três CAR que concluíram o programa (n = 32; janeiro de 2020) foram convidados a participar em grupos focais. Dezanove cuidadores, com diferentes funções profissionais, aceitaram participar de forma voluntária. Os motivos de recusa não foram recolhidos.

Foram conduzidos três grupos focais, um em cada CAR, com grupos compostos entre 6 a 7 participantes. Os grupos focais ocorreram duas semanas após a conclusão do programa. Estes grupos foram moderados pela doutoranda e coorientadora desta tese, que apresentava experiência com esta técnica e não possuía contacto prévio com os participantes. Dois alunos de mestrado em ciências da educação assistiram aos grupos focais e tiraram notas de campo.

Os grupos focais foram conduzidos de acordo com o guião de discussão descrito no ponto 3.2.5.2, previamente concebido para captar informação acerca das experiências de participação no TMC-C, relevância das aprendizagens e respetivas transferências para as CAR, bem como o impacto percebido. No início de cada grupo focal, foi esclarecido que o objetivo daquele estudo seria compreender as experiências de participação no programa e não avaliar os seus conteúdos. Foram explicadas as regras e solicitado o consentimento de cada participante para concretizar a gravação áudio. Durante os grupos focais, as moderadoras encorajaram os participantes a partilhar e a clarificar as perspetivas individuais e coletivas.

As gravações áudio foram transcritas manualmente pela doutoranda.

3.5 Análise de dados

3.5.1 Cálculo do tamanho das amostras e análise do poder estatístico

Nos estudos empíricos I (Emotional Climate in Residential Care Scale for Youth: Psychometric properties and measurement invariance) e II (Development and validation of the Current Experiences of Warmth and Safeness Scale in community and residential care adolescents), referentes à adaptação e validação de escalas, foi utilizada a recomendação de Nunnaly (1978) para o cálculo do tamanho da amostra, que indica 10 sujeitos por cada parâmetro a estimar da escala em estudo.

No estudo empírico III (Impact of early memories and current experiences of warmth and safeness on adolescents' psychological distress) utilizou-se a recomendação de 10 sujeitos por parâmetro para os modelos de equações estruturais (Kline, 2016) e a recomendação de um mínimo de 100 sujeitos por cada variável contínua utilizada para estabelecer os perfis na análise de perfis latentes (Muthén & Muthén, 2002).

No que diz respeito ao CRT, o tamanho da amostra foi calculado considerando um desenho fatorial (2 grupos) de medidas repetidas (4 momentos de avaliação) com efeitos de interação entre grupos, com recurso ao G*Power, versão 3.1.9.7, considerando um $\alpha = .05$. magnitude de efeito média (d de Cohen = .36), a fim de obter um poder de pelo menos 80%, assumindo uma correlação de .80 entre medidas repetidas (Lovakov & Agadullina, 2021). De acordo com estes parâmetros, devem ser recrutados 54 sujeitos, 27 em cada condição.

3.5.2 Análises estatísticas preliminares

O Statistical Package for the Social Sciences (SPSS; versão 25) foi utilizado para a análise preliminar dos dados.

Foi estudada a incidência e distribuição de dados omissos (*missings*) por sujeito e por item. Não foram analisados os sujeitos com uma taxa de não resposta a uma escala superior a 20% (Peng et al., 2006). Através do teste de Little MCAR (*Missing Completly at Random*) testou-se a aleatorização dos itens omissos ($p > .05$; Little, 1988). Os dados omissos foram tratados de diferente forma consoante as características dos estudos e dos programas informáticos utilizados. Nos estudos conduzidos no MPlus, os itens omissos foram substituídos por 999, dando-se, posteriormente, esse comando ao programa, uma vez que o mesmo usa o estimador *full information Maximum Likelihood* para produzir estimativas de parâmetros não enviesados (Muthén & Muthén, 2012). Nos estudos conduzidos no SPSS, procedeu-se à imputação dos itens omissos através da interpolação linear (Meyers et al., 2005).

Foram também analisados os *outliers* univariados e multivariados. A existência de *outliers* univariados foi explorada através do gráfico caixa de bigodes (Field, 2018). Para explorar a existência de *outliers* multivariados foi calculada a medida de distância de Mahalanobis (Tabachnick & Fidell, 2013). Dado o número reduzido de sujeitos com *outliers,* os mesmo foram excluídos.

Para analisar a distribuição dos dados, testou-se a normalidade univariada e multivariada. Para testar a normalidade univariada recorreu-se ao teste de Kolmogorov-Smirnov (distribuição normal quando $p > .05$; Field, 2018) ou aos indicadores de assimetria (SK) e curtose (Ku) (SK <| 3 | and Ku <| 10 |; Kline, 2016). Para testar a normalidade multivariada, recorreu-se ao teste de Mardia (Korkmaz et al., 2014).

Foram ainda calculadas estatísticas descritivas e inferenciais para descrever as amostras e comparar grupos. Os grupos foram comparados com recurso a teste t de *student* para amostras independentes para variáveis contínuas e teste de qui-quadrado para variáveis categóricas. A magnitude do efeito foi calculada através do d de *Cohen*, para variáveis contínuas, considerando os seguintes valores de referência: .15 (efeito pequeno), .36 (efeito médio) e .65 (efeito grande; Lovakov & Agadullina, 2021). O V de *Cramer* foi utilizado para calcular a magnitude do efeito para variáveis categóricas, considerando os seguintes valores de referência: .10 (efeito pequeno), .30 (efeito médio) e .50 (efeito grande; Cohen, 1988).

O alfa de *Cronbach* foi utilizado como indicador de consistência interna dos questionários de autorresposta. Considerou-se que um questionário apresentava uma

consistência interna apropriada, quando α ≥ .70 (Pallant, 2011). No entanto, uma vez que estamos no campo das ciências sociais, considerou-se aceitável α ≥ .60 (DeVellis, 1991), interpretando-se os resultados com precaução. Um valor de α ≥ .80 foi classificado como bom, e α ≥ .90 excelente (George & Mallery, 2003).

3.5.3 Análise fatorial confirmatória e análise de propriedades psicométricas das escalas

O MPlus v.8 foi utilizado para testar a dimensionalidade e a invariância do modelo de medida das escalas adaptadas, bem como para comparar médias latentes entre grupos. O SPSS foi utilizado para o cálculo da consistência interna, estabilidade temporal e das correlações com outras medidas relevantes.

Para o estudo da dimensionalidade das escalas, realizou-se uma Análise Fatorial Confirmatória (*Confirmatory Factor Analyses* - CFA), uma vez que ambas as escalas validadas no âmbito dos estudos empíricos II e III, foram adaptadas a partir de escalas previamente validadas (Albuquerque et al., 2021; Richter et al., 2009) e baseadas num modelo teórico empiricamente validado. Uma vez que os dados das amostras não seguiam uma distribuição normal, as CFA foram conduzidas com o estimador *Maximum Likelihood Robust* (MLR).

Para determinar a qualidade do ajustamento do modelo de medida, para além do qui-quadrado, que é um indicador sensível ao tamanho da amostra (Bentler & Bonett, 1980), foram utilizados os indicadores de ajustamento recomendados por Hu & Bentler (1999): Comparative Fit Index (CFI), Root Mean Square Error Approximation (RMSEA) e Standardized Root Mean Square Residual (SRMR). Considerou-se que o modelo tinha um bom ajustamento quando alcançados os seguintes valores de referência: SRMR ≤ .09 combinado com RMSEA ≤ .06. ou com CFI ≥ .95 (Hu & Bentler, 1999). Considerou-se que o modelo apresentava um ajustamento aceitável quando alcançados os seguintes valores de referência: SRMR ≤ .09 combinado com RMSEA entre .05 e .08 (Kline, 2016) ou CFI ≥ .90 (Hu & Bentler, 1999). A qualidade dos itens foi verificada através da análise: (i) dos *loadings* (aceitável quando ≥ .40; Mâroco, 2018); (ii) das correlações entre o item e o total da escala; (iii) do coeficiente de *Cronbach* do fator a que o item pertence, caso o mesmo fosse eliminado.

A invariância do modelo de medida foi testada entre grupos (sexo e amostras) através da Análise Fatorial Confirmatória Multigrupos. De acordo com a abordagem proposta por Dimitrov (2010), a invariância do modelo foi testada a nível configuracional (i.e., modelo de medida ajusta-se a cada grupo separadamente), métrico (i.e., o *loading* de cada item é semelhante entre os grupos) e escalar (i.e., o valor do intercepto de cada item é semelhante estre os grupos). De acordo com as recomendações de Chen (2007), a invariância métrica é

alcançada quando: ΔCFI ≤ .01; ΔRMSEA ≤ .015 e ΔSRMR ≤ .03; e a invariância escalar quando: ΔCFI ≤ .01; ΔRMSEA ≤ .015 e ΔSRMR ≤ .01. Para os grupos serem comparados, deve ser alcançado, pelo menos, um nível parcial de invariância escalar. A invariância do modelo de medida permitiu proceder à comparação das médias dos grupos.

A validade do construto com variáveis externas e a estabilidade temporal foram calculadas através do coeficiente de correlação de *Spearman*. Consideraram-se os seguintes valores de referência para classificar as correlações entre variáveis: ≤ .39 (fraca), entre .40 e .69 (moderada), ≥.70 (forte; Dancey & Reidy, 2007).

3.5.4 Análise de trajetórias (Path analysis)

O programa Mplus v.8 foi usado para realizar a análise de trajetórias no estudo empírico III (Impact of early memories and current experiences of warmth and safeness on adolescents' psychological distress).

As memórias precoces de calor e segurança (EMWSS-A) foram introduzidas como variável independente (VI) e os sintomas de depressão e ansiedade (DASS-21) como variáveis dependentes (VD). As experiências atuais de cuidados e segurança (CEWSS-A) foram introduzidas no modelo como variável com efeito indireto entre a VI e as VDs. O modelo saturado inicial foi melhorado, sequencialmente, com base em indicadores estatísticos. Foram utilizadas as normas de ajustamento, atrás mencionadas, para a CFA (Hu & Bentler, 1999).

O efeito moderador do tipo de amostra (i.e., comunitária/acolhimento; rapazes/raparigas) foi também investigado, através da análise da invariância estrutural do modelo a nível: (1) configuracional (i.e., modelo adequa-se aos grupos quando considerados separadamente); (2) padrões (i.e., modelo sem restrições); (3) trajetórias (i.e., modelo com caminhos restritos); (4) fatores (i.e., modelo com médias restritas). Foi assumida a invariância do modelo quando sucessivas restrições ao mesmo não pioraram significativamente o valor do qui-quadrado.

3.5.5 Análise de Perfis Latentes

O estudo empírico III (Impact of early memories and current experiences of warmth and safeness on adolescents' psychological distress), para além da abordagem anterior centrada na variável, integrou também uma abordagem centrada no participante (i.e., Latent Profile Analysis - LPA). A LPA permite criar perfis de indivíduos com base nas semelhanças e/ou diferenças que os mesmos apresentam em determinadas variáveis (McLachlan & Peel, 2004).

A LPA foi conduzida no MPlus v.8 para identificar perfis distintos de adolescentes em acolhimentos, com base nas pontuações obtidas na EMWSS-A e na CEWSS-A. A LPA foi conduzida apenas junto da amostra de adolescentes em acolhimento por se considerar um grupo particularmente vulnerável e com necessidades específicas de intervenção.

A análise inicia com a determinação do número de classes (i.e., perfis) que caraterizam os participantes. Começa-se com um modelo com uma classe única e vai-se gradualmente aumentando o número de classes até que o modelo deixe de apresentar melhorias nos indicadores de ajustamento (Lubke & Muthén, 2007). A seleção do modelo baseou-se nas recomendações propostas por Ram e Grim (2009). Primeiro, os diferentes modelos foram comparados com base nos seguintes indicadores de ajustamento: Bayesian Information Criteria (BIC; Schwartz, 1978), Akaike Information Criteria (AIC; Akaike, 1987) e Sample-Size-Adjusted BIC (SSA-BIC; Sclove, 1987). Modelos com valores mais baixos nestes indicadores apresentam melhor ajustamento (Nylund et al., 2007). Neste processo de seleção, foi também considerado o valor da Entropia, que indica a precisão com que os modelos classificam os indivíduos na classe mais provável. Valores ≥.70 indicam uma classificação precisa e um maior poder do modelo em predizer a pertença dos indivíduos às diferentes classes (Muthén, 2001). Depois, comparou-se o ajustamento de um modelo mais complexo (k classes) com um modelo mais parcimonioso (k–1 classe), através dos testes Lo-Mendell-Rubin (LMR; Lo et al., 2001) e Bootstrap Likelihood Ratio (BLRT; McLachlan & Peel, 2004). Nesta comparação estatística, o teste BLRT é preferível (Nylund et al., 2007). Escolhido o modelo, no passo seguinte, é avaliado o tamanho das amostras das classes, sendo que modelos com classes com menos do que 25 participantes ou que correspondam a < 1% da amostra devem ser rejeitados ou apresentar uma base teórica ou científica para a sua inclusão (Bauer & Curran, 2004). Por último, foram consideradas as probabilidades de associação às classes. Valores ≥ .80 indicam uma elevada probabilidade de os indivíduos estarem corretamente classificados nas diferentes classes (Rost, 2006).

Após determinar o número ótimo de classes, testou-se se existiam diferenças significativas entre os perfis relativamente a sintomatologia depressiva e ansiosa (DASS-21), com recurso ao método BCH modificado (Bakk & Vermunt, 2016).

3.5.6 MANOVA e MANCOVA

Os estudos empíricos IV (Compassionate mind training for caregivers of residential youth care: Early findings of a cluster randomized trial), VI (Fostering an affiliative environment in residential youth care: A cluster randomized trial of a compassionate mind Training program for caregivers enrolling youth and their caregivers) e VII (The effects of the Compassionate Mind

Training for Caregivers on professional quality of life and mental health over time: A cluster randomized trial in residential youth care), decorrentes do CRT, foram realizados com o objetivo de avaliar o efeito do TMC-C em variáveis de relevo, avaliadas com recurso a metodologia quantitativa.

As estratégias analíticas utilizadas foram a Análise Mista Multivariada da Variância (MANOVA) (estudo empírico IV) e a Análise Multivariada Mista da Covariância (MANCOVA) (estudos empíricos VI e VII). Ambas as análises foram realizadas a dois fatores (i.e., entre grupos – condição – e dentro dos grupos – tempo), com recurso ao SPSS v.25.

A MANOVA permite integrar na mesma análise várias VDs, sendo uma análise mais potente do que a ANOVA, uma vez que tem em consideração as correlações entre as variáveis em estudo (Huberty & Morris, 1989). Os dados foram analisados de acordo com o princípio *per-protocol analysis*, segundo o qual apenas os participantes que completaram a intervenção e o protocolo de avaliação foram incluídos nas análises.

Previamente à análise, grupo de intervenção e grupo de controlo (das amostras de cuidadores e de jovens) foram comparados em pré-intervenção relativamente às variáveis sociodemográficas e VD em estudo, com recurso a testes t para amostras independentes (variáveis contínuas) e qui-quadrado ($\chi 2$) (variáveis categoriais). Não foram encontradas diferenças entre os grupos de cuidadores. Na amostra de jovens foram encontradas diferenças entre os grupos numa VD (CEWSS-A) e em variáveis sociodemográficas, como a idade e o ano escolar. Estas variáveis foram incluídas como covariadas, para controlar o eventual efeito das diferenças entre grupos nas variáveis em análise.

Ainda previamente à realização das análises, verificaram-se os respetivos pressupostos (Tabachnick & Fidell, 2013) das distribuições nas variáveis em estudo. Para além da verificação da normalidade e de *outliers*, tal como foi descrito no ponto 3.5.2., foi verificada a homogeneidade da matriz de variância-covariância, através do teste de Box (matrizes homogéneas quando $p > .001$; Field, 2018). A ausência de multicolinearidade ($r < .9$; Tabachnick & Fidell 2013) e presença de correlação mínima entre as VDs ($r > .10$; Cohen, 1988) foram também verificadas através de correlações de Pearson.

Na MANCOVA foram incluídas como covariadas variáveis que, de acordo com a literatura, pudessem ter potencial influência nas variáveis em estudo ou que revelassem diferenças entre grupos antes da intervenção, como sucedeu na amostra de jovens.

Para interpretar os resultados multivariados, foi escolhido o critério *Pillai's trace*, uma vez que este é critério mais robusto quando nem todos os pressupostos são cumpridos (e.g., normalidade multivariada; Field, 2018). A magnitude do efeito para o tempo e tempo x grupo

foi calculada através do eta quadrado parcial ($\eta p2$), considerando $\eta 2\ p = .01$ um efeito pequeno, $\eta 2\ p = .06$ um efeito médio e $\eta 2\ p = .14$ um efeito elevado (Tabachnick & Fidell, 2013). Para selecionar o critério de leitura dos resultados univariados, verificou-se a esfericidade das variáveis através do teste de *Mauchly*. Quando esse pressuposto não foi assumido ($p < .05$), o *Greenhouse-Geisser epsilon* foi verificado e quando $\varepsilon > .75$ utilizou-se o critério de *Huynh-Feldt* (Field, 2018). Para compreender as diferenças entre os grupos ao longo do tempo, foi calculado o d de *Cohen* entre pré e pós intervenção e entre pré-intervenção e os *follow-ups*, considerando os seguintes valores de referência: .15 (efeito pequeno), .36 (efeito médio) e .65 (efeito grande; Lovakov & Agadullina, 2021).

3.5.7 Análise temática

A análise temática foi o método analítico qualitativo utilizado no estudo empírico V (Compassionate Mind Training for caregivers in residential youth care: Investigating their experiences through a thematic analysis). A análise temática é um método sistemático usado para identificar, analisar e reportar padrões recorrentes num conjunto de dados (Braun & Clarke, 2013). Este método foi escolhido por ser flexível e acessível para agrupar aspetos-chave derivados de um conjunto amplo de dados, permitindo, paralelamente, destacar as diferenças existentes. É, por isso, um método útil para ser usado em informação recolhida através de grupos focais e para responder às perguntas de investigação propostas (Braun & Clarke, 2006).

Os dados dos grupos focais foram transcritos e, posteriormente, analisados de acordo com os seis passos propostos por Braun & Clarke (2013). Primeiro, as transcrições foram lidas várias vezes, para aumentar a familiarização com os dados, tendo sido registadas notas preliminares. Segundo, foi realizada uma codificação inicial à mão, que foi posteriormente refinada com recurso ao programa MAXQDA, versão 2020. Este processo envolveu rotular excertos potencialmente relevantes para responder às perguntas de investigação, de acordo com o seu conteúdo semântico ou latente. Terceiro, os códigos foram revistos e agrupados para gerar potenciais temas. De acordo com esta abordagem, temas são unidades que captam informação, pautada por um padrão coerente e relevante, que se encontre relacionada com a pergunta de investigação. Foi desenhado um mapa temático com os potenciais temas e relações entre eles. Quarto, uma segunda investigadora foi envolvida na revisão dos temas. Para avaliar o ajustamento dos temas, os códigos agrupados em cada tema foram confrontados com os dados transcritos. Quinto, os temas foram refinados e foram definidos nomes para os mesmos. Este passo foi efetuado pelas duas investigadoras e validado por um terceiro investigador. Por

último, os resultados foram interpretados e reportados, recorrendo-se a extratos dos grupos focais para ilustrar os temas.

A fim de aumentar a confiabilidade da análise, foram adotados procedimentos de triangulação (investigadores) e verificação de resultados por parte de três participantes dos grupos focais (Braun & Clarke, 2013). Os participantes envolvidos neste processo eram representantes das CAR em estudo, que se voluntariaram a colaborar no estudo.

4. Princípios éticos

Os procedimentos adotados na conceptualização, implementação, publicação e divulgação dos resultados inerentes ao presente trabalho de investigação foram conduzidos em conformidade com as recomendações éticas de investigação com seres humanos de associações científicas nacionais (Código Deontológico da Ordem dos Psicólogos Portugueses, Regulamento nº 258/2011, 20 de abril de 2011, revisto em 2016; OPP, 2021) e internacionais (APA, 2017), bem como em conformidade com a declaração da Associação Médica Mundial de Helsínquia (1964, revista em 2013; World Medical Association, 2013). Os procedimentos de recolha de dados respeitaram o Regulamento Geral sobre Proteção de Dados da União Europeia (RGPD) – Regulamento (UE) 2016/679 do Parlamento Europeu e do Conselho de 27 de abril de 2016, bem como da Lei n.º 58/2019, de 8 de agosto, que assegura a execução do RGPD.

No desenho e procedimentos de investigação dos diferentes estudos foram tidos em consideração os principais princípios de ética em investigação científica em psicologia, nomeadamente: (i) respeito pela dignidade e direitos da pessoa; (ii) competência; (iii) integridade e responsabilidade social; (iv) beneficência e não-maleficência (OPP, 2016). Estes orientaram a definição dos objetivos dos estudos propostos, a escolha de metodologias consistentes, e na ponderação em torno dos potenciais riscos e benefícios para os participantes.

O projeto foi submetido a aprovação da Comissão de Ética e Deontologia da Investigação (CEDI) da FPCE-UC e da Direção Geral de Educação. Após obtidas as devidas aprovações, procedeu-se à implementação dos estudos.

Em conformidade com o princípio respeito pela dignidade e direitos da pessoa, previamente à recolha de dados, os objetivos e procedimentos dos estudos foram primeiramente apresentados às direções das CAR (para recolha de amostras em CAR), e direções das escolas e associações desportivas/recreativas (para recolha de amostras comunitárias). Após recolhidas as autorizações das respetivas instituições, os objetivos e procedimentos dos diferentes estudos foram também apresentados aos participantes com critérios de elegibilidade, de forma a estes poderem tomar uma decisão informada acerca da sua

participação no estudo. Foi assegurado o cariz voluntário de participação, bem como a confidencialidade e anonimato dos dados recolhidos e seu uso exclusivo para fins de investigação. Não foi oferecida nenhuma compensação (e.g., monetária) a fim de incentivar a participação, tendo sido explicitado que os participantes poderiam desistir a qualquer momento, sem qualquer prejuízo para os próprios. Especificamente nas amostras de jovens em acolhimento, foi explicado que a sua decisão não teria qualquer impacto/interferência na medida de promoção e proteção, e que a informação recolhida não seria partilhada com terceiros. O formulário de consentimento informado foi lido e explicado aos participantes e foi cedido espaço para colocar dúvidas. O contacto da investigadora foi disponibilizado na folha do formulário de consentimento informado que ficou na posse dos participantes e encarregados de educação/responsáveis legais dos menores de 18 anos, para eventuais questões que pudessem surgir.

O consentimento informado foi solicitado a todos os participantes dos estudos que compõem esta tese. Na amostra comunitária, foram enviados formulários de consentimento informado para os encarregados de educação de adolescentes com idade inferior a 18 anos e recolhido o consentimento por escrito de todos os adolescentes, independentemente da sua idade, desde que o encarregado de educação consentisse a sua participação e o mesmo desejasse participar. Foram efetuados os mesmos procedimentos nas amostras de jovens em acolhimento, sendo nesse caso, o consentimento informado requerido ao diretor técnico da respetiva CAR, enquanto responsável legal. No CRT, o consentimento informado foi solicitado ao nível do cluster (CAR) e do participante (cuidadores e jovens). Foi ainda solicitado um consentimento específico para o registo áudio dos grupos focais.

Durante a execução dos estudos, foram adotados procedimentos para assegurar a confidencialidade e anonimato dos participantes: (i) sempre que possível, a recolha de dados da amostra de jovens em CAR foi realizada em gabinete ou espaço que permitisse manter a confidencialidade das respostas; (ii) os consentimentos informados foram separados dos protocolos de avaliação, para evitar a identificação dos participantes por terceiros; (iii) foi utilizado um código pessoal, criado pelo participante, para emparelhar os questionários nos diferentes momentos de avaliação; (iv) na transcrição dos grupos focais os nomes dos participantes foram substituídos por códigos; (v) foram recolhidos apenas dados pessoais estritamente necessários à investigação; (vi) os dados foram inseridos numa base de dados informática e analisados exclusivamente de forma coletiva; (vii) os protocolos encontram-se guardados em local seguro e serão destruídos após cinco anos.

De acordo com o princípio da competência, os investigadores envolvidos no projeto de investigação apresentam competência para o desenvolvimento das funções designadas. O programa foi aplicado pela doutoranda, graduada em Psicologia Clínica - Mestrado Integrado em Psicologia Clínica e da Saúde, Especialidade em Intervenções Cognitivo-Comportamentais nas Perturbações Psicológicas e Saúde, formação em terapias de terceira geração e experiência profissional em contexto de acolhimento residencial de crianças e jovens.

Especificamente nos estudos do ensaio clínico, encontrava-se inicialmente previsto facilitar o programa às CAR alocadas no grupo de controlo, após terem concluído o último momento de avaliação do ensaio clínico. No entanto, não foi possível executar este procedimento devido aos constrangimentos associados à pandemia. Como alternativa, a doutoranda comprometeu-se a partilhar os resultados dos estudos com as CAR envolvidas e convidar as mesmas para formações futuras.

Os resultados dos estudos foram disseminados na comunidade científica, de acordo com os parâmetros internacionais de divulgação científica e os princípios éticos de integridade e responsabilidade social, através de publicação de artigos em revistas internacionais com revisão por pares e apresentação de comunicações em formato oral/poster em encontros científicos nacionais e internacionais. O programa de TMC-C e respetivos resultados têm sido igualmente divulgado junto do ISS e IPSS, nacionais e internacionais, bem como em encontros técnicos de CAR portuguesas.

PARTE III

REVISÃO SISTEMÁTICA DA LITERATURA E ESTUDOS EMPÍRICOS

CAPÍTULO 4

PROGRAMAS PARA CUIDADORES DESTINADOS A PROMOVER A SAÚDE MENTAL E EMOCIONAL NAS CASAS DE ACOLHIMENTO RESIDENCIAL – UMA REVISÃO SISTEMÁTICA

Revisão Sistemática da Literatura

Fostering emotional and mental health in residential youth care facilities: A systematic review of programs targeted to care workers

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Abstract

Children and youth placed in residential youth care (RYC) exhibit complex emotional needs and significant mental health problems. Better outcomes in RYC have been associated with emotional availability from care workers. Nevertheless, many care workers struggle either with their own mental health and/or with adequately providing support for the mental health problems of youth under their care. Thus, staff training is recommended by international guidelines. The present study performed a systematic review of research on training programs aiming the fostering of emotional and mental health in RYC, following PRISMA guidelines. A systematic search was conducted in nine digital databases and other sources (websites, relevant journals, reference lists of included articles and relevant reviews), for publications from 1980 to 2021. Empirical studies published in peer-review journals, dissertations, and reports were included when assessing the effectiveness of RYC staff training on fostering emotional and mental health in staff and/or youth. The methodological quality of included studies was assessed using the Mixed Methods Appraisal Tool (Hong et al., 2018b). Subsequently, a narrative synthesis was conducted. After multi-stage screening, 18 eligible articles were selected for analysis. One study was excluded considering the quality assessment. Seventeen trainings and their outcomes were analyzed, suggesting mixed evidence of effectiveness on care workers, youth, and relationships. Most programs aimed to reduce youth problematic behaviors, and only a few specifically addressed care workers' mental health. Findings also suggest that effectiveness was not properly tested in most studies. Future research resorting to rigorous methodologies should be conducted to provide evidence-based interventions for RYC.

Keywords: care workers; children and youth at-risk; emotional and mental health; residential youth care; systematic review; training programs.

Introduction

Residential youth care (RYC) is an umbrella term which integrates a variety of child and youth care services (Lee et al., 2011). In this systematic review, RYC refers to 24/7 group care facilities, where children and youth live under child protection care.

Previous literature has pointed out that children and youth living in RYC present significantly higher mental health difficulties, comparing to those placed in other care settings (Duppong-Hurley et al., 2017; Evans et al., 2017; Leloux-Opmeer et al., 2016; Li et al., 2017). Thus, RYC should not be limited to providing basic care. Instead, it should involve specialized interventions paired with a therapeutic environment (James et al., 2017; Whittaker et al., 2015). The therapeutic potential of RYC lies in the care workers' ability to establish secure relationships with youth and to respond in a sensitive and adequate manner to their emotional needs (Sellers et al., 2020; Whittaker et al., 2015), so that care workers can foster adaptive relational models and help youth to develop adaptive emotion regulation strategies (Huefner & Ainsworth, 2021).

Caregiving challenges and training needs

Residential care placement commonly occurs after a history of abuse or neglect. These previous pervasive experiences frequently trigger complex emotional needs which are challenging to work with (Eenshuistra et al., 2019; Steels & Simpson, 2017; Wilke et al., 2020). On the one hand, care workers must look after youth's emotional needs arising from traumatic experiences. On the other hand, they need to handle youth´s non-compliance (e.g., fail to follow the rules, impulsivity), frequently leading to defiant or aggressive behaviors (Bürgin et al., 2020; Eenshuistra et al., 2019; Molnar et al., 2017; Seti, 2008). In addition, care workers are poorly paid and not always well-trained, they have heavy workloads, limited autonomy, lack of support from colleagues and/or from the leadership, being also a devalued workgroup in comparison with other helping professionals (Eenshuistra et al., 2019; Hermon & Chahla, 2019; Seti, 2008).

Research reveals that care workers are particularly vulnerable to emotional and mental health problems. For example, they present high levels of stress (Hermon & Chahla, 2019; Wilke et al., 2020), burnout (Seti, 2008), secondary traumatic stress (Molnar et al., 2017), and depression (Raskin et al., 2015), potentially leading to a high turnover (Colton & Roberts, 2007). Such conditions can, directly or indirectly, impact the quality of caregiving (Bürgin et al., 2020). As a matter of fact, better outcomes in RYC are associated with caring care workers who are able to establish sensitive and consistent caregiver–child relationships and to promote a positive relational environment (Esaki et al., 2013; Hermenau et al., 2017). When care workers become less emotionally available, it is less likely they can attune with youth's needs, impairing their role

as a suitable attachment figure (Esaki et al., 2013). Moreover, better outcomes in RYC are also linked with the degree of professional training and support care workers get, and well as with the use of evidence-based practices and interventions (De Swart et al., 2012). Consequently, organizations must guarantee more support and specialized training to their staff (Colton & Roberts, 2007; Pinheiro et al., 2022). Even if building caring relationships is a core feature of care workers performance (Everson-Hock et al., 2011), training should not be limited to professional competence. Instead, care workers' own mental health needs should also be addressed to avoid poor and inconsistent care practices (Steels & Simpson, 2017).

Overview of previous systematic reviews

Previous research has systematically reviewed training programs for professionals within different child welfare settings, aiming to clarify what works, and how it works (cf., Overview Table on supplementary materials). Former reviews have either included a heterogeneous range of professionals from different welfare responses (Bailey et al., 2019; Perry et al., 2020; Purtle, 2020), or covered programs for specific welfare responses, such as adoption, foster, or kinship care (Everson-Hock et al., 2011; Fergeus et al., 2017, Kerr & Cossar, 2014; Kinsey & Schlosser, 2012), but excluded care workers from RYC. Since different settings were included, confounding factors associated with fluctuating levels of youth's permanency and different kinds of care might have offered limited conclusions (Morison, 2018). Also, given the specificities in youths' intervention needs within each welfare response (Duppong-Hurley et al., 2017; Leloux-Opmeer et al., 2016; Whittaker et al., 2015), training designs and delivery format in different settings may not adequately attend the distinctive needs of RYC.

Three previous systematic reviews were found, focusing on studies conducted within RYC settings (Eenshuistra et al., 2019; Hermenau et al., 2017; Morison, 2018). The review conducted by Hermenau and colleagues (2017) investigated the effects of structural interventions combined with caregiver training. Interventions identified on this review were mostly delivered to babies and young children's homes. Its effects were assessed for child development and living conditions (Hermenau et al., 2017). The other two reviews investigated the effects of caregivers' training on caregivers' skills (Eenshuistra et al., 2019; Morison, 2018). Morison (2018) also included child outcomes (e.g., behavior). Regarding care workers outcomes, knowledge acquisition (e.g., about attachment or trauma) or general skills (e.g., interpersonal behavior, parenting and communication) were addressed. These outcomes intended exclusively the increase of professional competence and the management of children's behaviors (e.g., coping with crisis) (Eenshuistra et al., 2019; Morison, 2018). Youth outcomes were mostly focused on behavioral (Morison, 2018) or developmental outcomes (Hermenau et al., 2017).

Trainings included in these systematic reviews did not target the specific needs regarding the emotional and mental health of care workers. Also, youth' intervention needs regarding their own mental and emotional health, as proposed by the therapeutic residential care approach, were not covered (Whittaker et al., 2015). Previous systematic reviews also presented some methodological limitations. They were restricted to high income countries, to quantitative outcomes (Morison, 2018), and to articles written in English (Hermenau et al., 2017). Such eligibility criteria may potentially exclude existing relevant research about this topic. Also, one review did not conduct a quality assessment of the included studies (Eenshuistra et al., 2019). Although training appears to have a substantial impact on staff knowledge, beliefs, and skills, attendance alone does not necessarily translate into behavioral change (Kirkpatrick & Kirkpatrick, 2005). Particularly, the role played by emotional and/or mental health variables continues to be underinvestigated (Bunting et al., 2019; Morison, 2018; Perry et al., 2020).

The current systematic review

The emerging consensus concerning RYC suggests that intervention in this setting should look beyond individual treatment (James et al., 2017). It must be complemented with therapeutic environments, using evidence-based interventions and including care workers as therapeutic agents (De Swart et al., 2012; Sellers et al., 2020; Whittaker et al., 2015). Therefore, staff should be trained and supported, since professional training is associated with better outcomes in RYC (De Swart et al., 2012). Although previous systematic reviews concerning training for welfare professionals do exist (Eenshuistra et al., 2019; Hermenau et al., 2017; Kinsey & Schlosser, 2012; Morison, 2018; Perry et al., 2020; Purtle, 2020) some research gaps still persist. First, former systematic reviews included studies mainly focused in increasing staff knowledge and developing staff attitudes/skills. Second, they do not address the impact of staff training over mental health outcomes. Third, youth in RYC tend to present more mental health needs than youth living in other settings (Duppong-Hurley et al., 2017; Leloux-Opmeer et al., 2016; Li et al., 2017). Their complex needs make the care process in RYC more challenging for care workers. Moreover, mental health of care workers might be compromised due to work emotional demands, what could deteriorate the quality of care displayed to children and youth (Bürgin et al., 2020). Considering that mental health concerns are responsible for distress or impairment in important areas of functioning, as well as for high turnover (WHO, 2022), it is still an open question which training programs do help care workers fostering emotional and mental health in RYC, either for themselves and/or for the youth under their care.

The current study proposes to systematically review training/interventions for care workers, and assess its effectiveness regarding mental health in youth and/or care workers. The

following research questions will be addressed: 1) What training/intervention programs exist, targeting staff working in RYC, in order to promote emotional or mental health either in care workers or youth? 2) Which study designs are used to test its effectiveness? 3) Do these trainings effectively improve emotional and mental health outcomes on care workers and/or youth? 4) How successful have been those trainings in improving the environment and relationships?

Methods

This systematic review follows the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA; Page et al., 2021). The research protocol was registered in advance on the International Prospective Register of Systematic Reviews (PROSPERO; registration number CRD42021254783), available from https://www.crd.york.ac.uk/prospero/display_record.php?ID=CRD42021254783

Eligibility criteria

Studies were included (see Table 1) if they focused on evaluating the impact of training conducted with care workers. Throughout this review, training is defined as any intervention targetting staff with the purpose of improving emotional and mental health in RYC (either measured for staff or for youth). Studies were excluded when comprising other components (e.g. therapy for youth; Bunting et al., 2019; James, 2011). This criterion relies on the fact that multi-targeted interventions prevent the understanding about the specific contributions of staff training by itself.

Care workers are defined as all professionals who provide direct day-to-day care and support to youth within RYC. Studies targeting care workers from other welfare settings, such as foster parents or case management, were excluded, considering their different roles and responsibilities (Glisson et al., 2006).

Regarding the setting, the concept of RYC often aggregates: (1) different services targeting diverse populations (e.g., welfare, justice, mental health), (2) diverse duration of stay, and (3) different levels of restrictiveness (e.g., from open to secure settings; James, 2011; Lee et al., 2011). In this study, RYC refers predominantly to the child protective services. Residential treatment was also included considering youth may be referred both by child welfare and mental health agencies. Besides, residential treatment also provides residential full-time supervision and treatment to youth who have experienced early traumatic experiences (Rivard et al., 2003). Studies conducted in baby homes were excluded, considering the intervention specificities with such population.

Table 1. *Eligibility criteria*

Category	Inclusion criterion	Exclusion criterion
Training setting	Residential youth care settings, including residential treatment	Foster care, kinship care, adoption, baby homes, juvenile justice, medical setting, residential care for people with disabilities
Training participants	Professionals working in RYC settings	Children or adolescents, parents, teachers.
Intervention	Training/program/intervention targeting staff working in RYC in order to promote emotional or mental health either in care workers or youth.	- Interventions targeting youth, parents, families. - Interventions aiming to foster other outcomes
Outcomes	- Outcomes reflecting mental health, emotion regulation, well-being or quality of life collected with care workers and/or youth living in RYC (from 6 to 25 years old, living full time in residential care facilities). - Secondary outcomes: Youth and/or care workers' perception of the institutional climate, quality of relationships, or quality of care.	- Knowledge, parenting and social skills (e.g., communication, problems solving), satisfaction with training. - Outcomes collected regarding babies, toddlers, and preschoolers.
Design and research methods	Empirical studies, using quantitative measurement for at least two assessment points (e.g., pre and post intervention), qualitative or mixed methods assessment.	Non-experimental
Cultural and linguistic range	Studies available in English, Portuguese, Spanish, or French. No restrictions regarding country.	Other languages were excluded due to the cost and time involved in translation.
Time frame	Research carried out from 1980 until mid-2021, considering emotions has gained interest in the organizations since 1980 (Yurtsever & Rivera, 2010).	Before 1980
Publication type	Original research published in peer-reviewed journals or grey literature (e.g., reports, dissertations).	Reviews, meta-analyses, books, discussion articles, unpublished studies, communications, case studies, and ongoing studies.

Data sources and search strategy

A comprehensive literature search was performed by LS, on 22 and 23 of June 2021, for studies published between 1980- 2021, in the following digital databases: PsycINFO (via OVID), PsycARTICLES (via OVID), PsycArticles & Mental Health (via OVID), Proquest, Web of Science, SocIndex with full text, Medline (via EBSCO), ERIC (via EBSCO), and Scielo (via EBSCO). The combination of search terms used is presented on Table 2. The search strategy was used for all databases with slight adaptations to fit distinct web interfaces, paired with limits to the search strategy applied to peer-review, date and language.

To find other potentially relevant studies, supplementary searches were undertaken between 15th and 29th of July 2021 also by LS. Manual verification of the reference lists of included articles and relevant systematic reviews was carried out, as well as searches in websites

of relevant social care organizations (e.g., Better Care Network, National Child Traumatic Stress Network), and in a relevant journal in the field (i.e., Residential Treatment for Children & Youth).

Table 2. *Search terms*

Area	Search terms
Context	residential care OR residential youth care OR institutional care OR child care institution OR orphanage OR residential child care OR child welfare OR group homes OR institution* OR residential treatment
AND Intervention	Intervention OR program* OR training OR evidence-based practices OR support OR empower*OR effective*
AND Population	caregivers OR staff OR child care staff OR care worker* OR care providers OR caretakers OR carer* OR child care professionals OR professional caregivers OR child care practitioners OR residential care workers
AND Target population	adolescent* OR child OR children OR youth* OR young people OR teen* OR young*
AND Outcomes	well-being OR wellbeing OR mental health OR emotional health OR emotion regulation OR affect regulation OR emotional climate OR organizational climate OR social climate OR social environment OR burnout OR stress OR compassion fatigue OR depression

Study selection

Study selection was conducted using Rayyan (Ouzzani et al., 2016). After removing the duplicates, studies were screened based on title and abstracts against the inclusion criteria by two independent researchers (LS and RM). When eligibility could not be determined based on the title and abstract, the article was included for full-text inspection. Full-texts of potentially relevant or unclear articles were retrieved and independently screened by LS and RM. Disagreements were solved through discussions between the two researchers until consensus was achieved. There was no need to involve a third researcher to reach consensus. When the full text was not available, the corresponding author was contacted. A study was excluded when no answer was obtained. After reading the full text, 18 studies were included since they have met the inclusion criteria. Inter-rater agreement was computed with Cohen's Kappa coefficient, considering $k < 0.00$ as poor, $k < 0.20$ as slight, $k < 0.40$ as fair, $k < 0.60$ as moderate, $k < 0.80$ as substantial and $k > 0.81$ as almost perfect agreement (Landis & Koch, 1977).

Data extraction

Data extraction was conducted by LS and RM. A data extraction form was created based on Cochrane's Data collection form for intervention reviews. The template for intervention description and replication (TIDieR; Hoffmann et al., 2014) was also used. Data was collected regarding the following topics: (1) Source (title, author/s, year of publication, country, publication type); (2) Method (aim, setting, participant demographics, sample size, ethics, study

design, comparison); (3) Intervention (aim, components, theoretical framework, manualized, provider, modes of delivery, duration, number of sessions); (4) Outcome measures (outcomes and measures, assessment time points); (5) Key findings. When relevant information was missing, the corresponding author was contacted.

Quality Assessment

Quality assessment was performed independently by LS and RM, using the Mixed Methods Appraisal Tool version 2018 (MMAT; Hong et al., 2018b). MMAT is a reliable tool assessing the methodological quality of quantitative, qualitative, and mixed-methods (Hong et al., 2018a). It includes two screening questions (i.e., "Are there clear research questions? and "Do the collected data allow to address the research question?). Studies considered to respond positively to these questions were further assessed with five items related with specific methodological features of study design. Since MMAT does not suggest computing a total score (Hong et al., 2018a), the same rating system from previous research (Martins et al., 2019) was used in order to categorize the quality of each study: strong quality if > 60% of the criteria on the checklist were met; moderate quality if 40% to 60% of criteria were met; and poor quality if <40% of the criteria on the checklist were met. Inter-rater reliability was assessed using Cohen's Kappa statistic, and disagreements were solved through the same strategy described before. When relevant information was lacking, the corresponding authors were contacted.

Analyses

A descriptive synthesis of the included studies was conducted in accordance with the Centre for Reviews and Dissemination framework (CRD, 2009). Such analysis will focus on the training/program, study characteristics and outcomes in care workers, youths and environment/relationships. Meta-analysis was unfeasible due to the articles' heterogeneity about training, outcomes, measures, and analytic approach (CRD, 2009).

Results

Search results

A summary of the search results is presented in a flow diagram regarding the systematic search and study selection process (Figure 1) in accordance with PRISMA 2020.

The digital database, hand search on references, websites, and relevant journal yielded a total of 4784 records, with 4750 records obtained from digital data bases and 34 from other sources. After removing duplicates (N = 1596), titles and abstracts of 3154 studies were screened for eligibility. This first screening step reached almost perfect inter-rater agreement (k = .89), with 3090 records being excluded. Throughout the second screening (full texts assessment), 61

full texts from the digital database and 33 from other sources were examined for eligibility, with 18 studies being included in the review. The second screening achieved moderate inter-rater agreement (k = .74), with a total of 76 studies being excluded. Reasons for excluding studies included: the setting being other than RYC (e.g., foster care, juvenile justice; N = 24), wrong population (e.g., participants were parents, case managers; N = 16), wrong intervention (e.g., interventions targeted to youth; N = 6), wrong outcome (e.g., knowledge; N = 13) or being a background article (e.g., only describing the training with no results; N = 17).

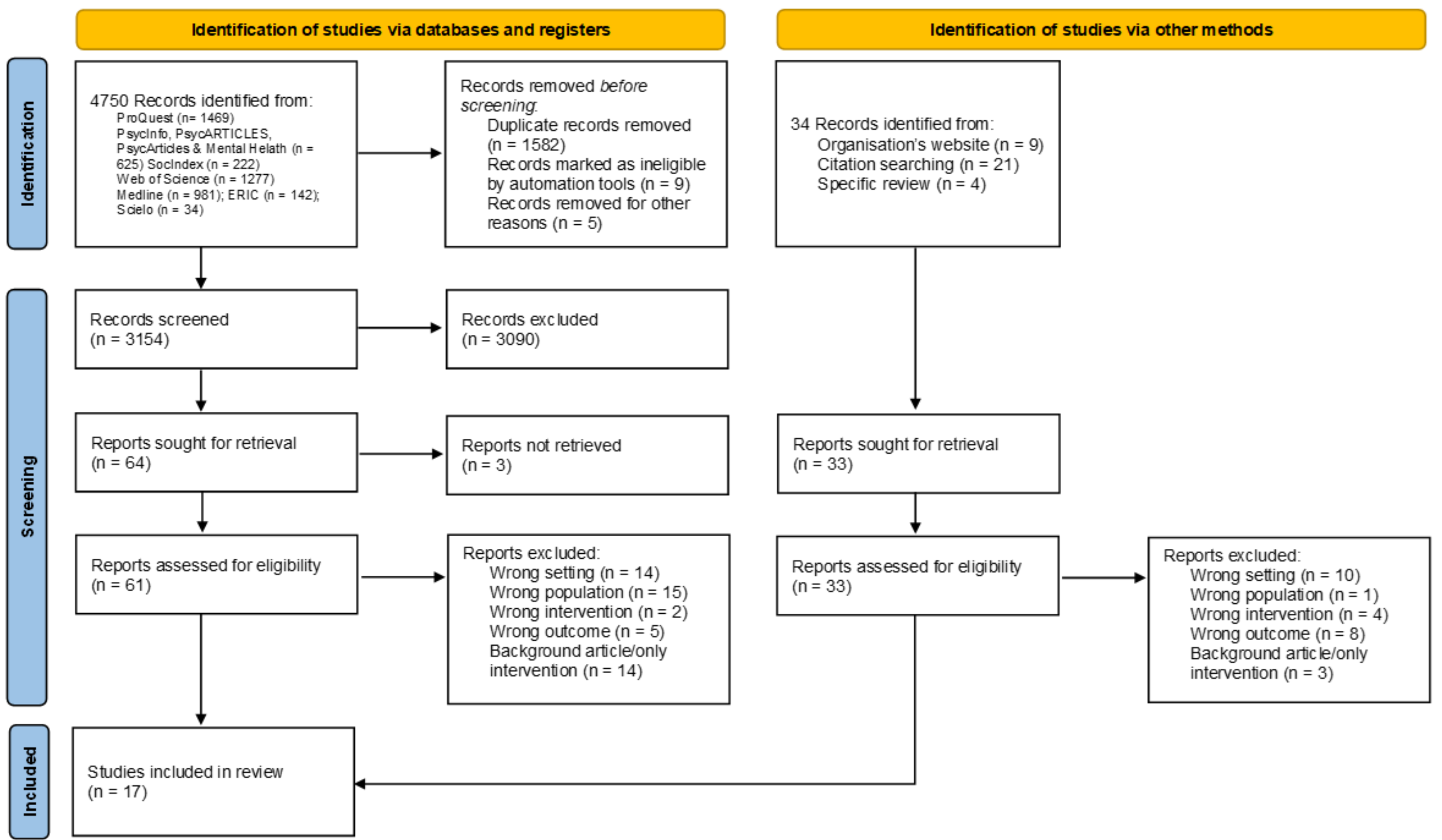

Figure 1. *Flow diagram of the systematic search and study selection process*

Quality assessment

One study (Domon-Archambault et al., 2020) did not adequately respond to the screening questions. Authors were contacted to obtain more information, but no answer was obtained; for this reason, this study was excluded. The remaining 17 studies were assessed according to their design (Tables 3, 4, and 5).

Only one study was assessed for qualitative study design (van Gink et al., 2018; Table 3). It met all the quality criteria, showing a strong quality rating and a perfect inter-rater agreement (k = 1).

Table 3. *Quality assessment of included qualitative studies*

Methodological quality criteria for qualitative studies	Authors, year
	van Gink et al., 2018
1.1. Is the qualitative approach appropriate to answer the research question?	Y
1.2. Are the qualitative data collection methods adequate to address the research question?	Y
1.3. Are the findings adequately derived from the data?	Y
1.4. Is the interpretation of results sufficiently substantiated by data?	Y
1.5. Is there coherence between qualitative data sources, collection, analysis and interpretation?	Y
Rating	Strong (100%)

Note. Y = Yes; N = No; CT = Can't tell.

None of the seven quantitative studies (i.e., nonrandomized controlled trials) fulfilled all the quality criteria (Table 4). Three studies were rated as moderate (42.86%), two as strong (28.57%) and two as poor quality (28.57%). Most studies used appropriate, validated, and reliable measures (85.71%), reporting complete outcome data (57.14%). Yet, the majority of the studies did not account for confounders in the analyses (57.14%). Besides, only two studies had a representative sample (28.57%), and only three assessed treatment integrity (42.86%). Inter-rater agreement was rated as perfect (k = 1). None of the nine mixed methods studies fulfilled the criteria for the three components (quantitative, qualitative and mixed methods items) (Table 5). Six studies were rated as having moderate quality (66.67%), two were rated as poor (22.22%), and one as strong (11.11%). Among these studies, the qualitative component was the strongest, with three studies fully meeting the quality criteria (Donald, 2015; Turner, 2017; Vallejos et al., 2016). The quantitative component was the one with the poorest rating, with no study successfully meeting all quality criteria items. Concerning mixed-methods specific criteria, only three studies clearly reported a rationale for integrating both qualitative and quantitative methods (Berridge et al., 2016; Donald, 2015; Hidalgo et al., 2016). Most studies (66.67%) integrated the different components to answer the research question and adequately interpreted the integrated outputs (55.56%). However, only 44.44% effectively addressed the divergences and inconsistencies between quantitative and qualitative components. Inter-rater agreement for the assessment of mixed-methods studies was substantial (k = 0.80).

Table 4. *Quality assessment of included quantitative nonrandomized studies*

Methodological quality criteria for quantitative studies	Authors, year						
	Cameron & Das, 2019	Hurley et al., 2006	Izzo et al., 2016	Osteen et al., 2018	Schmid et al., 2020	Silva & Gaspar 2014	Wahl, 2011
3.1. Are the participants representative of the target population?	N	CT	Y	N	Y	CT	N
3.2. Are measurements appropriate regarding both the outcome and intervention (or exposure)?	N	Y	Y	Y	Y	Y	Y
3.3. Are there complete outcome data?	Y	Y	CT	CT	Y	Y	CT
3.4. Are the confounders accounted for in the design and analysis?	N	N	Y	Y	Y	N	N
3.5. During the study period, is the intervention administered (or exposure occurred) as intended?	CT	N	Y	Y	CT	Y	CT
Rating	Poor (20%)	Mod (40%)	Strong (80%)	Mod (60%)	Strong (80%)	Mod (60%)	Poor (20%)

Note. Y = Yes; N = No; CT = Can't tell.

Table 5. *Quality assessment of included mixed-methods studies*

Methodological quality criteria		Authors, year								
		Barnett et al., 2018	Berridge et al., 2016	Donald, 2015	Griffing et al., 2021	Hermenau et al., 2015	Hidalgo et al., 2016	Nunno et al., 2003	Turner, 2017	Vallejos et al., 2016
Mixed-methods component	5.1 Is there an adequate rationale for using a mixed methods design to address the research question?	N	Y	Y	N	N	Y	N	N	N
	5.2. Are the different components of the study effectively integrated to answer the research question?	N	Y	Y	Y	N	Y	Y	N	Y
	5.3. Are the outputs of the integration of qualitative and quantitative components adequately interpreted?	N	Y	Y	Y	N	Y	N	N	Y

	5.4. Are divergences and inconsistencies between quantitative and qualitative results adequately addressed?	N	N	Y	N	N	Y	N	Y	Y
	5.5. Do the different components of the study adhere to the quality criteria of each tradition of the methods involved?	N	N	N	N	N	N	N	N	N
Qualitative component	1.1. Is the qualitative approach appropriate to answer the research question?	Y	Y	Y	Y	Y	Y	Y	Y	Y
	1.2. Are the qualitative data collection methods adequate to address the research question?	Y	Y	Y	CT	Y	Y	Y	Y	Y
	1.3. Are the findings adequately derived from the data?	CT	CT	Y	CT	Y	CT	CT	Y	Y
	1.4. Is the interpretation of results sufficiently substantiated by data?	Y	Y	Y	Y	N	Y	Y	Y	Y
	1.5. Is there coherence between qualitative data sources, collection, analysis and interpretation?	Y	CT	Y	CT	Y	Y	CT	Y	Y
Quantitative component	3.1. Are the participants representative of the target population?	CT	N	N	Y	N	CT	N	N	Y
	3.2. Are measurements appropriate regarding both the outcome and intervention (or exposure)?	N	N	Y	N	Y	Y	CT	Y	Y
	3.3. Are there complete outcome data?	N	CT	Y	Y	N	N	N	Y	N
	3.4. Are the confounders accounted for in the design and analysis?	N	N	N	N	N	N	N	N	N
	3.5. During the study period, is the intervention administered (or exposure occurred) as intended?	CT	CT	CT	Y	Y	CT	N	CT	CT
Rating		Poor (26.67%)	Mod (40%)	Strong (73.33%)	Mod (46.67%)	Mod (40%)	Mod (60%)	Poor (26.67%)	Mod (53.33%)	Mod (66.67%)

Note. Y = Yes; N = No; CT = Can't tell; Mod = Moderate.

Training/Intervention programs

Seventeen training/interventions were found, from which two studies implemented a Trauma-Informed Care (TIC) approach (Barnett et al., 2018; Schmid et al., 2020) (Table 6). Because different aims, procedures and contents were involved, these two were considered as different interventions. The training/interventions aims varied across studies. Some studies assessed intervention outcomes on youths, others on care workers, and others on both. Studies focusing on youth outcomes aimed to offer care workers numerous skills: (1) knowledge to better understand and address youth's needs (Cameron & Das, 2019; Donald, 2015; Griffing et al., 2021; Hidalgo et al., 2016; Nunno et al., 2003; Schmid et al., 2020); (2) to promote de-escalation techniques (Barnett et al., 2018; Hurley et al., 2006; Nunno et al., 2003); (3) to reduce mental health problems (Hermenau et al., 2015; Osteen et al., 2018; Silva & Gaspar, 2014). Moreover, other studies focused on providing staff support (Barnett et al., 2018; Griffing et al., 2021) and improving staff self-regulation and well-being (Hidalgo et al., 2016; Schmid et al., 2020; Turner, 2017; Vallejos et al., 2016). Some studies also intended to enhance the social dynamics (Hidalgo et al., 2016; Izzo et al., 2016; van Gink et al., 2018; Wahl, 2011), and to improve the quality of care (Hermenau et al., 2015).

Table 6. *Synthesis of the Staff Training/Interventions*

Training name (Author, year)	Aim of the training	Training components/content/methods	Theoretical framework	Provider	Modes of delivery	Sessions and training length	Manualization
Trauma-informed Care (TIC) (Barnett et al., 2018)	TIC aimed to engage senior leadership; use data to inform practices; provide extensive staff support, promote de-escalation techniques to replace seclusion and restraints; and support careful debriefing processes.	TIC included the assessment of youths' psychological needs, leadership buy-in, train the trainer model, reflective practice groups, staff incentives, and evaluation. Training topics: 1) Creating a trauma-informed agency; 2) Relationships and trauma; 3) Attachment and trauma; 4) Practical intervention strategies; 5) Worker resiliency and secondary traumatic stress;	- The Six Core Strategies - Risking Connection	Internal trauma specialist (train the trainer model)	Non-specified	7 Sessions (2h each) + 6 Reflective practice supervision groups (1h each)	Non-specified

		6) Reflective practice; 7) Creating a trauma-informed organization.					
Residential and Social Learning Theory (RESuLT) (Berridge et al., 2016)	RESuLT aims to promote whole-team interventions to support youth in their development and to assist in promoting positive behavior.	Training methods included: use of folders; hand-outs; video clips; discussion; role play; and applying learning to work in the home during the intervening week.	- Social learning theory - Relational skill building - Neuroscience	Non-specified	Training provided to all staff	10 Sessions, during 12 weeks	Non-specified
Model of professional childcare (Cameron & Das, 2019)	Group consultation protocol designed to provide knowledge about youth complex needs in order to provide professional support.	1) Helping children to self-manage their own maladaptive behaviors; 2) Meeting children's parenting needs and enhancing self-belief and inter-personal skills; 3) Understanding and supporting children who are experiencing developmental trauma to achieve reintegrative adaptive emotional adaptation; 4) Identifying and building on the children's strengths.	- Parental Acceptance–Rejection Theory (PARTheory) - Attachment - Pillars of Parenting	Educational psychologist consultant	Group format	6 Sessions (half day each), which took place fortnightly for the first 3 months, and then monthly, during 1 year + Regular supervision and support	Non-specified
Child Teacher Relationship Training (CTRT) (Donald, 2015)	CTRT aims to train care workers to be therapeutic agents	Care workers are trained in basic child-centered play therapy skills, including: 1) returning responsibility and facilitating decision making; 2) tracking, reflecting content, reflecting feelings, esteem-building and encouragement; 3) therapeutic setting.	- Child parent relationship therapy	The researcher, who is a registered play therapist, licensed professional	Individual format	Phase I: 10 Sessions + weekly sessions with a child of focus (30 min) for 7 weeks + 3 weeks of	Yes

		Training occurred through a format of didactic instruction, demonstration play sessions, required at-home laboratory play sessions, and supervision in a supportive atmosphere.		counselor, and national certified counselor		supervision (30-45 min each) Phase II: Coaching (30 min), during 6 weeks	
Empowering Direct Care Staff to Build Trauma-Responsive Communities for Youth (EQ2) (Griffing et al., 2021)	EQ2 is a psychoeducational training aimed to increase staffs' self-awareness and regulation, and to create ongoing staff support to buffer against secondary traumatic stress. The intervention focuses on helping staff to understand the impact of trauma on youths' behavior and improving staffs' ability to effectively respond to trauma-related responses.	EQ2 incorporates: 1) trauma-informed knowledge; 2) mindfulness-based practices (e.g., attention training, focused-breathing exercises, and guided visualizations reinforcing session content); and 3) practices from restorative justice. Didactic material includes: 1) information on the impact of trauma on development; 2) the responsibilities of emotion coaches; 3) how staffs' early life experiences influence caregiving beliefs and attitudes; and 4) interpersonal factors that contribute to reparative relationships.	- Trauma-informed approach as outlined by Substance Abuse and Mental Health Services Administration	One of the study authors in three sites. The fourth site designated an internal psychologist, who received ongoing training from the project team.	Group sessions delivered on-site	6 Sessions (60 to 90 minutes each) during 6 weeks	Two handbooks, one for the facilitator and other for the participant
Hermenau et al., 2015 (without name)	To improve care quality and to prevent maltreatment in institutional care.	Training components: 1) Child development; 2) Caregiver–child relationships; 3) Effective caregiving strategies; 4) Maltreatment prevention; 5) Supporting burdened children; 6) Child-	- Parenting guidelines of the American Academy of Pediatrics - The Fairstart Global training concept	A Tanzanian and a German psychologists Three trained Tanzanian	Training provided on a school	12 Sessions (8h each), during 2 weeks	Yes

		centered institutional care; 7) Team work and supervision.		interpreters to facilitate communication			
PATHS to Resilience (PATHS) (Hidalgo et al., 2016)	PATHS is designed to foster collaborative relationships, to learn skills to decrease job burnout and improve staff well-being, as well as addressing the clinical needs of traumatized youth.	PATHS' core elements: 1) The *Life is Good Playmaker* training aims to promote trusting connections and collaboration among participants by means of playful activities. Such activities are based on four domains: i) safety and empowerment; ii) social connection; iii) active engagement; and iv) joy. 2) Training in Trauma Systems Therapy (TST) focusing on building collaborative relationships and reducing triggers in the environment that can lead to youths' dysregulation. 3) Implementation planning in order to identify and deal with barriers underlying the program. It also includes the selection of an implementation team, setting up technical support and online supervision schedule.	- Play-based training - Trauma-informed - Trauma Systems Therapy	A clinician within each home.	Non-specified	2.5 training days + 6-9 months of weekly online technical support and supervision, + 2 full-day refresher trainings.	Non-specified
Managing Youth in Short Term Care (MYSTC)	MYSTC aimed to train emergency shelter staff in effective methods for dealing with youth who have behavioral and emotional problems	The main component was the daily, ongoing teaching of social skills through a therapeutic teaching method. It intends to provide staff with strategies to effectively de-escalate intense situations and prompt youth to use a self-control strategy (e.g., focused breathing). It is also sought proficiency in areas such as observation	Non-specified	Consultants from Girls and Boys Town (GBT) National Resource and Training Center	Training provided on-site	40-hour during one week + Technical assistance from GBT consultants and supervisors	Non-specified

(Hurley et al., 2006)		and assessment skills, cognitive and social development, and behavioral crisis management. Staff members also participated in four skill practice sessions, where they role-played the desired skill and receive feedback.					
Children and Residential Experiences (CARE) (Izzo et al., 2016)	CARE is a principle-based program designed to enhance the social dynamics in group care settings through staff development and reflective practice	Six underlying topics: 1) relationship-based; 2) trauma-informed; 3) developmentally focused; 4) family-involved; 5) competence-centered; 6) ecologically oriented. This process calls for changes in theoretical perspective, organizational norms, and role expectations. Technical assistance (TA) activities involve observation and feedback, training and coaching for front-line supervisors, developing routines for reflective practice, and addressing organizational barriers to creating a more therapeutic milieu.	- Ecological approach	Two CARE Consultants (graduated in Social Work or related fields, with several years of leadership and supervisory experience in group care settings) provided quarterly onsite TA	- Leadership training in CARE principles - Agency-based trainers are prepared to deliver the 5-day training to remaining staff.	5-day train the trainer	Yes
Therapeutic Crisis Intervention (TCI) (Nunno et al., 2003)	TCI aims to increase staff skills, knowledge, and confidence to respond the children's difficult feelings and behaviors when they are in crisis.	TCI curriculum teaches strategies to interpret children's aggressive behaviors as an expression of needs. It also motivates to choose skills and behaviors that reduces the potential for counter-aggression. TCI teach staff how to cope their own level of arousal to aggression, to use active listening skills, the Life Space Interview, and behavior management techniques to	- Crisis management, prevention and de-escalation theory	Train the trainer model	Training provided to all staff	5 Sessions to train the supervisors trainers (7 hour each); subsequently supervisors who received the previous training provide TCI for	Yes

		de-escalate the children's anger and frustration, helping them to gain self-control.				all staff in a 4-day program + technical assistance	
Youth Depression and Suicide: Let's Talk (YDS) (Osteen et al., 2018)	YDS aim to decrease suicide ideation and behavior.	Sessions were divided into three sections: 1) addressing myths about suicide and learning warning signs and risk/protective factors; 2) learning and practicing skills to identify and assess suicide risk; 3) identifying the protocol and resources for intervening with suicidal youth. Learning techniques used, included didactic information sharing, interactive role-plays, group activities, case-based scenarios, and printed materials and resources.	- Adapted from "Youth Depression and Suicide: Let's Talk" (YDS) gatekeeper training, developed by the Massachusetts Society for the Prevention of Cruelty to Children in collaboration with the Massachusetts Department of Children and Families	Four trainers	Group format	3 Sessions (3–4 hours), during 3 days	Non-specified
Trauma-informed care (TIC) (Schmid et al., 2020)	TIC is a milieu-therapeutic approach that aims to promote self-efficacy and self-care of staff by guiding them to a better understanding of their own and their clients' stress symptoms and countertransference.	TIC training includes: 1) knowledge of neurobiological and behavioral sequelae of trauma; 2) awareness of trauma triggers; 3) intervening in a trauma-sensitive way; 4) attention to self-care in response to working with traumatized clients. In between trainings, the implementation process also includes supervision of challenging interactions between clients and staff, psychoeducational sessions and resilience hours in a one-to-one situation, including training in emotion regulation,	- Grounded in an understanding of and responsiveness to the impact of trauma.	Non-specified	Non-specified	- Six 3-day trainings for management and counsellors (organizational development, supervision skills, and burnout prevention).	Non-specified

		mindfulness, mentalization and social problem-solving skills.				- Eight 2.5-day trainings for staff.	
Incredible Years Basic Parent Program (IY) (Silva & Da Fonseca Gaspar, 2014)	IY intends strengthen 'parenting' skills, aiming to prevent, reduce and/or treat conduct problems among children aged 3-8 years while increasing their social competence.	The training involved facilitator led group discussion, videotape modelling and rehearsal of intervention strategies. The first sessions emphasize the importance of play and special time activities. It moves on to cover coaching children in academics, persistence, emotion regulation, and social skills. Sessions follow on effective praise and the use of rewards and incentives focusing on behavior that adults wish to establish. The second half of the program focuses on strategies to reduce unwanted behavior including limit-setting, giving clear instructions and following through, ignoring, redirecting and distracting, timeout, and consequences for problem behavior.	- Cognitive social learning - Modelling - Self-efficacy - Attachment - Child development	Two facilitators, who were trained and had previous experience with the program delivery. Facilitators received regular supervision by an IY certified leader and peer-coach.	Group format with up to 12-15 caregivers from the same residential care home	13 Weeks (2h each)	Two handbooks, one for the facilitator and other for the participant
Healing Rhythms biofeedback program (Turner, 2017)	It is a consumer marketed, self-administered biofeedback program that intends to improve autonomic self-regulation.	In the first session, the researcher trained the participant to use the Healing Rhythms program. Between sessions 2 and 15 biofeedback is self-administered using the Healing Rhythms training software. It comes with a 15-step guided training manual and teaches mind/body wellness through guided meditations, visualizations, breath work, mindfulness, relaxation exercises, soothing sounds, and biofeedback technology. Three	- Social-cognitive theory	Self-administered	Self-administered at place of employment in a quiet room free from distraction.	15 Sessions over 5 weeks (3 times a week)	Yes

		biofeedback sensors connect to the participant’s fingertips to record blood volume pulse and offer two types of simultaneous feedback to reward improvements in heart rate variability.					
Kundalini yoga (Vallejos et al., 2016)	To facilitate a calmed and relaxed state of mind and body.	Each session was structured to include warming up, one or two periods of meditation or rest combined with physical movements ranging from warm ups to a peak session of dancing, running, shaking and squats, combined with some static postures, cooling down, 10 min of relaxation, and ending with 3-5 min of meditation.	- Secular version of Kundalini yoga, which is a dynamic type of yoga with a special focus on breath and movement that works on the glands and nervous system	Non-specified	Non-specified	20 Sessions (44-60 min each), during 20 weeks	Non-specified
Non-violent Resistance (NVR) (van Gink et al., 2018)	NVR focuses on improving the relation between staff and children.	The NVR training consisted of a non-violent resistance attitude and communication. It includes delayed responses in order to decrease the chance of escalation, reducing the number of rules and improving non-verbal and verbal communication skills. NVR tools are: 1) Reparation Act (giving the child a chance to repair the damage that has been done); 2) Three baskets technique can help a team to decide on their priorities and to be clear about which unacceptable behavior they will deal with; 3) Announcement, a formal letter that informs a child about the staff's intentions, their will to resist particular behavior and, for example, the team plan to ask help from parents; 4) Sit-in, staff members and	- Method “Non-violent Resistance: A new approach to violent and self-destructive children”	Non-specified	Group format	2-Days training + 6-9 months supervision	Non-specified

		enter a child's room for fifteen minutes and ask the child to come up with a solution, whereupon staff members will wait silently for the child's answer.					
Positive psychology training for staff (Wahl, 2011)	The training intends to decrease the number of runaway incidents in group homes. It also seeks to help staff build relationships with clients and offer youths an opportunity to break the cycle of violence, abuse, neglect, poverty, or substance abuse.	Session contents: Session 1: Introduction to positive psychology and Happiness; Session 2: Engagement; Session 3: Positive Psychology and meaning; Session 4: Positive Psychology and life satisfaction. Topics were administered by lectures, group exercises, handouts, questions, research article reviews, and verbal observation.	- Positive psychology	Researcher	Group format, delivered in-service	4 Sessions (2h each), over 4 weeks	Non-specified

Only six studies clearly specified the theoretical frameworks on which the training was based. The most common theories were social-cognitive (Berridge et al., 2016; Silva & Gaspar, 2014; Turner, 2017) and attachment (Barnett et al., 2018; Cameron & Das, 2019; Silva & Gaspar, 2014). Regardless of not mentioning a particular theoretical framework, most studies included trauma-informed principles (Barnett et al., 2018; Cameron & Das, 2019; Griffing et al., 2021; Hidalgo et al., 2016; Izzo et al., 2016; Schmid et al., 2020). Behavioral techniques (Berridge et al., 2016; Hurley et al., 2006; Nunno et al., 2003; Silva & Gaspar, 2014; van Gink et al., 2018), mindfulness or meditation exercises (Griffing et al., 2021; Schmid et al., 2020; Turner, 2017; Vallejos et al., 2016), positive psychology (Wahl, 2011), and playful approach (Donald, 2015; Hidalgo et al., 2016) were also among the components of the included studies.

From available data, trainings varied between three (Osteen et al., 2018) to 20 sessions (Vallejos et al., 2016), with duration ranging between three days (Osteen et al., 2018) and one year (Cameron & Das, 2019). Group format seemed to be the most frequent delivery mode (Berridge et al., 2016; Cameron & Das, 2019; Griffing et al., 2021; Nunno et al., 2003; Osteen et al., 2018; Silva & Gaspar, 2014; van Gink et al., 2018; Wahl, 2011). Only five studies ensured treatment fidelity through checklists, video-tape recordings, and/or supervision (Donald, 2015; Griffing et al., 2021; Hurley et al., 2006; Izzo et al., 2016; Silva & Gaspar, 2014). Only seven studies reported using a program handbook (Donald, 2015; Griffing et al., 2021; Hermenau et al., 2015; Izzo et al., 2016; Nunno et al., 2003; Silva & Gaspar, 2014; Turner, 2017).

Studies design and characteristics

Studies were conducted between 2003 and 2021. While most studies were published on peer-reviewed journals (n = 14), three were dissertations (Donald, 2015; Turner, 2017; Wahl, 201), and one was a research report (Berridge et al., 2016) (Table 7).

Table 7. *Characteristics of the included studies*

Author, year, country	Setting and target group	Sample characteristics	Study design	Comparison	Outcomes and Measures	Key findings
Barnett et al., 2018 USA	1 Residential treatment facility with accompanying day school	178 Staff (residential counselor, program manager, paraprofessional, teacher, administrator) 60% female	Uncontrolled study: pre- post-and 12 months follow-up; Mixed-methods	No comparison	Outcomes: - Staff sense of felt safety - Trauma-informed skills - Job satisfaction - Staff turnover - Critical incidents. Measures: - Administrative data - Felt Safety Survey - Trauma-Informed Skills Survey - Survey with open ended questions	Bivariate correlations showed positive associations between the number of trainings and supervision attended, with Trauma Skills, but not with Felt Safety or Job Satisfaction. - Critical incidents decreased 22% over the implementation and sustainment phases; - No effect on staff turnover.
Berridge et al., 2016 UK	10 Children's Homes IG = 6 CG = 4	82 Staff 17 Young people IG = 10 CG: = 7	Controlled study: pre- post-test; without random assignment; Mixed-methods	No intervention	Outcomes: - Confidence - Skills - Knowledge - Youths' behavior Measures: - Staff at Work questionnaires - Strengths and Difficulties Questionnaire - Individual interviews (42 Staff and 10 youth from IG at post-test)	Staff outcomes: - No statistically significant improvements were found between IG and CG - After the training IG improved in Motivation, Communication (with co-workers) and Quality of Work. - Qualitative data revealed: 1) staff used inputs from training on daily-basis; 2) staff reported better understanding and coping strategies to manage children's behaviors. Youth outcomes: - No statistically differences on youth after training. - Qualitative data revealed: 1) staff reporting that youth were calmer. 2) fewer conformations and sanctions; 3) youth reported more positive interactions with staff and Home being calmer.
Cameron & Das, 2019	11 Children's homes	? Staff	Uncontrolled study:	No comparison	Outcomes: - Personal and interpersonal development	- Significant improvements on young people´s responses to support from their careers, in general, in behavioral and

UK		53 Young people	Pre- post-test; Quantitative		- Well-being and Self-identity - Self-efficacy and Self-management - Social Interaction and Responsibility Measures: - Progress and development checklist	affective measures and across all the three phases of model implementation.
Donald, 2015 USA	1 Residential treatment facility for youth aged 5-14 years old	3 Front-line staff 66% Female 3 Children, aged 6-10 years old	Multiple baselines across participants single-case experimental design, with 6-week follow-up. Mixed methods	No comparison	Outcomes: - Perceptions of children's behaviors - Relationship with the child of focus - Ability to demonstrate empathy in play sessions - Ability to generalize child-centered play therapy skills to a classroom/group environment -Symptoms of burnout Measures: - Child-Teacher Relationship Building Skills-Center Time Observation Form - Student Teacher Relationship Scale - Teacher Report Form - ASEBA - Maslach Burnout Inventory - Preventative Resources Inventory - Play sessions rated using the Measurement of Empathy in Adult-Child Interaction - Individual semi-structured interviews with staff (pre-post)	- Changes on children's behaviors were not consistently supported across quantitative and qualitative data. - Qualitative approach identify self-reporting of feeling closer to their child of focus, though this was not consistently supported quantitatively. - Quantitative and qualitative data support participants' capacity to integrate CTRT skills into practice and an increase of empathy within play sessions. - Symptoms of burnout did not improve, but participants described job improvements related to the training.
Griffing et al., 2021 USA	4 Agencies (a short-term crisis stabilization program, a program for adolescent	35 Staff (Direct care, supervisors, administrators) 77.4% female	Uncontrolled study: Pre- post-test; Mixed-methods	No comparison	Outcomes: - Skills - Attitudes - Knowledge Measure:	Over 90% of participants agreed or strongly agreed with training: - helped them to better understand how a youth's trauma history affected their behavior; - gave them skills to better respond to youth; - improved their ability to resolve conflict with other staff;

	mothers, and a residential treatment, a community-based program for youths with court or gang-involvement)				EQ2 survey, including quantitative and open-ended items	- helped them to become more effective in their professional role; - applied these skills to other areas of their life. Qualitative data indicated: - learning/sharing with colleagues (participants reported benefitting from receiving psychoeducation and emotional support); - developing a greater understanding of youth and trauma (changing one's perspective on youth behavior); - increasing self-awareness; - utilizing skills and course material; - changing response patterns to challenging behaviors.
Hermenau et al., 2015 Tanzania	? Orphanages, for youth aged 0-15 years old	29 Care workers 90% female 28 Children, aged 7-12 years old	Uncontrolled study: pre- post-and 3-month follow-up; Mixed-methods	No comparison	Outcomes: - Caregiver–child relationships - Children's behavior and mental health Measures: - Children's Depression Inventory - Strengths and Difficulties Questionnaire - Reactive-Proactive Questionnaire - Interviews with staff and children	- Caregivers reported a better relationship to the children and a positive change in the behavior of the children as a result of their own modified behavior. - Children showed significant decrease in depressive symptoms, aggressive behavior and internalizing and externalizing problems after staff training.
Hidalgo et al., 2016 USA	4 Shelters for unaccompanied migrant youth (<18 years)	280 Staff (front-line, clinical and administrative) filled out the follow-up, but only 160 participated on the training	Uncontrolled study: Pre-test, 6 and 12-month follow-up; Mixed-methods	No comparison	Outcomes: - Quality of relationships among staff - Vicarious trauma as measured by changes in beliefs about safety, trust, intimacy, self-esteem and control - Job satisfaction - Job performance - Frequency of restraints, medication use, and critical behavioral incidents - Staff's beliefs regarding the residential facility's capacity to address mental health issues	- Analysis conducted at a setting level indicated that at the 12-month assessment, staff reported statistically significant decreases in distress on self-safety, other safety, other trust, other esteem, self-intimacy, other intimacy, self-control and the TABS total score; - Changes in staff beliefs about mental health capacity of the residential facilities. - Statistically significant improvement in job satisfaction - Decrease in number of restraints and reductions in the use of psychotropic medications, mental health interventions, aggression, and behaviorally-related critical incidents.

					Measures: - Trauma Attachment Belief Scale (TABS) - Mental Health Capacity Instrument - Andrews and Withey Job Satisfaction Questionnaire - Administrative data - Semi-structured interviews (at 12-month follow-up)	- Qualitative analysis revealed that training improved staff stress and communication among staff, and staff's ability to reduce youth's emotional dysregulation.
Hurley et al., 2006 USA	Short-term emergency shelter for youth, aged 6-18 years old	221 Direct-care staff 8,829 Youth, aged 6-18	Uncontrolled study: Pre- post-test; Quantitative	No comparison	Outcomes: - Behavioral incidents Measures: - Administrative data	- 30% Decrease of serious youth incidents; - Significant decrease in responding to behavior, inappropriate behavior, and other incidents from pre to post. - Runaway significantly increased over time.
Izzo et al., 2016 USA	11 Group care agencies for youth, aged 7-18 years old	Non-specified	Multiple baseline interrupted time series	6 Agencies in waiting list also received the training (Cohort 2)	Outcomes: - Behavioral incidents Measures: - Administrative data	- Significant decrease in aggression toward staff, property destruction, and runaways; - Cohort 2 trends did not differ from cohort 1 for aggression toward staff, property destruction, and runaway, but they did differ for aggression toward peers and self-harm.
Nunno et al., 2003 USA	4 Residential units for youth, aged 5-18 years old	120 Staff (management, clinical, supervisory, direct care) 52% female	Uncontrolled study: Pre- post-test; Mixed Methods	No comparison	Outcomes: - Critical incidents - Knowledge - Confidence - Skills levels Measures: - Confidence scales - Critical incident reports - Interviews with care workers and supervisors	- Statistically significant increase in confidence levels in four major areas - Decrease in overall critical incidents
Osteen et al., 2018 USA	1 Agency	43 Staff (clinical, residential, administrative)	Uncontrolled study: pre- post, 3 and 6-month follow-up;	No comparison	Outcomes: - Knowledge - Attitudes - Self-efficacy - Skills/practice behaviors	- Large effect sizes for increasing self-efficacy and moderate effect for efficacy to perform gatekeeper role, that maintained the over time; - A modest increase in use of gatekeeper behaviors following training, that were not maintained over time;

		71% female	Quantitative		Measures: - Suicide Prevention, Exposure, and Awareness Knowledge Survey - Attitudes to Suicide Prevention Scale - The Perceived Preparedness for Gatekeeper Role measures - Efficacy to Perform Gatekeeper Role scale - Gatekeeper Behaviors with Suicidal Clients	- No change in attitudes and reluctance for engagement in assessment skills.
Schmid et al., 2020 Switzerland	14 Residential youth welfare institutions for children and youth, aged between 7 and 25 years	47 Staff (mostly social education workers) 66% female IG = 18 CG = 29	Controlled study; pre-test, 12, 24 and 36-month follow-up (with cluster as unit of allocation); Quantitative	No intervention	Outcomes: - Psychological stress - Physical aggression towards caregivers Measures: - Hair cortisol concentration (HCC) - A survey about physical aggression by youth towards staff	- At 36-month follow-up, IG showed significantly lower HCC, and significantly less physical aggression than the CG.
Silva & Gaspar, 2014 Portugal	4 Short-term residential care facilities IG = 2 CG = 2	47 Staff IG = 27 CG = 20	Controlled study; pre-post, and 6-month follow-up (without random assignment)	No intervention	Outcomes: - Empathy - Sense of competence - Depression - Child rearing practices Measures: - Adult-Adolescent Parenting Inventory - Parenting Sense of Competence - Beck Depression Inventory	- Improvement of empathic attitudes in one of the intervention groups and improved perceptions of the children's role in the other.
Turner, 2017 USA	1 Agency (group homes and residential treatment)	6 Care workers 66.67% female	Uncontrolled study: Pre- post-test;	No comparison	Outcomes: - Heart rate variability - Perceived stress - Burnout	- Heart rate variability and sense of personal accomplishment increased over the study period, while perceived stress and burnout decreased.

			Mixed Methods		Measures - Nexus- 10 biofeedback instrument and Bio-Trace software - The Perceived Stress Scale - Maslach Burnout Inventory - Semi-structured interviews	- Qualitative data indicated that participants have benefited from the program, including a calming effect, increased mindfulness, slowing down, increased awareness, reduced stress, and ease of burnout.
Vallejos et al., 2016 UK	3 Children's homes	29 Staff 72% female 9 Youth, aged 13-17 years old	Uncontrolled study: Pre- post-test; Mixed Methods	No comparison	Outcomes: - Social inclusion - Mental health - Well-being Measures: - Warwick-Edinburgh Mental Health Well-being Scale - Social inclusion - General Health Questionnaire - Semi-structured interviews (at post-test with 9 staff and 3 youth)	- No statistically significant effects on well-being and mental health among children and staff. - Qualitative data suggested that participants experienced both individual (e.g., feeling more relaxed) and social benefits (e.g., feeling more open and positive). Some staff noticed positive changes on children, describing them as quieter and calmer after the yoga sessions.
van Gink et al., 2018 Netherlands	3 Residential facilities	13 Staff (psychiatrists, psychologists, counselors, group workers) 84.62% female	Qualitative study	No comparison	Outcomes: - Benefits of the method - Beliefs on how the method achieves its effect - Factors that help or prevent the method from being executed in daily practice Measure: - Interviews	- Results showed that participants reflect on their own way of working more critically, considering their role in escalation processes. Most staff mentioned the focus on being a team, working together to create a better climate and cope with aggression as the most useful aspect of the training. Staff also reported the training helped them to feel more relaxed and to prevent or stop a situation from escalating or getting out of control.
Wahl, 2011 USA	5 Group homes for youth, aged 12-18 years old	27 Behavioral health technicians 67% male	Uncontrolled study: Pre- post-test; Qualitative	No comparison	Outcomes: - Runaway - Aggressive behaviors Measure: - Administrative data	- Runaways and aggressive behavior rates decreased significantly (30% and 60% respectively) after the training.

Note. IG= Intervention Group; CG = Control group; ? = information absents from original paper or non-specified.

Most studies were conducted in the United States of America (n = 10). The remaining ones were undertaken in United Kingdom (n = 3), the Netherlands (n = 1), Portugal (n = 1), Switzerland (n = 1), and Tanzania (n = 1). All the included studies were conducted in countries with high-income economies (World Bank, 2022), with the exception of one study conducted in a lower-middle income country (Hermenau et al., 2015).

Regarding the research design, one study presented qualitative methods, seven studies were quantitative, and nine included mixed-methods. Most studies employed a pre and posttest design and only seven studies conducted follow-up assessments, ranging from six weeks (Donald, 2015) to 36 months (Schmid et al., 2020). The remaining studies employed a multiple baseline interrupted time series (Izzo et al., 2016), and a single-case experimental design with multiple baseline (Donald, 2015). No study performed a randomized controlled trial, and the majority of studies (76.47%) did not include a control group. From the four controlled studies, three used no treatment as comparison (Berridge et al., 2016; Schmid et al., 2020; Silva & Gaspar, 2014), and one included a waitlist control group (Izzo et al., 2016). Among these controlled studies, two did not perform between-group comparisons (Berridge et al., 2016; Silva & Gaspar, 2014).

The number of participants from each study ranged from three to 221 staff members, and from three to 8829 youths (aged between six and 18 years old). Apart from one study (Wahl, 2011), all samples were mostly composed by female workers. Many studies included not only direct care staff, but also other professionals (e.g., administrators, supervisors, psychologists, social workers, or administrative staff).

Regarding data collection, most studies included reports only from staff, and only four studies reported data from both staff and youth (Berridge et al., 2016; Donald, 2015; Hermenau et al., 2015; Vallejos et al., 2016).

Concerning staff, outcomes related with emotional or mental health were: stress (Schmid et al., 2020; Turner, 2017), burnout (Donald, 2015; Turner, 2017), vicarious trauma (Hidalgo et al., 2016), depression (Silva & Gaspar, 2014), general mental health (Vallejos et al., 2016), well-being (Vallejos et al., 2016), heart rate variability (Turner, 2017), turnover (Barnett et al., 2018), and job satisfaction (Barnett et al., 2018; Hidalgo et al., 2016). Other outcomes, such as the staff sense of safety (Barnett et al., 2018), empathy (Donald, 2015; Silva & Gaspar, 2014), confidence (Berridge et al., 2016; Nunno et al., 2003), self-efficacy (Osteen et al., 2018), and sense of competence (Silva & Gaspar, 2014) were also included in view of the impact over mental health and well-being. Across studies, around 20 different self-report measures were used to collect data from staff, several of which had not been validated (Barnett et al., 2018;

Berridge et al., 2016; Griffing et al., 2021; Nunno et al., 2003). Physiological measures, such as hair cortisol (Schmid et al., 2020) and heart rate variability (Turner, 2017), were also used.
In what concerns youths' outcomes, most of the studies focused exclusively on the frequency of critical incidents, assessed by administrative data (e.g., aggressive behaviors, runways; Barnett et al., 2018; Hidalgo et al., 2016; Hurley et al., 2006; Izzo et al., 2016; Nunno et al., 2003; Schmid et al., 2020; Wahl, 2011), or youths' behavior (Berridge et al., 2016; Donald, 2015; Hermenau et al., 2015). Only three studies comprised other type of mental health outcomes, such as well-being (Cameron & Das, 2019; Vallejos et al., 2016), and internalizing problems (Hermenau et al., 2015). Only three studies collected data through validated self-report questionnaires (Berridge et al., 2016; Hermenau et al., 2015; Vallejos et al., 2016), and two used hetero-report questionnaires filled out by staff about youth (Cameron & Das, 2019; Donald, 2015).

Eight studies also reported outcomes related with the quality of relationships (Berridge et al., 2016; Cameron & Das, 2019; Donald, 2015; Griffing et al., 2021; Hermenau et al., 2015; Hidalgo et al., 2016; Vallejos et al., 2016; van Gink et al., 2018). Changes in relationships were assessed mostly resorting to data collected in interviews. Eight studies included individual interviews to complement quantitative data, having been conducted only with staff (Donald, 2015; Hidalgo et al., 2016; Nunno et al., 2003; Turner, 2017), or with both staff and youth separately (Berridge et al., 2016; Hermenau et al., 2015; Vallejos et al., 2016). Qualitative data was also gathered with questionnaires with open-ended questions (Barnett et al., 2018; Griffing et al., 2021).

Due to the small sample size, some studies have been unable to perform comparisons based on statistical testing (Berridge et al., 2016; Donald, 2015; Turner, 2017). Some mixed-methods studies were not clear about the approach used in the qualitative analysis (Barnett et al., 2018; Berridge et al., 2016; Griffing et al., 2021; Hermenau et al., 2015; Nunno et al., 2003). The only study included in this review using exclusively qualitative methods (van Gink et al., 2018) did not clearly report data analysis procedures. Finally, some studies did not properly describe data analysis procedures (Berridge et al., 2016; Griffing et al., 2021; Nunno et al., 2003; Vallejos et al., 2016).

Effects of training/interventions on care workers

The included studies displayed mixed results. When assessing well-being and mental health, Vallejos and colleagues (2016) found that, although after participating in Kundalini Yoga staff reported feeling more relaxed, questionnaires did not show any significant effect. Schmid and colleagues (2020) showed that physiological stress levels significantly decreased at follow-up in participants of a Trauma-Informed Care (TIC) training, when compared with controls.

Participation in the Healing Rhythms Biofeedback Program (Turner, 2017) also showed a trend to decrease stress and burnout, paired with congruent heart rate variability. Qualitative data within the same study supported quantitative data, with participants reporting benefits related with the program, such as increased mindfulness and awareness, as well as reduced stress and burnout. Yet, this study had a small sample size and was based only on descriptive statistics. Still regarding burnout, participants in the Child Teacher Relationship Training (CTRT) did not show improvements (Donald, 2015). In Hidalgo and colleagues (2016) study, after 12-month of the PATHS program, care workers reported statistically significant decreases in trust, intimacy, self-esteem and control, which were assumed to be related with vicarious trauma. The same study also reported a better perception of staff regarding the service capacity to address mental health issues. PATHS showed a significant improvement in staff job satisfaction. TIC did not produce changes in job satisfaction, feelings of safety, and staff turnover (Barnett et al., 2018).

Both the CTRT (Donald, 2015) and the Incredible Years Basic Parent Program (Silva & Gaspar, 2014) seemed to be helpful in increasing care workers empathy. However, the first study relied on a reduced sample and the second one showed mixed results, with changes occurring both in the intervention and control groups. The same was observed concerning decreasing depressive symptoms (Silva & Gaspar, 2014).

Improvements in confidence (Berridge et al., 2016; Nunno et al., 2003) and self-efficacy (Osteen et al., 2018) were also reported. The Youth Depression and Suicide: Let's Talk (YDS) was associated with improvements in performing a gatekeeper role from pretest to posttest assessments and change was maintained over time; there was also a modest increase in the use of gatekeeper behaviors after training (Osteen et al., 2018).

Also concerning changes in behavior, the EQ2 seemed to help staff members in increasing self-awareness and better understanding their own emotional responses and those of youth. This awareness seemed to influence the way care workers responded to youths' challenging behaviors (Griffing et al., 2021). Likewise, the Non-violent Resistance (NVR; van Gink et al., 2018) also seemed to be helpful to prevent or stop a situation from escalating. Participants in NVR reported reflecting more critically on their own way of working, perceiving the program as helpful to created time to think, and also reported an increase of relaxed feelings (van Gink et al., 2018).

Effects of training/interventions on youth

Studies reporting staff training effects on youths also showed mixed evidence. Most studies focused on critical incidents, reporting a decrease from pre to post intervention (Hurley et al., 2006; Izzo et al., 2016; Nunno et al., 2003; Wahl, 2011), and/or at follow-up (Barnett et

al., 2018; Hidalgo et al., 2016; Schmid et al., 2020). However, findings regarding the type of incidents varied within and across studies. For example, Hurley and colleagues (2006) reported a significant decrease in inappropriate behavior, but runaways significantly increased. Nunno and colleagues (2003) found a significant reduction in aggressive incidents and physical restraint only in one unit out of three, while the other two units showed a slight increase. Izzo and colleagues (2016) study showed a significant decrease on youths' aggression towards staff, property destruction, and runaway, but the effects on aggression towards peers and self-harm were inconsistent. In Barnett and colleagues (2018) study, critical incidents were already decreasing prior to the initiation of the project. Thus, the results could not be ascribed unequivocally to intervention.

Only six studies focused on mental health or well-being of youths as an effect of staff training. Three of those studies reported inconsistent findings between qualitative and quantitative results (Berridge et al., 2016; Donald, 2015; Vallejos et al., 2016). Based on staff interviews, the PATHS program (Hidalgo et al., 2016) seemed to have improved communication, as well as the staff's ability to reduce youth's emotional dysregulation. In Hermenau and colleagues (2015) study, qualitative findings indicated a positive change in children's behavior as a result of caregivers' modified behavior. This finding was supported by the significant decrease in youths' self-reported depressive symptoms, internalizing and externalizing problems, and aggressive behavior. Nevertheless, the reported decreases from baseline to pre-assessment limits the attribution of effects to the training. Finally, the child-care model (Cameron & Das, 2019) produced significant improvements in personal and adaptive emotional development, but resilience and well-being were significant only in some children's homes.

Effects of training/intervention on relationships

Since included studies did not comprise organizational measures, only relational outcomes will be summarized. Eight studies reported improvements in caregiver–child's relationships (Berridge et al., 2016; Cameron & Das, 2019; Donald, 2015; Hermenau et al., 2015; Hidalgo et al., 2016; Vallejos et al., 2016) and among care workers (Berridge et al., 2016; Griffing et al., 2021; van Gink et al., 2018).While participants qualitatively reported interpersonal benefits (e.g., feeling more open and positive; Vallejos et al., 2016), proximity (Donald, 2015), and positive interactions with staff and a calmer home (Berridge et al., 2016), such improvements were not supported by quantitative data. In Cameron and Das (2019) study, a boost in relational outcomes was significant only in a few children's homes.

Discussion

This study aims to systematically identify and assess the effectiveness of trainings delivered to care workers from RYC, with the purpose of promoting emotional and mental health, either in care workers or in youth. This review tried to overcome limitations form previous reviews by reducing publication bias. It followed PRISMA guidelines (2020) in order to reduce subjectivity, to increase consistency across review stages, and to provide methodological transparency.

The current review relies on 17 studies. Many studies had poor reporting, with relevant information being absent or unclear. For these reasons, it is difficult to draw clear conclusions about the effectiveness of the included trainings. Even so, a narrative synthesis of the trainings and their outcomes was conducted.

Trainings aiming to improve care workers emotional and mental health

It is well established that mental health is an important precursor of the quality of provided care (Esaki et al., 2013; Steels & Simpson, 2017). However, the current review demonstrates that care workers in RYC are an underserved population since training continues to disregard their mental health needs. Among the analyzed 17 trainings/interventions, only five aimed to improve care workers' mental health, well-being or emotion regulation (Griffing et al., 2021; Hidalgo et al., 2016; Schmid et al., 2020; Turner, 2017; Vallejos et al., 2016). Yet, the few available programs showed limited findings and generalizability due to methodological concerns (CRD, 2009; Kazdin, 2003). For instance, mix-methods studies showed contradictory findings (Vallejos et al., 2016), or used instruments with limited validity (Griffing et al., 2021; Hidalgo et al., 2016). Positive outcomes were found for stress (Schmid et al., 2020; Turner, 2017) and burnout (Turner, 2017). However, the study conducted by Turner (2017) did not perform inferential statistics due to the limited sample size. The Schmid and colleagues' (2020) controlled study showed promising results, demonstrating that, at 36-month follow-up, staff in the intervention group presented lower stress levels, and experienced less physical aggression from youth, than staff in the control group.

The five aforementioned programs had some common features. Most of them included a meditative component and trauma-informed principles. Mindfulness-based interventions have become popular in the past few decades for the promotion of mental health. Goldberg and colleagues (2022) carried out a systematic review of 44 meta-analysis that explored randomized controlled trials testing mindfulness-based interventions, and findings showed a transdiagnostic relevance of mindfulness-based interventions (e.g., anxiety, depression) with effects persisting

at follow-up. Hence, the established efficacy of mindfulness-based interventions suggests its dissemination and implementation targeting care workers within RYC may be appropriate.

Programs targeting care workers emotional and mental health, including a trauma-informed approach, seem to impact not only care workers mental health outcomes, but youths' behavior as well (Hidalgo et al., 2016; Schmid et al., 2020). When staff understands the impact of trauma, they tend to better cope with youths' challenging behaviors (Griffing et al., 2021), and the staff ability to reduce youth's emotional dysregulation seems to improve (Hidalgo et al., 2016). This is in line with findings from research in other child welfare settings (Fergeus et al., 2017; Zhang et al., 2021).

Other training programs, not specifically designed to attend the care workers emotional and mental health needs, did not reveal significant improvements in staff mental health (Donald, 2015; Silva & Gaspar, 2014). This finding might suggest that specific interventions are needed, and simply improving skills, such as empathy or relational skills, is not enough to increase staff mental health.

Effects of staff trainings on youth outcomes

Most of the included studies in this review aimed to develop care workers relational and professional skills, in order to improve youth outcomes. Despite the methodological limitations of the included studies, it seems that changes in care workers attitudes are linked with some positive outcomes in youth. For example, the development of some skills (e.g., communication, relationships) led to fewer sanctions and decreases in the number of critical incidents, and to improvements in youth behaviors (Barnett et al., 2018; Berridge et al., 2016; Hermenau et al., 2015; Hidalgo et al., 2016; Nunno et al., 2003). Since some studies were exclusively focused on youth outcomes (Cameron & Das, 2019; Hurley et al., 2006; Izzo et al., 2016; Wahl, 2011), and most of them did not include a control group, it was not possible to understand if improvements in youth undoubtedly rely on changes in care workers after intervention enrollment. Nonetheless, in some studies, youths' outcomes not only seemed to have improved during training implementation, but also at follow-up assessment (Barnett et al., 2018; Hermenau et al., 2015; Hidalgo et al., 2016). Indirect interventions, such as teacher or parents-mediated interventions, have a solid tradition in psychology. Literature shows emotional and behavioral benefits from such interventions (Aldabbagh et al., 2022; Buchanan-Pascall et al., 2018). Even if the specific mechanisms/components are not yet totally clarified, and further research is needed, intervention with care workers seems to be important to foster behavioral change in children and youth in RYC.

It is noteworthy to mention that most programs aimed to reduce critical incidents or externalizing problems. Only four studies aimed to improve youth's well-being or to reduce their internalizing problems (Cameron & Das, 2019; Hermenau et al., 2015; Osteen et al., 2018; Vallejos et al., 2016). This is a matter of concern, considering that internalizing problems and suicide ideation are silent but prevalent problems among youth in RYC (Evans et al., 2017; Jozefiak et al., 2016). The great focus on training in behavior management techniques may be linked with the need to manage and reduce dysfunctional behaviors and critical incidents, which frequently disturbs RYC climate and routines (Hodgdon et al., 2013). Because many youths in RYC also exhibit comorbid internalizing problems (Jozefiak et al., 2016), behavioral techniques alone may not be as effective as intended and might trigger previous traumatic experiences, increasing dysregulation (Hodgdon et al., 2013). Also, previous research regarding mediated-interventions failed to show a cross-impact effect on internalizing problems when interventions were designed to address youth externalizing problems (Buchanan-Pascall et al., 2018).

Effects of staff trainings on relationships

Few studies analyzed outcomes related with the quality of relationships. Available findings suggest improvements in caregiver–child relationships (Berridge et al., 2016; Cameron & Das, 2019; Donald, 2015; Hermenau et al., 2015; Hidalgo et al., 2016; Vallejos et al., 2016) and between team workers (Berridge et al., 2016; Griffing et al., 2021; van Gink et al., 2018). However, some mixed-methods studies reported inconsistencies, as qualitative findings were not in agreement with the quantitative ones (Berridge et al., 2016; Donald, 2015; Vallejos et al., 2016). Ultimately, the quality of residential care services relies on the care workers ability to establish positive relationships with youth (Moore et al., 2018). Former research suggests that the quality of relationships depends not only on professionals' skills and characteristics, but is also influenced by organizational factors (e.g., climate, culture, routines) (Moore et al., 2018; Pinheiro et al., 2022). Nevertheless, organizational outcomes were not reported in any of the included studies. The scarce attention to this kind of outcomes has also been reported in former reviews (Hermenau et al., 2017; Perry et al., 2020). Overall, most trainings included in the current review did not show the tendency to effectively address these needs.

Limitations from included studies

As in former systematic reviews (Bailey et al., 2019; Eenshuistra et al., 2019; Everson-Hock et al., 2011; Hermenau et al., 2017; Morison, 2018), most of the included studies presented poor reporting and methodological flaws, which might result in a greater risk for bias and limit the generalizability of findings (CRD, 2009; Kazdin, 2003).

First, most programs were not manualized and only a few studies included appropriated procedures to ensure treatment integrity. Thus, it is unclear if the trainings were implemented as intended, compromising findings and limiting replication. Second, only four studies achieved strong methodological quality assessment (Donald, 2015; Izzo et al., 2016; Schmid et al., 2020; van Gink et al., 2018). However, one is a single-case experimental study conducted with only three participants from one RYC facility (Donald, 2015) and other is a qualitative study (van Gink et al., 2018), both having limited generalizability. Considering that study quality moderates the result of mediated interventions, this is a matter of concern (Buchanan-Pascall et al., 2018). Third, none of the 17 included studies followed a randomized controlled trial design, considered the golden standard to test intervention effectiveness (Hariton & Locascio, 2018). Therefore, associated biases (e.g., selective enrolment of participants; unclear report of attrition rate underlying systematic loss of participants over the course of the training) can have distorted the outcomes (CRD, 2009). Fourth, most of the included studies had no control group, limiting their internal validity, since observed effects may have not been necessarily determined by intervention. Among the four studies that included a control group, two did not compare intervention and control groups (Berridge et al., 2016; Silva & Gaspar, 2014). Fifth, most studies did not have a representative sample, which may cause selection bias and a lack of generalizability. The reduced sample size may limit both the statistical procedures and the power to detect intervention effects (Zhang et al., 2021). Sixth, although some studies had given incentives, in general, adherence was limited and drop-out was high. Seventh, and regarding outcome assessment, although most studies conducted mix-method research, making an effort to integrate quantitative and qualitative data, some studies included outcome measures with inadequate reliability or validity, and others were not clear regarding the approach used in the qualitative analysis. In addition, some studies did not provide any information regarding youth, being unclear if the staff training translated into any kind of improvements in youth. Furthermore, since most studies did not present follow-up assessments, the maintenance of changes over time was unclear. This may contribute to reinforce the criticism around RYC outcomes. Finally, few studies accounted for possible confounders and reported power analysis calculations in statistical analyses.

Limitations of the current systematic review

Although conclusions can be drawn from the findings of the current review, some caution is required concerning its interpretation. The main limitation of the present review was the general weak outcome on the quality assessment of the included studies. In addition, the use of inconsistent terminology regarding the definition of RYC across studies and countries may

have increased the risk of bias in the search and study selection processes. Also, the inclusion of organization wide programs might have created some bias. Even when such programs include training as a main component, it is difficult to isolate the training effects from those arising from other parts of intervention (e.g., supervision). Finally, the heterogeneity of trainings, study designs, and outcome variables precluded the performance of a meta-analysis. Thus, the estimates of the effect of trainings were not analyzed.

Implications for research

The consistent methodological limitations described across studies (Bailey et al., 2019; Everson-Hock et al., 2011; Morison, 2018) illustrate the obstacles involved in performing experimental research within this field. Recognized roadblocks were linked to the different functioning across residential care homes, agencies, and consequent heterogeneity of records (Nunno et al., 2003), rotativity either of staff (due to turnover) and youth (who have histories of numerous placements), leading to large drop-out rates in data collection among longitudinal studies (Schmid et al., 2020). Therefore, researchers have to adapt their work to the reality of RYC facilities, conducting feasibility studies to test their designs and interventions. More robust methodologies and designs are also needed, including collecting control groups with random assignment and conducting follow-up assessments, as much as possible or feasible (Bailey et al., 2016; Eenshuistra et al., 2019; Perry et al., 2020).

The combination of effects from staff training on organizational (i.e., climate, culture, quality of care) and youth outcomes (i.e., including externalizing and internalizing problems, school achievement) should be addressed in future research. Resorting to different types of variables (e.g., physiological measures; administrative records) and multi-informants, could also be important to demonstrate the effectiveness of training in RYC (Purtle, 2020).

Contrary to a previous review (Perry et al., 2020), only few training programs included in the current review incorporated mindfulness or empathic skills. Since such skills seem able to help individuals to be aware of their own and others' affective experiences (Singer & Lamm, 2009), future research should include these skills in the trainings in order to improve emotion regulation and care practices.

Implications for practice and care polices

Recognizing the vulnerability and poor outcomes of youth in RYC throughout development (Kahsay et al., 2020) is a first step to establish a bridge between research and organizations. Training/interventions clearly based on robust empirical evidence should be provided to care workers. To create a therapeutic environment, such interventions must be

received by all staff, independently of their role within the RYC facility (Bailey et al., 2016). Programs should train care works to appropriately respond to both externalizing and internalizing problems among youth. In addition, particular attention should be given to the mental health of care workers, providing trainings focused on their own emotion regulation difficulties. Finally, it seems also important to create effective ways of transferring knowledge and integrate mental health routines on RYC. Budget and resources constraints could impair the implementation of some of these measures (Whittaker et al., 2015). However, public policies should invest on the welfare quality, in order to prevent and mitigate the impact of trauma on youth.

Conclusions

The current review extends the existing literature by providing a systematic synthesis of existing trainings offered to care workers, aiming to foster emotional and mental health in RYC. Findings point to the scarcity of programs aimed to specifically improve the mental health of care workers. Most available training programs aim to promote care workers' professional and interpersonal skills rather than their psychological well-being. Such programs seem to be able to reduce to some degree the critical incidents and youths' behavior problems that cause major disturbances in the day-to-day residential care homes management. Still, emotional difficulties expressed by youth in RYC remain unattended. Findings also suggest that most studies were not adequately designed. Future research should resort to more rigorous methodologies to provide evidence-based programs targeting emotional competencies of care workers, aiming to foster therapeutic environments for vulnerable children and youth placed in RYC.

Compliance with Ethical Standards

Ethical Approval: This article does not contain any studies with human participation or animals performed by any of the authors.

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Authors' Contributions

Laura Santos: Conceptualization, Methodology, Investigation, Formal analysis, Writing - Original Draft, Review & Editing, Funding acquisition. **Rita Ramos Miguel:** Conceptualization, Methodology, Formal analysis, Writing – Review & Editing. **Maria do Rosário Pinheiro:** Writing - Review. **Daniel Rijo:** Conceptualization, Writing - Review.

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Appendix A. *Overview of previous systematic reviews*

Review	Aim	Eligibility Criteria	Included studies	Setting and participants	Interventions	Outcomes	Main conclusions
Bailey et al., 2019 (Systematic review)	To investigate the empirical evidence for organization-wide, trauma-informed therapeutic care models in out-of-home care.	Restricted to: -2002-2017 - Peer-reviewed articles - written in English	7 Studies 3 Models	Out-of-home care for children and youth (0–17 years old)	Organization-wide, trauma-informed therapeutic care models	Children's mental health and behavioral outcomes	Evidence for trauma-informed care models was low.
Eenshuistra et al., 2019 (Systematic review)	To explore the effects of training on the skills of residential care workers.	Peer-review articles, books, dissertations and reports Restricted to: written English, German or Dutch	12 Studies 9 Trainings	Residential youth care Care workers	Training programs aiming to improve care workers' skills and knowledge	Care workers' characteristics and work environment.	Some trainings may produce positive outcomes in professional's individual characteristics or in the work environment. Two studies reported negative training outcomes. Nevertheless, due to its methodological limitations little is known about their effectiveness.
Everson-Hock et al., 2011 (Systematic review)	To synthesize the effectiveness of training and support provided to carers on the physical and emotional health and well-being of children and youth.	Restricted to: - 1990-2008 - written in English	6 Studies	Foster Care Carers, professionals or volunteers	Training and support provided to carers on the physical and emotional health and well-being of children and youth.	Physical health, emotional health, problem behaviors of children and youth. Placement stability.	The training programs have limited impact on the behavioral problems of children and youth, placement stability and emotional and mental health and well-being. Included studies have poor methodological and reporting quality.
Fergeus et al., 2017 (Scoping review)	To explore the nature and extent of the relationship between carers and the mental health of children in foster and kinship care.	Peer review and grey literature Restricted to: - 2000-2014 - written in English	82 Studies	Foster and kinship care Carers	Interventions and/or support assisting carers in responding to the mental health needs of the children and youth.	Children's mental health	Interventions showed promising results.
Hermenau et al., 2017	To investigate the effects of structural interventions and	Peer review and grey literature	24 Studies	Residential youth care	Structural interventions and caregiver training	Child development, child's health	Caregiver trainings, structural changes, and enriched caregiving environments have beneficial effects on the child's emotional,

(Systematic review)	caregiver trainings on child development in institutions.	Restricted to: written in English		Children (0-17 years old) living full time in child care institutions	aiming to improve children's development and living conditions.	status, caregiving quality, or attachment	social, and cognitive development. Few studies focused on interventions' effects on the child–caregiver relationship or the institutional environment. Included studies have poor methodological quality.
Kerr & Cossar, 2014 (Systematic review)	To identify the impact of attachment interventions with foster and adoptive parents on children's behavioral, emotional and relational functioning	Restricted to: Quantitative design	10 Studies	Foster care and adoption Foster and adoptive parents of child (0-18 years old)	Attachment interventions	Children's behavioral, emotional and relational functioning.	Some evidence support the positive impact of these interventions in behavioral functioning and among children aged six months to six years. Yet, included studies have poor methodological quality, and few included measures of emotional and relational functioning.
Kinsey & Schlosser, 2012 (Systematic review)	To examine interventions that have been empirically assessed in foster care.	Restricted to: - 1995 to 2009 - written in English - peer-reviewed articles - quantitative design	30 Studies 20 Interventions	Foster and kinship care Foster carers and/or foster children	Wraparound services, relational interventions, non-relational interventions for carer and child, carer training programs and interventions for the foster child.	Child's functioning	Most interventions aimed to reduce children's behavior difficulties. There is good support for wraparound services and relational interventions. Little support was found for caregivers training programs.
Morison, 2018 (Systematic review)	To synthesize the types and effectiveness of training delivered to staff within residential youth care on psychosocial outcomes.	Peer review articles and theses Restricted to: - high income countries - quantitative design	18 Studies	Residential youth care Care workers and/or children and youth	Training programs delivered to residential staff	Child and/or staff psychosocial outcomes	Studies indicate a trend for staff skills improvement. Unclear impact upon staff knowledge, attitudes or child outcomes (mostly focused on child behavior). The effectiveness of trainings remains unclear due to the methodological limitations of the included studies.
Perry et al., 2020 (Scoping review)	To synthesize evidence about interventions aiming to develop and/or enhance emotional intelligence	Restricted to: - Peer-review - 2003 – 2018 - written in English	18 Studies	Child Welfare System Child welfare professionals	Interventions aiming to develop and/or enhance emotional intelligence	Components of emotional intelligence	Some effective intervention components (e.g., mindfulness) were identified. However, none of the studies were conducted with child welfare professionals, focusing instead on social work students or professionals.

	on child welfare professionals.	- North America, Europe, or Australia - quantitative design					
Purtle, 2020 (Systematic review)	To synthesize evidence about the effects of trauma informed organizational interventions that include staff trainings on staff and children's outcomes.	Restricted to: - Peer-reviewed articles - 2000 – 2017 - written in English - quantitative design	23 Studies	Child Welfare System Staff	Trauma-informed organizational interventions that include staff trainings	Staff knowledge, attitudes, and behaviors related to trauma-informed practice. Children's outcomes	Staff knowledge, attitudes, and behaviors related to trauma informed practice improved after the training. It is unclear if the changes are retained over time and translate into children's outcomes. Included studies have poor methodological quality.

CAPÍTULO 5

VALIDAÇÃO DE MEDIDAS DE AUTORRELATO PARA ADOLESCENTES

Estudo Empírico I

Emotional Climate in Residential Care Scale for Youth: Psychometric properties and measurement invariance

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Emotional Climate in Residential Care Scale for Youth: Psychometric properties and measurement invariance

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Abstract

Objective: Research has shown that social and contextual factors, such as climate in Residential Youth Care (RYC), are key protective factors for better outcomes in youth who experienced maltreatment. Even if increasing attention has been given to residential climate as a therapeutic tool, available measures are still scarce and revealed some limitations. This study aims to adapt and validate a brief self-report measure to assess the emotional climate of residential care homes as perceived by youth who live there: the Emotional Climate in Residential Care Scale for Youth (ECRC-Y).

Method: Participants were 372 youth (61.8% girls), aged between 12 and 24 years old, living in 33 Portuguese residential care facilities. The ECRC-Y was adapted from the Emotional Climate in the Classroom Scale, which is a 15-item measure based on an evolutionary approach, assessing the emotional climate according to three affect regulation systems: threat, drive, and soothing systems. A Confirmatory Factor Analysis (CFA) was performed, and measurement invariance was tested for sex.

Results: The CFA indicated a trifactorial measurement model, in agreement with the theoretically proposed model. The ECRC-Y showed adequate internal consistency and construct validity in relation to external variables. Measurement invariance was supported for the ECRC-Y. Girls presented higher levels of threat related emotions, when compared with boys.

Conclusions: The ECRC-Y is an appropriate self-report measure that may be useful for research and practice purposes within RYC settings, giving information about the emotional climate of residential care homes as perceived by youth in care.

Keywords: emotional climate; measurement invariance; psychometrics; residential youth care; youth.

Introduction

Residential Youth Care (RYC) is an alternative care response provided by the welfare system for children and youth who are unable to remain in the care of their families (Simkiss, 2012). In Portugal, in 2021, 6369 children and youth were under the care of the welfare system, of which 96.7% were placed in Residential Care Homes (RCH) (ISS, 2022). RCHs are 24/7 open facilities, providing care and pedagogical support to children and youth, aiming to protect them from the adverse experiences that threatened their healthy development and well-being. RCHs vary in the number of fostered children and youth and may be mixed or segregated by sex. Adolescence is the most common age group in RYC, and sex is relatively balanced. The length of placement is usually high, with 23% of youth living in RYC for over 6 years (ISS, 2022).

As in other developed countries, adverse experiences, such as neglect and maltreatment, are among the main causes of removal from home in Portugal (Graham & Johnson, 2021; ISS, 2022; Simkiss, 2012). Considering its nature and frequency, these experiences may compromise attachment and result in the experience of trauma, impacting on children healthy development and well-being (Graham & Johnson, 2021). Accordingly, children and youth in RYC show a higher frequency of mental health problems, in comparison to the population living with their families (Fernández-Daza & Fernández-Parra, 2013; Santos et al., 2023b; Schmid et al., 2008). International research suggests that girls tend to have higher internalizing mental health problems than boys, such as anxiety, depression, withdrawal, and somatic complaints (Campos et al., 2019; Handwerk et al., 2006; Santos et al., 2023b). In turn, boys tend to reveal more externalizing mental health problems, such as aggressive and delinquent behavior than girls (Campos et al., 2019; ISS, 2022; Sonderman et al., 2021b). Research also showed that stressful life events have more impact on symptomatology for girls, comparatively with boys (Handwerk et al., 2006) and that girls display higher risk to develop trauma related symptoms and emotion regulation problems (Gutterswijk et al., 2022; Olff, 2017).

As an alternative care response, RYC should be able to provide effective support, ensuring a positive, safe, and therapeutic environment where youth should feel secure to heal and thrive (Santos et al., 2023b; Strijbosch et al., 2018a). The current study aimed to validate a scale based on an evolutionary approach to assess the emotional climate of RCHs as perceived by youth.

Affiliation and emotion regulation from an evolutionary framework

According to evolutionary theory, human beings need to be cared for and form attachment bonds with others to survive and thrive (Gilbert, 2020; Hermanto & Zuroff, 2016). A secure attachment results from consecutive interactions where the parent/caregiver meets the child's needs in an appropriate manner, resulting in a reduction of distress and feelings of relief (Cyr et al., 2010). When these interactions occur in a safe environment based in warmth, safeness, and proximity, in which verbal and non-verbal signs of interest, care, kindness, and feelings of belonging are expressed, they have soothing properties and the child is reassured (Depue & Morrone-Strupinsky, 2005; Gilbert, 2010). Comparatively, when children are exposed to neglectful and abusive environments, where the parent/caregiver denotes insensitivity, intrusion, or rejection in relation to the child's needs, it may result in an insecure or disorganized attachment, impacting on children's healthy development and compromising their capacity to regulate affect and to form supportive relationships, showing greater risk for psychopathology (Cyr et al., 2010; Sellers et al., 2020).

Based on neuroscience research and attachment theory (Bowlby, 1969; Depue & Morrone-Strupinsky, 2005), Gilbert (2010, 2014) proposed that early interpersonal experiences influence the development of three evolved interacting systems responsible for affect regulation: the threat, the drive, and the soothing systems. With the function of self-protection, the threat system evolved to respond to signals of threat, activating negative affect (such as fear, anger, or disgust) that alerts the body to defend against potential threats, giving rise to fight, flight, freeze or submissive behaviors. The drive system triggers high-arousal positive affect (such as enthusiasm, excitement), to engage the individual in rewards/resources seeking to accomplish the satisfaction of biological needs and achievement of goals. The soothing system evolved to respond to signals of affiliation, and it triggers a different kind of positive affect (such as safeness, warmth, calmness) associated with well-being, as well as prosocial and non-search behaviors, which promotes the individual's reassurance (Armstrong et al., 2021; Depue & Morrone-Strupinsky, 2005; Gilbert, 2020). When these systems are unbalanced, emotion dysregulation and mental health difficulties may arise (Gilbert, 2015).

In accordance with this approach, a child who experiences abusive, threatening, or neglectful relationships with parents/caregivers, may more easily develop a defensive orientation and may tend to see others as potentially harmful, shameful, or rejecting (Irons & Gilbert, 2005). Thus, these children may present an overdeveloped and overactivated threat system, and, consequently, an increased sensitivity and vigilance to potential sources of threats, as well as higher levels of negative affect and defensive behaviors, such as withdrawal,

submission, avoidance, and/or aggression (Gilbert, 2015). Additionally, these children are also prone to present a drive system focused on immediate rewards. Yet, when reward is not reached, the threat system can be easily triggered, as well as congruent negative affect of anxiety, frustration, and/or anger. In turn, the lack of warmth and safeness experiences with parents/caregivers can lead to an underdeveloped soothing system. When this is the case, resorting to the soothing system to calm down threat can be challenging, thwarting the regulation of difficult emotions and reassurance. In addition, others are often perceived as abusive and/or as possible abandoners/rejecters, not as a source of safeness and reassurance (Gilbert, 2014, 2015), compromising these children's ability to trust and attach to others throughout their life span (Byers & Lutz, 2015). As a result, children and youth raised in these environments, which is the case of those placed in RYC, have a greater risk of developing both internalizing and externalizing problems (Campos et al., 2019; Fernández-Daza & Fernández-Parra, 2013; Schmid et al., 2008).

In this matter, it is important to consider that although early experiences influence the development and activation of these evolved systems, their accessibility is also influenced by opportunities afforded in the individual's current social context (Gilbert, 2010; Hermanto & Zuroff, 2016). While threatening environments stimulate stress regulation behaviors, non-threatening environments associate with empathic warmth, relaxed attention, and positive affect (Irons & Gilbert, 2005). In this sense, the transition to the RYC can be an opportunity for experiencing new relationships in a safe and caring environment (Mota et al., 2018), which may play a therapeutic role in affect regulation and shape youth development (Bryson et al., 2017).

Emotional climate in residential youth care

Research has shown that the current experiences with residential staff and positive group climate are critical to recovery, growth, and development (Costa et al., 2019; Graham & Johnson, 2021; Leipoldt et al., 2018; Leipoldt et al., 2019; Santos et al., 2023b; Sellers et al., 2020; Strijbosch et al., 2018a). Concerning sex differences, findings differ across studies. While Sonderman and colleagues (2021b) found that girls seemed to have a more positive perception of group climate, other studies revealed that boys scored higher on positive group climate measures (Strijbosch et al., 2018a). Research also suggests that girls are particularly sensitive to their placement environment (Lanctôt et al., 2016), with relationships with peers and staff seeming to be greatly valued (Mathys et al., 2013; Sonderman et al., 2021a).

Considering that these youth accumulate several biological and social risk factors, and that they continue to face stressful and emotionally overwhelming experiences within RYC (Schmid et al., 2008; Sellers et al., 2020), it seems essential to promote a positive emotional

climate in RCH (Leipoldt et al., 2019). According to research, a positive social climate comprises high levels of support and autonomy, low levels of repression and anger, and a safe and structured environment, based on warmth, affection, and closeness with caregivers. In turn, a negative social climate involves low levels of support and autonomy, and high levels of repression and anger (Leipoldt et al., 2019; Moos, 2003), which has been related to negative outcomes throughout development, as well as in physical and mental health (Hermenau et al., 2017). In this sense, RCHs' climate became a recommended therapeutic tool (Bailey et al., 2019; Lanctôt et al., 2016), which must be evaluated (Leipoldt et al., 2019; Strijbosch et al., 2018a; Tonkin, 2015).

Measurement tools to assess climate in residential youth care settings

Social climate has been conceptualized in several different ways, including relational climate, group climate, psychosocial environment, social atmosphere, ward atmosphere, or emotional climate (Leipoldt et al., 2018; Leipoldt et al., 2019; Mathys et al., 2013; Moos, 2003; Pianta et al., 2008; Tonkin, 2015; van der Helm et al., 2011). In accordance, different instruments for measuring social climate have been developed, integrating a range of dimensions tailored to specific settings and clients (Tonkin, 2015), such as prisons and forensic psychiatric hospitals (van der Helm et al., 2011), childcare homes (Bradley et al., 2003), or classrooms (Albuquerque et al., 2021; Pianta et al., 2008).

Inherent to the recommendation of fostering therapeutic climates, some measures were also validated within RYC settings. Mathys and colleagues (2013) proposed a tridimensional measure with 62 items to assess group climate, adapted from the Socio-Educational Environment Questionnaire (Janosz & Bouthillier, 2007). The Psycho-Educational Placement Environment Questionnaire (PEPEQ) assesses three social climate dimensions in the out-of-home placement: peer relation, relation with educators, and educative practices. Although the authors found good psychometric properties, the PEPEQ was exclusively validated with a sample of girls. Strijbosch and colleagues (2014, 2018b) adapted the Prison Group Climate Instrument (Van der Helm et al., 2011) to children and adolescents in specialized residential care. The Group Climate Instrument for Children (GCIC) has a child and adolescent version with 12 and 14 items, respectively, both showing good psychometric properties. These instruments comprise two scales: positive climate (i.e., receiving support from care workers, and opportunities for growth and autonomy) and negative climate (i.e., negative group atmosphere and interactions, lack of help from care workers), corresponding to basic childcare goals, such as providing physical and emotional security, personal development, enhancing social skills, and the development of values and norms (Strijbosch et al., 2014, 2018b). In another study,

conducted by Leipoldt and colleagues (2018), the psychometrics and usability of the Community Oriented Programs Environment Scale (COPES; a self-report measure aiming to assess the current experienced environment, Moos, 2009), was adapted for therapeutic residential care. COPES was reduced from 100 to 40 true/false statements about social climate, grouped into 10 subscales (i.e., involvement, support, spontaneity, autonomy, practical orientation, personal problem orientation, anger and aggression, order and organization, program clarity, staff control). This scale allows the assessment of a range of social climate features in residential environment such as relationship, personal growth, system maintenance (Moos 2003), yet the validation study was conducted with a small sample.

While these measures address a multifaceted approach of group climate, considering the interaction between material, physical, social, and emotional conditions of a unit (Moos, 2003; van der Helm et al., 2011), they show some methodological limitations. Some instruments could be extensive for unmotivated respondents, such as youth in RYC (Leipoldt et al., 2018; Mathys et al., 2013), which could increase their resistance when answering these measures (Fan et al., 2006). In addition, given the reduced sample sizes, none of them tested measurement invariance by sex.

The current study

Recognizing the importance of providing a sensitive and responsive relational climate to the emotional needs of youth in RYC (Santos et al., 2023b), it seems mandatory to assess the emotional climate of RCH from the perspective of youth. To do so, measures should be brief and focused to balance reliability and the burden on participants (Stanton et al. 2002). The current study aimed to adapt and validate a brief measure to assess the Emotional Climate in Residential Care (ECRC-Y) as perceived by youth. Considering climate as organized around emotions (de Rivera & Paez, 2007), this measure aims to assess emotional climate, which refers to the perceived quality of social and emotional interactions within a particular milieu, describing the quality of that environment and reflecting how members feel (de Rivera & Paez, 2007; Pianta et al., 2008). The current measure is focused on the emotional component and not on the whole facets of social climate, as other measures are (Leipoldt et al., 2018; Mathys et al., 2013; Strijbosch et al., 2014, 2018b). The ECRC-Y was adapted from the Emotional Climate in the Classroom Scale (ECCS; Albuquerque et al., 2021; Henriques, 2019), which is a psychometric sound measure based on an evolutionary approach, assessing the emotional climate according to Gilbert's affect regulation systems, i.e., threat, drive, and soothing system (2010, 2014). The current study includes research on the dimensionality of the scale, test-retest reliability, and construct validity in relation to external variables. Due to different needs of boys and girls within

RYC (Sonderman et al., 2021ab) and since some authors have reported interactions between sex and treatment (Granski et al., 2020; Weis et al., 2005), measurement invariance between boys and girls was also investigated in order to allow for comparisons between sexes. As the original scale (Albuquerque et al., 2021), the ECRC-Y is expected to present a three-factor structure (i.e., threat, drive and soothing related emotions), to be sex invariant, and to present appropriate levels of internal consistency and test-retest reliability. Threat related emotions are expected to be negatively associated with positive affect and current experiences of warmth and safeness (Armstrong et al., 2021; Depue & Morrone-Strupinsky, 2005; Santos et al., 2021), and positively associated with negative affect, and internalizing and externalizing problems (Depue & Morrone-Strupinsky, 2005; Gilbert, 2015). Drive related emotions are expected to be positively associated with positive affect and negatively associated with negative affect (Gilbert, 2010, 2014). Soothing related emotions are expected to be positively associated with positive affect and current experiences of warmth and safeness (Armstrong et al., 2021; Depue & Morrone-Strupinsky, 2005; Santos et al., 2021), and negatively associated with negative affect and externalizing and internalizing problems (Depue & Morrone-Strupinsky, 2005; Gilbert, 2015). As there are no available research findings concerning sex differences within the current framework in RYC, we would refrain from formulating hypothesis in this regard.

The ECRC-Y will enable research on emotional climate, which has been found to be an important factor of the effectiveness of RYC interventions (Lanctôt et al., 2016; Leipoldt et al., 2019; Strijbosch et al., 2018a). In addition, the ECRC-Y will provide information about the perception that boys and girls have about RCHs climate where they live, contributing to foster a therapeutic approach and to facilitate gender-specific interventions in RYC (Gutterswijk et al., 2022; Sonderman et al., 2021b).

Materials and Methods

Participants

Participants were 372 youth, including 142 (38.2%) boys and 230 (61.8%) girls, aged between 12 and 24 years old [*M* = 15.93; *SD* = 2.11; 12-14 YO: N = 91 (24.5%); 15-18 YO: N = 252 (67.7%); 19-24 YO: N = 29 (7.8%)], from 33 Portuguese residential care homes (RCH). In average, youths have been living in the current RCH for 39.47 months (*SD* = 38.80; range = 1-219). The main reason that conducted to the current protection measure was neglect (48.1%), followed by some kind of maltreatment (21.6%) and desviant behavior (13.6%). Concerning the educational level, most participants (54.1%) were attending a middle school level (7 to 9 years), 34% were attending high school (10 to 12 years), 10.1% elementary school (5 to 6 years) and

1.9% university. When comparing boys and girls, no significant differences were found concerning age [*t* (370) = -1.661; *p* = .098; for boys *M* = 15.70, *SD* = 1.82 and for girls *M* = 16.07, *SD* = 2.26], educational level [$\chi 2(3) = 4.51$; p = .212], motive of being in RYC [$\chi 2(10) = 13.87$; p = .179], and time lived in the current RCH [*t* (364) = -1.812; *p* = .071; for boys *M* = 34.76, *SD* = 34.09 and for girls *M* = 42.32, *SD* = 41.20].

To study test-retest reliability, the ECRYC-A was filled out one month and a half after the first measurement, by a subsample of 43 adolescents from seven RCHs, composed by six boys (14%) and 37 girls (86%), aged between 12 and 20 years old (*M* = 15.51, *SD* = 2.00).

Measures

Emotional Climate in Residential Care – Youths (ECRC-Y; original version by Albuquerque et al., 2021; adapted by Santos et al., 2023)

ECRC-Y is a self-report scale assessing the emotional climate of the RCH, over the past two weeks, as perceived by youth who live there. The ECRC-Y was adapted from of the Emotional Climate in the Classroom Scale (ECCS; Albuquerque et al., 2021), which is a 15-item self-report scale aiming to assess how adolescents have felt in classroom over the past two weeks. This scale is divided into three subscales, which one with five items, describing different emotions associated to the three affect's regulation systems: the threat, the drive, and the soothing systems. Items are answered according to a five-point Likert-type scale (0 = Never, to 4 = Always). The original scale showed adequate internal consistency values, with a Cronbach's alpha of .70 for the threat system, .73 for the soothing system and .86 for the drive system. After obtaining approval from the authors of the original scale, instructions were changed, asking participants to rate how frequently they experienced each emotion over the past two weeks in the RCH, rather than in school. Analyses of the psychometric properties of the ECRC-Y will be presented in the results section.

Current Experiences of Warmth and Safeness Scale for adolescents (CEWSS-A; Santos et al., 2021)

CEWSS-A is a 12-item self-report scale designed to assess how often adolescents felt emotional experiences of care, warmth, and safeness with others, along the two previous weeks. Items are answered using a five-point Likert-type scale (0 = No, never, to 4 = Yes, most of the time). The CEWSS-A presented a single factor structure, with an excellent internal consistency value ($\alpha = .94$), and an acceptable test-retest reliability in the community (r = .62) and residential care adolescents (r = .77) (Santos et al., 2021). In this study, the internal consistency value was .97.

Positive and Negative Affect Schedule (PANAS; Watson et al., 1998; Portuguese version by Galinha & Pais-Ribeiro, 2005)

PANAS is a 20-item self-report scale designed to assess two mood states: positive affect (PA) and negative affect (NA). Each subscale is composed by 10 items that describe feelings and emotions (e.g., enthusiastic, proud, and excited on the PA subscale, and afraid, hostile, guilty, and sad on the NA scale). Participants are asked to rate the severity and frequency of these feelings in the last few weeks, using a five-point Likert-type scale (1=nothing or very slightly, to 5=extremely). Cronbach's alphas values in the original version were .88 for PA and .87 for NA (Watson et al., 1998). The Portuguese version revealed alphas of .86 for PA and .89 for NA (Galinha & Pais-Ribeiro, 2005). In the present study, the internal consistency values were .90 for PA and .88 for NA.

Strengths and Difficulties Questionnaire (SDQ; Goodman et al, 2010; Portuguese version by Fleitlich et al., 2005)

SDQ is a 25-item self-report scale aiming to assess socio-emotional problems. Items are rated using a three-point Likert-type scale (0 = not true, to 2 = certainly true). SDQ is organized into five subscales – emotional symptoms, behavioural problems, hyperactivity/inattention difficulties, peer relationship problems and prosocial behaviours. Also, a bi-factor model, using internalizing and externalizing dimensions has been extensively used. The Internalizing Problems subscale presents 10 items and assesses emotional and peer problems, the Externalizing Problems subscale comprises 10 items and assesses behavioural and hyperactivity problems; and the Prosocial Behaviours subscale has 5 items assessing prosocial behaviours. Cronbach's alphas in the original version were .66 for internalizing and .76 for externalizing subscales, and .66 for prosocial behaviours subscale (Goodman et al., 2010). In the Portuguese population, there are no available studies comprising the aforementioned model, only a total difficulties index, which presented a Cronbach's alpha of .60 (Fleitlich et al., 2005). Nevertheless, for parsimony reasons, in this study we used the internalizing and externalizing subscales, with internal consistency values of .66 and .71, respectively.

Procedures

Data collection

Ethical approval was obtained by the Ethics Committee of the Faculty of Psychology and Educational Sciences of the University of Coimbra. Using a convenience sampling method, 71 RCHs from Portugal mainland, listed in a national database, were contacted and informed about the study goals and procedures. Thirty-three accepted to collaborate. Due to the pandemic

situation, data were collected in person by a researcher (when possible) or were sent by post and collected by the psychologist of the RCH. Participants' inclusion criteria were aged between 12 (young children were excluded as self-report measures, and namely what concerns self-report emotions, might be inconsistent or biased due to cognitive and language skills; Conijn et al., 2020; Eddy et al., 2011) and 25 years old (maximum age comprised in the Portuguese Law for RYC; ISS, 2022) and leaving in the current RCH for more than a month. Youths identified by RCHs' psychologists as having cognitive impairment were excluded. Eligible participants were informed about the purpose of the study and were invited to voluntarily participate. Those who accepted to participate gave their written informed consent. In representation of the legal guardian, the technical directors of each RCH gave written informed consent to each youth, who volunteer to participate in the study.

To investigate test-retest reliability, participants from seven RCHs included in the study were invited to fill out the ECRC-Y again, approximately, after one month and a half after the first measurement.

Data analysis

Data were analysed with the IBM SPSS Statistic 25 and Mplus v8.0 software. The Mplus was used to perform the Confirmatory Factor Analysis (CFA), measurement invariance and to compare latent means between sexes. The IBM SPSS was used to perform the preliminary, descriptive, construct validity and test-retest reliability analyses, and to compute the Cronbach Alpha.

Prior to the analyses, univariate and multivariate outliers were investigated via boxplots and Mahalanobis distance, respectively (Field, 2018; Tabachnick & Fidell 2013), leading to the exclusion of 28 subjects from the sample (i.e., neither included in the description of participants nor in the analyses).

Considering that the present scale was based in previous research (Albuquerque et al., 2021), a three-factor structure was defined prior to the analyses, and the adequacy of the model was tested via CFA. The multivariate normality was analysed using the Mardia test (Korkmaz, et al., 2014), which indicated that the data did not present a normal distribution [Mardia'$\chi 2$ skew = 825.61, p = 1.65; Mardia'$\chi 2$ kurtosis = 9.02, $p < .001$]. Consequently, the CFA and multi-group analyses were conducted using the Maximum Likelihood Robust estimator. For the model to be considered an acceptable fit for the data it was considered an SRMR $\leq .09$ combined with an RMSEA $\leq .08$ or a CFI $\geq .90$ (Hu & Bentler, 1999). Items' standardized loadings were also analyzed, with values equal or greater than .40 considered to be acceptable (Marôco, 2018). The best

fitting measurement model of the ECRC-Y was tested for sex invariance. Measurement invariance was conducted following a forward approach as suggested by

Dimitrov (2010) by testing configural, metric, and scalar invariance. According to Chen (2007), metric measurement invariance is determined when ΔCFI $\leq$ -.01 combines with ΔRMSEA $\leq$.015 or with ΔSRMR $\leq$ .03, and scalar invariance is established when ΔCFI $\leq$ -.01 combines with ΔRMSEA $\leq$.015 or with ΔSRMR $\leq$ .01. After establishing measurement invariance, latent mean comparisons were analysed for boys and girls, according to the guidelines provided by Dimitrov (2006).

Internal reliability analysis was conducted by examining Cronbach's alpha. In general, appropriate internal reliability is considered when $\alpha \geq .70$ (Pallant, 2011), yet in social sciences, an $\alpha \geq .60$ may be also considered acceptable (DeVellis, 1991).

Construct validity in relation to external variables (i.e., CEWSS-A, PANAS, SDQ) and test-retest reliability were examined by computing Spearman's correlation coefficient. Correlation values above .39 were considered weak, between .40 and .69 moderate, and higher than .70 strong (Dancey & Reidy, 2007).

Results

Factor structure, measurement invariance, and internal reliability

The 15 items were submitted to CFA to test the same three-factor solution proposed by the authors of the original scale (Albuquerque et al., 2021): threat, drive, and soothing related emotions. The measurement model did not reveal an appropriate adjustment for the complete sample [χ^2/df=309.792/87, p<.001; CFI = .894; RMSEA =. 083; SRMR = .090]. To improve the quality of model fit, a correlation of the error covariance between items 15 (i.e., anxious) and 12 (i.e., restless; both part of the threat-related emotions latent factor), was performed, based on the highest modification index. This model achieved an acceptable adjustment in the complete sample [χ^2/df=288.720/86, p<.001; CFI = .904; RMSEA =. 080; SRMR = .084], and in the girls' sample [χ^2/df=194.983/86, p<.001; CFI = .914; RMSEA =. 074; SRMR = .067], but not in the boys' sample [χ^2/df=199.105/86, p <.001; CFI = .875; RMSEA =. 096; SRMR =.114]. When inspecting item loadings, item 15 (i.e., anxious) presented a negative and non-significant loading in the boys' sample (λ = -0.141, p = 0.418), and although significant it was also the worst item within the girls' sample (λ = 0.446). In addition, for boys, the alpha value increase from .57 to .63 if item 15 was deleted. So, considering these statistical criteria and presuming that "anxious" could be misunderstood (Eddy et al., 2011) for respondents of this age range, this item was removed.

The 14 items model, as representing three latent constructs (cf. Figure 1), achieved an acceptable measurement fit for the combined, girls' and boys' samples (cf. Table 1), without any correlation of error covariance between items. Items of this model presented significant loading values ($p < .05$) higher than .40, with exception of item 7 (i.e., scared) in the boys' sample, which showed a low and non-significant value ($\lambda = 0.237$, $p = 0.063$) (cf. Table 2). Considering that the removal of the item would lead to a reduced spectrum of threat-related emotions, and that this seemed a specific issue related with boys, that does not interfere with the general measurement model, the item was kept. The correlations between the ECRC-Y dimensions were significant and in the expected direction. Threat-related emotions were negatively correlated both with drive (r = -.29) and soothing (r = -.51) related emotions, with a weak and moderate magnitude, respectively. In turn, the drive and soothing showed to be positively correlated with each other (r = .68) with a moderate magnitude. Acceptable internal consistency values were found; yet, the threat-related emotions subscale in boys should be interpreted with caution.

Concerning measurement invariance between sexes, configural invariance was achieved (cf. Table 1). Consequently, metric, and scalar invariance analyses were able to be conducted. Metric (ΔCFI = 0, ΔRMSEA =.004, ΔSRMR=.008) and scalar invariance (ΔCFI =.010, ΔRMSEA =.002, ΔSRMR=.004) are supported by the data. Thus, measurement invariance was supported for the ECRC-Y, meaning statistics can be meaningfully compared between groups.

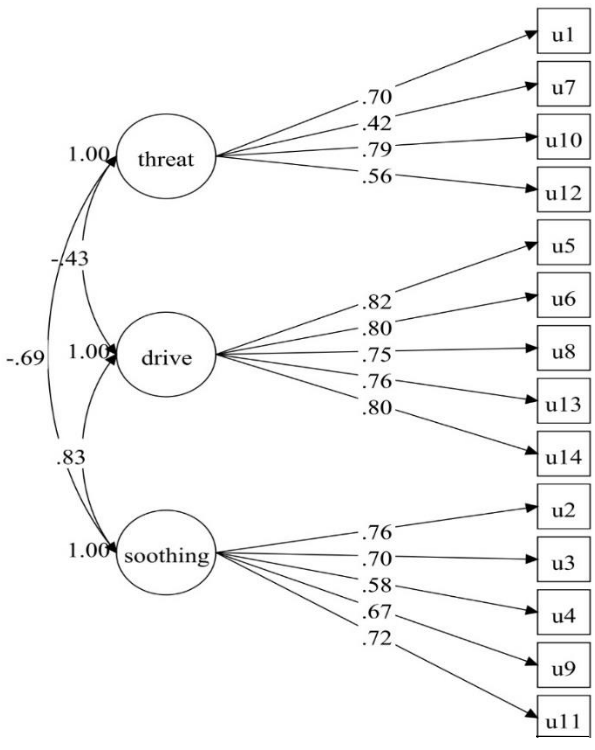

Figure 1. *Final model of Emotional Climate in Residential Care Scale – Youths (ECRC-Y)*

Table 1. *Fit indicators for CFA and configural invariance by sex*

	χ^2	df	RMSEA	90% CI for RMSEA	CFI	SRMR
Complete sample	235.889	74	.077	.066; .088	.919	.067
Male	153.410	74	.087	.067; .106	.905	.086
Female	172.448	74	.076	.061; .091	.918	.063
Unconstraint model (configural invariance)	326.445	148	.081	.069; .092	.913	.073
Loading constraint model (metric invariance)	336.288	159	.077	.066; .089	.913	.081
Intercept constraint model (scalar invariance)	369.028	170	.079	.068; .090	.903	.085

Note. χ2 = Chi-Square; df = degrees of freedom for Chi-square; RMSEA = root mean square error of approximation; CI = confidence interval; CFI = comparative fit index; SRMR = standardized root means square residual; χ2 values were significant at p <.001.

Table 2. *Standardized loadings and internal consistency values for the ECRC-Y dimensions in the complete sample and by sex*

Item e dimensions	Total	Male	Female
Threat	α = .71	α = .63	α = .75
1. Angry	.70**	.73**	.71**
7. Scared	.42**	.24	.50**
10. Stressed	.79**	.75**	.79**
12. Restless	.56**	.43*	.62**
Drive	α = .89	α = .89	α = .88
5. Lively	.82**	.83**	.81**
6. Cheerful	.80**	.83**	.78**
8. Active	.75**	.71**	.77**
13. Enthusiastic	.76**	.82**	.72**
14. Energetic	.80**	.82**	.78**
Soothing	α = .82	α = .83	α = .81
2. Content	.76**	.81**	.73**
3. Calm	.70**	.65**	.73**
4. Warmth	.58**	.64**	.55**
9. Relaxed	.67**	.67**	.64**
11. Safe	.72**	.76**	.71**

Note. ** p <.001; * p <.050.

Sex differences

Sex differences were assessed based on latent mean comparisons between the scores of boys and girls. Significant differences were found in threat-related emotions (latent mean for girls = 0.224, *p* = .031), indicating that girls presented the higher scores of threat related emotions when compared with boys. No sex differences were found for drive related emotions

(latent mean for females = -0.175, p = .127) and soothing related emotions (latent mean for females = -0.084, p = .387), indicating that boys and girls experienced the same levels of these kind of emotions in their RCHs. Descriptive measures are presented in Table 3.

Table 3. *Descriptive measures for the ECRC-Y dimensions for the complete sample and by sex*

	Total		Male		Female	
	M	*SD*	*M*	*SD*	*M*	*SD*
Threat	9.60	4.21	8.65	3.79	10.14	4.35
Drive	11.84	4.78	12.32	5.15	11.58	4.55
Soothing	11.90	4.34	12.23	4.61	11.72	4.18

Note. M = Mean; *SD* = Standard deviation

Construct validity in relation to external variables

The ECRC-Y was found to be significantly associated with the external variables in the expected directions (cf. Table 4). Positive and moderate correlation values were found between threat related emotions and negative affect as well as with self-reported externalizing and internalizing problems. These emotions were also negatively and moderately correlated with current experiences of warmth and safeness with caregivers in RCHs, as well as with positive affect, showing a negative but weak association.

Drive related emotions were positively and moderately associated with both current experiences of warmth and safeness and positive affect. This kind of emotions showed to be negatively associated with negative affect, and with internalizing problems, all with a weak magnitude. No significant correlation was found between drive related emotions and externalizing problems.

Soothing related emotions were positively and moderately associated with current experiences of warmth and safeness with caregivers and with positive affect, and negatively associated with negative affect and internalizing and externalizing behaviors, with a weak magnitude.

Table 4. *Correlation matrix between ECRC-Y dimensions and other variables*

		PANAS		SDQ	
	CEWSS-A	Positive affect	Negative affect	Internalizing Behaviour	Externalizing Behaviour
Threat	-.48**	-.25**	.52**	.43**	.48**
Drive	.60**	.56**	-.18**	-.24**	-.11
Soothing	.65**	.44**	-.31**	-.25**	-.29**

Note. CEWSS-A = Current Experiences of Warmth and Safeness Scale for Adolescents; PANAS = Positive and Negative Affect Schedule; SDQ = Strengths and Difficulties Questionnaire; *** p* <.001.

Test-retest reliability

Spearman correlation values between the scores of ECRC-Y at time 1 and 2 (retest) revealed a temporal stability of .47 ($p < .001$) for threat-related emotions, .61 ($p < .001$) for drive-related emotions, and .39 ($p < .050$) for soothing related emotions.

Discussion

This study encompasses the validation of the Emotional Climate in Residential Care Scale for Youth (ECRC-Y), within a Portuguese sample of youth in RYC. The ECRC-Y was adapted from the Emotional Climate in the Classroom Scale (ECCS; Albuquerque et al., 2021) to assess the emotional climate of the RCH as perceived by youth who live there. Although measures designed to assess social climate as perceived by youth do exist (Leipoldt et al., 2018; Mathys et al., 2013; Strijbosch et al., 2014, 2018b), this short measure aimed to focus on how youth perceived the lived emotional environment of RCH using an evolutionary approach to affect regulation (Gilbert, 2010, 2014, 2015), while trying to overcome the burden associated with longer scales (Stanton et al. 2002).

ECRC-Y dimensionality

Since the ECRC-Y was adapted from the ECCS, which formerly presented a trifactor solution (i.e., threat, drive, and soothing related emotions), the same measurement model was assumed and tested for the ECRC-Y. The CFA procedure confirmed the former solution; yet item 15 (i.e., anxious; belonging to threat dimension) showed low loading values in all samples. Particularly on boys' sample, this item showed a negative and non-significant loading value. In addition, the alpha value of threat dimension changed from an unacceptable to an acceptable internal consistency value when item 15 was deleted (DeVellis, 1991). Hence, based on statistical criteria and considering that anxiety is not as specific to the threat system as other emotions are (e.g., fear, anger) (Sousa et al., 2021), and that "anxious" could be misunderstood (Eddy et al., 2011), this item was removed. In previous research with community samples using the same theoretical framework, "anxious" item also presented a low loading value (Albuquerque et al., 2021). According to these authors, feeling anxious seemed to be of difficult understanding for children. Moreover, in a study encompassing an experimental procedure, adolescents did not report anxiety as related with threat, but with a drive scenario (Sousa et al., 2021). In fact, in another study conducted with children and youth, some participants interpreted anxiety as over excited or "really wanting to do something" (Eddy et al., 2011), thus interpreting anxious as a drive-related emotion instead of a threating one. The same could have

happened in our study, since in Portuguese language, feeling anxious is also synonymous with eager to achieve something.

The CFA procedure was repeated and the 14-item ECRC-Y, presenting a trifactor solution, achieved an acceptable fit for the data in all samples and an adequate internal consistency. The correlations between the ECRC-Y dimensions were significant and in the expected directions, in accordance with the theoretical framework (Gilbert, 2010, 2014, 2020). Regarding items loadings, it should be noted that in the boys' sample, the item "scared" presented a loading value below the reference standards (Marôco, 2018). Despite the internal consistency for this dimension in boys is considered acceptable in social sciences research (DeVellis, 1991), the threat dimension showed some statistical fragilities in the boys' sample. Thus, it should be interpreted with some caution.

ECRC-Y psychometric properties

In what concerns construct validly with external variables, youth that reported higher levels of threat related emotions expressed higher levels of negative affect, as well as more externalizing and internalizing problems, and lower levels of positive affect. These findings are aligned with previous research, supporting that the threat system is a negative affect regulation system (Depue & Morrone-Strupinsky, 2005) and that its activation is related with psychopathological symptoms and disorders (Gilbert, 2015). In the same sense, one study conducted within RYC settings found that children with social-emotional problems were less likely to feel safe (Seller et al., 2020), which agrees with the negative associations found between threat related emotions and current experiences of warmth and safeness with caregivers of the RCH. This finding reinforces the relevance of the current experiences with caregivers, that when felt as secure could downregulate the negative affect associated with the activation of the threat system (Armstrong et al., 2021; Santos et al., 2021; Santos et al., 2023b).

Concerning drive related emotions, youth who reported higher levels of these kind of emotions expressed higher levels of positive affect, and lower levels of negative affect. This finding is congruent with research showing that the drive system is a positive affect regulation system (Depue and Morrone-Strupinsky, 2005). In addition, the positive associations found with current experiences of warmth and safeness might be indicative that when youth feel supported, they more easily feel energizing emotions that may help them to engage with actions that move them to achieve their goals. This is particularly relevant for the autonomy process of these youth. Although no significant association was found between drive related emotions and externalizing problems, youth who felt more drive related emotions showed to have fewer internalizing problems. This in in line with research, since drive is an energized and motivation

system, which is compromised in some internalizing problems, such as depression (Gilbert, 2010).

Youth who reported higher levels of soothing related emotions also showed higher levels of positive affect and lower levels of negative affect. Also, youth who reported higher levels of soothing related emotions showed less internalizing and externalizing problems (Gilbert, 2015). The highest correlation found in the current study was between soothing related emotions and current experiences of warmth and safeness with caregivers, which showed a positive and moderate association. This is in line with theory and research (Armstrong et al., 2021; Depue & Morrone-Strupinsky, 2005; Gilbert, 2010, 2014, 2020) and reinforces the idea that affect regulation systems are sensitive to current contextual factors. Other studies also found an association between climate and relationships with caregivers (Strijbosch et al., 2018a). Overall, affiliation with current caregivers can be seen as an important factor to activate and stimulate both the soothing and drive systems of youth in RYC, which may act as regulators of the threat system and related socio-emotional problems (Izzo et al., 2020; Santos et al., 2023b). Hence, this study reinforces the relevance of youth relational milieu and the recommendation about the use of a therapeutic approach in RYC (Bailey et al., 2019; Lanctôt et al., 2016).

In what concerns test-retest reliability, the ECRC-Y was filled out approximately one and a half month after the first measurement. Findings showed unacceptable values of temporal stability for soothing and threat dimensions and fair value for drive dimension. In fact, the stability of group climate was also weak in other studies (Strijbosch et al., 2018a). More specifically, studies with the original scale with children and adolescents in schools also found unacceptable to fair values for the same dimensions (Albuquerque et al., 2021; Henriques, 2019). It is important to consider that factors such as time between measurements, characteristics of samples and the construct being measured might affect the reliability (Crocker & Algina, 1986). Considering that this measure aimed to assess emotional climate within RCHs based on the perceptions of emotionally unstable youth, and that many situational factors may affect the stability of group climate (Souverein et al., 2013), these findings could be expected. Hence, the ECRC-Y seems to be sensitive to contextual factors.

Measurement invariance was supported for the ECRC-Y, allowing for meaningfully comparisons between boys and girls (Chen, 2007).

Sex differences in perceptions of RCH emotional climate

Differences between sex were found regarding the threat dimension, with girls reporting higher frequency of threat related emotions. In the validation study of the original

scale conducted with community adolescents in schools, girls also showed increased threat scores when compared with boys (Henriques, 2019). This finding might be explained, at least partially, by sex differences in the expression of emotions (Chaplin & Aldao, 2013). Such differences might have influenced the way participants responded to the items pertaining to the threat related emotions factor. In Western cultures, traditional masculinity is centred on culturally defined standards of male being powerful, dominant, aggressive, and controlling one's emotions (Kirby & Kirby, 2017). On the contrary, emotional expression of negative affect is culturally expected and more acceptable in females (Chaplin & Aldao, 2013). Research also demonstrated that parents respond to the expression of emotions differently, depending on the child's sex, with fathers more easily punishing boys for expressing sadness and fear (Garside & Klimes-Dougan, 2002). Hence, particularly boys raised in threatening environments, may be taught that feeling fear is neither acceptable (e.g., "boys don't cry"), nor adaptative (e.g., peer/social rejection). They might have learned to suppress the expression of difficult emotions (Chaplin & Aldao, 2013; Kirby & Kirby, 2017), and to cope differently with these kinds of emotions to protect the self (Paulo et al., 2020; Vagos et al., 2018). Another possible explanation might be linked with the higher prevalence of trauma related symptoms and emotion dysregulation among girls in RYC (Gutterswijk et al., 2022; Olff, 2017), which might higher their sensitiveness to threat stimulus in the environment.

Implications for practice and research

The ECRC-Y could be relevant for research as well as for interventions in RYC. The ECRC-Y can be used to screen the emotional climate, by providing information on how girls and boys perceive the climate of their RCH. This knowledge can be used: 1) to assess the quality of care provided by a RCH; 2) to compare RCHs in terms of the quality of care they provide (Tonkin, 2015); 3) to understand how each youth can benefit from RYC (Sonderman et al., 2021a); 4) to inform institutions regarding interventions aimed at improving organizational climate, care procedures, and staffing (Leipoldt et al., 2019).

Findings of the current study reinforce the recommendation regarding the use of a therapeutic approach in RYC. In this sense, interventions and supervision targeted to caregivers aiming to support the improvement of the relational and emotional climate are recommended (Santos et al., 2023a; Seller et al., 2020).

Limitations and future research

This study is not free of limitations. Firstly, the sample is unbalanced in what concerns sex. Since some statistical fragilities emerged in relation to boys, future research should

replicate this study with a larger sample of boys. The test-retest subsample is small and unbalanced as well; thus, replication is also needed. In addition, factors that could affect the stability of the emotional climate should be explored. Secondly, considering the wide range of age, measurement invariance should be also tested by age group. The smaller representativeness of the 18 years old age group within the current sample precluded the performance of this analysis. Yet, we choose to maintain this age group, since these youth are part of the Portuguese RYC population (ISS, 2022). The same occurred with the length of placement, which should also be investigated in future research. Thirdly, a developmentally adapted version for younger children with age lower than 12 years old should also be developed and validated, as well as a caregiver's version, by taking into considering that climate should be analyzed by combining the perspectives of different groups/informants (de Rivera & Paez, 2007; Leipoldt et al., 2019). Finally, the ECRC-Y was validated with a Portuguese sample; hence, its structure and measurement invariance should be investigated in other languages and cultures.

Conclusions

The ECRC-Y could be used as a quicker, but psychometric sound way to obtain information regarding how youth perceive the emotional climate of the RCH where they live. The ECRC-Y can be used to identify environmental problems and design interventions to foster targeted therapeutic approaches, as well as to improve the quality of care provided and outcomes in RYC.

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Compliance with Ethical Standards

Ethics approval: This research received approval from the Ethics Committee of the Faculty of Psychology and Educational Sciences of the University of Coimbra (CEDI22.03.2018). All procedures performed in this study were in accordance with the Code of Ethics of the World Medical Association (Declaration of Helsinki) for experiments involving humans.

Conflicts of Interest: The authors of this manuscript declare no conflict of interest.

Informed Consent: Adolescents aged between 14 and 16 years old gave informed assent, while the older than 16 years old gave written informed consent. A written informed

consent was also gathered from legal representatives of all adolescent participants under 18 years old.

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Authors' Contributions

Laura Santos: Conceptualization, Methodology, Investigation, Resources, Formal analysis, Writing - Original Draft, Review & Editing, Funding acquisition. **Joana Martins:** Investigation, Resources, Formal analysis, Writing - Review & Editing. **Diana Ribeiro da Silva:** Writing - Review, Supervision. **Marcela Matos:** Methodology, Writing - Review. **Maria do Rosário Pinheiro:** Writing - Review. **Daniel Rijo:** Writing - Review, Supervision.

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Estudo Empírico II

Development and validation of the Current Experiences of Warmth and Safeness Scale in community and residential care adolescents

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Development and validation of the Current Experiences of Warmth and Safeness Scale in community and residential care adolescents

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Abstract

Interpersonal experiences of warmth and safeness have a key role on emotion regulation and social development during childhood and adolescence. This paper presents a new and brief scale designed to assess the adolescents' perception of current experiences of warmth and safeness (CEWSS-A). Its dimensionality and psychometric properties were investigated using a Portuguese sample of 453 adolescents from the community and 319 adolescents from residential care facilities. A confirmatory factor analysis indicated that the 12-item scale has a one-factor measurement model. The CEWSS-A showed adequate internal consistency in the different samples ($\alpha > .92$) and construct validity in relation to external variables. The CEWSS-A proved to be group invariant. Community adolescents reported a higher frequency of current experiences of warmth and safeness in comparison with residential care participants, and boys showed significantly higher scores than girls, within both samples. The CEWSS-A is an appropriate self-report measure for clinical and research purposes.

Keywords: adolescence; measurement invariance; psychometrics; residential youth care; warmth and safeness experiences.

Introduction

According to an evolutionary perspective, humans are a social species (Cacioppo et al., 2000). In order to survive, the human warmth system evolved in the context of supporting and nurturing social relationships (MacDonald, 1992). Being affiliated with others is considered crucial to an individual's healthy development and psychological well-being across the life span (Cacioppo et al., 2000).

It has been proposed that different types of psychosocial vulnerabilities can be understood taking into consideration the development, functioning, and interaction of three main affect regulation systems, specifically oriented toward threats, resources and affiliation, which are sensitive/responsive to different types of stimuli (Gilbert, 2010). While the threat system alerts individuals and activates defensive strategies, the drive system is related to the availability of resources and rewards, activating seeking-engagement strategies; by its turn, the soothing system gives rise to positive affect, such as calmness, contentedness and reassurance, helping to regulate negative affect and behaviour (e.g., aggression, isolation) associated with the activation of the threat system (Depue & Morrone-Strupinsky, 2005).

The soothing system evolved in parallel with the attachment system, being shaped by the quality of the child-parent/caregiver relationship (Gilbert et al., 2009). On the one hand, if the parents/caregivers nurture, reassure and soothe the child, feelings of soothing and social safeness will be further developed. On the other hand, if this relationship is poor, abusive, threatening or if no one is available as a source of care and support, the threat system will be mostly stimulated and the maturation of the soothing system will become compromised (Gilbert, 2015). Consequently, those children will tend to be less emotionally regulated, more rank-focused and self-focused, and avoid interpersonal relationships or become more aggressive towards others (Gilbert, 2005; Matos et al., 2013). They may also struggle to feel safe and soothed in relationships later in life (Gilbert, 2015). Feelings of connectedness have also been found to be related with the individuals' ability to be compassionate towards others, and, when underdeveloped, can affect children's ability to trust and receive demonstrations of care and compassion from others (Gilbert, 2005, Gilbert et al., 2011; Kelly & Dupasquier, 2016). Hence, the lack of secure relationships in early years as well as difficulties in activating the soothing system were conceptualized as vulnerability factors for both internalizing and externalizing problems (Gilbert, 2005). Overall, affiliative experiences with others and the recall of warmth, safeness and nurturance will set the grounds for the development of the soothing system and regulation of threat-related emotions and behaviours (Gilbert et al., 2006; Kelly & Dupasquier, 2016).

Throughout adolescence, living in a supportive and secure environment and feeling socially accepted and valued have been recognized as relevant factors affecting mental well-being (Gilbert, 2010). Also, the occurrence of negative experiences within closer relationships (e.g., family, peers) has been suggested to negatively impact emotional and social changes across this developmental stage (WHO, 2018). This seems to be of upmost relevance, since adolescence is considered a critical period for the emergence of mental health problems (Polanczyk et al., 2015), including internalizing and externalizing disorders (Wolfe & Mash, 2006), with significant impact later in life (Schulenberg et al., 2004). Therefore, relationships with significant others (e.g., parents, peers, teachers) based in care, warmth, safeness and reassurance, play a central role not only in childhood, but also during adolescence, helping adolescents to better regulate their affect and behaviour (Irons & Gilbert, 2005), and enabling a better and smoother transition into adulthood (O'Connor et al., 2017).

In addition to the emotional, social and cognitive developmental challenges of adolescence (Steinberg, 2005), the majority of youngsters living in residential care homes (RCH) presents a personal history of maltreatment (psychological, physical and sexual abuse, and neglect) (Courtois, 2004), having experienced disruptions in their attachment relationships with primary caregivers (Hawkins-Rodgers, 2007). Since these adolescents did not receive appropriate and consistent levels of nurturance and warmth in early relationships, the opportunity to develop their soothing system in a desirable manner might have been compromised, affecting their ability to feel safe and soothed in current relationships (Gilbert, 2010, 2015). Additionally, institutionalized adolescents tend to reveal interpersonal vulnerabilities such as withdraw, resistance to close relationships, less contact with significant adults and a fragile social support network (Campos et al., 2019; Wallis & Steele, 2001). For these reasons, nurturance should not be neglected in the daily intervention in residential care settings (Hawkins-Rodgers, 2007). As significant figures, caregivers should be able to support adolescents in regulating their emotions in a healthy and non-damaging way (Mota et al., 2016), in order to help them to cope with the negative events they were/are forced to face (Bravo & del Valle, 2003). Since the quality of the adolescent-caregiver relationship has been recognized as a key mechanism of effective interventions serving at-risk adolescents (Li & Julian, 2012), particular attention should be paid to the assessment and enhancement of such relationships.

Considering the relevance of caring experiences for the human development, the association between early memories of parental figures and later psychosocial adjustment and psychopathology has been largely investigated. Based on the assumption that it is important to assess the recall of how one felt in relation to others' behaviour, instead of others' behaviour

per se (Gilbert et al., 2003), Richter, Gilbert and McEwan (2009) developed the Early Memories of Warmth and Safeness Scale (EMWSS) to evaluate the recall of inner positive feelings and experiences of warmth and safeness during childhood. The EMWSS was also adapted and validated for adolescents (Cunha et al., 2014; Vagos et al., 2017). As in adults, the adolescents' version showed a one-factor solution, with good psychometric properties, both with forensic (Vagos et al., 2017) and community samples (Cunha et al., 2014). Vagos and colleagues (2017) made a brief version for adolescents of different samples (i.e., community and residential care/juvenile detention facilities), which also performed well from a psychometric point of view. Regarding gender comparisons, findings differed across studies. While, Tahirović & Jusić (2016) found that girls scored significantly higher than boys on the EMWSS, other studies revealed that boys and girls recalled similar levels of early warmth and safeness experiences (Cunha et al., 2014; Vagos et al., 2017). In what concerns different samples, community participants presented higher scores of early caring memories, when compared with behaviourally disturbed youngsters, both from residential care and juvenile justice settings (Vagos et al., 2017). Research also showed that early memories of caring experiences were negatively associated with symptoms of depression, anxiety and stress (Cunha et al., 2014; Vagos et al., 2017), and were positively associated with self-reassurance and the recall of positive parental behaviour (Cunha et al., 2014).

As stated above, adolescents present an increased vulnerability for the emergence of psychopathology. Considering that not only the early caring experiences with significant others, but also current feelings of being cherished, supported and valued associate with psychological well-being (Gilbert et al., 2006; Kelly & Dupasquier, 2016), an instrument allowing to assess those experiences throughout adolescence would be useful for both clinical and research purposes. Nonetheless, there is no available self-report measure aiming to assess the current perception of such kind of experiences.

This study describes the development of a brief self-report measure designed to assess the frequency with which adolescents feel emotional experiences of warmth, care and safeness in current relationships: The Current Experiences of Warmth and Safeness Scale for adolescents (CEWSS-A). It includes research on the dimensionality, measurement invariance between boys and girls and between participants from the community and from residential care homes, test-retest reliability and validity in relation to external variables.

Methods

Participants

Participants included 772 Portuguese adolescents, from the general community and from residential care homes, aged between 14 and 18 years old (i.e., combined sample; cf. Table 1). Boys (*M* = 15.57; *SD* = 1.21) and girls (*M* = 15.67; *SD* = 1.30) had similar mean ages t(770) = −1.180, *p* = .238) and were similarly distributed by socioeconomic status (SES; χ2(2)=1.901, *p* = .387).

Table 1. *Demographic characteristics of the samples*

	Gender		Age	Socioeconomic status			School years
	Male	Female		Low	Medium	High	
Complete sample	378 (49)	394 (51)	15.62 (1.25)	447 (57.90)	238 (30.80)	24 (3.10)	9.51 (1.41)
Community sample	224 (50)	229 (51)	15.43 (1.22)	244 (53.90)	186 (41.10)	17 (3.80)	9.82 (1.14)
At-risk sample	154 (48)	165 (52)	15.90 (1.25)	203 (77.50)	52 (19.80)	7 (2.70)	9.09 (1.57)

Note. Socioeconomic status (SES) was measured by parents' professions, considering the Portuguese professions classification (INE, 2011). Examples of professions in the high SES group are judges, higher education professors, or MDs; in the medium SES group are nurses, psychologists, or school teachers; and in the low SES group are cleaning staff or undifferentiated workers. Information for gender and socioeconomic status are presented as n (%); information for age is presented as M (SD). M= mean. SD = standard deviation.

The community sample comprised 453 adolescents. Within this sample, no significant differences between boys and girls were found concerning age (t (451) = -1.111; *p* = .267; for boys *M* = 15.36, *SD* = 1.16 and for girls *M* = 15.49, *SD* = 1.28), number of school years (t(451) = -1.070, *p* = .285; for boys *M* = 9.76, *SD* = 1.10 and for girls *M* = 9.87, *SD* = 1.18) and SES distribution (χ2(2) = .365, *p* = .546).

Of the combined sample, 319 adolescents were placed in RCH[1], composing the at-risk sample. The length of placement in RCH ranged from 0 to 204 months (M = 35.90; SD = 37.56). Within this sample, no significant differences between gender were found regarding age (*t* (317) = -.454; *p* = .650; for boys *M* = 15.86, *SD* = 1.21 and for girls *M* = 15.93, *SD* = 1.29) and SES (χ2(2)

[1] Portuguese Residential Care Homes (RCH) may vary in the number of children and youngsters fostered and may be mixed or segregated by gender. Most of the placements (89%) are due to history of maltreatment (neglect and psychological, physical and sexual abuse), and the remaining are related with abandonment by caregivers or the lack of family support (ISS, 2019). Each RCH has a technical team (e.g. board members, psychologists, social workers), and education/support staff (e.g. educators, educational assistants).

= 1.349, *p* = .509). Girls completed more school years than boys (t(316) = -2.200, *p* = .029; for boys *M* = 8.89, *SD* = 1.58 and for girls *M* = 9.27, *SD* = 1.59).

Adolescents in RCH were significantly older than those in the community (t (770) = -5.221; *p* < .001). Additionally, adolescents in RCH completed significantly less schooling (t (769) = 7.476, *p* < .001) and were of a lower SES than their community peers ($\chi2(2)$ = 37.665, *p* < .001). The samples were not significantly different with regard to gender distribution ($\chi2(1)$ = .103, *p* = .748).

In order to study test-retest reliability, the CEWSS-A was filled out one month after the first measurement, by a subsample of 107 adolescents from the community sample, composed by 52 boys (49%) and 55 girls (51%), aged between 14 and 17 years old (M = 14.86, SD = .76), and a subsample of 110 adolescents from the at-risk sample, composed by 53 boys (48%) and 57 girls (52%), with ages ranging from 14 to 18 years old (M = 15.82, SD = 1.23).

Adolescents from the community in the retest subsample were significantly younger than those in the community sample (t (304) = -7.364; p < .001) and completed less schooling (t (436) = -8.303, p < .001). There were no significant differences regarding gender ($\chi2(1)$ = .040, p = .841) and SES distribution ($\chi2(2)$ = .384, p = .825). The retest subsample of at-risk adolescents did not differ from the RCH sample regarding age (t (317) = -.813, p = .417), gender ($\chi2(1)$ = .001, p = .981) and SES ($\chi2(2)$ = 2.774, p = .250), having though less schooling (t (187) = -2.262, p = .025).

Measures

Early Memories of Warmth and Safeness Scale – Adolescents (EMWSS-A; Richter et al., 2009; Portuguese version for adolescents by Cunha et al., 2014)

EMWSS-A is a 21-item self-report scale designed to measure the recall of feeling warm, safe and cared for in childhood (e.g., 'I felt secure and safe', 'I felt that I was a cherished member of my family'). Participants are asked to rate how frequently each statement applied to them in their childhood, using a 5-point Likert scale (0 = No, never, to 4 = Yes, most of the time). The original version for adults revealed a one-factor solution and good psychometric properties, with excellent internal consistency (α =.97) and good test-retest reliability (*r* = .91) (Richter et al., 2009). The Portuguese version for adolescents confirmed a single factor structure as well and presented an excellent internal consistency value (α = .95) and good test-retest reliability (*r* = .92) (Cunha et al., 2014). In this study, the internal consistency value for the EMWSS-A was .98.

Depression Anxiety and Stress Scales (DASS-21; Lovibond & Lovibond, 1995; Portuguese version by Pais-Ribeiro, Honrado, & Leal, 2004)

DASS-21 is a 21-item self-report scale designed to assess symptoms of depression, anxiety and stress. Participants are asked to rate how much each statement applied to them over the previous week, using a 4-point Likert scale (0 = did not apply to me at all, to 3 = applied to me very much, or most of the time). On the original version, the DASS-21 subscales presented high internal consistency: Depression Subscale α = .91, Anxiety Subscale α = .84 and Stress Subscale α = .90 (Lovibond & Lovibond, 1995). The Portuguese version showed good internal consistency (Depression α = .85, Anxiety α =. 74 and Stress α = .81) and good convergent and discriminant validity (Pais-Ribeiro et al., 2004). In this study, the internal consistency values were .87, .83 and .87 for Depression, Anxiety and Stress subscales, respectively.

Positive and Negative Affect Schedule (PANAS; Watson et al., 1998; Portuguese version by Galinha & Pais-Ribeiro, 2005)

PANAS is a 20-item self-report scale designed to assess two mood states: positive affect (PA) and negative affect (NA). Each subscale is composed by 10 items that describe feelings and emotions (e.g., enthusiastic, proud and excited on the PA subscale, and afraid, hostile, guilty and sad on the NA scale). Participants are asked to rate the severity and frequency of these feelings and emotions in the last few weeks, using a 5-point Likert scale (1=nothing or very slightly, to 5=extremely). Cronbach's alphas values in the original version were .88 for PA and .87 for NA (Watson et al., 1998). The Portuguese version revealed alphas of .86 for PA and .89 for NA (Galinha & Pais-Ribeiro, 2005). In the present study, the internal consistency values coincided: .86 for PA and .89 for NA.

Compassion Scale - Adolescents (CS-A; Pommier, 2011; Portuguese version for adolescents by Sousa et al., 2022)

CS-A is a 24-item self-report scale that measures compassion for others. Participants are asked to answer each item according to how frequently they feel and act towards others in that way, using a 5-point Likert scale (1 = almost never, to 5 = almost always). In the original version for adults, a confirmatory factor analysis (CFA) showed the existence of six subscales (Kindness, Common Humanity, Mindfulness, Indifference, Separation and Disengagement) and a higher order factor labelled Compassion. The total scale presented an alpha of .90 and the subscales presented acceptable internal consistency values, ranging from α = .57 for Disengagement to α = .77 for Kindness (Pommier, 2011). For the Portuguese version for adolescents, CFA revealed the existence of six subscales and two higher-order factors: Compassion (comprising the positive

subscales: Kindness, Common Humanity, Mindfulness) and Disconnectedness (comprising the negative subscales: Indifference, Separation and Disengagement). Considering the two higher order factors, Compassion showed an alpha of .90 and the Disconnectedness an alpha of .87 (Sousa et al., 2022). For parsimony reasons, only the two higher order factors, Compassion and Disconnectedness, were used in the current paper to examine the construct validity of the CEWSS-A. In the present study, alpha coefficients were .87 for Compassion and .85 for Disconnectedness.

Peer Conflict Scale (PCS; Marsee et al., 2011; Portuguese version by Vagos et al., 2014)

PCS includes 40 items designed to assess four types of aggression (i.e., overt reactive aggression, overt proactive aggression, relational reactive aggression and relational proactive aggression). Each subscale is composed by 10 items, which are rated using a 5-point Likert scale (0 = has little to do with me, to 4 = has everything to do with me). These 4 subscales can be grouped into two aggression functions: Reactive Aggression (composed of Overt Reactive and Relational Reactive Aggression) and Proactive Aggression (composed by Overt Proactive and Relational Proactive Aggression). The original version showed good internal consistency values, with alphas ranging from .79 for the Relational Reactive Aggression to .89 for the Overt Reactive Aggression (Marsee et al., 2011). In the Portuguese version, alphas ranged from .87 for the Relational Reactive Aggression, to .91 for the Overt Reactive Aggression (Vagos et al., 2014). Again, for parsimony reasons, only the Reactive Aggression and the Proactive Aggression were used. In the current study, alpha coefficients were .91 for the Reactive Aggression and .90 for the Proactive Aggression.

Procedures

Scale development

The Current Experiences of Warmth and Safeness Scale for adolescents (CEWSS-A) was based on the EMWSS-A (Cunha et al., 2014) and was developed to assess how often adolescents felt emotional experiences of care, warmth and safeness with others, along the two previous weeks. After obtaining approval from the authors of the original scale (Richter et al., 2009), the verbal tense of the EMWSS-A items was adapted to the present perfect continuous. The content of four items was adapted in order to facilitate its comprehension or to adjust it to the diversity of adolescents' relationships (i.e., not limited to family experiences). As an example, item 9 ("'I felt that I was a cherished member of my family'.") from EMWSS-A was modified to "I have been feeling that I'm loved by the people I live with". Instructions were changed, asking to rate how frequently each statement applied to the participant over the past two weeks, rather than in

their childhood. Like for the EMWSS-A, items are rated with a 5-point scale (ranging from 0 = No, never, to 4 = Yes, most of the time).

Considering that one latent construct could be over-identified using the 21 items (Hair et al., 2009), and that fatigue may influence answers to self-report measures, namely in more resistant and unmotivated respondents, such as adolescents (Fan et al., 2006), we proposed to reduce the number of items and to test if a shorter version would present good psychometric qualities. Hence, the most relevant items assessing the intended construct were selected, according to theoretical and statistical criteria (DeVellis, 2012). Firstly, six experts in psychology rank-ordered the 21 items of the complete scale taking into consideration feelings and experiences more related to the soothing system (i.e., 1 = most relevant, 21 = less relevant). Experts considered that some items could also be related to the other affect regulation systems, such as the drive system (i.e., positive affect associated with excitement, joy and vitality) and the threat system (i.e., safety feelings associated with vigilance, escape from, and/or avoidance of threat scenarios, instead of feelings of safeness associated with warmth and calming experiences). Accordingly, items that were rated as potentially related to drive (e.g., I have been feeling happy) or threat (e.g., I have been feeling relaxed and comfortable) were eliminated. Items judged as better representing experiences of warmth and safeness, including those reflecting connection with others (e.g., I have been feeling comfortable sharing my feelings and thoughts with people around me), emotions associated with the soothing system (e.g., I have been feeling a sense of warmth by people around me), and social connectedness in suffering or difficult moments (e.g., I have been feeling it was easy to be soothed and comforted by those close to me when I was unhappy) were kept. Secondly, following the procedure by Vagos and colleagues (2017), the item rankings were averaged and items with averages of 10 or lower were selected. These procedures resulted in the selection of 12 items, each one with CFA loadings greater than .50 based on the 21-item one-factor model. Item quality analysis revealed moderate to high values of item-total correlations. Moreover, the alpha values did not decrease if the item was deleted. So, 12 items were kept as the best theoretical and statistical representation of the construct. This short version includes items 1, 3, 4, 5, 7, 9, 10, 12, 14, 17, 18, 20 of the initial full scale (cf., Table 2).

Data collection

Study procedures were approved by the institutional and national ethics committee and direction boards. The community sample consisted of adolescents from 8 schools and 4 sports/recreational groups based on convenience. The RCH sample consisted of adolescents from 34 RCH. Adolescents identified as cognitively impaired by school or RCH professionals were

excluded. Eligible participants, aged between 14 and 18 years old, were invited to voluntarily participate. Adolescents with ages raging between 14 and 16 years old provided informed assent and youngsters older than 16 provided informed consent. Informed consent was also obtained from parents/legal guardians in the community and RCH samples. In the community sample, data was collectively collected during class time or drills in the presence of the researcher. In the RCH sample, data was collectively collected in small groups though some adolescents completed it individually if they showed difficulties in reading and understanding, with the assistance of a researcher. Given the similarity between the CEWSS-A and the EMWSS-A, the protocol was divided into two parts (A and B). Part A included the CEWSS-A, DASS-21, PANAS and CS-A, and part B included the EMWSS-A and PCS. Parts A and B were administered within one week of each other for each class/group in alternating order. Additionally, the order of the scales within an administration timepoint was randomized. To investigate test-retest reliability, the first 3 schools in the community and the first 13 RCH completed the CEWSS one month after the first measurement.

Data Analysis

Since the present scale was developed from previous research (Cunha et al., 2014; Richter et al., 2009; Vagos et al., 2017) and founded on theoretical assumptions, an unifactorial model structure was defined prior to the analyses. Based on a combination of theoretical and statistical criteria, a brief version of the CEWSS-A was developed according to the procedures previously described (c.f. procedures section). Then, we sought out to explore the adequacy of the final 12-item one-factor model, via Confirmatory Factor Analysis (CFA). The normality of the CEWSS-A variables was analysed using the Kolmogorov-Smirnov test. Results indicated that the data did not present a normal distribution (KS = .108, p <.001). Consequently, the CFA and multi-group analyses were conducted using the Maximum Likelihood Robust estimator. Chi square is the most commonly reported fit statistic; however, it is very sensitive to sample size and may overestimate the lack of model fit. To overcome this limitation, additional goodness-of-fit indexes were selected according to the guidelines provided by Hu and Bentler (1999): The Standardized Root Mean Square Residual (SRMR) ≤ .09 combined with either a Comparative Fit Index (CFI) ≥ .95 or a Root Mean Square Error of Approximation (RMSEA) ≤ .06.

The best fitting measurement model of the CEWSS-A was tested for gender and group (community *versus* at-risk samples) invariance, in order to be able to draw credible conclusions of between-group comparisons. Measurement invariance was conducted by testing configural, metric and scalar invariance. As suggested by Dimitrov (2010), at least partial scalar invariance should be obtained in order to proceed with group comparisons. According to Chen (2007),

metric measurement invariance is determined when ΔCFI ≤ -.01 combines with ΔRMSEA ≤.015 or with ΔSRMR ≤ .03 and scalar invariance is established when ΔCFI ≤ -.01 combines with ΔRMSEA ≤.015 or with ΔSRMR ≤ .01. After establishing measurement invariance, mean comparisons were computed with the nonparametric Mann-Whitney U test, for mean scores comparison of boys and girls from each sample and between samples. Effect sizes were calculated by dividing Z by the square root of N (r = Z / √N) (Fritz et al., 2012).

Construct validity in relation to external variables (i.e., EMWSS-A, CS-A, PCS, PANAS, DASS-21) and test-retest reliability were examined by computing Spearman's correlation coefficient. Internal reliability analysis was conducted by examining the Cronbach's alpha.

The CFA and multi-group analyses were performed using Mplus v8 (Muthén & Muthén, 2015). IBM SPSS Statistics 22 software was used to perform the descriptive and psychometric analyses of the scale, to compare gender and groups and to compute the Cronbach Alpha.

Results

Factor structure

Table 2. *Psychometric properties of the CEWSS-A 12 items for the complete sample*

Item	Expert average rating score	M	SD	r	Λ	α
1 …safe and secure	6.83	3.21	1.03	.68	.70	.94
2 …understood	9.00	2.69	1.09	.73	.74	.94
3 …a sense of warmth by people around me	7.00	3.00	1.06	.76	.77	.94
4 …comfortable sharing my feelings and thoughts with people around me	8.00	2.43	1.22	.68	.69	.94
5 …I could count on empathy and understanding of those closest to me when I was unhappy	7.50	2.94	1.06	.74	.77	.94
6 …I was cherished by the people I live with	6.83	3.10	1.02	.72	.75	.94
7 … it was easy to be soothed and comforted by those close to me when I was unhappy	9.00	2.88	1.08	.81	.84	.94
8 …comfortable turning to people important to me when I needed help or advice	9.00	2.94	1.09	.75	.76	.94
9 …loved even when people were bored with something I did	9.00	2.60	1.15	.70	.72	.94
10 …I could count on those close to me to comfort me when I felt down	7.00	2.93	1.06	.81	.82	.94
11 …others cared about me	7.67	2.87	1.06	.76	.78	.94
12 …I could count on the help of those close to me when I was unhappy	8.50	2.95	1.04	.80	.82	.94

Note. M = mean; SD = standard deviation; r = corrected item-total correlation; λ = loadings of items; α= alpha if item is deleted. All loading values were significant at p < .001.

Table 3. *Fit indicators for CFA and multi-group configural invariance analyses by samples*

	χ^2	df	RMSEA	90% CI for RMSEA	CFI	SRMR
Complete sample	158.025	53	.051	.042;.060	.971	.026
Male participants	107.412	53	.052	.038; .066	.965	.034
Female participants	126.454	53	.059	.046; .073	.968	.027
Community sample	120.220	53	.053	.040; .065	.968	.030
Male participants	81.990	53	.049	.027; .070	.965	.038
Female participants	110.973	53	.069	.051; .087	.960	.034
At-risk sample	99.424	53	.052	.036; .068	.970	.033
Male participants	82.560	53	.060	.033; .084	.957	.048
Female participants	90.437	53	.065	.041; .088	.961	.035

Note. χ2 values were always significant at p <.001. Acceptable fit indicators were achieved after allowing residual correlations between items 12 and 10. This residual correlation was equally applied in all models.

Table 4. *Loading and internal consistency values for the 12 items-unifactorial model of the CEWSS-A by samples*

Item	Complete sample			Community sample			At-risk sample		
	Total	Male	Female	Total	Male	Female	Total	Male	Female
	α=.95	α=.94	α=.95	α=.94	α=.92	α=.95	α=.94	α=.94	α=.95
1	.70	.68	.71	.63	.59	.65	.69	.68	.70
2	.74	.77	.72	.73	.69	.74	.74	.81	.67
3	.77	.76	.78	.76	.72	.79	.75	.75	.75
4	.69	.66	.71	.67	.60	.73	.66	.66	.65
5	.77	.77	.78	.76	.72	.80	.75	.79	.73
6	.75	.73	.75	.68	.63	.71	.74	.73	.73
7	.84	.81	.86	.81	.78	.83	.83	.78	.86
8	.76	.75	.78	.76	.72	.79	.75	.74	.76
9	.72	.70	.73	.66	.57	.72	.73	.77	.71
10	.82	.78	.86	.81	.77	.83	.82	.75	.87
11	.78	.71	.83	.80	.76	.83	.76	.64	.85
12	.82	.78	.85	.83	.83	.83	.79	.69	.86

Note. All loading values were significant at p <.001.

The 12 items identified as best to represent the construct (cf. procedures section) were submitted to CFA, as representing one latent construct (Table 2). The measurement model revealed an appropriate adjustment for the data taken from all samples, except for the data of girls from the community sample, which showed the following fit indicators χ^2/df=143.860/54, p<.001; CFI = .938; RMSEA =. 085; SRMR = .037. In order to improve the quality of model fit, a correlation of the error covariance between items 10 and 12, based on the highest modification

index, was performed. Moreover, this procedure was adopted because the measurement model of the scale is unidimensional and items 10 and 12 have a similar content (Table 2). This measurement model achieved a good fit for the combined sample, community sample, at-risk sample and respective girls' and boys' samples (Table 3), alongside with significant loading values (p < .001) higher than .50, and excellent internal consistency values (Table 4).

Measurement invariance

Concerning measurement invariance between the community and the at-risk samples, configural invariance was achieved (cf. Table 3). Consequently, metric and scalar invariance analyses were able to be conducted. Full metric (ΔCFI =-.005, ΔRMSEA =.001, ΔSRMR=.021) and scalar invariance (ΔCFI =.005, ΔRMSEA =.007, ΔSRMR=.021) were also found between samples.

Between gender measurement invariance was investigated in the complete sample, as well as in the community and at-risk samples, separately. Configural invariance was achieved for all samples (cf. Table 3). Full metric and scalar invariance were found for the complete sample (ΔCFI =-.001, ΔRMSEA =-.002, ΔSRMR=-.01; ΔCFI =-.003, ΔRMSEA=-.001, ΔSRMR=-.001, respectively), the community sample (ΔCFI =.003, ΔRMSEA =-.005, ΔSRMR=.011; ΔCFI =-.005, ΔRMSEA=.001, ΔSRMR=.017, respectively) and the at-risk sample (ΔCFI =-.007, ΔRMSEA =.002, ΔSRMR= .023; ΔCFI =-.005, ΔRMSEA=0, ΔSRMR=.006, respectively).

Measurement invariance across community and at-risk adolescents was also investigated for each gender separately. Configural invariance was achieved for boys of both samples, as for girls (cf. Table 3). After, both metric invariance (for boys ΔCFI =-.009, ΔRMSEA =.003, ΔSRMR= .035; for girls ΔCFI =-.003, ΔRMSEA =-.001, ΔSRMR=.015) and partial scalar invariance were found. Partial scalar invariance was obtained after allowing the intercepts of item 6 to vary between groups (for boys ΔCFI =-.002, ΔRMSEA =-.001, ΔSRMR= .003; for girls ΔCFI =-.007, ΔRMSEA =.002, ΔSRMR= .008).

Measurement invariance analyses showed that the same measurement model fits all samples (configural invariance) and that loadings across samples were similar (metric invariance). Finally, scalar invariance was found between groups (at-risk and community samples) and between gender (within the complete, the community and the at-risk samples), showing similar intercepts between community and at-risk adolescents, as well as between boys and girls. The CEWSS-A proved to be invariant, allowing further comparisons between groups.

Mean comparisons

Due to the non-normal distribution of the data, the Mann-Whitney U test was used for all comparisons between groups.

When comparing community and at-risk samples, adolescents from the community reported a higher frequency of current experiences of warmth and safeness with others, in comparison with at-risk adolescents (U = 41144, p < .001, r = -.3). This comparison achieved a medium effect size.

Gender comparisons were performed for the complete, the community and the at-risk sample. Boys and girls reported different frequencies of current experiences of warmth and safeness. Boys scored significantly higher than girls, in the complete (U = 56680, p = .001, r = -.123), community (U = 20252.5, p = .012, r = -.121) and at-risk (U = 9078, p = .024, r = -.132) samples; all comparisons with small effect sizes.

Comparisons between community and at-risk adolescents were also performed for each gender separately. Considering males, boys from the community scored higher in the CEWSS-A than boys from the at-risk sample (U = 9671.5, p < .001, r = -.3). Regarding females, girls from the community also scored higher in the CEWSS-A, when compared with girls from the at-risk sample (U = 10894, p < .001, r = -.3; cf. Table 5). Medium effect sizes were found in both comparisons.

Table 5. *Descriptive measures for the CEWSS-A by samples*

	M	SD
Complete sample	34.55	10.22
Male participants	35.90	9.54
Female participants	33.27	10.68
Community sample	37.18	8.45
Male participants	38.38	7.64
Female participants	36.01	9.04
At-risk sample	30.66	11.32
Male participants	32.12	10.86
Female participants	29.33	11.61

Note. M = mean; SD = standard deviation

Construct validity in relation to external variables

Positive and significant correlation values were found between current experiences of warmth and safeness and early memories of warmth and safeness, compassion and positive affect. Current experiences of warmth and safeness and early memories of this kind of experiences proved to be moderately correlated (r>.5), while the association with the remaining variables was week (Dancey & Reidy, 2007).

Significant negative correlations were found between current experiences of warmth and safeness and depression, anxiety and stress symptoms, reactive/proactive aggression, negative affect and disconnectedness. Depression, stress and negative affect were moderately correlated with current experiences of warmth and safeness (r>.4), while the association with the remaining variables was week (Dancey & Reidy, 2007) (Table 6).

Table 6. *Correlation matrix between CEWSS-A and other variables*

	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
(1) CEWSS-A	1.000	-	-	-	-	-	-	-	-	-	-
(2) EMWSS-A	.528**	1.000	-	-	-	-	-	-	-	-	-
CS-A											
(3) Compassion	.247**	.132**	1.000	-							
(4) Disconnectedness	-.172**	-.110**	-.439**	1.000	-	-	-	-	-	-	-
PANAS											
(5) Positive affect	.372**	.257**	.152**	-.033^{NS}	1.000	-	-	-	-	-	-
(6) Negative affect	-.428**	-.276**	.001^{NS}	.133**	-.095*	1.000					
DASS-21											
(7) Depression	-.560**	-.368**	-.042^{NS}	.149**	-.303**	.649**	1.000	-	-	-	-
(8) Anxiety	-.398**	-.297**	.007^{NS}	.122**	-.100**	.618**	.698**	1.000			
(9) Stress	-.450**	-.289**	.009^{NS}	.099**	-.148**	.675**	.789**	.780**	1.000	-	-
PCS											
(10) Reactive agression	-.253**	-.205**	-.233**	.264**	NS	.202**	.206**	.251**	.256**	1.000	-
(11) Proactive Agression	-.206**	-.170**	-.281**	.313**	NS	.181**	.134**	.175**	.169**	.730**	1.000

Note. CEWSS-A - Current Experiences of Warmth and Safeness Scale for adolescents; EMWW-A – Early Memories of Warmth and Safeness Scale for adolescents; CS-A – Compassion Scale-Adolescents; PANAS - Positive and Negative Affect Schedule; DASS-21 - Depression Anxiety and Stress Scales; PCS - Peer Conflict Scale

NS nonsignificant; ** $p < 0.01$; * $p < 0.05$.

It is also noteworthy that the correlations between early memories of warmth and safeness and the remaining variables followed a similar pattern of associations of the current experiences of warmth and safeness and the external variables. Nevertheless, the magnitude of the correlations is always stronger for the current experiences scale.

Test-retest reliability

Spearman correlation values between the scores of CEWSS-A at time 1 and 2 (retest) revealed an acceptable value in the community ($r = .623$, $p < .001$) and at-risk samples ($r = .768$, $p < .001$).

Discussion

The present study includes the development and validation of the Current Experiences of Warmth and Safeness Scale for Adolescents (CEWSS-A), within a Portuguese sample of community and residential care adolescents. This new measure was designed to assess how frequently adolescents feel soothed, safe, connected, and warm in their current relationships. The CEWSS-A was built from the 21 items of the Early Memories of Warmth and Safeness Scale (EMWSS-A). Items were re-written in order to describe current experiences and a brief 12-item version of the CEWSS-A was proposed, based on theoretical and statistical criteria. The 12-item CEWSS-A presented a one-factor model solution, achieving a good fit for the data in all samples. Findings revealed an excellent internal consistency and acceptable test-retest reliability for a one-month time interval in both community and at-risk adolescents.

Considering that interpersonal experiences of care, warmth and safeness have been found to be linked to psychological adjustment (Matos et al., 2013; Richter et al., 2009), and that adolescence is a period of relevant biopsychosocial changes and increased vulnerability for the emergence of psychopathology (Polanczyk et al., 2015; Steinberg, 2005), investigating caring experiences throughout this developmental stage may provide useful information on how adolescents perceive and feel their relationships, namely adolescents presenting psychological and social vulnerabilities, as is the case of youth placed in residential care facilities (Campos et al., 2019; Wallis & Steele, 2001).

Caring experiences have already been studied retrospectively as emotional memories of childhood, through research conducted with the EMWSS-A, aiming the assessment of emotional memories of affiliative experiences (Cunha et al., 2014; Richter et al., 2009; Vagos et al., 2017). However, there was not any available measure designed to assess experiences of warmth and safeness within adolescents’ current relationships.

Since a one-factor solution had formerly been proposed as an adequate measurement model for the EMWSS, with adult (Richter et al., 2009) and adolescent samples, either from the community (Cunha et al., 2014; Vagos et al., 2017), as from the child protection care services and juvenile justice facilities (Vagos et al., 2017), the CEWSS-A was assumed to feature a unidimensional measurement model. A CFA procedure confirmed that the 12-item scale presented a one-factor measurement model, achieving an adequate internal consistency in the different samples. Additionally, the CEWSS-A measurement model proved to be group and gender invariant, thus allowing valid comparisons between adolescents from different samples (Chen, 2007).

Findings showed that adolescents from the community sample reported higher frequency of warmth and safeness experiences, when compared with adolescents from residential care facilities (medium effect size). Adolescents placed in residential care seemed to express more difficulties in feeling safe and cared within their current relationships. Comparisons between samples were also made for each gender separately. Boys from RCH reported a lower frequency of current experiences of warmth and safeness when compared with boys from the community, and girls showed a similar pattern (medium effect sizes).

These findings may be tied, at least partially, with the current living environments (i.e., family vs residential care homes). Despite residential care facilities efforts to simulate as much as possible a family environment, care provision is not consistently tailored, and the stability and responsiveness of caregivers is reduced due to the low ratio of caregivers per adolescent and the high turnover (Rushton & Minnis, 2008). Thus, residential care workers may have difficulties in promoting significant emotional experiences (Campos et al., 2019). This might mean that these adolescents have fewer opportunities to activate their soothing system, as a healthy way to regulate threat related emotions, usually more prominent given the amount of early toxic experiences they were exposed to (e.g., abandonment, neglect, emotional deprivation and abuse; Gilbert, 2010), increasing their vulnerability for the development of mental health problems (Mota et al., 2016). Also, adolescents placed in RCH were taken away from their families due to either neglect and/or abusive relationships with primary caregivers, having experienced less consistent levels of nurturance and emotional warmth, as well as fewer secure attachment in earlier relationships (Tahirović & Jusić, 2016; Vagos et al., 2017). Consequently, they are more prone to possess an underdeveloped soothing system, making it harder to feel safe, soothed and reassured in their present relationships, and thus failing to perceive, seek out, and/or trust in others (Gilbert, 2015).

In fact, in this study, the CEWSS-A showed positive correlations with a measure of early memories of warmth and safeness, suggesting that adolescents' memories of their earlier relationships with primary caregivers are associated with their current view of relationships as being warmth and caring.

Differences between genders were found in both samples (community and at-risk adolescents), with boys reporting higher frequency of current caring experiences when compared to girls (small effect sizes). These findings might be related with girls' greater investment in social relationships (Rueger et al., 2010), revealing more vulnerability to interpersonal relations. This may mean that girls tend to show more concerns about the quality and maintenance of their interpersonal relationships, tending to experience more feelings of loneliness and helplessness, fears of abandonment, and desires for intense closeness (Leadbeater et al., 1999). These findings may also relate to how boys and girls perceive and use social support as a coping strategy (Rueger et al., 2010). While girls are more likely to seek support from others, boys tend to resort more to avoidance or physical recreation (Eschenbeck et al., 2007).

Regarding the association between current experiences of warmth and safeness and other external variables, associations followed the expected directions, supporting that these experiences are significantly associated with measures of psychological (mal)adjustment. Adolescents reporting more experiences of warmth and safeness with others, also reported higher positive affective states and showed to be more compassionate towards others. They also tended to experience less negative affective states, engage less in proactive/reactive aggressive behaviours, and feel less psychological distress and less disconnection from others. These findings are in line with the affect regulation systems theory (Gilbert, 2010). As stated before, experiences of warmth and safeness with others are positively associated with positive affect and negatively associated with negative affect. Affiliative experiences may trigger the soothing system, which enhances specific positive affective states (e.g., warmth), and tones down the negative affect (e.g., fear) associated with the activation of the threat system.

Regarding associations with psychopathological symptoms, current experiences of warmth and safeness were negatively associated with both internalizing and externalizing problems. Particularly, negative associations of moderate magnitude were found between current experiences of warmth and safeness and depressive and stress symptoms. These findings are in line with previous research, stating that the way adolescents experience their interpersonal relationships has a significant impact over the development of internalizing disorders (Leadbeater et al., 1999). Also, current caring experiences showed to be negatively

associated with aggressive behaviour, which can be conceptualized as an externalizing defensive response of the threat system (Gilbert, 2010). These findings support the idea that, not only the recalling of feeling soothed, reassured, warmth, safe as a child (Cunha et al., 2014; Matos et al., 2013; Richter et al., 2009; Vagos et al., 2017), but also current affiliative experiences with others, may function as triggers of the soothing system, which regulates negative affective states and behaviours associated with the activation of the threat system (Gilbert et al., 2006; Kelly & Dupasquier, 2016). Thus, throughout the human development (at least until adolescence), caring and supporting experiences seem to maintain a relevant role in affect and behaviour regulation.

Findings from previous research suggest that the soothing system sets the base for individuals' capacity for compassion (Kelly & Dupasquier, 2016). In this study, current experiences of warmth and safeness revealed a positive association with compassion and a negative one with disconnectedness. When individuals feel safe with others, they might feel more comfortable sharing their difficulties and seeking support in difficult times, thereby being more open and connected with others (Gilbert et al., 2011). Additionally, a compassionate posture is recognized as an important skill to cope with life struggles in an adaptive manner and to avoid more severe and persistent psychosocial difficulties, being associated with well-being and better treatment response (Gilbert, 2010). This may be particularly relevant for at-risk adolescents.

The CEWSS-A could be relevant for research as for clinical purposes. Current interpersonal experiences based on nurturance, warmth, and safeness may play a relevant role on emotion regulation and may function as a protective factor over psychopathology, namely internalizing disorders. Given the major impact of such disorders on disease burden and suicide during adolescence (WHO, 2018), particularly among girls, who tend to reveal more emotional problems, both in residential care (Campos et al., 2019) and in community samples (Verhulst et al., 2003), current affiliative experiences should be further investigated concerning their relationship with different psychopathologies.

The CEWSS-A can be useful in clinical and care settings, informing about adolescents' perception of their current relationships and sense of safeness. Furthermore, this tool can be useful when assessing intervention outcomes, namely the impact of therapeutic interventions designed to stimulate the soothing system (i.e., Compassion Focused Therapy). Concerning residential care settings, it seems fundamental that adolescents in RCH could have a significant caregiver, who has been properly trained to play a role in trauma recovery and in promoting positive change through nurturant relationships (Bravo & del Valle, 2003). In this sense, the

CEWSS-A could be used to assess if adolescents do feel soothed, safe, warmth and cared for by caregivers, functioning as a relational quality estimator, allowing to assess the impact of residential care interventions.

This study is not free of limitations. Since this is the first study examining the factor structure and psychometric properties of a new tool, future research should confirm current findings with different samples and within different settings and cultures. Findings from adolescents in residential care facilities may not generalize to at-risk adolescents from other settings. Other at-risk adolescents, living in their parents' house or in a different setting, may answer to the CEWSS-A in a different manner. Future research should also explore to what extent early childhood memories of warmth and safeness might influence current caring experiences during adolescence. Finally, this scale was developed and validated in Portuguese; thus, its structure and measurement invariance should be investigated in other languages.

In conclusion, and taking into consideration the psychometric properties of the CEWSS-A, this measure can be used as a brief, valid and reliable tool to assess current experiences of warmth and safeness in community and at-risk adolescents from both genders.

Summary

CEWSS-A is a new measure designed to assess the adolescents' perception of current experiences of warmth and safeness. Its dimensionality and psychometric properties (i.e., measurement invariance, test-retest reliability and validity in relation to external variables) were investigated, using a Portuguese sample of 772 adolescents (49% boys and 51% girls, with a mean age of 15.62 years old), from the community and residential care facilities. A confirmatory factor analysis supported a 12-item unifactorial scale with good fit for the data from all samples. The CEWSS-A showed an adequate internal consistency in the different samples ($\alpha > .92$), acceptable temporal stability in the community ($r = .623$) and the at-risk ($r = .768$) samples, and construct validity in relation to external variables (i.e., early memories of warmth and safeness, compassion, negative and positive affect, aggressive behaviour and internalizing symptoms). The measurement model proved to be invariant across gender and samples. Community adolescents reported a higher frequency of current experiences of warmth and safeness in comparison with residential care participants, and boys scored significantly higher than girls, within each sample. This new measure can bring important contributions for research and clinical practice, providing a deeper understanding about the impact of this kind of caring experiences in the adolescents' psychological functioning.

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Compliance with Ethical Standards

Ethics approval: This research received approval from the Ethics Committee of the Faculty of Psychology and Educational Sciences of the University of Coimbra (CEDI22.03.2018) and the Portuguese General Directorate of Education (n. º0638900001). All procedures performed in this study were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards.

Informed Consent: Adolescents aged between 14 and 16 years old gave informed assent, while the older than 16 years old gave written informed consent. A written informed consent was also gathered from parents/legal representatives of all adolescent participants under 18 years old.

Conflicts of Interest: The authors declare that they have no conflict of interest.

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Authors' Contributions

Laura Santos: Conceptualization, Methodology, Investigation, Resources, Formal analysis, Writing - Original Draft, Review & Editing, Funding acquisition. **Rúben Sousa:** Formal analysis, Writing - Review & Editing. **Maria do Rosário Pinheiro:** Writing - Review. **Daniel Rijo:** Writing - Review & Editing.

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CAPÍTULO 6

MEMÓRIAS PRECOCES E EXPERIÊNCIAS ATUAIS DE CUIDADOS E SEGURANÇA:

IMPACTO NO SOFRIMENTO PSICOLÓGICO DOS ADOLESCENTES

Estudo Empírico III

Impact of early memories and current experiences of warmth and safeness on adolescents' psychological distress

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Impact of early memories and current experiences of warmth and safeness on adolescents' psychological distress

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Abstract

A variable-centered and a person-centered approach were performed to examine the role of early memories of warmth and safeness (EMWS) and current experiences of warmth and safeness (CEWS) on depressive and anxious symptoms among adolescents from community and residential youth care (RYC) settings. Variable-centered results revealed EMWS were only indirectly (through CEWS) associated with depressive and anxious symptoms. Person-centered outcomes allowed to identify four different profiles based on EMWS and CEWS, that differed on depressive and anxious symptoms. EMWS and CEWS seem to play an important role in psychological distress during adolescence. CEWS seem to have a protective role on RYC adolescents' psychological distress, even when EMWS were poor.

Keywords: adolescents; affiliation; latent profile analysis; psychological distress; residential youth care; structural equation modelling.

Introduction

It is well established that attachment and early affiliative relationships with primary caregivers have crucial effects over mental health across the lifespan (Bowlby, 1988; Mikulincer & Shaver, 2020; Rohner & Britner, 2002). Recent research suggested that not only early affiliative relationships, but also current affiliative relationships may play an important role on mental health (Depue & Morrone-Strupinsky, 2005; Nguyen, Phillips, Rodriguez, Young & Ramdass, 2022; Piña-Watson & Castillo, 2015; Rindlaub, 2015). This seems particularly relevant throughout adolescence, considered as a critical developmental stage in which relationships achieve particular relevance (Compas et al., 2017). In addition, several mental health problems may arise during adolescence, including depressive and anxious symptoms/disorders (Polanczyk, Salum, Sugaya, Caye, & Rohde et al., 2016; Rapee et al. 2019), which constitute a major concern due to its possible relationship with suicide at this developmental stage (WHO, 2018). Adolescents placed in residential youth care (RYC) tend to present higher mental health problems than youth living with their families (Jozefiak et al., 2016), as most of them were raised in environments marked by adverse experiences and by the lack of warmth and safeness experiences with their primary caregivers (Fischer, Dölitzsch, Schmeck, Fegert, & Schmid, 2016). Although affiliative relationships during adolescence appear to have a buffering impact on mental health (Depue & Morrone-Strupinsky, 2005; Rindlaub, 2015), there is a lack of research exploring the impact of both early memories of warmth and safeness (EMWS) and current experiences of warmth and safeness (CEWS) on mental health outcomes, including depression and anxiety.

The relationship between attachment and mental health is well well-known from the literature (Bowlby, 1988). A secure attachment, marked by early affiliative relationships of warmth, love, care, and affection, is central to the child’s healthy development, affect regulation, mental health, and positive social relationships across life (Mikulincer & Shaver, 2020; Siegel, 2012). By providing care and warmth experiences, parents act in a reassuring way, creating emotional memories of safeness and teaching children to trust others and to be able to be self-reassuring in stressful times (Gilbert, Baldwin, Irons, Baccus, & Palmer, 2006; Kelly & Dupasquier, 2016). In contrast, an insecure attachment, marked by adverse rearing experiences (e.g., abuse, neglect, lack of warmth and safeness) has been found to associate with increased vulnerabilities to psychopathological symptoms and disorders (Castilho, Pinto-Gouveia, Amaral, & Duarte, 2014; Irons, Gilbert, Baldwin, Baccus, & Palmer, 2006). Therefore, in stressful situations, these children have difficulties in recalling emotional memories of safeness, in being

self-reassuring, and/or in resorting to others for support and soothing, increasing their odds of developing mental health problems (Irons & Gilbert, 2005).

Adolescence is a period of profound and rapid developmental changes at different levels (e.g., anatomical, hormonal, cognitive, behavioral), during which there is an increased risk for mental health problems, including depressive and anxious symptoms and disorders, mostly for those raised in adverse environments (Compas et al., 2017; Polanczyk et al., 2016; Rapee et al. 2019). During this stage, developmental changes in affiliation (e.g., group identification, volatility and complexity of relationships) are a core normative task linked to emotion regulation and psychological adjustment (Compas et al., 2017). On the one hand, safe and supportive affiliative relationships stimulate relaxed attention, positive affect, emotion regulation, well-being, and mental health (Compas et al., 2017; Piña-Watson & Castillo, 2015; Rohner & Britner, 2002). On the other hand, both adverse early experiences and poor current relationships seem to contribute to increased emotion dysregulation, mental health problems, and decreased quality of life (Kouros & Garber, 2014; Rapee et al. 2019). Adolescents who were neglected, abused or have suffered withdrawal of love during childhood have a limited view of others as helpful and reassuring, and struggle in connecting with and trusting in others (Gilbert et al., 2006; Kelly & Dupasquier, 2016).

A significant proportion of adolescents in RYC were exposed to abuse, neglect, or parental loss, which prompted their placement outside their family home (Indias, Arruabarrena, & Paul, 2019). Linked with these disturbances, most adolescents in RYC exhibit high prevalence of traumatic experiences and suffer from emotional problems, including depression, anxiety, and/or emotional detachment (Fischer et al., 2016; Jozefiak et al., 2016; Moses, 2000). Additionally, many of these youth may experience an increased susceptibility for further wounds associated with disruptions in RYC (e.g., multiple caregivers and placement changes), which negatively impact over their already poor mental health (Villodas, Litrownik, Newton, & Davis, 2016).

According to research, positive and supportive relationships with significant others (e.g., offering a sense of safeness, and psychological resources to deal with adversities) may contribute to buffer the detrimental effects of adverse early life experiences over mental health, particularly during adolescence (Ferreira, Magalhães, & Prioste, 2020; Rindlaub, 2015; Singstad, Wallander, Lydersen, Wichstrøm, & Kayed, 2020).

Research also reports sex differences regarding this topic. While the recall of early memories of warmth and safeness seems to be equivalent between sexes (Cunha, Xavier, Martinho, & Matos, 2014; Vagos, Silva, Brazão, Rijo, & Gilbert, 2017), girls from the community

and those living in RYC tend to perceive others as less warmth and caring when compared with boys from the community and from RYC settings, respectively (Santos, Sousa, Pinheiro, & Rijo, 2021). Additionally, when compared to boys, girls tend to display a greater amount of mental health problems, namely depression and anxiety, both in the community (Abad, Forns, & Gómez, 2002), as in RYC settings (Campos, Barbosa Ducharne, Rodrigues, Martins, & Leal, 2019; Jozefiak et al., 2016).

Research also showed that adolescents in RYC have less EMWS, perceive fewer CEWS, and present more psychopathology (including depressive and anxious symptomatology; Greeson et al., 2011) than their community peers (Campos et al., 2019; Jozefiak et al., 2016; Santos et al., 2021; Vagos et al., 2017), keeping them as vulnerable group (Indias et al., 2019). Research within RYC settings suggests that social support plays an important role in the psychological functioning of youth in care (Degner, Henriksen, Ahonen, & Oscarsson, 2014). Professional caregivers, as agents of change (i.e., parental, therapeutic, and social functions), have the potential to create opportunities for adolescents to engage in meaningful relationships in a supportive environment of safeness and growth (Quiroga & Hamilton-Giachritsis, 2016; Singstad et al., 2020; Sellers, Smith, Izzo, McCabe, & Nunno, 2020). However, besides the difficulties of these adolescents to trust and form relationships with others, there are also contextual factors that usually contribute to hamper the establishment of close relationships between caregivers and adolescents. These may include the small number of staff members per youth, the working shifts, turnover, and the regimented schedules (Quiroga & Hamilton-Giachritsis, 2016). In a study conducted by Campos et al. (2019), only half of the youths in RYC were able to identify a significant caregiver with whom they could establish a close, trustworthy, and meaningful relationship. Thus, difficulties in experiencing warm and safe relationships may persist inside and outside home (Singstad et al., 2020).

Using community and RYC adolescent samples from both sexes, the current work employed variable- and person-centered approach to examine the impact of both EMWS and CEWS on depressive and anxious symptoms.

Within the variable-centered approach, this study aimed to test a model involving pathways linking the impact of EMWS and depressive and anxious symptoms, as well as the indirect effects of CEWS in that association, also considering invariance across samples (i.e., community and RYC) and sexes. We hypothesized that EMWS would have a negative direct and indirect (through CEWS) association with depressive and anxious symptoms (Cunha et al., 2014; Irons & Gilbert, 2005; Richter, Gilbert, & McEwan, 2009; Vagos et al., 2017). In addition, it is expected that the RYC sample would display fewer EMWS and CEWS (Santos et al., 2021; Vagos

et al., 2017) and increased levels of depressive and anxious symptoms, when compared with the community sample (Campos et al., 2019; Jozefiak et al., 2016). A similar pattern is expected for girls of both samples, when compared with boys within each sample (Abad et al., 2002; Campos et al., 2019; Santos et al., 2021; Rapee et al. 2019).

Within the person-centered approach, this study aimed to identify groups of adolescents in RYC based on their levels of EMWS and CEWS. This approach was used only with RYC adolescents, considering they are a vulnerable group with specific intervention needs. Finally, we compared the profiles of the RYC sample on depressive and anxious symptoms. We expected to find a subgroup of adolescents with both few EMWS and CEWS, another subgroup of adolescent with both high EMWS and CEWS. Mixed subgroups were also expected. Adolescents with both few EMWS and CEWS were expected to be the ones presenting greater amount of depressive and anxious symptoms than any other profile, whereas the profile with high EMWS and CEWS was expected to be the one presenting fewer depressive and anxious symptoms (Santos et al., 2021; Vagos et al., 2017).

Variable- and person-centered approach are considered complementary methods that, together, provide a comprehensive picture of how variables differ across and within youth, which is crucial in several research areas, particularly in the study of adverse life experiences as it may provide recommendations for policies and practices with both families and child services (Mervielde & Asendorpf, 2000; O'Donnell et al., 2017).

Methods

Participants

Participants were 726 adolescents (51.8% female) (i.e., combined sample), 433 from the community (59.6%) (i.e., community sample) and 293 from residential care facilities (40.4%) (i.e., Residential Youth Care sample; RYC). These samples were equally distributed by sex ($\chi2(1) = .001$, $p = .969$). Participant’s mean age was 15.60 years old ($SD = 1.26$; age ranging from 14-18 years old). Adolescents in RYC ($M = 15.84$; $SD = 1.26$) were significantly older than those in the community ($M = 15.43$, $SD = 1.23$); $t(724) = -4.429$; $p < .001$. On average, participants had completed 9.49 school years ($SD = 1.41$), with adolescents in RYC having completed, on average ($M = 9.01$, $SD = 1.63$), significantly less schooling than community adolescents ($M = 9.82$, $SD=1.13$); $t(723) = 7.873$, $p < .001$. Regarding socioeconomic status (SES), 421 (58%) participants had a low SES, 227 (31.3%) had a medium SES, and 21 (2.9%) had a high SES. RYC participants were of a lower SES than their community peers ($\chi2(2) = 33.842$, $p < .001$).

Within the complete sample, boys (M = 15.53; SD = 1.22) and girls (M = 15.65; SD = 1.30) had similar mean ages (t(724) = −1.317, p = .188), and were similarly distributed by socioeconomic status (SES; $\chi2(2)$=1.282, p = .527). On average, girls (M = 9.62; SD = 1.40) had completed significantly more school years than boys (M= 9.35, SD = 1.41); t (724) = −2.556, p = .011).

The community sample was composed by 209 boys (48.3%) and 224 girls (51.7%), with similar mean age (t(431) = -1.515; p = .130; for boys M = 15.33, SD = 1.16, and for girls M = 15.51, SD = 1.28), number of school years (t(431) = -1.565, p = .118; for boys M = 9.73, SD = 1.07, and for girls M = 9.90, SD = 1.18) and SES ($\chi2(2)$ = 2.243, p = .326).

The RYC sample was composed by 141 boys (48.1%) and 152 girls (51.9%), who had been placed in 34 Portuguese residential care homes (RCH), for an average of 35 months (SD = 37.66, ranging from 0 to 204 months). Before their institutionalization in the current RCH, 55.3% (n = 162) of participants had lived at least with one of their parents, 11.3% (n = 33) with other relatives, and 0.3% (n = 1) with adoptive parents. Ninety-two participants (31.4%) had previously lived in another RCH. Within the RYC sample, no significant differences between sexes were found regarding age (t(291) = -.265; p = .791; for boys M = 15.82, SD = 1.23, and for girls M = 15.86, SD = 1.30) and SES ($\chi2(2)$ = .685, p = .710). Girls had completed more school years than boys (t(290) = -2.163, p = .031; for boys M = 8.79, SD = 1.65, and for girls M = 9.21, SD = 1.60).

A subsample of youth from the RYC sample was then used to perform the LPA, i.e., 253 RYC adolescents: 121 boys (47.8%) and 132 girls (52.2%), aged between 14 and 18 years old (M = 15.86, SD = 1.27). The remaining 40 adolescents from the RYC sample were excluded due to missing data in the variables used to form the profiles.

Measures

Early Memories of Warmth and Safeness Scale - Adolescents (EMWSS-A; Richter et al., 2009; Portuguese version for adolescents by Cunha et al., 2014)

The EMWSS-A is a 21-item self-report questionnaire designed to measure the recall of feeling warm, safe, and cared for in childhood (e.g., "I felt that I was a cherished member of my family"). Participants are asked to rate how frequently each item applied to them in their childhood, using a 5-point scale (0 = No, never, to 4 = Yes, most of the time). The original version for adults revealed a one-factor solution, with excellent internal consistency (α =.97) and good test-retest reliability (*r* = .91) (Richter et al., 2009). The Portuguese version for adolescents confirmed a unifactorial structure, with excellent internal consistency value (α = .95), good test-retest reliability (*r* = .92) (Cunha et al., 2014), and measurement invariance across sex and groups

(i.e., community, RYC and juvenile justice) (Vagos et al., 2017). In this study, the internal consistency values were .96 for the community and .98 for the RYC samples.

Current Experiences of Warmth and Safeness Scale for adolescents (CEWSS-A; Ritcher et al., 2009; adapted by Santos et al., 2021)

CEWSS-A is a 12-item self-report questionnaire designed to assess how often adolescents felt emotional experiences of care, warmth, and safeness with others, along the two previous weeks (e.g., "I have been feeling that others cared about me"). CEWSS-A was developed from the EMWSS-A, and have been validated with adolescents from the community and from RYC settings. Items are answered using a 5-point scale (0 = No, never, to 4 = Yes, most of the time). The CEWSS-A presented a single factor structure, with an excellent internal consistency value (α = .94) in both samples, and an acceptable test-retest reliability in the community (r = .62) and RYC samples (r = .77). Measurement invariance was found across sexes and groups (Santos et al., 2021). In this study, the internal consistency values were .94 for the community and .95 for the RYC samples.

Depression, Anxiety and Stress Scales (DASS-21; Lovibond & Lovibond, 1995; Portuguese version by Pais-Ribeiro, Honrado, & Leal, 2004)

DASS-21 is a 21-item self-report questionnaire designed to assess symptoms of depression (e.g., "I felt sad and depressed"), anxiety (e.g., "I experienced breathing difficulty), and stress (e.g., "I tended to over-react to situations"). Participants are asked to rate how much each statement applied to them during the previous week, using a 4-point scale (0 = not apply at all to me, to 3 = applied to me most of the time). In the original version, the DASS-21 subscales presented high internal consistency (Depression α = .91, Anxiety α = .84, and Stress α = .90; Lovibond & Lovibond, 1995). The Portuguese version showed good internal consistency (Depression α = .85, Anxiety α =. 74 and Stress α = .81; Pais-Ribeiro et al., 2004). Given the focus of the current study on depression and anxiety, only those two subscales were included. In the community sample, the internal consistency values were .88 for Depression and .82 for Anxiety. For the RYC sample, internal consistency values were .86 for Depression and .84 for Anxiety.

Procedures

Ethical approvals were collected from the Ethics Committee of the Faculty of Psychology and Educational Sciences of the University of Coimbra (CEDI22.03.2018) and the Portuguese Education General Directorship (n. º 0638900001). Research aims were explained to institutions' boards, and authorizations were gathered. Data from the community sample was collected in eight schools and four sports/recreational groups based on convenience; data from the RYC

sample was collected in 34 RCHs. In both samples, eligibility criteria for participants included: having 14 to 18 years old and no suspect of cognitive impairment (identified by school or RYC psychologists). Adolescents who accepted to voluntarily participate provided their written informed consent. Written informed consent was also obtained from parents/legal guardians in both samples. In the community sample, data was collected in groups during class time or drills in the presence of the researcher. In the RYC sample, data was collected after school in small groups with the assistance of a researcher. Confidentiality and anonymity of responses were assured.

Data analysis

Data were analysed with the IBM SPSS Statistic 25 (for the initial statistical analysis) and Mplus v8.0 (for variable-centered and person-centered analyses).

Little's (1988) MCAR tests revealed that data in some variables were not missing completely at random ($p < .05$). Full information Maximum Likelihood estimation was used to deal with missing values (Muthén & Muthén, 2012).

The Mardia's Test indicated that data were not multivariate normal (Korkmaz, Goksulik, & Zararsiz, 2014). Consequently, analyses were conducted using the Maximum Likelihood Robust estimator and Spearman correlations were performed to explore the association between variables under study. Differences between gender and groups were checked via independent samples t-tests. The effect sizes were calculated, using Cohen's d, with .15 indicating a small effect, .36 a medium effect, and .65 a large effect (Lovakov & Agadullina, 2021).

For the variable-centered analyses (Structural equation modelling; SEM), early memories of warmth and safeness (EMWSS-A) was posited as the independent variable and depressive and anxious symptoms (DASS-21) as dependent variables. Indirect effects between independent and dependent variables were considered, through current experiences of warmth and safeness (CEWSS-A).

SEM was performed for the complete, RYC, and community samples. In addition to the chi-square test of model fit, additional goodness-of-fit indices were selected according to the two-index approach provided by Hu & Bentler (1999): Standardized Root Mean Square Residual (SRMR) ≤ .09 combined with either a Comparative Fit Index (CFI) ≥ .95 or a Root Mean Square Error of Approximation (RMSEA) ≤ .06. The most statistically significant model was further tested for structural invariance between samples and sexes, in terms of patterns (i.e., unrestrictive model), pathways (i.e., path constraint model), and factor means (i.e., mean constraint model);

invariance was established if successive equality constraints did not significantly worsen the chi-square.

Concerning person-centered analyses (Latent profile Analysis; LPA), EMWSS-A and CEWSS-A were used to define the profiles for the RYC sample. The first stage in LPA was to determine the number of classes with well-defined differentiated profiles, through the performance of a series of modelling steps starting with the specification of a one class model. The number of classes was then subsequently increased until there was no further improvement in the model; adjustment and decision about the model were judged by the guidelines proposed by Ram and Grim (2009). First, models with different numbers of classes were compared using Information Criteria fit statistics (i.e., Bayesian Information Criteria – BIC, Schwartz, 1978; Akaike Information Criteria – AIC, Akaike, 1987; and Sample-Size-Adjusted BIC - SSA-BIC, Sclove, 1987), with lower values indicating a better model fit. Second, entropy values, which assess the accuracy with which models classify individuals into their most likely class, were also examined; entropy values greater than .70 indicate clear classification and greater power to predict class membership (Muthén, 2001). Third, the statistical significance was tested resorting to the Lo-Mendell-Rubin test (LMR; Lo, Mendell, & Rubin, 2001) and the Bootstrap Likelihood Ratio Test (BLRT; McLachlan & Peel, 2004), in order to determine whether a more complex model (k classes) would fit the data significantly better than a more parsimonious model (k – 1 classes). For statistical model comparisons, the BLRT is preferred over the LMR test (Nylund, Asparouhov, & Muthén, 2007). Fourth, classes' sample sizes were evaluated; models with a class of <1% and/or numerically $n < 25$ members should be rejected or grounded by theory and research (Bauer & Curran, 2004). Finally, the average probabilities of class membership were assessed, considering a good class solution when equal or larger than .80 (Rost, 2006).

After determining the optimal number of classes, significant mean differences on outcome variables across profiles were tested, using the auxiliary variable function in Mplus. The modified BCH method (Bakk & Vermunt, 2016) was selected to examine the relationship between profiles and continuous outcomes (depressive and anxious symptoms) across latent profiles.

Results

Variable-centered (SEM) results

The baseline model was tested through a fully saturated model (i.e., zero degrees of freedom), including depressive and anxious symptoms as dependent variables. Considering usual comorbidity and correlation values between depression and anxiety (cf., Table 1),

correlations between dependent variables were included in the model. EMWS were entered as the independent variable associated with depressive and anxious symptoms either directly or indirectly (through CEWS).

Table 1. *Correlations between variables and descriptive measures for boys and girls from the Complete, the Community and RYC samples*

					Complete (n = 726)					Community (n = 433)					RYC (n = 293)						
	1	2	3	4	total	boys	girls	t	d	Total	boys	girls	t	d	total	boys	girls	t	d	t*	d
1.CEWS	-	-	-	-	34.51	35.83	33.30	3.240**	.25	37.08	38.29	35.97	2.795*	.28	30.58	32.02	29.26	1.989*	.24	8.513**	.64
					(10.28)	(9.58)	(10.77)			(8.51)	(7.68)	(9.09)			(11.48)	(10.94)	(11.83)				
2.EMWS	.527**	-	-	-	61.56	64.23	59.08	3.406**	.27	67.69	68.88	66.59	1.663^{NS}	.17	52.74	57.55	48.24	3.368**	.41	10.410**	.79
					(19.59)	(17.28)	(21.25)			(13.65)	(12.95)	(14.21)			(23.18)	(20.33)	(24.80)				
3. Dep	-.564**	-.368**	-	-	5.68	4.81	6.48	-4.434**	.33	4.85	3.98	5.65	-3.685**	.36	6.92	6.06	7.72	-2.691*	.32	-5.456**	.41
					(5.08)	(4.83)	(5.17)			(4.76)	(4.61)	(4.75)			(5.29)	(4.90)	(5.52)				
4. Anx	-.398**	-.297**	.702**	-	4.76	3.95	5.52	-4.614**	.35	4.10	3.16	4.97	-4.571**	.45	5.75	5.12	6.33	-2.052*	.24	-4.779**	.36
					(4.61)	(4.18)	(4.87)			(4.18)	(3.42)	(4.62)			(5.04)	(4.89)	(5.13)				

Note. CEWS- Current Experiences of Warmth and Safeness; EMWS – Early Memories of Warmth and Safeness; Dep –Depression; Anx - Anxiety. Descriptive measures are presented as M (SD); t for comparisons between sex; t* for comparisons between samples; d for Cohen's d. ** p < .001, * p < .05, ns – nonsignificant.

This model was tested in the complete sample, presenting an oversaturated model with a nonsignificant pathway between EMWS and Depression. Thus, this path was removed, and the model was recalculated, achieving good fit indicators (model I) (Table with fit indicators for each model by samples and sexes on supplementary file). This model was tested in the community and in the RYC samples, taken separately, and the direct path between EMWS and Anxiety emerged as nonsignificant in both samples. For this reason, this path was further removed. These changes resulted in the modified model II, which achieved good fit indicators across samples. The model II and the variance of each dependent variable explained by this model for community and RYC adolescents are presented in Figures 1 and 2, respectively. EMWS were negatively and indirectly (through CEWS) associated with depressive and

anxious symptoms. Since model II fitted equally well in both samples, configural invariance was assumed and sample type moderating effect was investigated. The unrestrictive model presented a good fit when considering both samples at once. Regarding pathways constraint, only partial invariance was achieved ($\Delta\chi^2$ (1) = 2.90, p = .089), i.e., when 3 out of 4 pathways were allowed to differ between RYC and community samples (i.e., Depression on CEWS Community = -.578, p <.001; RYC = -.493, p <.001; CEWS on EMWS Community = .580, p <.001; RYC = .367, p <.001; Anxiety with Depression Community = .601, p <.001; RYC = .679, p <.001). As expected, given the different mean scores across samples (with medium to large effect sizes), the intercepts constraint significantly worsened the fit of the model, and the model was not mean invariant ($\Delta\chi^2$ (7) = 157.79, p < .001).

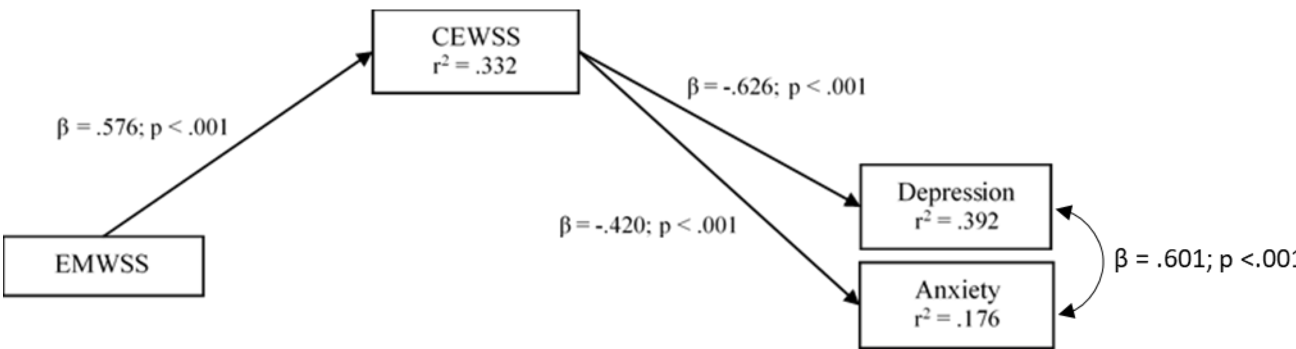

Figure 1. *Early memories of warmth and safeness and depression and anxiety, through current experiences of warmth and safeness (Model II in the community sample)*

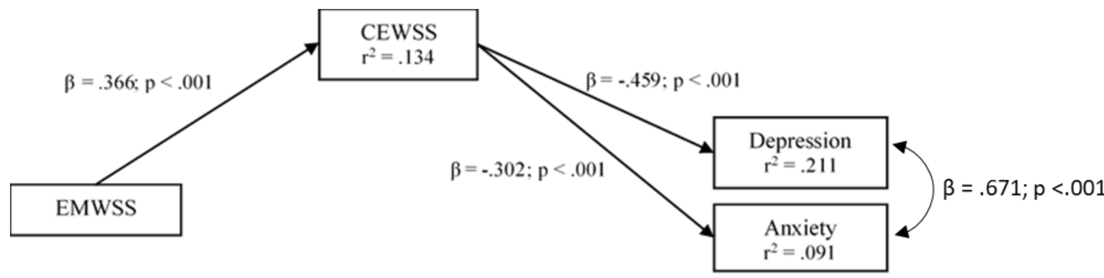

Figure 2. *Early memories of warmth and safeness and depression and anxiety, through current experiences of warmth and safeness (Model II in the RYC sample)*

To investigate sex moderating effects, model II was replicated for boys and girls within each sample. Model II fitted equally well for boys and girls of the community and the RYC samples, and so configural invariance was assumed. Moreover, the unrestrictive model also

presented a good fit when simultaneously considering boys and girls from the community sample, as well as boys and girls from the RYC sample.

Regarding adolescents from the community, although acceptable fit indicators were achieved when forcing an equality constraint on the structural weights of all pathways, model fit significantly worsened in comparison with the unrestrictive model ($\Delta\chi^2$ (4) = 10.70, p = .030). So, not all structural weights should be considered equal. In specific, 1 out of 4 pathways had to be allowed to differ between boys and girls within the community sample (i.e., Anxiety with Depression for boys = .570, p <.000; for girls = .624, p <.000), so that a nonsignificant change in model fit was achieved ($\Delta\chi^2$ (3) = 6.87, p = .076), indicating partial invariance at this level. As expected, due to the different mean scores between boys and girls (with small to medium effect sizes; see Table 1), the subsequent constraint of all variables' intercepts to be equal across sex significantly worsened the fit of the model, in comparison with the partially invariant pathway model ($\Delta\chi^2$ (5) = 25.85, p < .001). Partial invariance was found, after allowing all intercepts to vary between boys and girls ($\Delta\chi^2$ (1) = 3.14, p = .076).

For the RYC sample, when forcing an equality constraint on the structural weights of all pathways, fit indicators did not worsen significantly, in comparison with the unrestrictive model ($\Delta\chi^2$ (4) = 8.52, p = .074). So, structural weights should be considered equal between boys and girls within the RYC sample. Again, and as expected due to the different mean scores across sex (with small to medium effect sizes; see Table 1), means were not invariant ($\Delta\chi^2$ (4) = 17.32, p < .001), indicating discrepancies between boys and girls at the mean level.

Person-centered (LPA) results

In order to identify the risk for depressive and anxious symptoms in the RYC sample, an LPA was conducted based on participants' answers to the CEWSS-A and the EMWSS-A. Table 2 shows the LPA model fit indicators. LPA findings suggest that a solution with latent profiles fits the data better than a unitary solution without latent profiles. A model with four-profiles was selected in accordance with Ram and Grim (2009) guidelines. Although the five-profile solution presented similar model fit indicators as the four-profile solution, some of the recommended guidelines were overstepped: the sample size of some classes was below the recommended thresholds (one class had 21 and another 23 subjects), and the average probabilities of class membership were also below the recommended thresholds (76% in two classes) (Bauer & Curran, 2004; Rost, 2006). A four-profile solution was also preferable over a three-profile solution, since its BIC, AIC and BIC - SSA-BIC indicators presented lower values. Despite the nonsignificant LMR value, the BLRT which is generally preferred over the LMR test, was significant (Nylund et al., 2007). Moreover, the sample size of the classes and the average

probabilities of class membership also supported the number of profiles (Bauer & Curran, 2004; Rost, 2006).

Table 2. *Model fit of the latent profile analyzes for the RYC subsample*

	Log-likelihood	Nº of free parameters	AIC	BIC	SSA-BIC	Entropy	LMR *p*	BLRT *p*
RYC sample (n = 253)								
1 Class	-725.969 (100/100)	4	1459.939	1474.072	1461.392	-	-	-
2 Classes	-679.341 (100/100	7	1372.682	1397.416	1375.225	.85	<.001	<.001
3 Classes	-671.643 (100/100)	10	1363.286	1398.620	1366.918	.80	.057	<.001
4 Classes	**-662.692 (100/100)**	**13**	**1351.384**	**1397.318**	**1356.106**	**.78**	**.285**	**<.001**
5 Classes	-652.403 (100/100)	16	1336.805	1393.339	1342.616	.78	.215	<.001

Note. AIC = Akaike Information Criteria; BIC = Bayesian Information Criteria; SSA-BIC = Sample-Size Adjusted BIC; LMR *p* = *p* value of the Lo-Mendell-Rubin adjusted test; BLRT *p* = *p* value of the Bootstrap Likelihood Ratio Test. Optimal model is highlighted in boldface.

Table 3 reports profile allocation based on maximum posterior probability and the EMWSS-A and CEWSS-A mean scores for the four latent profiles. Considering the combined frequency of EMWS and CEWS, the four classes were labelled as: +EM+CE, corresponding to high frequency of both EMWS and CEWS; +EM-CE, corresponding to greater frequency of EMWS and fewer CEWS; -EM+CE, corresponding to fewer EMWS and greater frequency of CEWS; -EM-CE, corresponding to low frequency of both EMWS and CEWS. The +EM+CE was the profile with the highest percentage of adolescents and the +EM-CE had the lowest percentage of adolescents.

Table 3. *Profile allocation based on maximum posterior probability for four latent profiles. Mean probabilities of latent profiles in the RYC subsample. Mean scores on the CEWSS-A and EMWSS-A.*

	N	%	Latent Profile*				EMWSS-A	CEWSS-A
			+EM+CE	+EM-CE	-EM+CE	-EM-CE		
+EM+CE	141	55.73	.92				3.20 (.09)	3.08 (.09)
+EM-CE	27	10.67		.85			2.98 (.16)	1.42 (.30)
-EM+CE	52	20.53			.79		1.44 (.26)	2.74 (.18)
-EM-CE	33	13.04				.86	.79 (.13)	1.34 (.22)

Note. +EM+CE = high levels of both early and current experiences of warmth and safeness; +EM-CE = more early memories and less current experiences of warmth and safeness; -EM+CE = less early memories and more current experiences of warmth and safeness; -EM-CE = low levels of both early memories and current experiences of warmth and safeness. Information for CEWSS-A and EMWSS-A descriptive statistics is presented as M (SE). * Average probabilities of profile membership.

Table 4 presents the relationships between the four profiles and depressive and anxious symptoms, as well as overall chi-square tests and chi-square statistics for pairwise differences between profiles. Results indicated that adolescents in the -EM-CE profile were at a higher risk

for depressive and anxious symptoms, and the ones from the +EM+CE profile were at a lower risk for these symptoms. Comparisons between profiles also showed significant differences between -EM+CE and -EM-CE for depressive and anxious symptoms, with -EM+CE significantly presenting fewer depressive and anxious symptoms than -EM-CE. Differences were also found between +EM+CE and +EM-CE; +EM+CE significantly presented fewer depressive symptoms than +EM-CE. Additionally, when comparing +EM-CE and -EM+CE, the +EM-CE profile had more probability of endorsing depressive symptoms than the -EM+CE profile.

Table 4. *Relationships of the four latent profiles to depressive and anxious symptoms*

	+EM +CE (n = 141)	+EM -CE (n = 27)	-EM +CE (n = 52)	-EM -CE (n = 33)	*χ2*	+EM+CE vs +EM-CE	+EM +CE vs -EM +CE	+EM +CE vs -EM -CE	+EM -CE vs -EM +CE	+EM -CE vs -EM -CE	-EM +CE vs -EM -CE
Dep	.69 (.06)	1.50 (.18)	.89 (.13)	1.64 (.16)	43.63 *p* <.001	16.84 *p* <.001	1.84 *p* =.175	32.26 *p* <.001	7.42 *p* =.006	.34 *p* =.557	11.25 *p* =.001
Anx	.61 (.06)	.94 (.15)	.84 (.14)	1.35 (.16)	22.66 *p* <.001	3.55 *p* =.060	2.09 *p* = .148	19.67 *p* <.001	.22 *p*=.638	3.60 *p* =.058	4.94 *p* =.026

Note. Analyzes were performed with BCH procedure. Dep = Depression; Anx = Anxiety; +EM+CE = high levels of both early and current experiences of warmth and safeness; +EM-CE = more early memories and less current experiences of warmth and safeness; -EM+CE = less early memories and more current experiences of warmth and safeness; -EM-CE = low levels of both early memories and current experiences of warmth and safeness. Information for relations of the four latent classes to continuous outcomes variables is presented as M (SE).

Discussion

To the best of our knowledge, this is the first study that used both variable- and person-centered methods to provide a comprehensive picture of how EMWS and CEWS differ across and within adolescents from the community and from RYC settings (Mervielde & Asendorpf, 2000).

The variable-centered approach (SEM) aimed to examine the indirect effect of CEWS on the relationship between EMWS and depressive and anxious symptoms, using both community and RYC samples of adolescents. Findings showed that EMWS were only negatively and indirectly (through

CEWS) linked with depressive and anxious symptoms, either in boys and in girls from the community and from RYC settings. This is contrary to previous findings, which found direct associations between poor-quality caregiving during childhood and mental health problems (Mikulincer & Shaver, 2020; O'Donnell et al., 2017). This seems to be an interesting finding, that can be explained, at least partially, by the measure used to assess early rearing experiences. In detail, the EMWSS-A assesses the recall of one feeling warm, safe, and cared for in childhood, which often differs from the objective experience of care *per se* (Castilho et al., 2014; Downey & Crummy, 2021; Irons et al., 2006; Gilbert et al., 2006; Richter et al., 2009; Vagos et al., 2017). Nonetheless, current findings support the hypothesis that the more one recalls warmth and safeness experiences during childhood, and also endorses this kind of experiences during adolescence, the less likely one is to present depressive and anxious symptoms. Thus, it seems that it is the continuous experience of lack of warmth and safeness during childhood and throughout adolescence that accounts for depressive and anxious symptoms both in community and RYC adolescents. Considering that some of the major developmental tasks during adolescence are orientated towards others (e.g., group identification, complexity of relationships) (Compas et al., 2017), these findings highlight the relevance that relationships of warmth and safeness during adolescence may play in buffering the impact of negative early experiences. These findings agree with previous research, which found warmth and support from others to be associated with lower rates of depression and anxiety (Kouros & Garber, 2014; Piña-Watson & Castillo, 2015; Rohner & Britner, 2002). They also reinforce that from birth and throughout all life stages, humans benefit from establishing caring relationships with others to whom they can turn for comfort and support, in order to regulate affective processes (Gilbert, 2015; Rindlaub, 2015).

Regarding sample type and sex differences, though configural invariance of this model was established, findings indicated some differences on pathways and/or mean scores across samples and sexes. In specific, when comparing community and RYC samples, the model was invariant regarding pathways (though partially), but not on mean scores. This was an expected outcome, considering the different samples' characteristics and findings from previous research showing that community adolescents presented lower mental health problems (Campos et al., 2019; Jozefiak et al., 2016) and higher perception of both EMWS and EMWS with others (Santos et.al, 2021; Vagos et al., 2017), when compared to RYC adolescents. Concerning sex differences in the community sample, results showed differences in one pathway and in mean scores of the variables under study. In detail, the correlation between anxiety and depression was more pronounced for girls than for boys. Regarding means, as it was found in previous studies

(Campos et al., 2019; Santos et al., 2021; Vagos et al., 2017), boys and girls from the community showed different mean scores in all variables under study (with small to medium effect sizes), with the exception of EMWS. This finding strengthens the argument that, although girls tend to recall the same levels of warmth and safeness in their childhood as boys (Cunha et al., 2014; Vagos et al., 2017), they tend to report less CEWS than boys, whereas boys tend to report less depressive and anxious symptom than girls (Abad et al., 2002; Campos et al., 2019; Santos et al., 2021). In line with research from developmental studies (Rohner & Britner, 2002), these findings may be indicative of specific gender vulnerabilities to the development and maintenance of depressive and anxious symptomatology during adolescence.

When comparing boys and girls within the RYC sample, results suggested that pathways leading to depressive and anxious symptoms were invariant across sexes, meaning that the processes linking EMWS and CEWS to depressive and anxious symptoms were consistent for boys as for girls. In turn, and as expected, results showed sex differences in mean scores for the variables under study (with small to medium effect sizes). In accordance with previous research (Campos et al., 2019; Jozefiak et al., 2016; Santos et al., 2021), adolescent girls from the RYC tended to show increased vulnerability for depressive and anxious symptoms, to recall less EMWS, and to experience less warmth and safeness in current relationships, in comparison with boys.

Taken together, findings from the variable-centered approach suggest that, during adolescence, EMWS may have a different impact over depressive and anxious symptoms across different types of samples and sexes, depending on the perception of CEWS with others. While CEWS seem to play a protective role on mental health, the lack of this kind of experiences appears to have a detrimental impact over mental health.

Regarding the person-centered approach (LPA), this method aimed to identify distinct subgroups of adolescents within RYC settings, based on their levels of EMWS and CEWS, and to examine and compare those profiles on depressive and anxious symptoms. The LPA allowed to identify a four latent profile solution in adolescents living in RYC: a profile with high scores of both EMWS and CEWS (+EM+CE; the one with the highest percentage of adolescents); a profile with high scores on EMWS and low scores on CEWS (+EM-CE; the one with the lowest percentage of adolescents); a profile with low scores on EMWS and high scores on CEWS (-EM+CE); and another profile with low scores on both EMWS and CEWS (-EM-CE). Approximately half of the sample fitted the +EM+CE profile. This is somehow in contradiction with the literature, showing that most adolescents in RYC came from adverse rearing environments and tend to reveal difficulties in connecting to and trusting in others (Moses, 2000; Quiroga &

Hamilton-Giachritsis, 2016). However, again, this could be explained by the nature of the measures used to assess EMWS and CEWS, both of which grasp the subjective perception of adolescents and not the experiences *per se* (Downey & Crummy, 2021; Richter et al., 2009; Santos et al., 2021; Vagos et al., 2017).

Regarding comparisons between the four profiles on depressive and anxious symptoms, several differences were found. Results showed that, as predicted, adolescents with lower levels of both EMWS and CEWS (-EM-CE) were the ones with the highest risk for depressive and anxiety symptoms. The profile showing more EMWS and less CEWS (+EM-CE) was the second profile expressing more risk for these symptoms, followed by the profile with less EMWS but more CEWS (-EM+CE), which presents a lower risk for depressive and anxious symptoms than the previous described profiles. Lastly, and also as expected, adolescents with higher levels of both EMWS and CEWS (+EM+CE) were the ones with the lowest risk for reporting both depressive and anxious symptoms.

When comparing profiles, the +EM+CE profile significantly differed from the -EM-CE on depressive and anxious symptoms; the same occurred when comparing -EM-CE vs. -EM+CE. In turn, depressive symptoms additionally differed when comparing +EM-CE vs. +EM+CE, and +EM-CE vs. -EM+CE. Anxious symptoms did not differ when comparing any other profiles. These findings are in line with the findings from the variable-centered approach. Both approaches support that the likelihood of having depressive and anxious symptoms is lower when adolescents in RYC recall higher levels of both warmth and safeness experiences during childhood and frequently experience those feelings in current relationships with others. Taken together, these findings agree with previous research findings, suggesting that the presence of both early and current experiences of warmth, affection, care, and love are protective factors against mental health problems (Irons & Gilbert, 2005; Rapee et al. 2019; Santos et al., 2021; Vagos et al., 2017). Noteworthy, it seems that CEWS play a protective role towards mental health outcomes, even when there is a lack of EMWS (Rindlaub, 2015; Santos et al., 2021). In fact, the +EM+CE profile did not differ from the -EM+CE on depressive and anxious symptoms; the same occurred when comparing the -EM-CE vs. the +EM-CE. In turn, the -EM+CE profile presented a significantly lower risk for depressive symptoms than the +EM-CE. This is also in line with the findings from the variable-centered approach, showing that EMWS were only indirectly linked to depressive and anxious symptoms when considering CEWS.

In sum, findings from both variable- and person-centered approach highlight that both EMWS and CEWS play an important role on the mental health of adolescents of both community and RYC settings. Concerning RYC participants, CEWS with others seem to play a protective role

over the development of depressive and anxious symptoms, even when there was a lack of memories of warmth and safeness experiences during their childhood.

These findings present relevant implications for policies, practices, and future research, regarding the functioning of the child and family services and facilities (e.g., schools, welfare services). The importance of attachment and of warmth and safeness experiences during childhood should be included in parental competencies training programs at a primary preventive level and within early intervention efforts with at-risk families. During adolescence, despite youth greater investment in peers and romantic relationships and their expression of autonomy, they still need to fell cared for, valued, and understood by their caregivers (Compas et al., 2017). Thus, CEWS with parents, teachers or other significant figures are still of upmost relevance to support and help them to overcome developmental challenges. Findings also indicated sex vulnerabilities for depressive and anxious symptoms during adolescence, with girls from both samples experiencing less CEWS in their relationships than boys, as well as higher symptomatology. Considering that girls tend to seek more social support (Eschenbeck, Kohlmann, & Lohaus, 2007), CEWS with significant others seem to be particularly important for them in order to feel safe and understood. Thus, current experiences of warm and safeness should be promoted in order to achieve better mental health outcomes in both settings (Sonderman, Kuiper, van der Helm, & van de Mheen, 2022).

Regarding adolescents in RYC, to dwindle the impact of their early experiences over mental health, placement in RYC should be focused in providing them warm and safe affiliative experiences. Considering the nature of caregivers' functions within these settings, their potential protective role in the process of healing needs to be valued and enhanced. In the same line, previous research also suggested that the availability of caregivers to provide emotional support (e.g., the ability to listen and to be emotionally connected) is fundamental to respond to the emotional needs of adolescents in RYC and counteract their mental health problems (Ferreira et al., 2020; Rindlaub, 2015; Sellers et al., 2020). Therefore, considering that not all residential care homes might favour significant and warmth emotional experiences (Campos et al., 2019), the consequences of early adverse rearing environments may be exacerbated by the lack of CEWS within RYC settings (Villodas et al., 2016). These findings reinforce the need to improve the quality of relationships between caregivers and adolescents in RYC, using relationships as a therapeutic tool, emphasizing relationship-building rather than control and order (Moses, 2000). Within the framework of attachment theory (Bowlby, 1988), these relationships can be seen as an opportunity to create a secure base and a safe haven, providing adolescents with the conditions to reorganize their earlier relationships with others, regulating

negative affect, and coping with difficult experiences in more healthy ways. To achieve this goal, caregivers need support, training, and supervision in the care taking process (Quiroga & Hamilton-Giachritsis, 2016; Singstad et al., 2020).

These findings should be carefully interpreted in light of some limitations. This was a cross-sectional study and, consequently, causal directionality between the variables of interest cannot be assumed (Maxwell & Cole, 2007). Data were exclusively collected with reliance on self-report measures, which, regardless of their good psychometric proprieties, may present some bias (e.g., social desirability, influence of current emotional states on recollections). Despite the undoubtable value of the subjective experience over the experiences *per se,* as assessed by the EMWSS-A and CEWSS-A (Cunha et al., 2014; Santos et al., 2021), it is important to acknowledge that some defensive mechanisms (e.g., denial) may be interfering with responses, particularly for participants from the RYC sample (Downey & Crummy, 2021). The shared variance that stems from the similarities between these two measures is also to be considered.

Longitudinal studies should be conducted to extend the understanding about the causal relations between these variables, using different assessment methods and informants (Maxwell & Cole, 2007). The assessment of both internalizing and externalizing symptoms and disorders should also be considered in future research, as this kind of mental health problems is relatively common during adolescence, mostly in adolescents from RYC settings (Campos et al., 2019; Fischer et al., 2016; Jozefiak et al., 2016; Rapee et al. 2019).

To conclude, findings from variable- and person-centered approach suggested that not only EMWS, but also CEWS with others have an important role over the mental health of adolescents both from community and from RYC settings. Further, in adolescents from RYC, current relationships with others based on warmth and safeness experiences seem to have a buffering effect over depressive and anxious symptoms, even when previous affiliative experiences of this nature were poor or absent. One of the most important purposes of the welfare system is to protect and take care of youngsters placed in RYC because they have multiple and severe risk factors for physical injuries and psychological disorders, due to their adverse and persistent experiences with primary caregivers. Thus, it is a responsibility of the welfare system to provide warmth and safe relationships to those youth as well as tailored interventions capable of helping them to heal and thrive (Degner et al., 2014).

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Compliance with Ethical Standards

Ethics approval: This research received approval from the Ethics Committee of the Faculty of Psychology and Educational Sciences of the University of Coimbra (CEDI22.03.2018) and the Portuguese General Directorate of Education (n. º0638900001). All procedures performed in this study were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards.

Informed Consent: Adolescents aged between 14 and 16 years old gave informed assent, while the older than 16 years old gave written informed consent. A written informed consent was also gathered from parents/legal representatives of all adolescent participants under 18 years old.

Conflicts of Interest: The authors declare that they have no conflict of interest.

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Authors' Contributions

Laura Santos: Conceptualization, Methodology, Investigation, Resources, Formal analysis, Writing - Original Draft, Review & Editing, Funding acquisition. **Diana Ribeiro da Silva:** Conceptualization, Methodology, Formal analysis, Writing - Review & Editing, Supervision. **Maria do Rosário Pinheiro:** Writing - Review. **Daniel Rijo:** Conceptualization, Methodology, Writing - Review, Supervision.

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Appendix A. *Fit indicators for each model by samples and sexes*

	χ^2	df	RMSEA	CI for RMSEA	CFI	SRMR
Complete sample						
Baseline model	0.000**	0	0.000	0.000; 0.000	1.000	0.000
Modified model I	3.832*	1	0.065	0.000; 0.140	0.995	0.022
Modified model II	11.878*	2	0.086	0.044; 0.137	0.983	0.038
Unconstraint model	10.814*	4	0.066	0.019; 0.116	0.990	0.033
All pathways equal	57.822**	8	0.127	0.098; 0.159	0.929	0.113
Partially equal pathways	13.709**	5	0.067	0.026; 0.111	0.988	0.042
All intercepts equal	163.182**	12	0.181	0.157; 0.206	0.784	0.164
Community sample						
Baseline model	0.000**	0	0.000	0.000; 0.000	1.000	0.000
Modified model I	1.199NS	1	0.023	0.000; 0.139	1.000	0.014
Modified model II	5.248NS	2	0.065	0.000; 0.135	0.992	0.029
Male participants	2.713NS	2	0.044	0.000; 0.158	0.996	0.026
Female participants	3.306NS	2	0.057	0.000; 0.162	0.995	0.034
Unrestrictive model	6.008NS	4	0.048	0.000; 0.122	0.995	0.028
All pathways equal	17.007*	8	0.072	0.021; 0.120	0.978	0.060
Partially equal pathways	12.933NS	7	0.063	0.000; 0.115	0.986	0.047
All intercepts equal	38.286**	12	0.101	0.066; 0.137	0.936	0.106
Partially equal intercepts	16.215*	8	0.069	0.015; 0.117	0.980	0.069
RYC sample						
Baseline model	0.000**	0	0.000	0.000; 0.000	1.000	0.000
Modified model I	1.982NS	1	0.060	0.000; 0.185	0.995	0.027
Modified model II	5.515NS	2	0.081	0.000; 0.164	0.984	0.044
Male participants	1.081NS	2	0.000	0.000; 0.145	1.000	0.028
Female participants	3.618NS	2	0.076	0.000; 0.200	0.985	0.051
Unrestrictive model	4.812NS	4	0.037	0.000; 0.135	0.997	0.038
All pathways equal	13.171NS	8	0.066	0.000; 0.128	0.979	0.068
All intercepts equal	30.035*	12	0.101	0.056; 0.147	0.926	0.097

Note. RMSEA = root mean square error of approximation; CI = confidence interval; CFI = comparative fit index; SRMR = standardized root mean square residual. ** $p < .001$, * $p < .05$, NS nonsignificant

CAPÍTULO 7

AVALIAÇÃO DA EFICÁCIA DO PROGRAMA DE TREINO DA MENTE COMPASSIVA PARA CUIDADORES: ENSAIO CLÍNICO ALEATRORIZADO POR CLUSTERS E ESTUDO QUALITATIVO

Estudo Empírico IV

Compassionate Mind Training for Caregivers of residential youth care: Early findings of a cluster randomized trial

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Compassionate Mind Training for Caregivers of residential youth care: Early findings of a cluster randomized trial

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Abstract

Objective: Compassion plays a significant role in caregiving and its benefits have been largely reported in different settings. Nonetheless, compassion-based interventions have not yet been delivered to Residential Youth Care (RYC) staff. This study presents early findings of a Cluster Randomized Trial on the efficacy of a Compassionate Mind Training program for caregivers of RYC (CMT-Care Homes) following CONSORT guidelines.

Method: Participants were 85 caregivers (89.4% female), aged between 25 and 62 years old, working on a regular basis with adolescents in RYC. Eleven Portuguese residential care homes for at-risk adolescents were selected and randomly allocated to the treatment (n = 5) or control (n = 6) conditions. Caregivers were assessed at pre- and post-intervention (n = 41 treatment, n = 44 control) through self-report scales on compassion and emotional climate related outcomes.

Results: To investigate CMT-Care Homes effects, a two-factor mixed MANOVA was performed. Multivariate tests showed a significant and large Time × Group interaction effect (Pillais' trace = .291, F = 2.719, p = .005, η_p^2= .291). Univariate tests indicated significant and positive effects in compassion and fears of compassion (low and medium effect sizes), as well as in soothing related emotions (emotional climate) and social safeness (both with medium effect sizes), in favor of the treatment group.

Conclusions: Findings offer preliminary evidence of the effectiveness of the CMT-Care Homes program, suggesting that this training allows the development of an affiliative mentality in caregivers working within RYC settings.

Keywords: caregivers; caregiving social mentality; compassion; compassionate mind training; cluster randomized trial; residential youth care.

Introduction

Many children and adolescents cannot live within their families, due to maltreatment or inadequate parental care, being placed in Residential Care Homes (RCH) (Eurochild, 2010). As an alternative care response, Residential Youth Care (RYC) aim to meet children and adolescents' needs and improve their chances of protection, healthy development and well-being (Petrowski et al., 2017).

As a consequence of being maltreated during the course of their lives, many youngsters living in RCHs present psychosocial maladjustment and mental health problems (Greger et al., 2015), that negatively impact their well-being, not only during adolescence, but also later in life (Jonson-Reid et al., 2012).

Nurturance, sensitive caregiver-child relationships, and a positive social climate, are fundamental to achieve successful placements and better outcomes in RYC (Costa et al., 2019; Leipoldt et al., 2019). Specifically, a good relational context and having supportive adults are key factors for youths' psychosocial adjustment (Li & Julian, 2012). Caregivers should not only provide the basic physical needs, but also offer a sensitive response to youths' unmet emotional and social needs, including individual attention, safeness and nurturance. Nevertheless, RCHs usually lack adequate means to attend those individual needs (Vashchenko et al., 2010), thus perpetuating socio-emotional neglect at some level (Bakermans-Kranenburg et al., 2008).

Research also suggests that youths' well-being and adjustment in RYC is tied with caregivers' stability and well-being (Costa et al., 2019; Steinlin et al., 2017). Although playing a key role in the daily intervention with youths in RYC (Li & Julian, 2012), caregivers face many working challenges (Barone et al., 2016; Bastiaanssen et al., 2014). Youth in residential care may become verbally and physically aggressive towards peers and caregivers, may engage in self-harming behaviors, may present rule-breaking behaviors and tend to resist to intervention (Bürgin et al., 2020). They can also present significant difficulties in relating and connecting with others, due to previous adverse experiences and current neglect of caregivers, who are, themselves, also vulnerable and in need of care (Hawkins-Rodgers, 2007). In addition, most of the caregivers work in shifts, have work overload (i.e., due to the reduced number of staff per child ratio), and have inadequate training on how to promote youths' well-being, as well as on how to deal with challenging working conditions (Vashchenko et al., 2010). These difficulties may leave them vulnerable, emotionally distant, and less effective (Barone et al., 2016). The perceived lack of support at work (e.g., from colleagues, management) is also reported as a common problem in RYC (Del Valle et al., 2007; Vashchenko et al., 2010). Consequently, the emotional demands of these settings may be the cause of additional stress and a high turnover

among caregivers, compromising the quality of care and the stability needed to create a secure and healthy environment (Bürgin et al., 2020; Steinlin et al., 2017).

In order to enhance the efficacy and quality of care, caregivers should be carefully selected, trained, cared for, and adequate support should be offered (Leipoldt et al., 2019). However, most of the available training programs are based on general skills (e.g., communication, behavior management), are not theory-based or manualized, and have not been tested with robust methodologies, impacting on their effectiveness and preventing a rigorous outcome assessment (Eenshuistra et al., 2019; Hermenau et al., 2017; Morison, 2018). There is a clear need for evidence-based programs that facilitate interpersonal relationships, focusing the child–caregiver relationships, and addressing caregivers' affect management, self-care practices and well-being (Barone et al., 2016; Bastiaanssen et al., 2014; Bürgin et al., 2020; Morison, 2018; Steinlin et al., 2017).

Compassion-based interventions have been highlighted as effective in cultivating an affiliative self (e.g., Gilbert, 2014; Neff & Germer, 2013) and compassion has been suggested to play a significant role in caregiving (Gilbert, 2019; Sinclair et al., 2021). According to the Social Mentalities Theory (Gilbert, 2015b, 2019), the caregiving or affiliative mentality has its roots in the mammalian capacity for attachment, encompassing motivations to care, to be empathic and altruist. Compassion is a motivational system that evolved as part of the affiliative mentality, involving the capacity to be attuned and emotionally moved by one's own or someone else's suffering, as well as actions to give support, which might be learned and trained in order to regulate negative affect and to flourish (Gilbert, 2015b). From this perspective, compassion encompasses three interactive flows, involving compassion for ourselves, compassion towards others and being open to receive compassion from others. Each of these flows may have associated fears, blocks and/or resistances, which might affect individual abilities to be open to the helpfulness of others and to experience affiliative emotions (Gilbert, 2019; Gilbert et al., 2011).

According to Gilbert (2017), compassion has an important role in affect regulation. A well-adjusted affect regulation results from the balance between the threat (responsible for the detection of danger and protection), the drive (linked to motivation and reward) and the soothing (connected with attachment and social signals of affiliation and care) affect regulation systems, in response to external/internal demands. Aligned with attachment theory, activation and maturation of the soothing system depends upon the caregiver's responses over time to reassure the child, and neglect/abuse behaviors compromise its maturation (Gerhardt, 2015). As a motivation to care, compassion predisposes the individual to nurture, look after, sooth,

protect, offer feelings of acceptance and belonging (Gilbert, 2019). In this sense, compassion, social connection and soothing experiences are suggested to foster affect regulation and mental health benefits (Gilbert & Procter, 2006). Individuals who are more committed to care for others and for themselves have higher levels of compassion (Gilbert, 2015b) and self-compassion (Hermanto & Zuroff, 2016), leading to a greater sense of connection with oneself, the others and the community, as well as to a collective motivation for improvement (Welford & Langmead, 2015).

The Compassionate Mind Training (CMT) aims to balance the three affect regulation systems through cultivating a compassionate self. Specifically, CMT comprises psychoeducation on the nature of the evolved human mind, as well as a range of mind training techniques (e.g., cognitive and behavioral practices, breathing exercises, imagery), designed to nurture empathic, wise, and caring behaviors in order to cultivate physiological and psychological processes that lead to emotion regulation (Gilbert, 2017, 2019). The CMT has been used in different settings to cultivate a more compassionate attitude towards others and the self, and to help individuals to deal with difficulties in an adaptive manner (Gilbert & Procter, 2006; Matos et al., 2017).

Over the last years, the psychological and interpersonal benefits of compassion have been largely reported, in both clinical and community settings (e.g., Hutcherson et al., 2008; Matos et al., 2017; Yarnell & Neff, 2013). Outcomes from meta-analysis research demonstrated that compassion-based interventions have a moderate effect in reducing psychological distress, and increasing compassion, self-compassion, mindfulness, and well-being (Kirby et al., 2017). Particularly, developing self-compassion for one's thoughts, emotions and motives seems to help individuals to reduce self-criticism and to focus on self-improvement motivation (Breines & Chen, 2012). When delivered to parents of adolescents with psychopathology, compassionate-based interventions helped to strengthen relationships, and affiliation showed to be relevant in the adolescents' recovery process (Bratt et al., 2019). When delivered to professional caregivers, compassion-based interventions have showed efficacy in promoting compassion and well-being, as well as in increasing the quality-of-care practices (Sinclair et al., 2021) in health (Scarlet et al., 2017), social care (Sansó et al., 2017), and educational settings (Maratos et al., 2019). However, this kind of interventions have not yet been delivered to caregivers of RYC.

As described above, caregivers face frequent challenges in RYC, that might put them in a reactive threatening functioning mode. In order to be able to provide a safe place for those in care, caregivers need themselves to feel safe as well and to be able to regulate their own emotions and behaviors (Steinlin et al., 2017). As compassion has been suggested to foster

emotion regulation (Gilbert, 2015b; 2019), a training designed to cultivate a more compassionate self might help caregivers, either to manage the demands of these settings in a more balanced way, as to engage in compassionate care, by being more attuned and responsive to youth emotional needs. On one hand, when dealing with youngsters, caregivers may break the negative interaction circle, contributing to a less threatening environment (Brown et al., 2013). On the other hand, they may foster the maturation of youngsters' soothing system and model their emotion regulation strategies, by providing soothing experiences and social connection in a more secure climate for all RYC agents (Gilbert, 2015b).

With the aim of delivering a compassionate-based intervention in RYC, a Compassionate Mind Training program for Caregivers (CMT-Care Homes) was developed. The CMT-Care Homes program was designed to promote the enhancement of an affiliative/caregiving mentality in self-to-self relating and when relating to others, in order to create a safe and secure environment in residential care facilities.

The present study was conducted as part of a larger Cluster Randomized Trial (CRT), examining the efficacy of the CMT-Care Homes program. Since this program is targeted for RCH teams, for practical reasons and to avoid contamination, the unit of randomization was the RCH (i.e., cluster). The current study aimed to investigate effects of the CMT-Care Homes on self-reported compassion-related and emotional climate/social safeness variables, analyzing preliminary evidence. It is hypothesized that the CMT-Care Homes will produce significant improvements in the outcome measures, when comparing caregivers who received the training with those in the control group. After intervention, caregivers are expected to present a greater sensibility to their own suffering and the suffering of others, and more easily engage in efforts aiming at the relief of suffering.

Method

This trial was registered at ClinicalTrials.gov (Identifier: NCT04512092) and followed the standards of Consort 2010 statement: Extension to cluster randomized trials (Campbell et al., 2012) in conjunction with the Template for Intervention Description and Replication (TIDieR) Checklist (Hoffmann et al., 2014).

Participants

This study was carried out in 11 Portuguese residential care homes (RCH) for at-risk youth, from nine different organizations. RCHs were selected according to the following cluster eligibility criteria: (1) inclusion criteria - RCHs that receive youths aged between 12 and 25 years old; located in the center of Portugal (for practical reasons); (2) exclusion criteria - RCHs

receiving mostly children or specialized in mental and behavioral disorders and/or substance abuse problems. The 11 RCHs were randomly distributed to the treatment (5 RCH) and control (6 RCH) conditions. From the five RCHs allocated to the treatment group, four RCHs were mixed and two received only females, accommodating from 23 to 45 children and adolescents. These RCHs had between 10 to 21 multidisciplinary professionals, divided into three work teams (i.e., technical, educative and support team). Most RCHs function with a reference adult for each child. The six RCHs of the control group accommodated from 15 to 40 children and adolescents, four were mixed and two were gender specific, one for females, and the other one for males. These RCHs had between 14 to 23 multidisciplinary professionals, divided into the same three work teams. As in the treatment group, most of the control RCHs had a reference adult for each child. In Portugal, placements in RCHs are mostly due to history of maltreatment (neglect and/or psychological, physical and sexual abuse) (ISS, 2020).

From the 11 RCHs recruited, 85 caregivers participated in this study. To be included in the study, it was required that professionals were directly involved in the delivery of services to adolescents on a regular basis. The sample comprised technical (24.7%; e.g., board member, psychologist, social worker), educational (67.1%; e.g., educational assistant) and support staff (8.2%; e.g., cleaning staff, cooker). Participants' age ranged between 25 and 62 years old, with a mean age of 44.47 (*SD* = 10.71). Most of the them (89.4%) were female. Concerning marital status, the majority of the participants were married (71.8%), while 21.2% were single and 7.1% were divorced. On average, participants reported having worked in RYC for 12.02 years (*SD* = 9.28, range = 0–39 years). Most of the them (60%) reported working in shifts. Concerning the educational level, 42.4% of the caregivers had a higher education degree, 21.2% reported having completed high school, and 36.5% some level of elementary or middle school education. Only 4.7% of the caregivers reported to practice meditation previously to the program onset. No significant differences between groups were found in sociodemographic features (Table 1).

Sample size

Effective sample size was determined for usual factorial (2 groups) repeated measures (2 assessments) and interaction effects, using G*Power, version 3.1.9.2, considering alpha = 0.05, a small to medium effect size (Cohen's f =0.20) in order to obtain at least 80% power, assuming a 0.80 correlation coefficient within repeated measures. That effect size was considered to be detected at least in one of the dimensions of the scale applied. Afterwards, the total sample size was computed considering the effective sample size in a clustered randomized design, assuming an intra-cluster correlation coefficient of 0.30. Under these assumptions, a total of 82 caregivers should be enrolled, 41 in each experimental condition.

Table 1. *Sociodemographic features by group*

	Treatment group (N = 41)		Control group (N = 44)				
	M	*SD*	*M*	*SD*	*t*	*p*	Cohen's *d*
Age	43.17	10.10	45.68	11.22	-1.082	.283	0.24
Years of work in RCH	10.32	7.50	13.61	10.52	-1.653	.102	0.36
	N	*%*	*N*	*%*	χ2	*p*	Cramer's *V*
Gender							
Male	2	4.9	7	15.9	2.728	.099	0.179
Female	39	95.1	37	84.1			
Marital Status							
Single	10	24.4	8	18.2	0.932	.628	0.105
Married	29	70.7	32	72.7			
Divorced	2	4.9	4	9.1			
Educational degree							
Elementary/middle school	13	31.7	18	40.9	4.484	.106	0.230
High school	6	14.6	12	27.3			
Higher education degree	22	53.7	14	31.8			
Profession							
Board member	3	7.3	1	2.3	3.339	.765	0.198
Psychologist	5	12.2	6	13.6			
Social worker	2	4.9	2	4.5			
Social educator	7	17.1	4	9.1			
Educational assistant	21	51.2	26	59.1			
Cleaning staff	1	2.4	3	6.8			
Cooker	2	4.9	2	4.5			
Staff category							
Technical	11	26.8	10	22.7	0.243	.886	0.053
Educative	27	65.9	30	68.2			
Support	3	7.3	4	9.1			
Shifts							
Yes	27	65.9	24	54.5	1.131	.288	0.115
No	14	34.1	20	45.5			
Meditation practice							
Yes	3	7.3	1	2.3	1.204	.272	0.119
No	38	92.7	43	97.7			

Note. Elementary and middle school education correspond to 4-9 years of school; High school are 12 years of school; Higher education degree are Bachelor or Master degrees.

Intervention overview

The CMT-Care Homes was developed for professional caregivers working in RYC. It is mostly based on compassion theory and compassionate mind training practices (Gilbert, 2014, 2019). In specific sessions, exercises from the Acceptance and Commitment Therapy (Hayes et al., 1999), Mindfulness (Kabat-Zinn, 2003), and Mindful Self-compassion (Neff & Germer, 2013) were also adapted and included. CMT-Care Homes is a 12-session structured and manualized program to be delivered in a group format. Main goals are to cultivate a compassionate-self and foster a caregiving mentality in RYC. The CMT-Care Homes is organized across 3 sequential

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); (2) Compassionate mind training (understanding and cultivating the attributes and competencies of compassion in its three flows, and addressing its fears); and (3) Final session (revising key information/practices, and its application into the RCH settings). A brief description of each session content is provided in the supplemental materials. Each session has 2.5-hr (once per week), according to the following structure: (1) Check-in (grounding exercise, reviewing the previous session, sharing the weekly practice); (2) Exploration of the session's theme (psychoeducation and experiential practices followed by group opportunities to share experiences and discussion); (3) Check-out (session summary and application to the self, youth and RCH practices/routines, write the group memo on the Compassionate wall, weekly practice challenge, session evaluation, and session take-off). At check-out, participants receive a handout summarising the session's main learnings and a challenge for compassionate formal/informal practice to be trained between sessions. This constitutes an attempt to transfer the learnings into participants' everyday life and care provision in RYC. After the session, formal practices are provided in audio format for between sessions training. Materials and instructions of each session can be accessed on the handbook (Santos et al., 2020).

Measures

Compassion Scale (CS; Pommier, 2011; Portuguese version by Sousa et al., 2017)

The CS is a 24-item self-report scale that measures compassion for others. Participants answered each item according to how frequently they feel and act towards others, using a 5-point scale (1 = almost never to 5 = almost always). In the original version, the scale has a total score (α = .90) and six subscales (Kindness, Common Humanity, Mindfulness, Indifference; Separation, and Disengagement), with alpha values ranging from .57 for Disengagement to .77 for Kindness (Pommier, 2011). In the current study, we used the two-factor model found in the Portuguese version, which represents a positive and a negative valence of compassion: Compassion (comprising the positive subscales: Kindness, Common Humanity, Mindfulness) and Disconnectedness (comprising the negative subscales: Indifference, Separation and Disengagement). Compassion showed an alpha of .91 and Disconnectedness an alpha of .92 (Sousa et al., 2017). In the current study, alpha coefficients were .76 for Compassion and .84 for Disconnectedness.

Self-Compassion Scale (SCS; Neff, 2003; Portuguese version by Castilho et al., 2015)

The SCS is a 26 self-reported scale which addresses self-compassion. Participants are instructed to answer the items, regarding "how I typically act towards myself in difficult times", using a 5-point scale (1 = almost never to 5 = almost always). In the original version, the scale has a total score (α = .92) and six subscales (Self-Kindness, Self-Judgement, Common Humanity, Isolation, Mindfulness, and Over-Identification), with alpha values ranging from .75 for Mindfulness to .81 for Over-Identification (Neff, 2003). In the current study, we used the two-factor model found in the Portuguese version, which achieved strong psychometric validity: Self-Compassionate attitude (comprising the positive subscales: Self-Kindness, Common Humanity, Mindfulness) and Self-Critical attitude (comprising the negative subscales: Self-Judgement, Isolation and Over-Identification), with Self-Compassionate attitude showing an alpha of .91 and the Self-Critical an alpha of .89 (Costa et al., 2015). In the current study, alpha coefficients were .88 and .87, respectively.

Fears of Compassion Scales (FCS; Gilbert et al., 2011; Portuguese version by Matos et al., 2011)

The FCS integrates three self-reported scales designed to assess fears of being compassionate toward others (10 items), receiving compassion from others (13 items) and being self-compassionate (15 items). The items were rated on a 5-point scale (0 = Do not agree at all to 4 = Completely agree). In the original version these scales showed good internal consistency with Cronbach's alphas of .72 for fears expressing compassion for others, .80 for fears of receiving compassion from others, and .83 for fears in giving compassion to self (Gilbert et al., 2011). In the Portuguese version, the Cronbach's alphas were .88 for fears expressing compassion for others, .91 for fears of receiving compassion from others, and .94 for fears in giving compassion to self (Simões, 2012). In the current study alphas values were .91 for fears of expressing compassion for others, .95 for fears of receiving compassion from others and .96 for fears of giving compassion to self.

Emotional Climate in Organizations Scales (ECOS; Albuquerque et al., 2020)

The ECOS is a 30-item self-report scale, aiming to assess how workers felt and behaved at their workplace. This scale has two parts with 15 items each. Each part is composed by 3 subscales, referring to the three affect regulation systems: the threat, the soothing and the drive systems. The first part aims to assess the emotions felt in the workplace, and items describe different feelings associated with the three affect regulation systems. The second part aims to assess the motives that led the worker to behave in a certain way, and items describe behaviors associated with the three affect regulation systems. In both parts, items are answered according

to a 5-point scale (0 = Never to 4 = Always). For the present study, only the emotions subscales were considered. The original scale showed adequate internal consistency: Cronbach's alpha was .75 for the threat system, .83 for the soothing system and .86 for the drive system related emotions (Albuquerque et al., 2020). In the current sample, Cronbach's alphas were .75 for the threat and for the drive systems and .72 for the soothing system related emotions.

Social Safeness and Pleasure Scale (SSPS; Gilbert et al., 2009; Portuguese version by Dinis et al., 2008)

The SSPS is an 11-item unidimensional self-reported instrument that assesses the frequency with which individuals experience positive feelings in their relationships, and the world as a safe place. Items are rated through a 5-point scale (1 = almost never to 5 = almost always). The original version demonstrated a high internal consistency (α = .91) and a strong construct and discriminant validity (Gilbert et al., 2009). In the current study, Cronbach's alpha was .88.

Procedures

The current study was approved by the Ethics Committee of the Faculty of Psychology and Educational Sciences of the University of Coimbra. Written informed consent was sought at the cluster (i.e., boards of each RCH) and the individual level (i.e., caregivers), before randomization. Participants were informed of the goals and procedures of this research, and were asked to voluntarily participate. No incentives were offered for their participation. The anonymity was guaranteed, with the use of respondent-specific codes, which were also used to link the data from one timepoint to the other. Caregivers were assessed through self-report measures at pre- and post-intervention (3 months interval). Data was jointly collected in each RCH by a researcher assistant (master student). After the baseline assessment, a computer-generated randomization was conducted at the cluster level, following a completely randomized design by the third author of this paper (DR). Each RCH (i.e., cluster) was randomly assigned to one of two conditions: treatment and control group. Five RCH were allocated in the treatment group and received the CMT-Care Homes, and the remaining six were allocated to the control group (i.e., no training in compassion or any other group interventions).

The CMT-Care homes program was delivered in accordance with the handbook, in face-to-face format, weekly (2.5-hr session) in each RCH, to a group of 6-10 participants, over 3-4 months, from October 2019 to February 2020. The program was led by the first author, who is a clinical psychologist trained in cognitive-behavioral interventions and compassionate

approaches, with previous work experience in RYC. The sessions schedules were defined with participants and board members in order to promote attendance.

Data analysis

Data was analyzed with IBM SPSS Statistics v22.0. Missing data were examined by incidence and distribution, both by subject and per item. Eight participants presenting more than 20% of missing values in an outcome variable were removed (Peng et al., 2006). Little's (1988) MCAR tests revealed that data in some outcome variables were not missing completely at random ($p < .05$). Considering that deletion of cases would lead to a substantial loss of subjects, missing values were dealt via linear interpolation imputation method (Meyers et al., 2006).

In order to analyze differences between the two groups in the outcome variables at baseline, independent samples t tests with Bonferroni multiple significance-test correction (considering the multiple comparisons) were performed. Sociodemographic differences between groups at baseline were also checked via independent samples t-tests and chi-square statistics. The effect sizes were calculated, using Cohen's d, with .2 indicating a small effect, .5 a medium effect and .8 a large effect; and Cramer's V, with .1 indicating a small effect, .3 a medium effect, and .5 a large effect (Cohen, 1988).

In order to perform a Multivariate Analysis of Variance (MANOVA), its assumptions were checked (Tabachnick & Fidell, 2013). Although confirming normal univariate distribution by coefficients of skewness and kurtosis ($SK < | 3 |$ and $Ku < | 10 |$; Kline 2005), with skewness values ranging from −0.771 to 1.163 and kurtosis values ranging from −0.830 to 1.687, data did not reveal a multivariate normal distribution (assessed through Mardia's test; Korkmaz et al., 2014). Violations of normality can, however, be disregarded considering the inexistence of univariate and multivariate outliers (investigated via boxplots and Mahalanobis distance, respectively) (Tabachnick & Fidell 2013). The Box' M test was non-significant ($p = .085$), thus the homogeneity of Variance–Covariance Matrices was assumed. Finally, multicollinearity was absent, considering that Pearson correlations between outcome variables were not greater than .9 (Tabachnick & Fidell 2013). It was also verified whether the variables were minimally correlated with each other ($r > .1$) (Cohen, 1988). Despite some variables showing lower values than the required, they were kept due to being conceptually related. Thus, to investigate intervention effects on the multiple outcomes, a two-factor (i.e., between subjects—groups—and within subjects—time) mixed MANOVA was conducted. The Pillai's criterion was used, as it is considered most robust when assumptions are not fully met. Effect sizes for the time effects and time × group effects were calculated using partial eta squares (η^2_p), with $\eta^2_p = .01$

referring to a small effect size, .06 to a medium effect size and .14 to a large effect size (Tabachnick & Fidell, 2013). Bonferroni significance-test correction was performed for Manova tests.

Results

Recruitment and Retention

From the 11 RCHs included in this study, 114 caregivers were invited to collaborate (see Figure 1). Since no one refused to participate, all caregivers completed the baseline assessment. Randomization took place at the cluster level. Five RCHs were allocated to the treatment group (53 subjects; 46.5%), and six RCHs were allocated to the control group (61 subjects; 53.5%). From the initial 53 treatment participants, one (1.89%) participant withdrew due to cancellation of the job contract, two (3.77%) due to prolonged medical discharge, and two (3.77%) dropped out of the program. Forty-eight (90.57%) participants completed the intervention and 46 the posttreatment assessments (86.79%; two caregivers were in medical discharge). Caregivers attended 5 to 12 sessions (M = 9.44; SD = 2.07). The main reasons for not completing the whole program were working in shifts/day off, vacation, brief medical discharge or urgent professional diligences. Four caregivers (8.33%) who attended less than 60% of the sessions were excluded from the analyses. Of the 61 caregivers assigned to the control group, 51 (83.61%) completed the posttreatment assessment, one (1.64%) left the study due to cancellation of the job contract, one (1.64%) was transferred to another social response, and eight (13.11%) dropped out the study. Seven (3.57%) control group participants were excluded from analyses due to missing data.

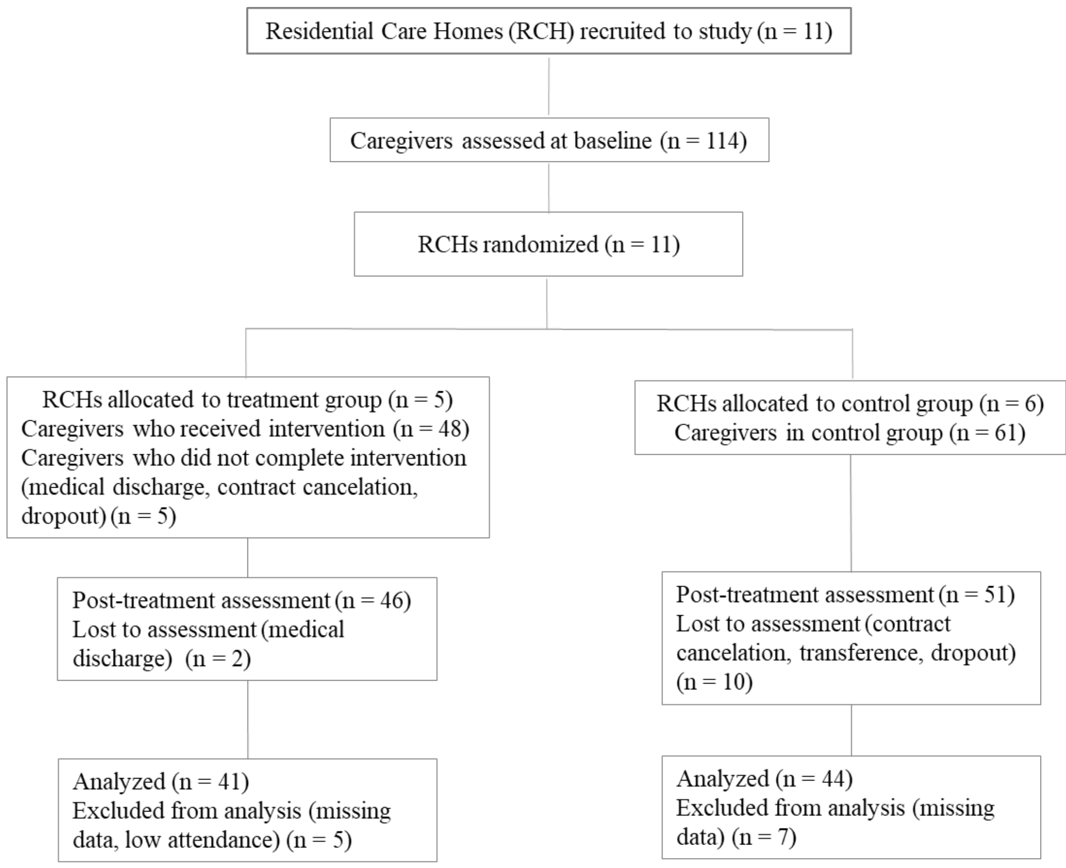

Figure 1. *Flowchart of caregivers' participation*

Baseline Differences

There were no significant differences between treatment and control group at the onset of the study concerning demographics (cf., Table 1). The Bonferroni adjustment for multiple comparisons revealed nonsignificant differences between groups at baseline for the outcome variables ($p > .005$) (cf., Table 2).

Table 2. *Baseline differences on the outcome measures*

Outcome measures	Treatment group		Control group				
	M	*SD*	*M*	*SD*	*t*	*p*	Cohen's *d*
Compassion for others							
Compassion	49.90	5.40	49.95	4.85	-0.422	.963	0.01
Disconnectedness	22.81	6.76	23.95	6.10	-0.824	.412	0.18
Self-compassion							
Self-compassionate attitude	42.52	7.67	42.55	6.32	-0.014	.989	0.01
Self-critical attitude	31.12	7.04	33.18	7.42	-1.310	.194	0.35
Fears of compassion							
Give compassion to other	15.78	8.14	18.25	7.44	-1.463	.147	0.32
Receive compassion from others	15.37	11.11	14.59	11.31	0.318	.751	0.07
Self-compassion	12.67	12.80	12.92	11.69	-0.094	.925	0.02
Social safeness	40.00	6.58	42.00	6.21	-1.442	.153	0.31
Emotional Climate							
Threat emotions	8.05	2.85	6.89	2.76	1.910	.060	0.41
Drive emotions	12.45	2.37	12.81	2.45	-0.679	.499	0.15
Soothing emotions	12.12	2.51	12.74	2.29	-1.184	.240	0.26

Note. Bonferroni $p < .005$

Two-factor mixed MANOVA

Multivariate tests showed a significant and large Time × Group interaction effect: Pillais' trace = .291, F = 2.719, p = .005, η_p^2 = .291. Univariate tests for Time × Group interaction indicated that there were significant intervention effects for seven of the 11 outcome variables under study, all favoring the treatment group, with exception of self-critical attitude. Specifically, significant differences were found, on the expected directions, for compassion towards others, fears of compassion in its three flows, social safeness, and emotional climate soothing/safeness related emotions. Some comparisons between groups achieved medium effect sizes, while others revealed small effect sizes. No differences were found between groups for disconnectedness, self-compassion attitude, as well as on the emotional climate threat and drive related emotions (Cf. Table 3).

Table 3. *Mean scores and standard deviations for both groups at pre- and posttreatment, intraclass correlation coefficient and univariate tests*

	Treatment group		Control group				
	T1	T2	T1	T2			
Outcome measures	*M (SD)*	*M (SD)*	*M (SD)*	*M (SD)*	*ICC (CI)*	*Time*	*Time x Group*
Compassion for others							
Compassion	49.90 (5.40)	50.70 (5.99)	49.95 (4.85)	48.39 (5.31)	.73 (.58-.82)	F = 0.532; p = .468; η^2_p = .006	F = 4.928; p = .029; η^2_p = .056
Disconnectedness	22.80 (6.76)	21.48 (6.09)	23.95 (6.10)	23.40 (5.64)	.73 (.59-.83)	F = 2.355; p = .129; η^2_p = .028	F = 0.395; p = .531; η^2_p = .005
Self-compassion							
Self-compassionate attitude	42.52 (7.67)	42.67 (6.84)	42.55 (6.32)	40.73 (5.77)	.78 (.66-.86)	F = 1.911; p = .171; η^2_p = .023	F = 2.639; p = .108; η^2_p = .031
Self-critical attitude	31.12 (7.04)	32.23 (7.90)	33.18 (7.42)	31.53 (6.59)	.81 (.70-.88)	F = 0.189; p = .665; η^2_p = .002	F = 4.954; p = .029; η^2_p = .056
Fears of compassion							
Give compassion to other	15.78 (8.14)	11.46 (8.32)	18.25 (7.45)	17.92 (6.41)	.69 (.52-.80)	F = 8.528; p = .005; η^2_p = .093	F = 6.258; p = .014; η^2_p = .070
Receive compassion	15.37 (11.11)	12.65 (9.38)	14.59 (11.31)	16.45 (10.56)	.71 (.55-.81)	F = 0.156; p = .694; η^2_p = .002	F = 4.481; p = .037; η^2_p = .051
Self-compassion	12.67 (12.80)	9.73 (9.06)	12.92 (11.69)	15.23 (12.35)	.64 (.44-.76)	F = 0.060; p = .807; η^2_p = .001	F = 4.126; p = .045; η^2_p = .047
Social safeness	40.00 (6.58)	42.54 (6.19)	42.00 (6.21)	40.70 (5.67)	.70 (.54-.81)	F = 1.017; p = .316; η^2_p = .012	F = 9.692; p = .003; η^2_p = .105
Emotional Climate							
Threat emotions	8.05 (2.85)	6.83 (2.71)	6.89 (2.76)	6.69 (2.47)	.68 (.51-.79)	F = 6.327; p = .014; η^2_p = .071	F = 3.340; p = .071; η^2_p = .039
Drive emotions	12.45 (2.37)	13.51 (2.35)	12.81 (2.45)	13.02 (2.86)	.70 (.54-.81)	F = 6.233; p = .015; η^2_p = .070	F = 2.730; p = .102; η^2_p = .032
Soothing emotions	12.12 (2.51)	13.22 (2.10)	12.74 (2.29)	12.49 (2.66)	.60 (.38-.74)	F = 2.418; p = .124; η^2_p = .028	F = 6.112; p = .015; η^2_p = .069

Note. T1 = pretreatment; T2 = posttreatment; ICC = Intraclass correlation coefficient; CI = Confident interval (95%); η2p = Partial eta square.

When examining means, standard deviations, and corresponding effect size (Cohen's d for each group), at the end of CMT-Care Homes delivery, the treatment group decreased in all the different fears of compassion assessed. Improvements were observed in the treatment group on fears of receiving compassion from others (Cohen's d = .26) and on fears of self-compassion (Cohen's d =.27), when compared with professionals in the control group, which deteriorated on both outcomes (Cohen's d = .16 and .19, respectively).

Concerning fears of giving compassion to others, differences were also found between groups, but they seem to be mostly due to the improvements in the treatment group (Cohen's d = .52), since the change in the control group was negligible (Cohen's d = .05).

In what concerns compassion towards others, differences were also observed between groups, yet these differences seemed to be mainly due to the deterioration in the control group (Cohen's d = .31), since this outcome only showed a very small increase in the treatment group (Cohen's d = .14).

While there were no differences between-groups concerning self-compassion, groups differed on the self-critical attitude, yet in a un unpredicted direction: a small increase observed on the treatment group (Cohen's d = .15) and a decrease on the control group (Cohen's d = .24). Regarding affiliative variables, improvements on the treatment group were also noticed. The report of soothing related emotions regarding the emotional climate felt on the RCH increased in the treatment group (Cohen's d = .48), when compared with controls (Cohen's d = .10). Additionally, social safeness seemed to improve in the treatment group (Cohen's d = .40), when compared with the control group (Cohen's d = .22), which deteriorated. Within groups comparisons were mostly of small effect sizes.

Discussion

Cultivating environments that foster compassionate care for self and others has been suggested to improve the quality of caregiving (Gilbert, 2019; Sinclair et al., 2021). There has been growing evidence on beneficial effects of compassionate-based interventions in several helping settings (e.g., Maratos et al., 2019; Sansó et al., 2017; Scarlet et al., 2017). Nevertheless, this approach was never tested in RYC.

This is a preliminary study of a new Compassionate Mind Training (CMT-Care Homes) for caregivers of RYC, aiming to establish its effectiveness, being the first study addressing compassion in RYC, and having being conducted in real-life settings. As a motivation rooted in the evolved need for care and attachment, compassion comprises motivational, emotional and cognitive–behavioral competencies to be caring of others and increase their chances of survival

and flourish (Gilbert, 2015a). The CMT-Care Homes was designed to promote an affiliative mentality in caregivers in order to provide warmth and supportive experiences to adolescents in a safer environment.

Data on recruitment and retention showed that most caregivers (90.57%) completed intervention. Among the small number of dropouts, only two voluntarily abandoned the program, suggesting that the CMT-Care Homes may account for a favorable program retention and adherence rates.

Comparisons between caregivers from the treatment group and controls on demographic and outcome measures did not yield significant differences between groups at baseline. These results may indicate that the cluster randomization was effective, allowing for reliable findings on the CMT-Care Homes' effects.

A Multivariate Analysis of Variance (MANOVA) was carried out in order to test the effects of intervention on compassion-related variables and emotional climate/social safeness outcomes. Findings from the multivariate analysis revealed significant differences between the two groups from pre- to post-intervention, corresponding to a large effect size, suggesting that the CMT-Care Homes can be effective, when delivered to professional caregivers of RYC.

Concerning univariate outcomes, the CMT-Care Homes program showed significant and positive effects in part of the assessed compassion-related variables, and in soothing related emotions (emotional climate), as well as in social safeness.

Regarding compassion-related outcomes, improvements were observed in fears of compassion in its three flows. Specifically, caregivers who received the CMT-Care Homes reduced their fears of receiving compassion from others, giving compassion to others and being self-compassionate, while the control group showed an increase in fears of receiving compassion from others and being self-compassionate, and no change in giving compassion to others. These findings suggest that the training may had a significant effect on the identification and unblock of fears, blocks and resistances to compassion, which is an important intervention focus of both compassion-focused therapy and compassionate mind training, either in clinical as in non-clinical settings (Gilbert et al., 2011). Yet, after the program delivery, although a small increase in compassion towards others was observed in the treatment group, the between group differences seemed to be mainly due to a deterioration observed in the control group from pre- to post-assessment. This finding may indicate that, while intervention was not able to improve compassion towards others in a stronger way, it may have been effective in buffering its deterioration across time. Regarding disconnectedness, no differences were observed between groups from pre- to post-assessment. It is worthy to note that scores for this dimension

were relatively low for both groups in all assessments. The organizational culture of RYC, as well as the daily attitudes of people working within these particular settings may explain, at least partially, these lower scores. In fact, being regularly in contact with deprived youth may hinder a disconnected attitude in face of their daily needs. Yet, being connected to others does not mean that compassion easily flows through those relationships. Actually, one can be strongly connected to other person, take care of that person, and still do it in a non-compassionate way.

In what respect self-compassion, and contrary to what was expected, no significant differences between groups were found. Among the three flows of compassion, self-compassion seems to be the more difficult to change (Savari et al., 2021). Viewing the self as the receiver of compassion can be particularly difficult for people who are used to attend and take care of other's needs (Figley, 2002). As a motivational system, compassion requires practice along time, in order for a shift in mentality to be observed (Gilbert, 2014; Savari et al., 2021). The observed decrease in all the three assessed fears of compassion may have been a first step in this direction. Action engagement shifts in compassion towards others and self-compassion might need longer time to be cultivated, and might have a more effective change over time, which should be investigated in follow-up research.

There was an unexpected finding on the self-critical attitude: while the control group showed a decrease on self-criticism, a slightly increase was observed for the treatment group. This increase in the treatment group might be due to a gain of awareness about self-critical thoughts and attitudes during intervention. During the program, great attention was paid to the way we treat ourselves, promoting the identification of self-critical thoughts, as well as their impact over our emotional reactions to these inner threats. These activities may account for the increase on self-critical attitude. In addition, self-criticism is commonly perceived as self-judgment used in a positive adaptive way to cope with inadequacies. As a stable and enduring cognitive-affective mental representation, self-criticism might need a more continued practice to be reduced (Low et al., 2020). Difficulties in reducing self-criticism were also found in other studies (Gilbert & Procter, 2006; Sansó et al., 2017; Savari et al, 2021).

The control group deteriorated on most compassion-related variables. This might suggest that, in face of the difficulties of this care setting, when no training or support is offered, caregivers might tend to decrease their motivation to care for themselves and others across time, which might have negative implications both for their own well-being, as well as for the quality of the care they provide (Sinclair et al., 2021).

Findings regarding social safeness revealed that the treatment group improved at the end of CMT-Care Homes, when compared with controls (which have deteriorated), showing the

largest of the observed effect sizes. In accordance with previous research, this finding may suggest that by cultivating compassionate motives, caregivers were able to establish more positive interactions, thus feeling safer with others (Gilbert et al., 2009; Yarnell & Neff, 2013). Considering that compassion flows have mutually reinforcing effects, a sense of connectedness and caring towards others may increase empathetic responses and cooperation, which tends to cause reciprocal behaviors in return (Hutcherson et al., 2008). In this sense, after intervention, caregivers within the treatment group reported a more soothing and safer climate at work, when compared with the control group, which remained almost unchanged. In a safe emotional climate, the activation of defensive emotions and behaviors tends to decrease, giving space to more stimulation of relaxed attention and positive affect (Gilbert, 2014; Gilbert & Procter, 2006). Hence, when caregivers feel safe, they are more able to provide a more soothing climate, and to offer opportunities for stimulating youths' soothing system. This is particularly relevant since these youth usually present difficulties in accessing their soothing system and in using it to regulate their difficult emotions (Gilbert, 2015a).

Changes on the threat-related emotions (e.g., anger, fear) did not reach a statistical difference between groups, although a tendency for a decrease was observed in the treatment group. This may be related with the improvement on soothing emotions found for the treatment group, which might have buffered threat emotions (Gilbert, 2017).

In what regards positive emotions linked to the drive system (e.g., enthusiasm) no differences between groups were found. As in other intervention studies, the activated positive emotions linked to the drive system did not change (Matos et al., 2017). This is consistent with theory, considering that the CMT-Care Homes is focused on the activation of an affiliative mentality, mostly focused on positive affect related with warmth and safeness (Gilbert, 2019), rather than drive related positive emotions.

Overall, findings related with emotional climate are of upmost relevance, considering that successful placements in RYC are related to the quality of the environment (Leipoldt et al., 2019). It has been highlighted that a safe and nurturing climate is warranted in RYC, in order to provide youths new relational opportunities and flourishment (Hawkins-Rodgers, 2007).

This potential utility of CMT outside the clinical setting is in line with other studies, who have already demonstrated benefits of this approach in helping professionals in different settings (e.g., Maratos et al., 2019; Sansó et al., 2017; Scarlet et al., 2017). Considering that it is essential to provide the best care for children and adolescents who have been exposed to neglect and maltreatment (Greger et al., 2015), this study has useful implications that can be

addressed in RCH in order to improve the quality of care, and create safer relationships and environments.

Limitations to the present research need to be addressed. Firstly, all assessment measures were self-report instruments. Considering that this kind of measures are not free of response bias, different methods of data collection (e.g., focus groups, behavioral observation) from multi-informants may yield different findings. Secondly, participants in the control group did not receive any other intervention. Finally, due to work demands, some caregivers were not able to attend consecutive training sessions, what could have prevented them to fully benefit from the training and embedding all the learnings into practice (Sinclair et al., 2021). However, considering that deletion of cases would lead to a substantial loss of subjects, participants with less than 80% of attendance were included. Thus, future studies should be carried out with a larger sample, and should include an active control group. The investigation of possible moderating effects of variables that could affect treatment response (e.g., education level, professional role) would also enrich the research on the impact of the CMT-Care Homes program. Within the current CRT, the follow-up assessment studies will test the long-term effects of intervention, namely if the variables that did not change at posttreatment will show a different pattern in follow-up assessments. Other caregiver's variables (e.g., burnout, resilience), informants (e.g., youths' perception of RCH emotional climate and relationships with caregivers), and methods (e.g., qualitative research) will be included for a more comprehensive assessment.

The current study provides new evidence regarding compassionate-based interventions for professional caregivers, in a new setting. CMT-Care Homes seemed to be an effective intervention in helping caregivers to cultivate a more compassionate self and an affiliative environment in RCH. Encouraging findings on compassion and emotional climate outcomes present value for further studies to be carried out.

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Compliance with Ethical Standards

Ethics approval: This research received approval from the Ethics Committee of the Faculty of Psychology and Educational Sciences of the University of Coimbra (CEDI22.03.2018). All procedures performed in this study were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards.

Informed Consent: Written informed consent was obtained from all participants included in the study.

Conflicts of Interest: The authors declare that they have no conflict of interest.

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Authors' Contributions

Laura Santos: Conceptualization, Methodology, Investigation, Resources, Formal analysis, Writing - Original Draft, Review & Editing, Funding acquisition. **Maria do Rosário Pinheiro:** Writing - Review. **Daniel Rijo:** Conceptualization, Methodology, Writing - Review, Supervision.

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Appendix A. *CMT-Care Homes modules, sessions and goals*

Module	No	Sessions	Goals
i) Our mind according to a compassion-based approach	1	Common Humanity	• To create a warmth and kind environment in the group • To recognize the universality of human suffering • To define compassion
	2	An evolutionarily determined mind	• To introduce mindfulness training • To provide participants with insight into the nature of the evolved and socially shaped mind • To understand the principle "It's not my fault, but it's my responsibility"
	3	Affect regulation systems "Colors of mind"	• To present the three affect regulation systems • To understand the balance between the three systems as the best way to achieve stability • To apply the affect regulation system model to the self and to the workplace
	4	Threat system "Red alert"	• To analyze the motives and outputs of the threat system and how to deactivate it • To do a functional analysis of self-criticism • To do the formulation of the threat functioning mode in the workplace
	5	Drive System "Where does the blue drive us?"	• To analyze the motives and outputs of the drive system • To recognize the Competitive Mentality • To distinguish shame from guilt
	6	Soothing System "Peaceful green"	• To analyze motives and outputs of the soothing system • To identify soothing strategies • To recognize the importance of the affiliative mentality in residential care
ii) Compassionate mind training	7	Compassion	• To identify the flows of compassion • To understand the attributes and competencies of compassion in the formation of a compassionate self
	8	Dealing with fears, blocks and resistance to compassion	• To identify and address fears/blocks/resistances of compassion
	9	Giving compassion to others	• To identify the qualities of the compassionate self • To build the Compassionate Self • To develop compassion for the other
	10	Receiving compassion from others	• To recognize the need to receive compassion from others • To stimulate the image of the compassionate friend • To practice receiving compassion from others
	11	Developing self-compassion	• To compare self-critical to self-compassionate functioning • To recognize the existence of multiple selves • To practice self-compassion
iii) Final session	12	Building a compassionate residential care home	• To synthesize personal insights about the CMT • To assess progress in the affect regulation systems and flows of compassion • To define strategies to promote a compassionate environment in the RCH

Estudo Empírico V

Compassionate Mind Training for Caregivers in residential youth care: Investigating their experiences through a thematic analysis

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Mindfulness

(em revisão)

Mindfulness, *under review*
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Compassionate Mind Training for Caregivers in residential youth care: Investigating their experiences through a thematic analysis

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Abstract

Objective: Compassion can be valuable in demanding helping settings, both to professionals and clients. Nevertheless, compassion-based interventions have not yet been investigated in residential youth care. This qualitative study aims to examined the caregivers' experiences with the Compassionate Mind Training program for caregivers (CMT-Care Homes), as well as their perceptions regarding the barriers/enablers, transference 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. While program's acceptability, combined with practice and transference of learnings seems to facilitate compassion, reported difficulties with some formal practices and fears, blocks, and resistances to compassion might be barriers to its development. Learnings 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 methods and data analysis should be considered.

Keywords: caregivers; compassion; compassionate mind training; focus groups; residential youth care; thematic analysis.

Introduction

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 working settings linked with helping services, where compassion can be enhanced towards clients to improve the care quality and clients' outcomes, but also towards the self to protect professionals against mental health concerns (Matos et al., 2022; Sinclair et al., 2016b). 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 helping settings, this kind of interventions has not yet been delivered in residential youth care, neither its usefulness has 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). In this scope, training for these professionals has been repeatedly

recommended (FICE et al., 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 helping settings (Liu & Smith, 2011; Lyddy et al., 2016).

Purpose of the present study

As an attempt to address these needs, a Compassionate Mind Training program for Caregivers (CMT-Care Homes) working in residential youth care was developed. We will elaborate further on the program in the Method's section. The current work is a qualitative study on CMT-Care Homes nested in a cluster randomized trial (Santos et al., 2022, 2023c). This study aims 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 transference of learnings 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).

Due to the innovative features of the CMT-Care Homes, a qualitative approach might help to understand the adequacy and value of such an approach within these settings (O'Cathain et al., 2013). 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), its barriers and enablers that may arise in situ, as well as the transference of learnings, using an intensity sample (Mascaro et al., 2020; Patton, 1990).

Methods

This study is nested in a Cluster Randomised Trial, examining the effectiveness of the CMT-Care Homes program. The trial was registered in 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 hours, weekly delivered at each Residential Care Home (RCH), during approximatively three months.

The CMT-Care Homes is based in the integrated biopsychosocial model within the Compassionate Focused Therapy framework and Compassionate Mind Training practices (Gilbert, 2017b).

The CMT-Care Homes is divided into three modules. The first one comprises six sessions designed to do 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, addressing its fears, blocks and resistances. The last module is composed by the final session, designed to revise key information and practices. Sessions had the following structure: (1) Check-in (grounding exercise, reviewing the previous session, evaluating and sharing the compassionate weekly challenge); (2) Exploration of the session theme (psychoeducation and experiential practices, such as compassionate imagery, role-play or group exercises are performed to explore the session's goals, followed by opportunities to share experiences in group and open discussion in a safe atmosphere); (3) Check-out (session summary, personal and group reflections about practical application to the self, youth and care practices, writing in the Compassionate wall, compassionate weekly challenge, compassionate song, session evaluation, session take-off). According to the Caffarella's 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. Formal practices are provided in audio format.

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 can be found on (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 RCH 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 (see Table 1). Reasons for declining were not collected.

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.

Procedures

Focus groups allows 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.

Data analysis

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 dataset (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 done across the entire data set based in their semantic or latent meaning. This process was done 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 were 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 (see Figure 1). Results are described and illustrated using participants quotations. Additional proof quotes and the frequency of data extracts are provided on Table 2.

Compassion development

This theme explores in what extend 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 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 saw 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, with compassion being directed not only towards youth, but also towards colleagues (Gilbert, 2017b; Mascaro et al., 2020).

Receiving compassion from others

Caregivers from two RCHs reported that they started to note 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).

Reports in the first and second person (i.e., to give and receive compassion) allowed to understand that compassion was also directed towards colleagues, who have started to become more available and open to receive compassion from others, including from their own colleagues in the working place.

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 was 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 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 was 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, 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 transference of learnings.

Practice and transference of learnings

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 breath 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. Transference 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 an 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 more healthy 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).

Overall, participants reported that they became more aware of their own emotions and started to use healthier emotion regulations strategies, reducing rumination, self-criticism, and reactive behaviors. They also mentioned that they can cope better with stressful experiences that previously were sources of suffering and well-being increased.

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 in a shared theoretical framework, and safeness in relying on colleagues for help. It can 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 in 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 in 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.

Table 2. *Overarching themes, themes and sub-themes, proof quotes and frequency of data extracts*

Overarching theme	Themes and sub-themes	Proof quotes	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 transference of learnings		207
	3.2.1 Meditation practice	"I have been practicing mindfulness daily… I often go to my safe place"	(59)

	(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)	
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
4.1 Caregiver's emotional health		178

4. Compassion effects	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)	(102)
		"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)	
	4.1.2 Relief of suffering	"I don't feel so guilty" (T12, RCH1)	(33)
		"I get less angry with myself" (T22, RCH2)	
		"I don't stress so much" (E31, RCH3)	
	4.1.3 Well-being	"I feel good, I feel calm, I don't have always those thoughts and the frustration of everyday life or the stress of work... I've even been more Zen with the girls" (E33, RCH3)	(43)
		"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)	
	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)	(24)
		"It was created more relationship between team members" (T31, RCH3)	
	4.2.2 Self-efficacy	"Little by little I think it gives us security, confidence" (T32, RCH3)	(20)

	“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)	
4.2.3 Motivation to work	"More willing to help, to work" (E21, RCH2)	(17)
	“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)	
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)	(71)
	“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)	
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)	(48)
	“There is no longer so much confusion, so much noise, so much talking loud” (T32, RCH3)	
4.3.3 Youth reactions to compassionate caregivers	“The kid became calmer, less stressed” (T22, RCH2)	(39)
	“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)	
		Overarching theme 4 total = 397

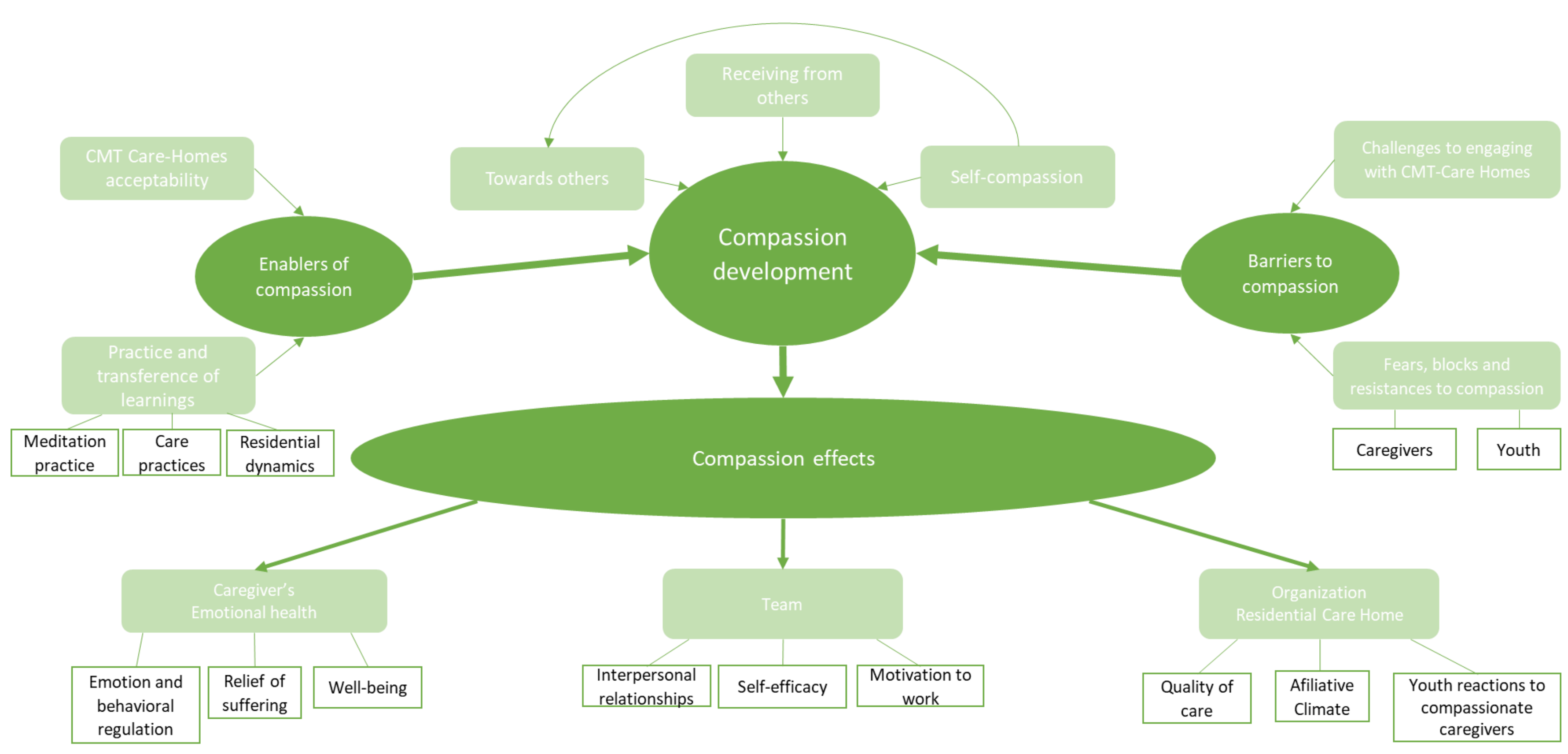

Figure 1. *Thematic map*

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 expand the knowledge about how the transference of learnings occurs, as well as the effects of compassion across different levels, within helping 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., 2016a).

As in other studies, self-compassion was recognized as particularly valuable to care professionals, in order 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 helping 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., 2016a). These obstacles may difficult the development of self-compassion and being open to receive compassion from others, 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., 2016b). 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' 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 at al., 2011).

Despite the above-mentioned 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 the sessions safe climate might have encouraged collective support for new practices (Liu & Smith, 2011). Considering that intervention outcomes are often limited due to challenges in the transference of learnings, 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 Lyddy and colleagues' study (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 helping 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 in 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 at al., 2016a). 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 constrains. 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 positivity biased the findings (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 that shout 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.

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Compliance with Ethical Standards

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.

Informed Consent: Written informed consent was obtained from all participants included in the study.

Conflicts of Interest: The authors declare that they have no conflict of interest.

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Authors' Contributions

Laura Santos: 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. **Maria do Rosário Pinheiro:** Collaborated with the study design, developed the resources and materials used in the study, assisted data collection and data analysis, reviewed the final manuscript. **Daniel Rijo:** Collaborated with the study design, developed the resources and materials used in the study, assisted data analysis and reviewed the final manuscript.

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Appendix A. *Focus Group Script*

[Welcome and Instructions]

[Informed consent]

Questions

1. To begin with, we are interested to know the experience of participation in the Compassionate Mind Training program with Caregivers. Could you please share your experience with us?
2. Considering learnings, practices or exercises carried out throughout the program, how did you apply them in your daily routine?

   Probes

   Specifically at a personal level, could you give me some examples?

   Specifically at a professional level, could you give me some examples?
3. As a team, what changes did you make in the practices/routines/intervention at the residential care home after the program?
4. Now, we will pose some questions regarding your perception of change linked with your participation in this program. We would like to hear you talk about the extent to which your way of thinking (i.e., about difficulties, about yourself, others and the world) has changed as a result of your participation in this program.

   Probes

   Could you tell a little bit more about your way of thinking regarding others (empathy, judgment, blame)?
5. Now, we would like to know if your behavior has changed. If changes were noticed, we would like to understand how your behavior has changed in personal and interpersonal terms.

   Probes

   Specifically at the professional context, could you give me some examples?
6. To what extent has the CMT-Care Homes program helped you to deal with your emotional difficulties and how has this contributed to your well-being, job satisfaction and satisfaction with life?

   Probes

   How has this program helped you to deal with your emotions? Could you give me some examples?

Specifically at the professional level, to what extent has this program contributed to increasing your well-being and job satisfaction? Could you give me some examples?

7. Specifically, in what concerns the three flows of compassion, what differences do you perceive when comparing the beginning and end of this program?
8. In your opinion, how did the Compassionate Mind Training program help the team to deal with the challenges, demands and difficulties of this setting?
9. Regarding the relationships you establish with children and youth, what impact do you perceive in the quality of those relationships?
10. Regarding children and youth, is there any change in their behavior that can be attributed to the team participation in the program? If yes, what changes do you perceive in them?
11. In your opinion, what is the impact of the Compassionate Mind Training in the residential care home?

    Probes

    Specifically at the residential care home environment. Could you give me some examples?

    Specifically on the relationship between colleagues. Could you give me some examples?

    Specifically in the residential care home functioning (e.g., intervention, rules, routines). Could you give me some examples?
12. To conclude, we would like to know how you intend to keep using the lessons learned and/or the tools learned on the program at the residential care home?

[Conclusion]

Estudo Empírico VI

Fostering an affiliative environment in residential youth care: A cluster randomized trial of a compassionate mind training program for caregivers enrolling youth and their caregivers

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Fostering an affiliative environment in residential youth care: A cluster randomized trial of a compassionate mind training program for caregivers enrolling youth and their caregivers

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Abstract

Objective: Affiliation has a positive role on well-being and human development. Most children and youth living in Residential Youth Care (RYC) experienced maltreatment from significant others, becoming a particularly vulnerable group. Their complex needs require well trained caregivers who help them to heal and thrive. This cluster randomized trial sought to test the Compassionate Mind Training program for Caregivers (CMT- Care Homes) effectiveness on affiliative outcomes across time.

Method: A sample of 127 professional caregivers and 154 youth from 12 Portuguese residential care homes (RCH) participated on this study. RCHs were randomized to treatment (n = 6) and control (n = 6) groups. Caregivers and youth completed self-report measures at baseline, post-intervention, and 6-month follow-up on social safeness and emotional climate. Caregivers were also evaluated on compassion outcomes.

Results: MANCOVA indicated large multivariate time X group effects. Univariate results suggested that caregivers from the treatment group showed improvements in compassion towards others and in self-compassion across time, while the control group gradually deteriorated in both variables. Youth and caregivers from the treatment group noticed a more soothing and safer RCH emotional climate, as well as feeling safer within relationships. At 6-month follow-up, improvements were retained by caregivers, but not by youth.

Conclusions: The CMT- Care Homes brings a new model to RYC, that represents a promising approach in promoting safe relationships and affiliative environments in RCHs. Supervision should be provided to monitor care practices and sustain change across time.

Keywords: caregivers; compassionate mind training; emotional climate; residential youth care; social safeness; youth at-risk.

Introduction

As an evolutionary motivation to care and to alleviate suffering, compassion has been linked with better personal and interpersonal outcomes, with benefits for both the caregiver and the care receiver (Crocker & Canevello, 2017; Galante et al., 2014; Gilbert, 2020). For this reason, compassion-based trainings have been offered in several helping settings in order to improve services (Delaney, 2018; Patel et al., 2019). Most children and young people placed in Residential Youth Care (RYC) were repeatedly exposed to harsh experiences with caring figures, which might have damaged their attachment and emotion regulation systems (Jenney, 2020; Steinkopf et al., 2020; Zelechoski et al., 2013). In RYC, the establishment of warmth and caring relationships with caregivers in a safe and secure environment have been highlighted as key factors for children and young people recovery and healing (Costa et al., 2020; Magalhães & Calheiros, 2017; Sellers et al., 2020). However, the challenges and demands of working within settings with extensive traumatized youth might threat the establishment of such kind of relationships (Brown et al., 2018; McCall & Groark, 2015). Hence, in order to ensure the quality of care, caregivers' training is recommended by international guidelines (UN, 2010). Nevertheless, research suggests that existing programs were not accurately tested and/or did not assess affiliative outcomes (Hermenau et al., 2017; Santos et al., 2023b). The current study proposed a new training program tailored to RYC caregivers, based on the integrative and evolutionary model and practices of Compassion Focused Therapy (Gilbert, 2010), which has been extensively tested in other populations and settings (e.g., Bratt et al., 2019; Matos et al., 2022; Rijo et al., 2023). Using a cluster randomized design, this study aims to assess the effectiveness of the Compassionate Mind Training program for Caregivers (CMT- Care Homes) on affiliative outcomes across time, including a sample of caregivers and another of youth in RYC, to integrate first and second person perspectives (Mascaro et al., 2020).

Through the lens of the evolutionary perspective, care provision and attachment were key changes that emerged with the mammalian caregiving of offspring (Gilbert, 2017). Caregiving or affiliative mentality, as proposed by the evolutionary model of Social Mentalities Theory, has its roots in this mammalian feature, encompassing motivations to care, to be empathic, and altruist, allowing the individual to be sensitive to others and attend their needs (Gilbert, 2020). Compassion is a motivational system that evolved as part of this caring mentality (Gilbert, 2010), being defined as a sensitivity to suffering in the self and in others, with a commitment to try to alleviate and prevent it (Gilbert, 2017). Compassion includes three interactive flows: the ability to be compassionate toward others, to receive compassion from others, and to direct compassion towards the self (Gilbert, 2020). This mindset allows to attune

to self and others' feelings, and to express warm and safeness in order to regulate negative affect, with benefits for mental health, emotion regulation, and interpersonal relationships (Crocker & Canevello, 2017; MacBeth & Gumley, 2012). As mammals, humans also possess a care seeking social mentality (Gilbert, 2010). In order to survive, when children feel emotionally upset, they express distress and are responsive to others' signals of care and soothing (Bowlby, 1980). When warm and caring experiences are provided, feelings of safeness arise, contributing to a better affect regulation, well-being, and a healthy development (Mikulincer & Shaver, 2020). In contrast, when these needs are not attended and children are exposed to abusive and neglectful experiences, as in the case of those living in RYC, they tend to show disruptions in attachment, poor affect regulation, and a high prevalence of mental health concerns (Campos, et al., 2019; Steinkopf et al., 2020).

According to this theoretical framework, caring also affects the organisation of three evolved emotion regulating systems: the threat, the drive and the soothing systems (Gilbert, 2010, 2017). The threat system serves the functions of self-protection. It was designed to rapidly detect threats and produce negative affect (e.g., fear, anger), and congruent defensive behaviours (e.g., fight, flight, freeze, submit), in order to maintain safety/harm free. The drive system is linked to motivation and rewards. It serves the function of energizing and pursuing resources that are essential to survival, encompassing activating positive emotions (e.g., excitement, joy, pleasure) and congruent behaviours (Depue & Morrone-Strupinsky, 2005; Gilbert, 2017). The soothing system is linked to the mammalian evolution of attachment. It was designed to detect and respond to signs of affiliation (e.g., care, kind attention, hug), and it triggers a different kind of positive affect, such as warmth (i.e., positive and mild emotion involving physiological heat and comfort) and social safeness (i.e., feeling reassured, connected, safe), that ease calming, settling, peacefulness, and openness. The positive and calm affect from the soothing system has been demonstrated to play a key role in down regulating negative affect, reducing psychological distress, and enhancing well-being (Depue & Morrone-Strupinsky, 2005; Gilbert, 2015). The soothing system is developed through a secure attachment with significant caregivers, who calm down the child in face of distress. In contrast, a child with an insecure attachment or whose relationship with caregivers were neglectful, abusive, or threatening, often develop difficulties in accessing the soothing system and reassure themselves (Lee & James, 2012). In addition, they more easily develop an over-stimulated threat system. As a result, they experience heightened vigilance to threats, paired with higher levels of negative affect and consequent automatic defensive responses to those threats. These children also tend to present a drive system focused on immediate rewards, which, combined with an over-

stimulated threat system, can lead to anxiety, frustration or anger, potentiating aggression (Gilbert, 2015).

Due to their exposure to repetitive harmful experiences with significant caregivers, most children and young people in RYC may experience complex trauma and difficulties in regulating emotions (Gilbert, 2015; Jenney, 2020) and, consequently, they present a greater risk of developing psychopathology (Campos, et al., 2019). In addition, they also tend to see others as possible abandoners, rejecters and/or source of harm (Gilbert, 2014), showing difficulties in connecting with others, relying on adults for support and care (Kelly & Dupasquier, 2016; O'Hara, 2019) and forming trusting relationships (Steinkopf et al., 2020). In fact, research indicates that one-third of adolescents in RYC reported they had never, rarely, or only sometimes felt safe (Sellers et al., 2020). These conditions hinder the ability of youth to benefit from RYC (O'Hara, 2019), since their recovery and developmental progress mainly occurs through their engagement with caregivers (Sellers et al., 2020).

Considering both the centrality of affect regulation in responding to trauma, and the role of affiliation in such process (Steinkopf et al., 2020), it seems essential to promote safe and supportive relationships and environments within RYC. Safe relationships are not simply related with the absence of threat. They are characterized by affiliative signals of warmth, kindness, and proximity, in which verbal and non-verbal signs of interest and care are expressed, offering a sense of safeness and providing children and young people a secure base and a safe haven to deal with adversities (Depue & Morrone-Strupinsky, 2005; Gilbert, 2015). A safe and positive climate (i.e., how the environment of the organization is perceived by those who live or work there and it impacts their affective response; Glisson, 2007) comprises high levels of support and autonomy, low levels of repression, and a safe and structured environment, based in warmth, affection, and closeness with caregivers (Leipoldt et al., 2019). Such social and contextual conditions may play a therapeutic role, that complements and extends beyond the psychotherapeutic interventions, contributing to the quality of services and better outcomes (Costa et al., 2020; Jenney, 2020; Sellers et al., 2020).

By cultivating a compassionate mind set, Compassionate Mind Training (CMT) aims to develop and strengthen affiliative affect (Gilbert, 2010). As mentioned before, compassion sets the base not only to care provision, but also to foster flourishing relationships (Pinard et al., 2020), and well-being (MacBeth & Gumley, 2012). For those reasons, compassion training has been delivered to helping professionals in other settings (Delaney, 2018; Matos et al., 2022; Patel et al., 2019) and to parents (Bratt et al., 2019), showing promising results that could also be relevant in RYC.

When providing care, if caregivers adopt a compassionate attitude towards youth, they may be more competent in calming and soothing them, while helping them to appropriately regulate their emotions. As a result, youth may gradually develop self-reassurance, and regulate their suffering in a healthier manner (Gilbert, 2015). Nevertheless, caregivers' capacity to provide a caring supportive relationship might be threaten if they feel overwhelmed by youth challenging behaviours and more easily detach from youth's needs (Steinkopf et al., 2020). Thus, it is essential that caregivers may be able to self-regulate their emotions and behaviours across time, in face of the requirements of this specific care setting. On the one hand, to avoid both the risk of coercive interactions and the modelling of inappropriate coping strategies (Scaramella & Leve, 2004) and, on the other hand, to maintain their own well-being (Ford & Blaustein, 2013). Research revealed that self-compassion is linked to increased well-being, and reduced stress and burnout (Babenko et al., 2019). By enhancing self-compassion, caregivers could be more motivated to take care of their own emotional needs, while taking care of the suffering others.

Research also suggested that compassion and self-compassion are also linked to cooperative mindsets, which lead to feeling more at ease and connected with others, and to better social relationships (Crocker & Canevello, 2017). This mindset could be particularly helpful in RYC settings, considering that in helping services, organizational characteristics such as work climate and the quality of interactions between co-workers, are often considered more stressful than interactions with clients *per se*, and these interactions have been identified as a significant burnout predictor (Del Valle et al., 2007). In turn, social support has been suggested to buffer caregivers' burnout (Seti, 2008). Hence, compassion towards others may be useful not only to enhance care provision, but also to improve relationships between co-workers. A compassionate person is more sensible not only to suffering, thus more prompt to provide social support, but it is also more sensible to signs of emotional warmth from colleagues. In turn, individuals who feel safe and supported more easily cope with challenging conditions (Cosley et al., 2010), and are less predisposed to stress and related conditions (Steinlin et al., 2017). When trained in teams, compassion may improve the quality of team-based relational exchanges and increase social safeness (Pinard et al., 2020).

Despite the relevance of relationships within RYC, the evaluation of interventions' effects on affiliation is relatively scarce (Hermenau et al., 2017; Santos et al., 2023b). Some programs delivered at the organizational-level revealed some evidence in this matter (e.g., Izzo et al., 2020; Parry et al., 2021). However, the complexity and multiplicity of components at different levels (e.g., training staff, leadership, intervention for children and youth) that organizational-wide interventions usually include may preclude the use of randomized

controlled trials (RCT) to test their effectiveness (Bailey et al., 2019; Bunting et al., 2019; Esaki et al., 2013). Despite RCTs are considered the golden standard to test interventions effectiveness (Hariton & Locascio, 2018), they are still scarce in RYC (Hermenau et al., 2017; Santos et al., 2023b).

Considering that the creation of a safe place for caregivers is just as important as creating a safe place for youth (Steinkopf et al., 2020; Steinlin et al., 2017), and intervention is needed to address not only youth social and emotional needs (Costa et al., 2020; Jenney, 2020), but also the emotional needs of caregivers (Perry et al., 2020), the current study aims to test the effectiveness of a Compassionate Mind Training for Caregivers (CMT-Care Homes) in fostering a compassionate mindset and environment in RYC. This program aims to promote an affiliative mentality and a nurturing environment through secure relationships between caregivers and youth and between co-workers. A cluster randomized trial enrolling youth and their caregivers was conducted to test its effects and their maintenance across time. Since this program is targeted for RCHs teams, for practical reasons, the unit of randomization was the RCH (i.e., cluster). The CMT-Care Homes' preliminary findings pointed out to its capacity in promoting safer relationships and climate. Nevertheless, this first study only looked at pre-post intervention and did not include youth (Santos et al., 2022). The current study research questions were: (1) Is the CMT-Care Homes effective in cultivating compassion and self-compassion in caregivers across time? (2) Did youth feel safer with others after their caregivers' participation on the CMT-Care Homes? (3) Did youth and caregivers perceive improvements in the RCH climate? (4) Are the effects of CMT-Care Homes sustained across time?

It is hypothesized that the CMT-Care Homes would allow to cultivate a compassionate mindset on caregivers. In addition, it is expected that youths whose caregivers participated in the program would feel higher levels of social safeness and perceive a calmer climate in RCH, when compared with youths of RCHs allocated to the control group. The same is expected to occur in relation to caregivers. It is hypothesized that the effects of the CMT-Care Homes would be maintained at 6-month follow-up.

Method

This trial was registered at ClinicalTrials.gov (Identifier: NCT04512092) and followed the standards of Consort 2010 to cluster randomized trials (Campbell et al., 2012).

Participants

This study was carried out between 2019 and 2020 in 12 Portuguese Residential Care Homes (RCH). The following cluster eligibility criteria were considered: (1) RCHs were included

if they receive youths aged between 12 and 25 years old, located in the center of Portugal; (2) RCHs specialized in mental and behavioral disorders and/or substance abuse problems were excluded, because they adopt different and specific intervention models. Participants eligibility criteria for youth were: having 12 (younger children were excluded since self-report could be inconsistent or biased due to cognitive and language skills; Conijn et al., 2020) to 25 years old (maximum age comprised in the Portuguese Law for RYC); and no cognitive impairment (as identified by RCHs' psychologists). Regarding caregivers, all professionals who were directly involved in the delivery of services to youth on a regular basis were invited to collaborate. A table with the number of staff members and youth from each RCH can be found on supplementary material. Reasons for not having participated were not collected.

This study comprises two samples, composed of 127 caregivers and 154 youth living in the same RCHs where caregivers work. Randomization took place at the cluster level after baseline assessment. Six RCHs were allocated to the treatment group, and six RCHs were allocated to the control group.

Caregivers were mostly female (89%), and were aged between 22 and 62 years old, with a mean age of 43.99 (SD = 10.96). The majority of them were married (69%), 23% were single and 7.9% were divorced. Participants had been working within RYC settings for less than a month to 39 years (M= 11.95, SD = 8.99), having a technical (29.4%; e.g., technical director, psychologist, social worker), educative (63.5%; e.g., educational assistant) or support (7.1%; e.g., cleaning staff, cook) function. Half of the them (52%) reported working in shifts. Concerning their educational level, 44.1% of the caregivers had a higher education degree, 19.7% reported having completed high school, and 36.2% some level of elementary or middle school education. No statistically significant differences between groups were found in sociodemographic features (Table 1).

Youth sample were mostly composed of female participants (55.8%), aged between 12 and 23 years old (*M* = 16.19, *SD* = 2.07). Most of them were from Portuguese citizenship (97.4%) and lived in the current RCH for an average of 40.81 months (*SD* = 41.94), ranging from 1 to 216 months. For most of them (62.3%), this is the first placement in RYC. The main reason for referral was neglect (46.8%), followed by different types of abuse (27%; e.g., physical, psychological or sexual), deviant behavior (9.7%), abandonment or temporary absence of family support (10.6%), or other reasons (4.5%). Concerning the educational level, most participants (49.3%) were attending a middle school, 38.8% high school, 5.9% elementary school, and 5.9% university. Youth in treatment group were statistically significant older than controls. Groups also differ on the school level (Table 2).

Table 1. *Caregivers' sociodemographic features by group*

	Treatment group (N = 66)		Control group (N = 61)				
	M	*SD*	*M*	*SD*	*t*	*p*	Cohen's *d*
Age	42.92	10.90	45.15	11.00	-1.143	.255	.204
Years of work in RCH	10.77	7.89	13.25	9.98	-1.536	.127	.276
	N	*%*	*N*	*%*	χ2	*p*	Cramer's *V*
Gender							
Male	5	7.6	9	14.8	1.665	.197	0.115
Female	61	92.4	52	85.2			
Marital Status							
Single	19	28.8	10	16.7	2.926	.232	0.152
Married	43	65.2	44	73.3			
Divorced	4	6.1	6	10.0			
Education degree							
Elementary/middle school	24	36.4	22	36.1	5.710	.058	0.212
High school	8	12.1	17	27.9			
Higher education degree	34	51.5	22	36.1			
Profession							
Technical Director	6	9.1	2	3.3	6.104	.729	0.220
Psychologist	8	12.1	6	10.0			
Social worker	5	9.1	3	5.0			
Social educator	6	9.1	6	10.0			
Educational assistant	34	51.5	36	60.0			
Socio-educational animator	2	3.0	1	1.7			
Teacher	1	1.5	0	0			
Cleaning staff	1	1.5	4	6.7			
Cook	3	4.5	2	3.3			
Staff functions							
Technical	22	33.3	15	25.0	1.152	.562	0.096
Educative	40	60.6	40	66.7			
Support	4	6.1	5	8.3			
Shifts							
Yes	36	54.5	30	49.2	.366	.545	0.054
No	30	45.5	31	50.8			

Note. Elementary and middle school education correspond to 4 to 9 years of school; High school from 10 to 12 years of school; Higher education degree are Bachelor or Master degrees. In Portugal, each RCH has technical (case managers), educational (ensure the daily routine and care provision), and support (cooking and cleaning) professionals. Despite their different roles, all professionals are directly involved in the delivery of services to children and youth on a regular basis, and for that reason all of them were considered caregivers.

Table 2. *Youth sociodemographic features by group*

	Treatment group (N = 65)		Control group (N = 89)				
	M	*SD*	*M*	*SD*	*t*	*p*	Cohen's *d*
Age	16.66	1.95	15.84	2.10	2.468	.015	.405
Length of stay in the current RCH	40.97	44.01	40.69	40.61	.041	.967	.007
	N	*%*	*N*	*%*	χ2	*p*	Cramer's *V*
Gender							
Male	24	36.9	44	49.4	2.386	.122	0.124
Female	41	63.1	45	50.6			
Education level							
Elementary school	1	1.5	8	9.2	12.629	.006	0.288
Middle school	26	40.0	49	56.3			
High school	35	53.8	24	27.6			
University	3	4.6	6	6.9			
First placement							
Yes	45	69.2	51	57.3	2.276	.131	0.122
No	20	30.8	38	42.7			
Reasons for placement							
Neglect	31	48.4	35	45.5	8.404	.494	0.244
Physical abuse	5	7.8	4	5.2			
Emotional/psychological abuse	9	14.1	11	14.3			
Sexual abuse	5	7.8	4	5.2			
Deviant behavior	4	6.3	11	14.3			
Abandonment	3	4.7	2	2.6			
Lack of family support	6	9.4	4	5.2			
Others	1	1.6	6	7.8			

Note. Elementary school correspond to 5 to 6 years of school, Middle school from 7 to 9 years of school; High school from 10 to 12 years of school; University corresponds to frequency of higher education.

Sample size

Effective sample size was determined for usual factorial (2 groups) repeated measures (3 assessments) between factors, using G*Power, version 3.1.9.7, considering alpha = 0.05, a medium effect size (Cohen's f =0.36) to obtain at least 80% power, assuming a 0.80 correlation coefficient within repeated measures. Under these assumptions, a total of 56 participants should be enrolled.

Intervention

The CMT-Care Homes is a 12-session group program developed for professional caregivers working in RYC. Main goals are to cultivate a compassionate mind and to foster a caregiving mentality in RYC. The program is manualized, being mostly based on the Compassion Focused Therapy (Gilbert, 2010, 2020) theoretical framework (e.g., affect regulation systems) and compassionate mind training practices (e.g., soothing rhythm breathing, compassionate friend, compassionate letter) adapted to RYC. For instance, caregivers are trained to balance their own affect regulation systems and also to help youth to balanced their systems, namely by

reducing potentially threatening stimulus and reinforcing affiliative behaviors (e.g., calm voice tone and touching/hugging when appropriate) to stimulate youths' soothing system.

Each session has 2.5-hours and should be delivered weekly in a face-to-face format with a group composed of 6 to 12 participants, in a total of 30 hours of group training. The 12 sessions are divided across three sequential modules. Module one (6 sessions) provides insight into the evolved and socially shaped mind and the affect regulation systems, explaining human suffering in light of an evolutionary perspective and the unbalance of the affect regulation systems. Attributes and competencies of compassion (e.g., reasoning, mentalizing, compassionate action, mindful attention, soothing the body and the mind) are trained on the second module (5 sessions) to cultivate the three flows of compassion and address compassion fears, blocks, and resistances (Gilbert, 2020). The last module corresponds to the final session, where learnings are revised and their transference to the RCH is reinforced. Program contents are explored through psychoeducation and experiential practices (e.g., imagery, role-plays) followed by group opportunities to share experiences and debates. Formal meditation is practiced in all sessions and it is encouraged to be practiced daily at home. A compassionate weekly challenge is also given to encourage the transference of learnings to caregivers' daily routine and work tasks. A more detailed description can be consulted on the handbook (Santos et al., 2020).

Measures for caregivers

Compassion Scale (CS; Pommier, 2011; Portuguese version by Sousa et al., 2017)

The CS is a 24-item self-report scale that measures compassion for others. Items are answered according to how frequently participants feel and act towards others, using a 5-point scale (1 = almost never to 5 = almost always). The original version has a total score (α = .90) and six subscales (Kindness, Common Humanity, Mindfulness, Indifference; Separation, and Disengagement), with alpha values ranging from .57 (Disengagement) to .77 (Kindness; Pommier, 2011). In the current study, we used the two-factor model found in the Portuguese version, which represents a positive and a negative valence of compassion: Compassion (comprising the positive subscales: Kindness, Common Humanity, Mindfulness) and Disconnectedness (comprising the negative subscales: Indifference, Separation and Disengagement), with alpha of .91 and.92, respectively (Sousa et al., 2017). In the current study, alpha coefficients were .79 for Compassion and .85 for Disconnectedness.

Self-Compassion Scale (SCS; Neff, 2003; Portuguese version by Castilho et al., 2015)

The SCS is a 26 self-reported scale assessing self-compassion. Items are answered according to "how I typically act towards myself in difficult times", using a 5-point scale (1 =

almost never to 5 = almost always). The original version has a total score (α = .92) and six subscales (Self-Kindness, Self-Judgement, Common Humanity, Isolation, Mindfulness, and Over-Identification), with alpha values ranging from .75 (Mindfulness) to .81 (Over-Identification; Neff, 2003). In the current study, a two-factor model found in the Portuguese version was used: Self-Compassionate attitude (comprising the positive subscales: Self-Kindness, Common Humanity, Mindfulness) and Self-Critical attitude (comprising the negative subscales: Self-Judgement, Isolation and Over-Identification), with Cronbach's alpha of .91 and.89, respectively (Costa et al., 2015). In the current study, alpha values were .87 and .88, respectively.

Social Safeness and Pleasure Scale (SSPS; Gilbert et al., 2009; Portuguese version by Dinis et al., 2008)

SSPS is an 11-item unidimensional self-report scale assessing how people experience the world as safe, warm, and soothing. Items are rated through a 5-point scale (1 = almost never to 5 = almost all the time). The original version achieved excellent internal consistency (α = .91; Gilbert et al., 2009). In the current study, the Cronbach's alpha was .88.

Emotional Climate in Organizations Scales (ECOS; Albuquerque et al., 2020)

The ECOS is a 30-item self-report scale, aiming to assess how workers felt and behaved at their workplace. Only the first part (how workers felt; 15 items) was used. It is composed of three subscales, referring to the three affect regulation systems: the threat, the soothing, and the drive systems, aiming to assess the emotions felt in the workplace. Items are answered according to a 5-point scale (0 = never to 4 = always). The original scale showed adequate internal consistency: Cronbach's alphas were .75 for the threat system, .86 for the drive system, and .83 for the soothing system related emotions (Albuquerque et al., 2020). In the current sample, Cronbach's alphas were .72 for the threat, .80 for the drive, and .72 for the soothing system related emotions.

The Professional Quality of Life Scale, version 5 (ProQOL-5; Stamm, 2010; Portuguese version by Carvalho, 2011)

ProQOL is a 30-item self-report scale measuring positive and negative effects of working in stressful environments. ProQOL is composed of three subscales: Compassion Satisfaction (CS), Burnout (BO), and Secondary Traumatic Stress (STS). Items are answered using a 5-point scale (1 = never, to 5 = very often), according to how frequently they were experienced at the workplace in the previous 30 days. The original version reported internal consistency values of .88 for CS, .75 for BO, and .81 for STS (Stamm, 2010). The Portuguese version also showed adequate internal consistency values (CS α = .86, BO α = .71, STS α = .83; Carvalho, 2011). In this

study, BO and STS were included as covariates, showing Cronbach's alphas of .64 and .67, respectively.

Measures for youth

Social Safeness and Pleasure Scale for adolescents (SSPS-A; Gilbert et al., 2009; Portuguese version for adolescents by Miguel et al., 2022)

SSPS-A is the adolescents' version of the SPSS, which was described above. It also comprises 11-items, which were adapted to facilitate its comprehension by adolescents. Scale and instructions were the same. The Portuguese version presented excellent Cronbach's alpha (α = .94; Miguel et al., 2022). In the current study, the Cronbach's alpha was .96.

Emotional Climate in Residential Care – Youths (ECRC-Y; original version by Albuquerque et al., 2021; adapted by Santos et al., 2023a)

ECRC-Y is a 14-item self-report scale assessing the emotional climate of the residential care home, over the past two weeks, as perceived by youths who live there. The ECRC-Y comprises three subscales, describing different emotions associated to the three affect's regulation systems: threat, drive, and soothing systems. Items are answered according to a 5-point scale (0 = never, to 4 = always). The ECRC-Y showed adequate Cronbach alphas (.71 for threat, .89 for drive and .82 for soothing), and proved to be sex invariant (Santos et al., 2023a). In this study, the internal consistency value was .71 for threat, .90 for drive and .87 for soothing system related emotions.

Current Experiences of Warmth and Safeness Scale for adolescents (CEWSS-A; Santos et al., 2021)

CEWSS-A is a 12-item unidimensional self-report scale, designed to assess how often adolescents felt emotional experiences of care, warmth, and safeness with caregivers, along the two previous weeks. Items are answered using a 5-point scale (0 = no, never, to 4 = yes, most of the time). The CEWSS-A presented an excellent internal consistency value (α = .94) and proved to be sex invariant (Santos et al., 2021). In this study, the internal consistency value was .96.

Procedures

The current study was approved by the Ethics Committee of the Faculty of Psychology and Educational Sciences of the University of Coimbra. RCHs from the center of Portugal, listed in a national database, were contacted and information about the study goals and procedures were provided. Written informed consent was sought for experimentation with human subjects at the cluster (i.e., boards of each RCH) and at the individual levels (i.e., caregivers and youth),

before randomization. Written informed consent was also obtained from legal guardians of youth under 18 years old. All participants were informed of the goals and procedures, and were asked to voluntarily participate. No incentives were offered for participation. Data were anonymized with respondent-specific codes, which were also used to link the data from one timepoint to the other. Both youth and their caregivers filled out the previously described self-report instruments at baseline, post-treatment, and 6-month follow-up. Follow-up assessments occurred during the Covid-19 first wave (June/July 2020). Instruments were filed out with the assistance of a master student (when possible) or were sent to each RCH to be filled out individually by caregivers, and collected by the RCH psychologist with youth in small groups. Items were read aloud individually when youth showed difficulties in reading or understanding. After the baseline assessment, a computer-generated randomization was conducted at the cluster level, following a completely randomized design by the third author of this paper. Each RCH (i.e., cluster) was randomly assigned to treatment or control group (i.e., no training in compassion or any other group interventions). Subsequently, caregivers from the treatment group attended the CMT-Care Homes program, which was delivered weekly (2.5-hr session) during suitable hours for both day and night staff. The program was held in accordance with the handbook, in a face-to-face format, to a group of 6-10 participants, in each RCH, over approximately 3 months. It was delivered by the first author, who is a clinical psychologist skilled in compassion and cognitive-behavioral interventions.

Data analysis

Data was analyzed using IBM SPSS Statistics v25. Prior to analysis, data was screened for missing, outliers, and Multivariate Analysis of Covariance (MANCOVA) assumptions (Tabachnick & Fidell, 2013). Missing data were examined by incidence and distribution. Participants presenting more than 20% of missing values in an outcome variable were removed (Peng et al., 2006). Little's (1988) MCAR tests revealed that data in some variables were not missing completely at random ($p < .05$). Missing values were dealt via linear interpolation imputation (Meyers et al., 2006).

Baseline differences between groups were examined for demographics and for outcome variables, via independent samples t-tests and chi-square statistics.

Although skewness and kurtosis coefficients (SK <| 3 | and Ku <| 10 |; Kline, 2005), indicated a normal univariate distribution, multivariate normally was not met (assessed via Mardia’s test; Korkmaz et al., 2014). Yet, this violation can be disregarded due to the absence of multivariate outliers (investigated via Mahalanobis distance; Tabachnick & Fidell, 2013). The only outlier found (youth sample) was deleted. The Box’ M test was non-significant (p > .001;

Field, 2018), guaranteeing the homogeneity of variance-covariance matrices. Multicollinearity was absent ($r < .90$; Tabachnick & Fidell 2013).

General Linear Model (GLM) of repeated measures two-factor Multivariate Analysis of Covariance (MANCOVA, i.e., between subjects—groups—and within subjects—time) was used to investigate the intervention effects on the multiple outcomes for caregivers and youth, separately. Covariates were included, assuming their potential influence on the outcome variables. Sex, years of service, burnout, and traumatic secondary stress (STS) were considered for caregivers. Reasons were: (1) gender differences on compassion and self-compassion reported on research (Yarnell et al., 2015); (2) the number of years of work spent in this challenging field may increase vulnerability and decrease motivation to care (Kind et al., 2018); (3) the association of burnout with greater barriers to compassion (Dev et al., 2018); (4) strong correlation between burnout and STS (Cieslak et al., 2014). For youth, age, education level, and current experiences of warmth and safeness were included as covariates, in order to control for the existing differences between groups at baseline. The length of stay was also included since it may influence relationships (Lino et al., 2016).

Considering that MANCOVA assumptions were not fully met, the Pillai's Trace was chosen for multivariate test. Mauchly's test was checked to verify sphericity. When this assumption was not met, the Greenhouse-Geisser epsilon were checked and when $\varepsilon > .75$ Huynh-Feldt criterion was used in univariate tests. Effect sizes for the time effects and time × group effects were calculated using partial eta squares ($\eta 2\ p$), with $\eta 2\ p = .01$ referring to a small effect size, .06 to a medium effect size and .14 to a large effect size (Tabachnick & Fidell, 2013). To understand within group differences, Cohen's d was computed for long-term (T1-T3) change, as well as to short-term changes (T1-T2 and T2-T3). The following reference values were considered: .15 indicating a small effect, .36 a medium effect, and .65 a large effect (Lovakov & Agadullina, 2021).

Results

Recruitment and retention

Twelve RCHs participated on this study. Caregivers (n = 127) and youth (n = 154) from the RCHs that accepted to participate completed the baseline assessment (Figure 1).

RCHs were randomly distributed to the treatment (6 RCH) and control groups (6 RCH). Of the initial 66 participants allocated to the treatment group, seven (10.61%) did not complete the program. Fifty-nine (89.39%) participants completed the intervention, 57 the posttreatment assessments (86.36%), and 48 (72.73%) the 6-month follow-up assessment. Caregivers in the

treatment group attended 5 to 12 sessions (*M* = 9.52; *SD* = 1.99). The main reasons for not completing the program were working in shifts/day off, vacation, brief medical discharge or urgent professional diligences. Four caregivers who attended less than 60% of the sessions were excluded from the analyses. Another two were excluded due to missing data. Of the 61 caregivers allocated to the control group, 51 (83.61%) completed the posttreatment assessment, and 41(67.21%) completed the 6-month follow-up assessment. Six participants were excluded from analyses due to missing data.

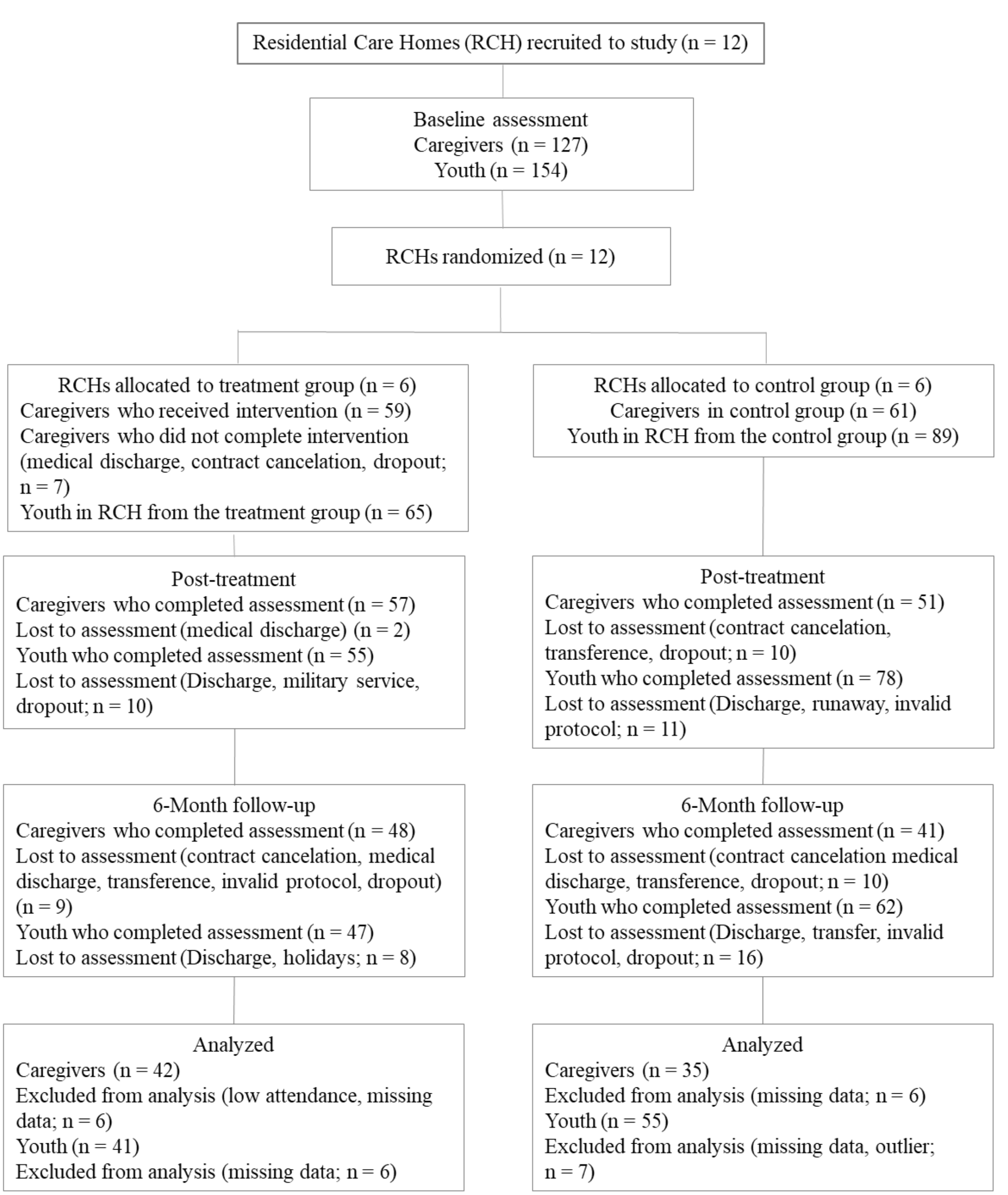

Figure 1. *Flowchart of caregivers and youth participation*

In total, 77 caregivers (88.3% females), aged between 22 and 62 years old, with an average of 12.60 years of service (*SD* = 9.36), were included in the analysis (treatment group = 42; control group = 35). Regarding the differences in the demographics between those who completed the study and those who dropped out, differences were found on the caregivers from the control group on age [t (59) = 2.365; p = .021; Completers M = 47.39, SD = 9.89 and Non-completers M = 40.55, SD = 11.97] and length of time working in residential care settings [t (54) = 2.661; p = .010; Completers M = 15.15, SD = 10.77 and Non-completers M = 9.16, SD = 6.52]. There were no differences between completers and non-completers in the remaining variables for the control group and no differences were found between completers and non-completers for any of the assessed variables in participants from the treatment group.

Of the 65 youth from RCHs allocated to the treatment group, 55 (84.62%) completed the posttreatment assessment, and 47 (72.31%) the 6-month follow-up assessment. Six youth were further excluded from analyses due to missing data. Of the 89 youth from RCHs allocated to the control group, 78 (87.64%) completed the posttreatment assessment, and 62 (69.66%) the 6-month follow-up assessment. Six youth were excluded from analyses due to missing data and one was deleted for being considered an outlier.

In total, 96 youth (56.3% females), aged between 12 and 23 years old, were included in the analysis (treatment group RCHs = 41; control group RCHs = 55). Regarding differences in the demographics between youth who completed the study and those who dropped out, and for the control group, non-completers were older [t (86) = -3.313; p = .001; Completers M = 15.39, SD = 2.04 and Non-completers M = 16.92, SD = 1.85]. There were no differences in the remaining variables for the control group participants. No differences were found between completers and non-completers concerning treatment group participants.

Baseline Differences

No statistically significant differences were found between caregivers of the treatment and control groups at the onset of the study for demographic (cf., Table 1) and outcome measures (all $p > .05$) (cf., Table 3). Youth from treatment and control RCHs differed on age, school level (cf. Table 2), and current experiences of warmth and safeness (cf. Table 3). Youth from RCHs from the two groups did not differ in the remaining outcome measures. Current experiences of warmth and safeness was included as a covariate, instead of an outcome, when analyzing data from youth.

Table 3. *Baseline differences on the outcome measures for caregivers and youth*

Caregivers	Treatment group (N = 66)		Control group (N = 61)		*T*	*p*	Cohen's *d*
	M	*SD*	*M*	*SD*			
Compassion Scale							
Compassion	49.95	5.90	49.44	4.84	.477	.634	0.095
Disconnectedness	22.53	7.05	24.34	5.93	-1.419	.159	0.278
Self-compassion Scale							
Self-Compassionate attitude	42.81	6.99	42.24	6.19	.444	.658	0.086
Self-critical attitude	32.27	7.48	33.58	7.22	-.916	.362	0.178
Social Safeness and Pleasure Scale	41.04	6.30	41.74	6.41	-.569	.570	0.110
Emotional Climate							
Threat related emotions	7.91	2.51	7.02	2.84	1.705	.091	0.332
Drive related emotions	13.01	2.59	12.78	2.45	.466	.643	0.091
Soothing related emotions	12.39	2.42	12.60	2.28	.262	.794	0.089
Youth	**Treatment group (N = 65)**		**Control group (N = 89)**		***T***	***p***	**Cohen's *d***
	M	*SD*	*M*	*SD*			
Current experiences of warmth and safeness	32.31	10.79	27.85	12.36	2.331	.021	0.367
Social Safeness and Pleasure Scale	36.77	11.60	34.72	11.38	1.095	.275	0.178
Emotional Climate							
Threat related emotions	8.94	4.36	9.31	4.28	-.521	.603	0.086
Drive related emotions	12.10	5.43	11.32	5.26	.862	.390	0.146
Soothing related emotions	11.86	5.20	10.90	4.80	-.454	.651	0.192

Two-factor mixed MANCOVA

Caregivers

Multivariate tests showed a statistically significant Time × Group interaction effect (Pillais' trace = .460, F = 2.987, p = .001), with a large effect size (η_p^2 = .460). Univariate tests for Time × Group interaction indicated that there were statistically significant intervention effects for self-reported measures of compassion towards others, self-compassion, social safeness, and emotional climate (threat and soothing related emotions), favoring the treatment group. Comparisons between groups achieved small to medium effect sizes. No differences were found between groups for self-reported measures of disconnectedness, self-critical attitude, neither on emotional climate drive related emotions (Table 4).

When examining means, standard deviations, and corresponding effect sizes (Cohen's d for each group), the treatment group gradually increased the levels of compassion towards others from pre-intervention to follow-up (Cohen's d = .32). On the contrary, the control group gradually deteriorated on compassion towards others in the same interval (Cohen's d = .33). Regarding self-compassion, while the treatment group maintained a self-compassionate attitude, showing a small tendency to increase over time, from pre-intervention to follow-up

(Cohen's d = .06), the control group gradually decreased their self-compassionate attitude in the three assessment moments (Cohen's d = .36).

Improvements from pre-intervention to 6-month follow-up were also found on the emotional climate for the treatment group (Cohen's d = .40, both for threat and soothing related emotions). Specifically, threat-related emotions decreased after the program (Cohen's d = .37), and were maintained from post-intervention to follow-up (Cohen's d =.02). Soothing related emotions increased after the program completion (Cohen's d =.45) and were maintained from post-intervention to follow-up (Cohen's d =.01). In the control group, the perception of emotional climate was kept stable from pre-intervention to 6-month follow-up (Cohen's d = .12 for threat, Cohen's d = .15 for soothing), showing though an increasing of threat related emotions from posttreatment to follow-up (Cohen's d = .22).

In what concerns social safeness, although little change occurred from pre-intervention to follow-up in both the treatment (Cohen's d =.16) and control (Cohen's d =.11) groups, when inspecting short term changes, both groups showed oscillations. After the program delivery, social safeness improved in the treatment group (Cohen's d = .21), and it was maintained from post-intervention to follow-up (Cohen's d = .05). The control group deteriorated from pre- to post-intervention (Cohen's d = .31), but improved again from post-intervention to follow-up (Cohen's d = .43).

Within group comparisons were of small and medium effect sizes.

Youth

Multivariate tests showed a statistically significant Time × Group interaction effect (Pillais' trace = .226, F = 3.036, p = .005), with a large effect size (η_p^2 = .226). Univariate tests for Time × Group interaction indicated that there were statistically significant effects for self-reported measures of social safeness and emotional climate soothing related emotions, favoring the youths living in the RCHs allocated to the treatment group. Comparisons between groups corresponded to small effect sizes. Concerning the self-reported measures of threat and drive related emotions in RCHs emotional climate, no differences were found between groups (Table 5).

Table 4. *Mean scores and standard deviations for caregivers of both groups at baseline, post-intervention, and 6-months follow-up, and univariate tests*

	Treatment group (N = 42)			Control group (N = 35)			ICC (CI)	Time	Time x Group
	T1 M (SD)	T2 M (SD)	T3 M (SD)	T1 M (SD)	T2 M (SD)	T3 M (SD)			
Compassion for others									
Compassion	49.62 (5.85)	50.75 (6.03)	51.44 (5.64)	50.20 (4.95)	48.86 (5.09)	48.31 (6.34)	.82 (.74-.88)	F = 2.077; p = .129; η^2_p = .028	F = 6.959; p = .001; η^2_p = .089
Disconnectedness	21.94 (6.80)	20.82 (5.94)	21.24 (5.55)	23.81 (5.58)	23.76 (5.91)	23.76 (7.12)	.77 (.67-.85)	F = 0.210; p = .811; η^2_p = .003	F = 0.298; p = .743; η^2_p = .004
Self-compassion									
Self-compassion attitude	43.24 (7.70)	43.45 (7.01)	43.71 (7.86)	43.06 (6.07)	41.46 (5.24)	40.94 (5.88)	.87 (.82-.92)	F = 0.779; p = .461; η^2_p = .011	F = 3.237; p = .042; η^2_p = .044
Self-critical attitude	31.00 (7.33)	31.75 (7.55)	31.16 (7.88)	33.77 (7.07)	31.36 (6.64)	33.20 (7.85)	.88 (.82-.92)	F = 0.086; p = .917; η^2_p = .001	F = 2.779; p = .065; η^2_p = .038
Social safeness	41.50 (6.55)	42.81 (5.98)	42.49 (5.82)	42.54 (6.25)	40.71 (5.58)	43.21 (6.11)	.80 (.71-.87)	F = 0.717; p = .490; η^2_p = .010	F = 4.731; p = .010; η^2_p = .062
Emotional Climate									
Threat emotions	7.74 (2.71)	6.74 (2.75)	6.69 (2.60)	6.86 (2.89)	6.61 (2.66)	7.20 (2.77)	.77 (.67-.85)	F = 0.132; p = .876; η^2_p = .002	F = 5.153; p = .007; η^2_p = .068
Drive emotions	13.14 (2.64)	13.93 (2.50)	13.55 (2.49)	12.70 (2.51)	13.29 (2.60)	12.91 (2.66)	.81 (.73-.88)	F = 0.703; p = .497; η^2_p = .010	F = 0.178; p = .837; η^2_p = .003
Soothing emotions	12.71 (2.41)	13.74 (2.22)	13.71 (2.63)	12.64 (2.41)	12.87 (2.55)	13.00 (2.54)	.78 (.68-.85)	F = 0.369; p = .692; η^2_p = .005	F = 3.097; p = .048; η^2_p = .042

Note. T1 = baseline; T2 = post-intervention; T3 = 6-month follow-up; M = Mean; SD = Standard deviation; ICC = Intraclass correlation coefficient; CI = Confident interval (95%); η2p = partial eta square.

Table 5. *Means and standard deviations for youth from RCHs of both groups at baseline, post-intervention, and 6-months follow-up, and univariate tests*

	Treatment group (N = 41)			Control group (N = 55)			ICC (CI)	Time	Time x Group
	T1 M (SD)	T2 M (SD)	T3 M (SD)	T1 M (SD)	T2 M (SD)	T3 M (SD)			
Social safeness	37.29 (11.80)	38.17 (9.86)	36.71 (12.36)	37.02 (11.49)	34.09 (10.16)	36.36 (11.27)	.84 (.77-.89)	F = 2.307; p = .103; η^2_p = .025	F = 3.421; p = .035; η^2_p = .037
Emotional Climate									
Threat emotions	6.32 (4.11)	5.34 (3.86)	6.43 (3.53)	6.65 (3.69)	7.13 (3.32)	6.29 (3.94)	.74 (.63-.82)	F = 1.300; p = .275; η^2_p = .014	F = 2.440; p = .090; η^2_p = .026
Drive emotions	13.46 (5.34)	13.83 (5.74)	12.80 (5.20)	12.56 (4.67)	12.00 (3.70)	12.13 (4.47)	.81 (.74-.87)	F = 0.482; p = .611; η^2_p = .005	F = 0.664; p = .510; η^2_p = .007
Soothing emotions	12.28 (5.70)	13.15 (4.68)	11.41 (4.36)	12.14 (4.53)	10.91 (3.97)	11.44 (3.87)	.79 (.70-.85)	F = 0.030; p = .963; η^2_p < .001	F = 5.243; p = .008; η^2_p = .055

Note. T1 = baseline; T2 = post-intervention; T3 = 6-month follow-up; M = Mean; SD = Standard deviation; ICC = Intraclass correlation coefficient; CI = Confident interval (95%); η2p = partial eta square.

When examining means, standard deviations, and corresponding effect sizes, little changes seemed to have occurred from pre-intervention to follow-up for social safeness (Cohen's d =.05 for treatment; Cohen's d =.06 for control) and for emotional climate soothing related emotions (Cohen's d =.17 for treatment and control) in both groups. Yet, when inspecting short term changes, mixed outcomes were found. After the participation of their caregivers in the CMT-Care Homes, youth reported small improvements on social safeness (Cohen's d = .08) and perceived the emotional climate a little bit more soothing/safer (Cohen's d = .17). However, these improvements were not sustained from post-intervention to follow-up (.13 and .36, respectively). Youth in the RCHs allocated to the control group reported a decrease both on social safeness (Cohen's d = .27) and on soothing emotional climate (Cohen's d = .29) at posttreatment, but reported an increase on those variables from post-intervention to follow-up (.21 and .14, respectively). Within group comparisons were of small effect sizes.

Discussion

This cluster randomized trial examined the effects of the Compassionate Mind Training for Caregivers (CMT-Care Homes) on compassion related variables in caregivers and on social safeness and emotional climate as perceived by youth and their caregivers in RYC across time. The CMT-Care Homes was designed to promote an affiliative mentality in caregivers in order to provide warmer and supportive experiences to youth in a safer environment. By using the lens of youth, this study evaluates whether changes in compassion as reported by caregivers were also felt by youth.

Despite caregivers' groups were balanced at the baseline, results suggested a borderline difference in the distribution by educational level when comparing groups. Specifically, treatment group included higher number of subjects possessing a university degree, while the control group had more subjects with a high school degree. This could associate with better adherence to treatment and eventually better outcomes for the treatment group. Nevertheless, both groups were balanced regarding the number of participants with elementary/middle school degree, participants who may present more difficulties about the contents of such kind of interventions. Data on recruitment and retention showed that most caregivers (89.39%) completed intervention. Approximatively 85% of participants (85% of caregivers and 86% of youth) completed the posttreatment assessments, and 71% of caregivers and youth completed the 6-month follow-up assessment. Regarding dropouts in the youth sample, non-completers in the control group were older than completers, which might be linked with participants reaching the care leaving age. These findings suggest favorable retention and adherence rates.

Two Multivariate Analyses of Covariance (MANCOVA), controlling for youth and caregivers' covariates, were performed in order to investigate the effects of the CMT-Care Homes on affiliative outcomes as perceived both by youth and their caregivers across time. Findings from the multivariate analyses revealed statistically significant Time x Group interaction effects of the CMT-Care Homes, with large effect sizes, both for caregivers and for youth. Concerning univariate outcomes, caregivers from the treatment group showed a gradual increase on compassion towards others from baseline to 6-month follow-up. Self-compassion levels were kept stable, showing though a tendency to increase across time. On the contrary, for the control group, these two flows of compassion greatly decreased from baseline to follow-up. Previous research indicated little changes in compassion and no statistically significant changes in self-compassion immediately after the CMT-Care Homes delivery (Santos et al., 2022), leading to the hypothesis that improvements would be achieved at follow-up, as it

occurred in the current work and other studies (Sommers-Spijkerman et al., 2018). Since compassion is conceptualized as a caring mindset, it requires time to be cultivated. The 12 sessions of the training might have helped caregivers to understand the pain-based nature of behaviours of youth under their care, but consistent changes in the mindset and attitude to address suffering could require more time to be fully developed (Gilbert, 2014; Savari et al., 2021). This mindset change could also need more time and practice when it concerns self-compassion, since compassion towards the self seems to be even more difficult to change (Gilbert et al., 2011; Savari et al., 2021). This might be particularly true for caregivers, who are used to attend and take care of other's needs (Figley, 2002), minimalizing their own needs for care and compassion.

It is also important to highlight that when no training is offered, caregivers might tend to decrease compassion and self-compassion over time. As a personal motivation to care, compassion is influenced by the individual earlier experiences, beliefs about the self and others, as well as current experiences and perceptions regarding the context (Gilbert, 2017). Such experiences and beliefs may increase compassionate motivation and actions, but can also block them (Gilbert et al., 2011). On the RCHs daily routine many conditions may contribute to block compassion (e.g., the high demands of bureaucratic tasks, conflicts within the team, work overload, caregiver's physical or mental illness) (Dutton et al., 2014; Kirby et al., 2019). Furthermore, the COVID-19 and related health measure exacerbated the demands within these settings (Parry et al., 2022). The continuous exposure of caregivers to such challenges might explain the deterioration of both flows of compassion (towards the self and towards others) in the control group. This is a matter of concern, not only because it may impact the well-being of caregivers, but also because it may decrease their availability and sensitivity to attend the needs of youth under their care and, consequently, reduce the quality of the care provided. Considering that these youth were removed from their families due to neglect and maltreatment, frequently revealing previous histories of unstable and unresponsive care, this could create some damage and exacerbate trauma symptoms (Steels & Simpson, 2017). Thereby, youth in RYC need safe and supportive relationships with caregivers in order to heal and thrive (Sellers et al., 2020).

Findings from the current research also indicated that both youth and caregivers from the RCHs from the treatment group noticed improvements on relationships and on the RCH emotional climate. As expected, due to the reported increases on the compassionate mindset, caregivers from the treatment group also reported perceiving less threat related emotions and more soothing related emotions on the RCH climate, which were maintained at 6-month follow-

up. These findings seem to be particularly important in this care setting, which has been described to operate within a culture of fear, involving constant vigilance to threats (Brown et al., 2018; Seti, 2008). After the program, caregivers have also reported to feel higher levels of social safeness with others, and this change was maintained at follow-up. These findings are in line with both theory (Gilbert, 2010) and previous findings (Pinard et al., 2020), showing that compassion enhances the sensitivity to signs of warmth from colleagues, which could foster good relationships through reciprocal behaviors and greater disposition to help. In addition, peer support has been showed to be associated with a positive organizational climate (Sedivy et al., 2020). When caregivers feel supported by colleagues in a soothing and safe work climate, they are more open to learn and correct errors, to manage stress, and to deal with unexpected and stressful situations (Cosley et al., 2010; Sedivy et al., 2020).

Findings from caregivers of the treatment group agree with reports by youth from the same RCHs, who have also reported to perceive their relationships and the emotional climate of the RCH as more soothing and safer after program delivery. Yet, improvements were not sustained at follow-up on both emotional climate and social safeness. These findings might be related, at least partially, with the impact of the social changes linked with the pandemic outbreak on closer relationships previously established between youth and caregivers from the treatment group. Due to the health-related measures, signs of affiliation, such as touch, hugs, and smiling faces, trained and encouraged during the program, were suddenly covered by masks and/or were not recommended at all. At the same time, caregivers had to face new challenges and staff was forced to work in different shifts and conditions. Some caregivers did not go to work for long periods due to medical discharge or because they had to stay at home, taking care of their own children. In addition, during the lockdown periods, some RCHs temporary hired new staff to respond to the imposing challenges. The new staff had not received the CMT-Care Homes intervention. Also due to pandemic related measures, continuous learning and supervision following the training delivery was not conducted. On the one hand, research suggests that turnover in RCHs is associated with the provision of inconsistent services, poor work-team performance, weaker relationships with care receivers, and negative climate in organizations, impacting on the outcomes of services (Aarons & Sawitzky, 2006; Albizu-García et al., 2004). On the other hand, the absence of continuous training and supervision following the program may have limited its potential benefits (Sinclair et al., 2021). After an increase in feeling safe and close to caregivers and let others in, social distancing and organizational changes due to pandemic measures (e.g., work in bigger shifts, isolations, fluctuations in staff), could have been felt as some kind of loss and may have produced an increase in fears of

receiving care and compassion from others, considering these youth are particularly sensitive to losses (Gilbert, 2014, 2015). According to research, fears of compassion, and particularly fears of receiving compassion from others, predict the lack of social safeness (Kelly & Dupasquier, 2016). Taken together, these changes might have compromised the maintenance of gains over time reported by youths from the treatment group, even if changes were observed at post-treatment.

Caregivers and youth from the control group showed the opposite tendency. At posttreatment, youth from the control group decreased on the perception of social safeness and emotional climate as more soothing/safer, but reported increases at follow-up on these variables. Caregivers from the control group reported the same tendency concerning social safeness. Regarding the emotional climate, while the perception of soothing related emotions did not change across time, a small increase on threat related emotions was reported from posttreatment to follow-up by caregivers from the control group. While findings concerning the increase in threatening related emotions on RCH climate can be easily understandable as resulting from the pandemic, which brought more potential dangers and worries to staff from these settings (Parry et al., 2022), findings related with increases in social safeness were somewhat unexpected. One possible explanation might be linked with changes in youth's daily routine; during the pandemic onset, youth did not go to school and were able to spent more time with their peers and caregivers at the RCH. By spending more time together, caregivers may have offered more support and companionship during the lockdowns, what might have been felt as greater availability and might have straightened relationships. In fact, a recent study found that children and young people in RCHs reported to feel closer and connected to their peers and caregivers during the pandemic, and reported to have more interactions and dialogue with caregivers (ISS, 2022). Additionally, as occurred in previous collective emergencies (Drury, 2018), the COVID-19 pandemic seems to have created a shared identity and confronted people with their common humanity, enhancing the meaning of social connection, offering a common struggle to connect, and motivating prosocial behavior (Smallen, 2021; Zaki, 2020).

As in the preliminary research (Santos et al., 2022), the CMT-Care Homes did not show statistically significant effects on discontentedness, neither on drive related emotions, as reported by caregivers. In the current study, self-criticism did not show statistically significant differences between groups, which has also occurred in several studies with other groups (Gilbert & Procter, 2006; Savari et al, 2021) and helping professionals (Beaumont et al., 2016; Maratos et al., 2019; Matos et al., 2022; Sansó et al., 2017). As a stable and enduring cognitive-

affective mental representation, self-criticism might need more continued and consistent practice in order to be reduced (Low et al., 2020).

These findings need to be interpreted in light of some limitations, which should be addressed in future research. Firstly, the dropout rate across time, linked to the high youth and caregivers' turnover and the pandemic outbreak, may have contributed to diminish sample size. Secondly, the oscillations of staff within RCHs during the pandemic might have influenced findings, namely from youth. Fluctuations of staff who did not collaborated on the study were not monitored. Third, this study relies only on self-report measures, which may encompass potential bias linked to this type of measures. Finally, despite the assessment has been conducted with the assistance of a master student, this study was not blinded, which might constitute a source of bias due to participants social desirability linked with self-report measures. Other kind of measures, such as psychophysiological measures and frequency of incidents of restraints would provide physiological and behavioral data that may contribute to enrich the program's effectiveness research. Future studies should also investigate the effectiveness of the CMT-Care Homes outside the pandemic related constraints, using larger samples and matching self-report with other kind of measures. Mechanisms of change also deserve to be investigated in the future.

Despite the above-mentioned limitations, this study offers evidence for a new program for caregivers that might enhance social safeness and a soothing climate in RCHs. In a safe RCH climate, youth may decrease the triggering of defensive emotions and behaviors, and may tend to show a greater likelihood of being able to engage in social affiliation, cooperation, and achievement of goals (Gilbert, 2015). Feeling safe has been associated with the child's perception about the quality of the relationship with caregivers (Sellers et al., 2020), which has been linked to lower psychological problems in youth (Izzo et al., 2020; Magalhães & Calheiros, 2017). For this reason, it seems critical that organizations serving child protection services might differentiate between physical safety and safeness (Sellers et al., 2020). Not only do youth need to be safe, but they also need to feel safe (Jenney, 2020). Hence, organizations must recognize that both are required to provide better care responses to youth complex needs, in order to improve their outcomes and properly prepare them to return to their families or to choose to pursue an independent life (Sellers et al., 2020). The CMT-Care Homes responds to such needs, as well as to the international guidelines for the quality of alternative care, as it might help to ensure caregivers training and support. Additional supervision is recommended after the program to ensure assistance and effective implementation of practices in order to maintain the program gains across time (Jenney, 2020; Sinclair et al., 2021). In addition, this study adds to

existing research on caregivers training in order to improve the quality of relationships and emotional climate within RYC, as research within these settings tends to be focused uniquely on behavioral and developmental outcomes (Bakermans-Kranenburg et al., 2008; Hermenau et al., 2017). It also extends the spectrum of compassion-based interventions to RYC, by investigating the effects of these approaches under real work conditions, including outcomes reported in the first (caregiver) and second person (care receiver) (Mascaro et al., 2020). Such compassionate and safe climate within RCHs may complement or optimize the individual interventions delivered to youth, and maximize the therapeutic benefits of RYC (Whittaker et al., 2016).

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Compliance with Ethical Standards

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 performed in this study were in accordance with the Code of Ethics of the World Medical Association (Declaration of Helsinki) for experiments involving humans.

Informed Consent: Written informed consent for experimentation with human subjects was obtained from all participants included in the study (i.e., caregivers and youth). Written informed consent was also obtained from legal guardians of youth under 18 years old.

Conflicts of Interest: The authors declare that they have no conflict of interest.

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Authors' Contributions

Laura Santos: Conceptualization, Methodology, Investigation, Resources, Formal analysis, Writing - Original Draft, Review & Editing, Funding acquisition. **Maria do Rosário Pinheiro:** Writing - Review. **Daniel Rijo:** Conceptualization, Methodology, Writing - Review, Supervision.

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Appendix A. *Number of staff members and youth from each RCH by conditions*

Condition	RCH	Number of staff in the RCH	Number of staff members in study	Number of vacancies per RCH	Number of youth included in the study
Treatment	RCH1	20	19	23	10
	RCH2	21	10	30	11
	RCH3	10	9	27	16
	RCH4	20	6	45	20
	RCH5	20	11	45	6
	RCH6	14	11	15	2
Control	RCH7	20	18	40	30
	RCH8	15	10	30	12
	RCH9	16	9	26	17
	RCH10	23	6	40	16
	RCH11	21	7	30	9
	RCH12	14	11	15	5

Estudo Empírico VII

The effects of the Compassionate Mind Training for Caregivers on professional quality of life and mental health: Outcomes from a cluster randomized trial in residential youth care settings

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The effects of the Compassionate Mind Training for Caregivers on professional quality of life and mental health: Outcomes from a cluster randomized trial in residential youth care settings

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Abstract

Objective: Psychological distress is highly noticeable among caregivers working in Residential Youth Care (RYC). Maintaining and enhancing caregivers' professional mental health and quality of life is crucial to achieve effective outcomes in RYC. Nevertheless, trainings to protect caregivers' mental health are scarce. Considering the buffering effect over negative psychological outcomes, compassion training could be beneficial in RYC. This study is part of a Cluster Randomized Trial examining the effects of the Compassionate Mind Training for Caregivers (CMT-Care Homes), looking at professional quality of life and mental health of caregivers working in RYC.

Method: The sample was composed of 127 professional caregivers from 12 Portuguese Residential Care Homes (RCH). RCHs were randomly allocated at experimental (N = 6) and control group (N = 6). Participants were assessed at baseline, post-treatment, and 3 and 6-month follow-ups, answering to the Professional Quality of Life Scale and the Depression, Anxiety and Stress Scale. Program effects were tested using a two-factor mixed MANCOVA, with self-critical attitude and education degree as covariates.

Results: MANCOVA showed a significant Time × Group interaction effects (F = 1.890, p = .014; η_p^2 = .050), with CMT-Care Homes participants presenting lower scores on burnout, anxiety, and depression at 3 and 6-months follow-ups, when compared with controls. Participants that received CMT-Care Homes considered the program useful to deal with pandemic threats and with youth during lockdowns.

Conclusions: This study shows the benefits of the CMT-Care Homes in helping professional caregivers reducing burnout, anxiety and depression, and dealing with pandemic challenges in RYC.

Keywords: caregivers; compassion; compassionate mind training; mental health; professional quality of life; residential youth care.

Introduction

Residential Youth Care (RYC) is an alternative care response to youth with prior history of maltreatment, aiming to offer them a chance to have a healthy development and shape their future (FICE et al., 2007). Research demonstrates that the resilience of those who suffer trauma can be enhanced if they are connected to a caring and responsive caregiver (Larkin et al., 2012).

Caregivers have a key role within RYC settings (Li & Julian, 2012; Santos et al., 2023d). Nevertheless, they face many challenges linked to the target group and working conditions, that might threaten both the quality of care and the relationships established not only with children but also among co-workers (Colton & Roberts, 2007; McElvaney & Tatlow-Golden, 2016). Specifically, caregivers are required to actively listen to youth previous experiences and, at the same time, they are expected to soothe them, offer counselling, and care without being overwhelmed by their own emotional responses (Pfaff et al., 2017). Caregivers have to deal with highly traumatized youth, frequently presenting mental health difficulties, while having to cope with episodes of aggression and disruptive behaviors (McElvaney & Tatlow-Golden, 2016). At the same time, they are expected to meet the complex needs and ensure the well-being of children and youth under their care (Barford & Whelton, 2010; Steinlin et al., 2017). Additionaly, working conditions are often poor and the care system frequently does not offer appropiate responses considereing the youth intervention needs (McElvaney & Tatlow-Golden, 2016). On the one hand, the high number of youths under care usually contributes to long hours of work which, combined with shifts, set the base for excessive workloads. On the other hand, the opportunities offered for professional and financial rewards are usually scarce for professionals working within these settings (Colton & Roberts, 2007). The lack of support among colleagues and also by the organization management, as well as communication barriers between professionals, have also been reported as a matter of concern (Del Valle et al., 2007; McElvaney & Tatlow-Golden, 2016).

The repeated exposure to emotional pain, in multiple stressful care situations, may lead caregivers to feel frustration, helplessness, and powerlessness, as well as to perceive the job as resulting in greater distress than satisfaction (Colton & Roberts, 2007; McElvaney & Tatlow-Golden, 2016; Stamm, 2010). As a result, caregivers are prone to experience stress, burnout, Secondary Traumatic Stress (STS), anxiety, and depression (Barford & Whelton, 2010; Bürgin et al., 2020; Del Valle et al., 2007; Hermon & Chahla, 2019; Raskin et al., 2015; Santos et al., 2023a; Steinlin et al., 2017). Such conditions may lead to diminished care, loss of interest in others, negative attitudes towards work, and reduced personal accomplishment (Maslach et al., 2001), limiting both the ability to establish empathic relationships and the emotional availability to care

(Bride et al., 2007). Besides affecting the quality of care (Steinlin et al., 2017), such condition may also lead to turnover, which is a common problem within RYC (Colton & Roberts, 2007), with negative consequences to the consistency of interventions (Barford & Whelton, 2010).

In addition to the multiple abovementioned work stressors, during the Covid-19 pandemic, residential care homes (RCH) were required to quickly adapt to the public health measures (e.g., lockdowns, closures of schools) and social distancing (Carvalho et al., 2022). As "frontline workers", while dealing with the risk of becoming infected, professional caregivers had to ensure the provision of care, maintain daily routines as much as possible, and reassure children and youth, who also could be experiencing some psychological disturbance (Ravens-Sieberer et al., 2020). Hence, professionals had to take care of a more stressed group, with even less resources (due to isolations, medical discharges; Whitt-Woosley et al., 2022). These challenges, combined with uncertainty, resulted in additional fears, worries, and stress (Carvalho et al., 2022).

Altogether, the above-mentioned demands reinforce the need to offer proper training to support caregivers in high-stress work environments, as it is the case of RYC (Barford & Whelton, 2010; McElvaney & Tatlow-Golden, 2016). Although some studies tried to overcome this need, some limitations still persist: (1) existing research showed that interventions didn't had the expected impact (Donald, 2015; Silva & Gaspar, 2014; Vallejos et al., 2016); (2) when positive effects on stress and related syndromes were reached, those studies presented methodological limitations, such as small sample size, lack of randomization and/or absence of control group (Hidalgo et al., 2016; Schmid et al., 2020; Turner, 2017; van Gink et al., 2018); (3) programs were specifically tailored to babies homes (St. Petersburg–USA Orphanage Research Team, 2008). Some trauma-informed approaches also addressed staff mental health. Yet, they also showed some limitations linked to implementation and evaluation (Raymond, 2020).

Compassion-based interventions have been delivered in organizations (Andersson et al., 2022) and in different caring-focused settings, showing a potential to improve care quality, strengthen relationships with clients, protect against burnout, and increase professionals' well-being (Boellinghaus et al., 2014; Delaney, 2018; Maratos et al., 2019; Matos et al., 2022a; Sansó et al., 2017). This kind of interventions aim to cultivate compassion towards the self and towards others. Compassion can be defined as a motivation to be responsive to one´s own and others suffering and to act in order to alleviate or prevent it (Gilbert, 2020). It may occur in three interactive flows, involving giving compassion to others, receiving compassion from others, and being self-compassionate (Gilbert, 2019). Each of these flows may reveal associated fears, blocks and/or resistances (Gilbert et al., 2011).

Within helping settings, cultivating compassion towards others may facilitate the 'self-other' distinction, in order not to absorb others' suffering or negative emotions as ours own (Vachon, 2016). In other words, if caregivers respond to youth's suffering with compassion, they will empathize with the suffering, but not identify themselves with it; thus, they will be able to better regulate their own negative affect (Singer & Klimecki, 2014). Hence, compassion can be seen as an emotion-regulation strategy that regulates negative affect (Preckel et al., 2018) and protects against stress (Matos et al., 2017), and mental health problems (Irons & Heriot-Maitland, 2020; Kirby et al., 2017).

Also, relevant to helping professionals is the fact that individuals who give care to others, but do not seek care from others, reveal some difficulties in self-compassion and self-reassurance (Hermanto & Zuroff, 2016). Professionals who lack self-compassion, and particularly those expressing a higher self-critical attitude, are more susceptible to burnout as a result of continuously caring for others, while ignoring their own emotional needs (Gracia-Gracia & Oliván-Blázquez, 2017). In addition, those who lack self-compassion are not only more self-critical, but also more critical and controlling towards others (Gilbert et al., 2011), which may compromise both the establishment of secure relationships as the provision of appropriate care. Self-compassion involves relating to oneself with care and concern when facing hardship or perceived inadequacy (Neff, 2003), and it has been linked to increased well-being (Barnard & Curry, 2011), and lower levels of psychopathology, including anxiety and depression (Ferrari et al., 2019; MacBeth & Gumley, 2012; Wilson et al., 2019). At a professional level, self-compassion can help in coping with uncertain and challenging conditions, resulting in increased job satisfaction and professional well-being, as well as less burnout, depression, anxiety, and stress (Andersson et al., 2022; Babenko et al., 2019). Considering that self-care has been associated with caregivers' quality of life (Sansó et al., 2015) and higher self-confidence as a caregiver (Bratt et al., 2019), motivating these professionals and raising their awareness on the need to care for their own well-being seems essential.

This study is part of a Cluster Randomized Trial (CRT) aiming to test the effectiveness of the Compassionate Mind Training for Caregivers (CMT-Care Homes) working within RYC settings in several compassion related variables (Santos et al., 2022; Santos et al., 2023c). It expands compassion-based approaches to RYC settings. It tests the effectiveness of a new training program specifically designed for RYC staff, based in a well-established therapeutic model and practices, resorting to a CRT in a real-world setting. In the current work, the effects of the CMT-Care Homes will be investigated on caregivers' professional quality of life and mental health symptoms, also investigating whether observed changes after program completion are

sustained across time. It responds to the gaps reported in recent systematic reviews about the scarcity of evidence-based and manualized programs to protect and enhance the mental health of RYC professionals, who work in a highly stressful and emotionally demanding setting (Santos et al., 2023b). Considering that caregivers are key agents of change in RYC, this program may contribute to improve the care practices and to reach better outcomes for children and youth placed in RYC, by providing support to those who have been given the responsibility to help these youth to heal and thrive.

The main research questions of this study are: (1) How does the CMT-Care Homes impacts Professional Quality of life and Mental Health symptoms among caregivers working in RYC settings? (2) Are the effects of CMT-Care Homes in these variables sustained across time? Considering that the pandemic situation started during the current CRT, secondary questions are: (1) Was the CMT-Care Homes useful to deal with the pandemic situation? (2) Was the CMT-Care Homes useful to deal with children and youth within RCHs during lockdowns? In accordance with previous research testing compassion-based approaches in helping settings (Matos et al., 2022a; Sansó et al., 2017), it is hypothesized that the CMT-Care Homes will produce significant improvements in burnout, STS, depression, anxiety, and stress, as well as an increase in compassion satisfaction, when comparing caregivers who received the training with those in the control group. In addition, it is expected that the effects of attending the CMT-Care Homes will be maintained at 3 and 6-month follow-ups (Ferrari et al., 2019; Irons & Heriot-Maitland, 2020; Matos et al., 2022a).

Methods

This cluster randomized trial followed the standards of Consort 2010 statement: Extension to cluster randomized trials (Campbell et al., 2012). The current study was approved by the Ethics Committee of the Faculty of Psychology and Educational Sciences of the University of Coimbra (CEDI22.03.2018) and its procedures were in accordance with the Code of Ethics of the World Medical Association (Declaration of Helsinki) for experiments involving humans. The authors have no competing interests to declare that are relevant to the content of this article.

Participants

This study was carried out between 2019 and 2020 in 12 Portuguese Residential Care Homes (RCH). The following cluster eligibility criteria were considered: (1) RCHs that receive youths aged between 12 and 25 years old, located in the center region of Portugal were included; (2) RCHs specialized in mental and behavioral disorders and/or substance abuse problems were excluded, because they adopt different and specific intervention models. Within

the selected RCHs, caregivers who were directly involved in the delivery of services to youth on a regular basis were invited to collaborate.

A total of 127 professional caregivers accepted to participate. Randomization took place at the cluster level, after baseline. Six RCHs were allocated to the treatment group (66 caregivers; 52%), and six RCHs were allocated to the control group (61 subjects; 48%). From the six RCHs allocated to the treatment group, four RCHs were mixed and two received only females, accommodating from 15 to 45 children and youth. These RCHs had between 10 to 21 professionals with different roles. The six RCHs of the control group accommodated from 15 to 40 children and youth, four were mixed and two were gender specific, one for females, and the other one for males. These RCHs had between 14 to 23 professionals with different roles. All RCHs included in this study were 24/7 open group homes (e.g., youth attend local public schools, they are integrated in community sports, and visit their families), they are located in urban and rural areas on the center of Portugal mainland, and receive mostly nationwide children and youth referred by the child protection services. In Portugal, RCHs have the main goal of time-limited protection of youth at-risk, aiming to ensure their safety, well-being, education, and healthy development. Most placements are due to maltreatment (e.g., neglect and psychological, physical and sexual abuse), and the remaining are due to abandonment by caregivers or the lack of family support (ISS, 2022). All RCHs have a technical (e.g., technical director, psychologist, social worker), educational (e.g., educators, direct care staff), and support (e.g., cook, cleaning staff) teams, being supervised by the public Welfare Services. Staff from educational and support teams often do not have an academic degree or pre-service training, and might work in rotating shifts. In accordance with a recent assessment of the quality of care in Portuguese RCHs, most of the RCHs revealed not to use evidence-based practices or interventions (Rodrigues & Barbosa-Ducharne, 2017).

Participants were mostly female (89%), and were aged between 22 and 62 years old, with a mean age of 43.99 (SD = 10.96). The majority of participants were married (69%), 23% were single and 7.9% were divorced. Participants had been working within RYC settings for less than a month to 39 years (M= 11.95, SD = 8.99), having a technical (29.4%; e.g., management, psychologist, social worker), educative (63.5%; e.g., educational assistant) or support (7.1%; e.g., cleaning staff, cooker) function. Half of them (52%) reported they were working in shifts. Concerning educational level, 44.1% had a higher education degree, 19.7% reported having completed high school, and 36.2% some level of elementary or middle school education. No significant differences between groups were found in sociodemographic features (cf. Table 1).

Table 1. *Sociodemographic features by group*

	Treatment group		Control group				
	M	*SD*	*M*	*SD*	*t*	*p*	Cohen's *d*
Age	42.92	10.90	45.15	11.00	-1.143	.255	.204
Years of work in RCH	10.77	7.89	13.25	9.98	-1.536	.127	.276
	N	*%*	*N*	*%*	χ2	*p*	Cramer's *V*
Gender							
Male	5	7.6	9	14.8	1.665	.197	0.115
Female	61	92.4	52	85.2			
Marital Status							
Single	19	28.8	10	16.7	2.926	.232	0.152
Married	43	65.2	44	73.3			
Divorced	4	6.1	6	10.0			
Education degree							
Elementary/middle school	24	36.4	22	36.1	5.710	.058	0.212
High school	8	12.1	17	27.9			
Higher education degree	34	51.5	22	36.1			
Profession							
Technical director	6	9.1	2	3.3	6.104	.729	0.220
Psychologist	8	12.1	6	10.0			
Social worker	5	9.1	3	5.0			
Social educator	6	9.1	6	10.0			
Educational assistant	34	51.5	36	60.0			
Socio-educational animator	2	3.0	1	1.7			
Teacher	1	1.5	0	0			
Cleaning staff	1	1.5	4	6.7			
Cooker	3	4.5	2	3.3			
Staff functions							
Technical	22	33.3	15	25.0	1.152	.562	0.096
Educative	40	60.6	40	66.7			
Support	4	6.1	5	8.3			
Shifts							
Yes	36	54.5	30	49.2	.366	.545	0.054
No	30	45.5	31	50.8			

Note. Elementary and middle school education correspond to 4-9 years of school; High school are 12 years of school; Higher education degree are Bachelor or Master degrees.

Sample size

Effective sample size was determined for usual factorial (2 groups) repeated measures (4 assessments) between factors, using G*Power, version 3.1.9.7, considering alpha = 0.05, a medium effect size (Cohen's f = 0.36) to obtain at least 80% power, assuming a 0.80 correlation coefficient within repeated measures. Under these assumptions, a total of 54 caregivers should be enrolled, 27 in each experimental condition.

Intervention

The CMT-Care Homes is a manualized program developed for professional caregivers working in RYC. Main goals are to cultivate a compassionate-self and foster a caregiving mentality in RYC. It is strongly based on the Compassion Focused Therapy theoretical framework

(e.g., affect regulation systems, flows and fears of compassion) and Compassion Mind Training practices (e.g., compassionate imagery, soothing rhythm breathing, compassionate letter) (Gilbert, 2020) applied to the RYC needs and practices. The CMT-Care Homes is made of twelve 2-hr and half structured sessions, offered once a week, during approximately three months. Sessions took place at the workplace in a group format, ranging from 6 to 12 participants.

All sessions present the same structure (check-in, exploration, and check-out). Program contents 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; composed of 6 sessions); (2) Compassionate mind training (understanding and cultivating the attributes and competencies of the three flows of compassion, and addressing its fears; composed of 5 sessions); and (3) a Final session (revising key information/practices, and its application into the RCH; composed of 1 session). Contents are explored through psychoeducation and experiential practices followed by group opportunities to debate and share experiences. Considering that the transfer of learnings from training to everyday life constitutes a recurrent problem in RYC (Liu & Smith, 2011), throughout the program, participants are invited to reflect on how session's learnings can be transferred into: (1) their own daily routine (e.g., self-regulation, self-care, balance between personal and professional life); (2) their relationship with children and youth (e.g., understanding their behavior and using adequate strategies to help them to regulate their emotions); (3) RCHs' practices and routines (e.g., team work, communication). A compassionate weekly challenge, including between sessions training of formal meditation practices and compassionate learnings, is also given to encourage the transference of CMT-Care Homes' learnings to caregivers' daily routine and work tasks.

Measures

The Professional Quality of Life Scale, version 5 (ProQOL-5; Stamm, 2010; Portuguese version by Carvalho, 2011)

ProQOL is a 30-item self-report scale designed to measure the positive and negative effects of working in stressful environments. ProQOL is composed of three subscales: Compassion Satisfaction (CS), Burnout (BO) and Secondary Traumatic Stress (STS). Participants are instructed to indicate how frequently each item was experienced in the workplace, during the previous 30 days, using a 5-point scale (1 = never, to 5 = very often). The original version reported internal consistency values of .88 for CS, .75 for BO, and .81 for STS (Stamm, 2010).

The Portuguese version also showed good internal consistency (CS α = .86, BO α = .71, STS α = .83; Carvalho, 2011). In this study, Cronbach's alphas were .81 for CS, .64 for BO and .67 for STS.

Depression, Anxiety and Stress Scales (DASS-21; Lovibond & Lovibond, 1995; Portuguese version by Pais-Ribeiro et al., 2004)

DASS-21 is a 21-item self-report scale designed to assess symptoms of depression, anxiety, and stress. Participants are asked to rate how much each statement applied to them during the previous week, using a 4-point scale (0 = not apply at all to me, to 3 = applied to me most of the time). In the original version, the DASS-21 subscales presented high internal consistency: Depression α = .91, Anxiety α = .84, and Stress α = .90 (Lovibond & Lovibond, 1995). The Portuguese version showed good internal consistency (Depression α = .85, Anxiety α =. 74, Stress α = .81) and good convergent and discriminant validity (Pais-Ribeiro et al., 2004). In this study, Cronbach's alphas were .87 for depression, .86 or anxiety and .87 for stress.

Self-Compassion Scale (SCS; Neff, 2003; Portuguese version by Castilho et al., 2015)

SCS is a 26 self-reported scale designed to assess self-compassion. Participants are instructed to answer the items regarding "how I typically act towards myself in difficult times", using a 5-point scale (1 = almost never, to 5 = almost always). In the original version, the scale has a total score (α = .92) and six subscales (Self-Kindness, Self-Judgement, Common Humanity, Isolation, Mindfulness, and Over-Identification), with alpha values ranging from .75 for Mindfulness to .81 for Over-Identification (Neff, 2003). In the current study, we used the two-factor model found in the Portuguese version: Self-Compassionate attitude (comprising the positive subscales: Self-Kindness, Common Humanity, Mindfulness) and Self-Critical attitude (comprising the negative subscales: Self-Judgement, Isolation and Over-Identification), with alpha coefficients of .91 and .89, respectively (Costa et al., 2015). In the current study, Self-Critical attitude was used as a covariate (α = .88).

Pandemic related questions

Considering that Covid-19 pandemic co-occurred with 3 and 6-month follow-up assessments, a brief questionnaire was developed to address the level of anxiety that the pandemic triggered on caregivers. It was assessed through one item question ("Please indicate the level of anxiety that the current situation of COVID-19 causes you"), ranging from 0 "nothing" to 10 "extremely". For the treatment group, the questionnaire also addressed the level of usefulness of the CMT-Care Homes to deal with the pandemic ("Please indicate to what extent CMT-Care Homes is useful to deal with the current situation of COVID-19, e.g., fear, anxiety, change in routines and habits, social isolation, uncertainty regarding the future") and

with children and youth during lockdown measures ("Please indicate how useful the CMT-Care Homes is to deal with children and young people in residential care during the current COVID-19 pandemic"), using the same scale.

Procedures

Written informed consent was sought at the cluster (i.e., boards of each RCH) and at the individual level (i.e., caregivers), before randomization. Participants were informed of the goals and procedures, and were asked to voluntarily participate, with no incentives offered for participation. Anonymity was guaranteed, with the use of respondent-specific codes, which were also used to link the data from one timepoint to the other. Caregivers were assessed through self-report measures at baseline, post-treatment, 3 and 6-month follow-up. Considering that the Covid-19 outbreak started during the current CRT, at 3 and 6-month follow-up caregivers were also asked to answer to a questionnaire about the level of anxiety concerning pandemic and usefulness of the program in that context. Due to the pandemic situation, data were collected in person by a researcher assistant (when possible) or were sent to each RCH to be filled out individually. After the baseline assessment, a computer-generated randomization was conducted at the cluster level, following a completely randomized design by the third author of this paper. Each RCH (i.e., cluster) was randomly assigned to treatment or control group (i.e., no training in compassion or any other group interventions). The CMT-Care Homes program was delivered in accordance with the handbook, in a face-to-face format, weekly (2.5-hr session) in each RCH, to a group of 6-10 participants, over approximately 3 months, from October 2019 to February 2020. All sessions were delivered by the first author, who is a clinical psychologist trained in cognitive-behavioral interventions and compassionate approaches.

Data analysis

Data was analyzed with IBM SPSS Statistics v25. Prior to analysis, data were screened for missing data, outliers, and Multivariate Analysis of Covariance (MANCOVA) assumptions (Tabachnick & Fidell, 2013). Missing data were examined by incidence and distribution, both by subject and per item. Five participants presenting more than 20% of missing values in an outcome variable were removed (Peng et al., 2006). Little's (1988) MCAR tests revealed that data in some outcome variables were not missing completely at random ($p < .05$). Considering that deletion of cases would lead to a substantial loss of subjects, missing values of participants with less than 20% of missing data in one outcome variable were dealt via linear interpolation imputation method (Meyers et al., 2006).

Baseline differences between the two groups were examined for demographics and for outcome variables, via independent samples t-tests and chi-square statistics. The effect sizes were calculated, using Cohen's d, with .15 indicating a small effect, .36 a medium effect and .65 a large effect (Lovakov & Agadullina, 2021); and Cramer's V, with .10 indicating a small effect, .30 a medium effect, and .50 a large effect (Cohen, 1988).

Although confirming normal univariate distribution by coefficients of skewness and kurtosis (SK <| 3 | and Ku <| 10 |; Kline, 2005), with skewness values ranging from −1.126 to 2.057 and kurtosis values ranging from −0.564 to 4.963, data did not reveal a multivariate normal distribution (assessed via Mardia's test; Korkmaz et al., 2014). Violations of normality can, however, be disregarded considering the absence of multivariate outliers (investigated via Mahalanobis distance; Tabachnick & Fidell 2013). The homogeneity of variance-covariance matrices was ensured (assessed via Box' M test, $p > .001$) (Field, 2018). Multicollinearity was absent, since correlations between outcome variables were < .90 (Tabachnick & Fidell 2013).

To investigate intervention effects on the multiple outcomes, a two-factor (i.e., between subjects—groups—and within subjects—time) mixed MANCOVA was conducted. In accordance with former research, baseline levels of self-critical attitude were controlled due to individual differences in self-criticism on the response to compassion-based interventions (e.g., chronically self-critical individuals have more difficulties in accessing self-reassuring imagery; Duarte et al., 2015; Gilbert et al., 2004; Matos et al., 2022a), and its role as a major vulnerability factor for several mental disorders (Werner et al., 2019). Education degree was entered as a co-variate in the analysis, considering its possible influence on stress levels (Del Valle et al., 2007; Santos et al., 2023a).

For MANCOVA multivariate test, the Pillai's criterion was used, as it is considered most robust when assumptions are not fully met (Field, 2018). Sphericity was analyzed via Mauchly's W. When this assumption was not verified, the Greenhouse-Geisser epsilon were checked and when $\varepsilon > .75$ Huynh-Feldt criterion was used in univariate tests. Effect sizes for the time effects and time × group effects were calculated using partial eta squares (η^2_p), with $\eta^2_p = .01$ referring to a small effect size, .06 to a medium effect size and .14 to a large effect size (Tabachnick & Fidell, 2013). To understand group differences, Cohen's d was computed for long-term changes.

Pearson correlations were computed between anxiety related with pandemic and outcome measures for follow-up assessments.

Results

Recruitment and retention

All caregivers from the 12 RCHs accepted to participate and completed the baseline assessment (N = 127) (Figure 1). RCHs were randomly distributed to the treatment (6 RCH; N = 66 caregivers) and control (6 RCH; N = 61 caregivers) groups. Of the initial 66 participants allocated to the treatment group, seven (10.61%) did not complete the program: two withdrew due to cancellation of the job contract, three due to prolonged medical discharge, and two dropped out from intervention. Fifty-nine (89.39%) participants completed the program and 57 the posttreatment assessments (86.36%; two caregivers were in medical discharge at time of assessment). Five participants (7.58%) were lost to assessment at 3-month follow-up: two of them due to job contract cancelation, one was transferred to another social response, one was at medical discharge, and one protocol was invalid. Another five participants were lost to assessment at 6-month follow-up (7.58%): two of them due to contract cancelation, two had invalid protocols, and one dropped out. Caregivers within this condition attended 5 to 12 sessions (M = 9.52; SD = 1.99). The main reasons for not completing the whole program were working in shifts/day off, vacation, brief medical discharge or urgent professional diligences. Four caregivers (6.78%) who attended less than 60% of the sessions were excluded from the analyses.

Of the 61 caregivers allocated to the control group, 51 (83.61%) completed the posttreatment assessment, one left the study due to cancellation of the job contract, one was transferred to another social response, and eight dropped out the study. Nine participants were lost to assessment at 3-month follow-up (14.75%): four of them due to contract cancelation, four due to medical discharge, and one dropped out. At 6-month follow-up four participants were lost to assessment (6.56%): one due to medical discharge, one was transferred to another social response, and two dropped out. Four participants (6.56%) were excluded from analyses due to missing data. In total, 77 caregivers (89.6% females), aged between 22 and 62 years old, were included in the analysis, at the experimental (N = 43) or control (N = 34) groups. At 3-month follow-up, 72.1% of the participants at CMT-Care Homes continued to practice exercises and 92.9% still applied the learnings related with the program. At 6-month follow-up percentages were 61.9% and 78.6%, respectively.

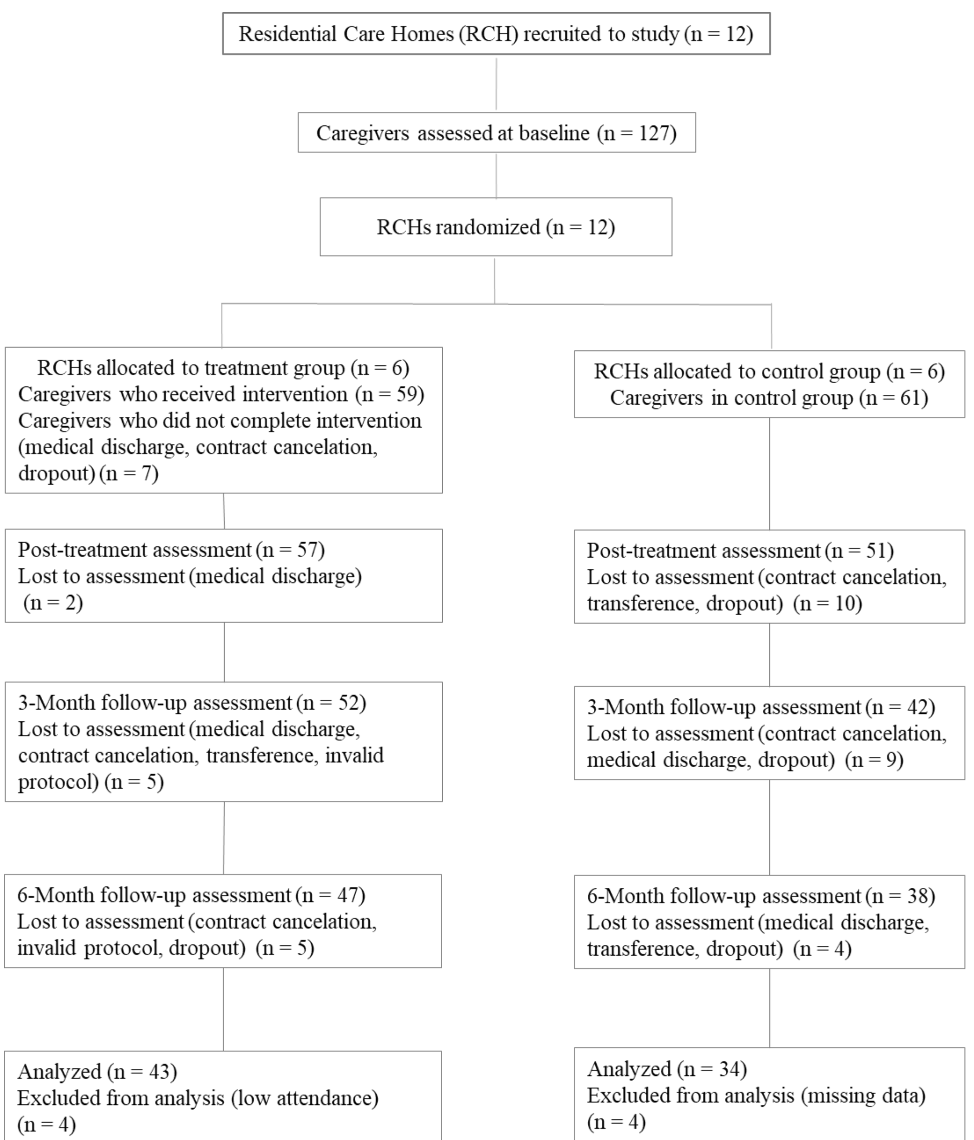

Figure. 1. *Flowchart of caregivers' participation*

Baseline Differences

No significant differences were found between treatment and control group at the onset of the study for demographics (Table 1) and outcome measures (all $p > .05$) (Table 2).

Table 2. *Baseline differences on the outcome measures*

Measures	Treatment group *M*	Treatment group *SD*	Control group *M*	Control group *SD*	*t*	*p*	Cohen's *d*
ProQOL-5							
Compassion satisfaction	37.81	4.69	36.41	4.51	1.618	.108	0.304
Burnout	24.35	4.30	24.71	4.25	-.452	.652	0.085
Secondary traumatic stress	25.94	4.47	25.47	4.80	.539	.591	0.104
DASS-21							
Depression	3.16	3.68	3.25	3.75	-.121	.904	0.023
Anxiety	3.45	4.12	2.39	3.48	1.483	.141	0.278
Stress	6.07	4.08	5.87	3.91	.262	.794	0.049

Two-factor mixed MANCOVA

Multivariate tests, with self-critical attitude and education degree as covariates, demonstrated a significant Time × Group interaction effect (Pillais' trace = .150, F = 1.890, p = .014) corresponding to a small effect size (η_p^2 = .050). Univariate tests for Time × Group interaction, with the same covariates, indicated that when compared with the control group, the treatment group had significantly lower scores in burnout, depression and anxiety (Table 3). These differences corresponded to small to moderate effect sizes. No significant differences were found between groups for stress, compassion satisfaction, and secondary traumatic stress.

When examining means, standard deviations, and corresponding effect sizes (Cohen's d for each group), results showed that caregivers from the treatment group gradually reduced their burnout levels from preintervention to 6-month follow-up (Cohen's d = .30). In turn, for the control group, burnout levels were kept stable from preintervention to 6-month follow-up (Cohen's d = .13).

In what concerns depression, caregivers from the treatment group progressively improved from preintervention to 6-month follow-up (Cohen's d = .49), while the control group did not change across time (Cohen's d = .10). Regarding anxiety symptoms, the treatment group gradually decreased anxiety levels from preintervention to 6-month follow-up (Cohen's d = .60). In turn, the control group showed a tendency for increasing anxiety from preintervention to 6-month follow-up (Cohen's d = .35). These differences corresponded to small to moderate effect sizes.

Table 3. *Mean Scores and Standard Deviations for Both Groups at baseline, Posttreatment, 3 and 6-months follow-up, and Univariate Test*

	Treatment group				Control group				ICC (CI)	Time	Time x Group
	T1	T2	T3	T4	T1	T2	T3	T4			
	M (SD)	M (SD)	M (SD)	M (SD)	M (SD)	M (SD)	M (SD)	M (SD)			
ProQOL											
CS	38.00 (4.99)	39.08 (4.26)	38.97 (4.54)	38.79 (4.07)	37.09 (3.44)	37.41 (4.08)	37.04 (5.14)	36.61 (4.16)	.87 (.82-.91)	F = 0.860; p = .463; η^2_p = .012	F = 0.861; p = .462; η^2_p = .012
BO	24.05 (4.59)	23.48 (3.81)	22.60 (3.79)	22.77 (3.86)	23.96 (3.65)	23.38 (3.07)	24.38 (3.50)	23.47 (3.86)	.85 (.79-.90)	F = 0.636; p = .129; η^2_p = .009	F = 3.393; p = .021; η^2_p = .044
STS	25.42 (4.33)	24.86 (4.54)	24.23 (4.36)	24.19 (3.92)	24.62 (3.70)	23.74 (4.06)	24.18 (3.70)	24.21 (3.25)	.84 (.77-.89)	F = 0.356; p = .769; η^2_p = .005	F = 1.230; p = .299; η^2_p = .017
DASS											
DEP	2.28 (3.21)	1.19 (2.00)	1.71 (1.89)	1.07 (1.47)	2.62 (2.73)	2.03 (2.19)	2.54 (2.40)	2.91 (2.97)	.67 (.53-.77)	F = 0.527; p = .664; η^2_p = .007	F = 2.954; p = .033; η^2_p = .039
ANX	2.64 (3.37)	1.35 (1.77)	1.56 (2.37)	1.02 (1.81)	1.32 (1.34)	1.41 (2.12)	1.43 (2.01)	2.00 (2.41)	.61 (.45-.74)	F = 0.120; p = .949; η^2_p = .001	F = 5.837; p = .001; η^2_p = .074
SS	4.88 (3.62)	3.98 (3.35)	4.15 (3.74)	3.63 (3.02)	4.94 (2.91)	4.32 (2.69)	4.99 (3.29)	4.70 (3.83)	.70 (.57-.79)	F = 0.044; p = .988; η^2_p = .093	F = 1.086; p = .356; η^2_p = .015

Note. CS = Compassion satisfaction; BO = Burnout; STS = Secondary traumatic stress; DEP = Depression; ANX = Anxiety; SS = Stress T1 = preintervention; T2 = postintervention; T3 = 3-month follow-up; T4 = 6-month follow-up; M = Mean; SD = Standard deviation; ICC = Intraclass correlation coefficient; CI = Confident interval (95%); η2p = partial eta square.

The impact of Covid-19 Pandemic

Anxiety related with the Covid-19 outbreak was correlated with outcome variables measured at follow-up assessments, showing significant positive, but weak, associations (all r <.40). Exceptions were for stress and compassion satisfaction. At 3-month follow-up, corresponding to the onset of the pandemic and lockdowns, stress and anxiety related to the pandemic achieved a significant and moderate positive correlation (r = .406), but this association was not significant anymore at 6-month follow-up, when lockdown measures were relaxed. Compassion satisfaction and anxiety related with the pandemic did not correlate at 3-month follow-up, but showed a significant and weak negative correlation at 6-month follow-up (r = -.293).

Groups significantly differed at the level of anxiety associated with the pandemic at 3-month follow-up (*t* (73) = -2.295; *p* = .025; treatment group *M* = 5.74, *SD* = 2.72 and control group *M* = 7.06, *SD* = 2.14), with controls showing higher levels. Groups did not significantly differ at 6-month follow-up (*t* (72) = -1.366; *p* = .176; treatment group *M* = 5.93, *SD* = 2.47 and control group *M* = 6.67, *SD* = 2.10).

Although CMT-Care Homes was not designed to deal with a pandemic, caregivers recognized the program usefulness when dealing with the contingencies associated with the Covid-19 outbreak (3-month follow-up *M* = 6.81, *SD* = 2.28; 6-month follow-up *M* =6.90, SD = 2.46) and with children and youth during lockdowns (3-month follow-up *M* = 7.62, *SD* = 1.83; 6-month follow-up *M* = 7.48, *SD* = 2.29).

Discussion

The current study intended to expand the preliminary evidence on the CMT-Care Homes (Santos et al., 2022) and test its effectiveness on caregivers' professional quality of life and mental health outcomes, within a cluster randomized trial in a real-world setting. The CMT-Care Homes aims to cultivate a compassionate mindset on caregivers, not only through promoting compassion towards others, which sets the base for any helping profession, but also through promoting self-compassion and the openness to receive compassion from others. This would facilitate feelings of safeness with others and help to improve emotion regulation (Preckel et al., 2018; Vachon et al., 2016). Alongside the cultivation of compassion (Santos et al., 2022; Santos et al., 2023c), the CMT-Care Homes was expected to reduce suffering and psychological distress as well. To the best of our knowledge, this is the first compassion-based program delivered to caregivers working in RYC settings.

At baseline, groups did not yield significant differences on demographic and outcome measures. These results may indicate that randomization was effective, allowing for reliable conclusions on the CMT-Care Homes' effects.

A Multivariate Analysis of Covariance (MANCOVA) was carried out in order to test for intervention effects on professional quality of life and mental health outcomes. When controlling for education degree and self-critical attitude at baseline, MANCOVA revealed statistically significant Time x Group interaction effects of the CMT-Care Homes on burnout, depression, and anxiety, with small to medium effect sizes. Improvements in the treatment group were observed at follow-ups. These findings are in line with previous research, highlighting the beneficial effect of compassionate-based interventions on psychological distress and mental health symptoms (Irons & Heriot-Maitland, 2020; Kirby et al., 2017; Matos

et al., 2017). Similar findings were also found using compassion-based interventions in organizations (Andersson et al., 2022), and specifically in caring-focused environments, with caregivers of patients with intellectual disabilities (Sansó et al., 2017) and teachers in school settings (Matos et al., 2022a).

Our findings indicated improvements from baseline to 6-months follow-up for burnout, anxiety, and depression. Research involving compassion-based interventions also revealed the maintenance of changes (Irons & Heriot-Maitland, 2020; Matos et al., 2022a) or continued improvements in depression symptoms at follow-ups (Ferrari et al., 2019). Other programs designed for the RYC setting, using other theoretical frameworks, did not show significant improvements on burnout (Donald, 2015) and mental health (Vallejos et al., 2016). Hence, both the compassion training and its theoretical framework seem a promising approach to counteract burnout, anxiety, and depression on caregivers, helping to improve their functioning and the quality of the care they provide.

Previous research suggested that the maintenance and improvements in changes may be related with the practice and the transference of learned techniques and strategies into the daily routine (Maratos et al., 2019). In fact, in the present study, more than 70% of participants having received the CMT-Care Homes reported to have kept practice three months after the program completion and more than 90% reported they were still applying the learnings related with the program during 3-month follow-up assessments. At 6-month follow-up, percentages decreased, but were still over 50%. This might have contributed to the observed improvements in mental health symptoms, even when facing new challenges linked to the pandemic context.
In contrast, and for the control group, burnout and depression levels did not change from baseline to 6-month follow-up, and anxiety symptoms seemed to have gradually increased. This might suggest that, in face of usual demands of this particular care setting, plus the additional challenges of the pandemic, when no training or support is offered, caregivers' mental health might tend to deteriorate over time, which might have negative implications both for their own quality of life, as for the quality of the care they provide (Sinclair et al., 2021). Also, the level of anxiety related with the pandemic reported on the first follow-up, which co-occurred with the first lockdown at the onset of the COVID 19 pandemic in Portugal, was significantly higher for the control than for the treatment group. Accordingly, participants in the CMT-Care Homes recognized the usefulness of the program in dealing both with the contingencies associated with the pandemic and with children and youth during the lockdowns. Although it has not been designed to deal with the Covid-19, a training of this nature seems to be helpful to cope with stressful events like a pandemic. This is in line with research conducted during the pandemic

outbreak, which demonstrated the protective role of compassion on mental health, by buffering the harmful effects of the Covid-19 (Matos et al., 2022b).

Compassion satisfaction, STS and stress did not reveal significant differences between groups across time. Compassion satisfaction refers to the pleasure derived from being able to provide care to others (Stamm, 2010). It is important to recognize that other organizational factors that are beyond the scope of this program (e.g., work overload, low payment) may have influenced these outcomes. In addition, compassion satisfaction changes have not been found in other studies with caregivers from other care settings (Delaney, 2018; Matos et al., 2022a; Pfaff et al., 2017; Potter et al., 2013). Similarly, a resiliency program including self-care strategies and mindfulness to deal with compassion fatigue in a health care setting did not achieve changes on compassion satisfaction or STS (Pfaff et al., 2017). STS commonly occurs in professionals who deal with traumatized clients, developing their own symptoms of traumatic stress and similar reactions as posttraumatic stress disorder (PTSD, e.g., re-experiencing, avoidance and hyperarousal; Bride et al., 2007). Hence, 12-group sessions may have not been sufficient or even adequate to treat a clinical condition such as STS. It is also important to emphasize that most participants did not report high levels of STS at baseline. Thus, this finding might be attributed to the sample's apparent floor effect, as it occurred in a former randomized controlled trial of acceptance and commitment therapy for social workers (Brinkborg et al., 2011), which did not find significant effects for professionals with low levels of stress at baseline.

In what concerns stress, stress levels were found to be moderately correlated with perceived threat of COVID-19 reported at the 3-month follow-up. Considering that the pandemic onset and its additional challenges (Carvalho et al., 2022; Ravens-Sieberer et al., 2020; Whitt-Woosley et al., 2022) co-occurred with follow-up assessments, this might have somehow influenced the results. This finding is aligned with research suggesting that the perceived threat of COVID-19 was associated with higher scores in stress (Matos et al., 2022b).

This CRT provides evidence about a new program to support the mental health and the quality of life of professionals working within RYC. The CMT-Care Homes covers the research gaps reported on a recent systematic review (Santos et al., 2023b) and is aligned with international recommendations to protect the RYC staff well-being (Whittaker et al., 2016). It also extends the research regarding compassion-based interventions in helping settings to RYC, showing that a compassion training may have a buffering effect over caregiver's mental health concerns. Findings also suggested that, when no training is offered, caregivers tend to deteriorate their mental health across time. Considering the personal and organizational costs of caring, organizations should prioritize staff training and support in order to protect caregivers'

well-being and to prevent staff turnover, which is a significant threat to the implementation of new models and evidence-based practices (Steinlin et al., 2017). Additionally, and in order to overcome the continuous changes in staffing as one of the major challenges to maintain effectiveness of trainings over time (Ogden & Fixsen, 2015), it seems essential that RCH psychologists can be trained to deliver the program to future staff members. To do so, training budgets, often viewed as dispensable when organizational cuts are made, must be protected (Hofmeyer et al., 2020).

Some limitations should be kept in mind when considering the findings of the current study. First, despite using standardized measures, the exclusive reliance on self-report instruments might encompass associated bias. Since psychophysiological measures (e.g., hair or salivary cortisol, heart rate variability) have been used to assess psychophysiological correlates of compassion, emotion regulation, and stress (Schmid et al., 2020; Sousa et al., 2021), future research should resort to such measures as a way to strengthen self-report findings. Second, the sample size prevented resorting to more sophisticated statistics to analyze longitudinal data (e.g., latent growth curve models). Other studies have also reported difficulties in collecting longitudinal data in these settings due to the rotativity of staff linked with turnover (Schmid et al., 2020; Turner, 2017; Vallejos et al., 2016). Nevertheless, future research should replicate this study with larger samples and in another time, in order to investigate the CMT-Care Homes effectiveness outside of pandemic related constraints.

To conclude, findings highlight the utility and relevance of compassion-focused interventions in RYC settings, showing the potential benefits of the CMT-Care Homes in helping caregivers to develop socio-emotional competencies for caring for their own mental health and professional quality of life, while taking care of vulnerable youth.

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Compliance with Ethical Standards

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 were

in compliance with the Code of Ethics of the World Medical Association (Declaration of Helsinki) for experiments involving humans and with APA ethical standards.

Informed Consent: Written informed consent was sought for all participants.

Conflicts of Interest: The authors declare that they have no conflict of interest.

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Authors' Contributions

Laura Santos: Conceptualization, Methodology, Investigation, Resources, Formal analysis, Writing - Original Draft, Review & Editing. **Maria do Rosário Pinheiro:** Writing - Review. **Daniel Rijo:** Conceptualization, Methodology, Writing - Review, Supervision.

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PARTE IV

DISCUSSÃO

CAPÍTULO 8

DISCUSSÃO GERAL

O acolhimento residencial é uma medida de promoção e proteção, que visa afastar a criança ou o jovem do perigo em que se encontra e proporcionar-lhe cuidados alternativos que permitam proteger e promover o seu desenvolvimento integral (Guerra, 2022). Devido à natureza e frequência das experiências adversas a que foram previamente expostas, crianças e jovens em acolhimento são vulneráveis ao desenvolvimento de dificuldades psicológicas e problemas de saúde mental, evidenciando necessidades complexas (Campos et al., 2019; Fernández-Daza & Fernández-Parra, 2013; Kahsay et al., 2020; Magalhães & Camilo, 2023). Por estas razões, a intervenção prestada no âmbito da medida de promoção e proteção deve ser capaz de garantir a sua recuperação física e psicológica (alínea c) do artigo 34º da LPCJP).

O paradigma atual do acolhimento residencial assenta no reconhecimento da individualidade da criança e da necessidade de lhe fornecer experiências reparadoras, capazes de favorecer a sua recuperação e crescimento saudável (Feeney & Collins, 2015; FICE et al., 2007; Guerra, 2022; Pinheiro et al., 2018). As orientações internacionais recomendam que a intervenção disponibilizada nas CAR integre intervenções psicológicas individualizadas, complementadas com ambientes terapêuticos e seguros (James et al., 2017; Whittaker et al., 2016). Neste contexto, os profissionais das CAR têm vindo a ser reconhecidos enquanto agentes ativos de mudança (Li & Julian, 2012; Sellers et al., 2020; Whittaker et al., 2016), sendo recomendado o estabelecimento de relações estáveis e afetuosas entre estes e as crianças e jovens de quem cuidam (FICE et al., 2007). No entanto, na execução das suas funções, estes profissionais são confrontados com diversas dificuldades e exigências, que podem comprometer a qualidade da prestação de cuidados (Bürgin et al., 2020). Em primeiro lugar, grande parte dos profissionais das equipas educativas, responsáveis pela prestação direta de cuidados, não possui formação especializada para intervir nas problemáticas do público-alvo das CAR (Rodrigues & Barbosa-Ducharne, 2017; Seti, 2008; Steels & Simpson, 2017). Em segundo lugar, as crianças e jovens em acolhimento carregam histórias de vida dramáticas e potencialmente traumáticas, que podem espoletar crises, comportamentos imprevisíveis e ameaçadores para o próprio e/ou para terceiros (Bürgin et al., 2020; Eenshuistra et al., 2019; Middleton & Potter, 2015; Molnar et al., 2017; Seti, 2008). Em terceiro lugar, as condições laborais são frequentemente precárias (e.g., poucos recursos humanos, financeiros e materiais) e a perceção de suporte entre colegas é fraca, acarretando sobrecarga de trabalho e descontentamento (Eenshuistra et al., 2019; Colton & Roberts, 2007; Hermon & Chahla, 2019; Lizano & Mor Barak, 2012; McElvaney & Tatlow-Golden, 2016; Middleton & Potter, 2015; Seti, 2008). Face a estas exigências, os cuidadores podem desenvolver dificuldades psicológicas e problemas de saúde mental, que comprometem o desempenho individual e da equipa na prestação de cuidados (Hermon &

Chahla, 2019; Lizano & Mor Barak, 2012; Middleton & Potter, 2015; Molnar et al., 2017; Raskin et al., 2015; Santos et al., 2023a; Seti, 2008; Wilke et al., 2020). Uma prestação de cuidados pouco adequada e negligente face às necessidades emocionais e sociais das crianças e jovens, compromete a finalidade de atuação das CAR, podendo, em determinadas situações, contribuir para retraumatizar a criança ou jovem (Vashchenko et al., 2010; Zelechoski et al., 2013).

Considerando a relevância do papel dos cuidadores na intervenção diária nas CAR, o nível de qualificação e apoio fornecido aos mesmos surge como um fator determinante na qualidade dos resultados desta resposta social (Bach-Mortensen et al., 2018). As normas para o Acolhimento de Crianças Fora da sua Família Biológica na Europa (Quality4Children; FICE et al., 2007) recomendam que os cuidadores devam receber formação e apoio profissional, a fim de garantirem o desenvolvimento global das crianças e jovens de quem cuidam. Mais concretamente, os profissionais das CAR necessitam de treino para intervir com crianças e jovens que experienciaram acontecimentos traumáticas e que apresentam problemas graves de saúde mental (Steels & Simpson, 2017). Paralelamente, dada a exigência emocional associada ao trabalho neste contexto, os cuidadores também necessitam ser objeto de cuidados (Krueger, 2007). As organizações deveriam facilitar formação e apoio aos profissionais destinados à promoção de estratégias de regulação emocional adaptativas nos próprios cuidadores, de modo a salvaguardar a sua qualidade de vida profissional (Garcia Quiroga & Hamilton-Giachritsis, 2017).

A investigação indica ainda que o clima da CAR é relevante para a obtenção de melhores resultados (Lanctôt et al., 2016) e que o mesmo poderá ser otimizado com intervenções que envolvam todos os seus profissionais (Brown et al., 2013; Glisson, 2007). A combinação destas vertentes poderá facilitar a qualidade dos cuidados interativos e otimizar a responsividade dos cuidadores, a fim de responderem adequadamente às necessidades das crianças e jovens, paralelamente à melhoria da qualidade da resposta de acolhimento (Garcia Quiroga & Hamilton-Giachritsis, 2016).

Não obstante, a investigação indica que as recomendações em torno da implementação de programas especificamente desenhados para o acolhimento residencial e direcionados a todos os profissionais da CAR, nem sempre são seguidas (James et al., 2017; Luke et al., 2014). Apesar da investigação sugerir que intervenções baseadas em evidência apresentam melhores resultados no processo de acolhimento (De Swart et al., 2012), o uso de modelos de intervenção e de práticas baseadas em evidência continua a ser escasso (James et al., 2017; Rodrigues & Barbosa-Ducharne, 2017). Assim, a investigação tem alertado para a necessidade de desenvolver ou adaptar programas de treino/intervenção, que incrementem não só

competências profissionais e relacionais, mas também que protejam e promovam a saúde mental dos cuidadores (Hermenau et al., 2017; Lizano & Mor Barak, 2012; Steels & Simpson, 2017; van Gink et al., 2018; Vashchenko et al., 2010).

Numa tentativa de ultrapassar as limitações evidenciadas na investigação e sentidas no terreno, o presente trabalho de investigação pretendeu trazer para o acolhimento residencial de crianças e jovens, uma abordagem compassiva no que diz respeito à prestação de cuidados. Tendo como base o modelo teórico e práticas utilizadas na Terapia Focada na Compaixão (Gilbert, 2010a), este projeto propôs-se desenvolver, implementar e estudar a eficácia de um programa de Treino da Mente Compassiva para Cuidadores (TMC-C). Este programa pretende promover o desenvolvimento de uma mente compassiva que permita, aos cuidadores, utilizarem formas compassivas de prestar atenção, pensar e agir, em relação a si e aos outros. Mais concretamente, o TMC-C pretende facilitar aos cuidadores maior sensibilidade e tolerância, não só às dificuldades emocionais e necessidades dos jovens, mas também às dificuldades manifestas por si e pelos colegas, disponibilizando um conjunto de estratégias que podem ser usadas para validar, apaziguar e atender a essas dificuldades. O TMC-C constitui um veículo para promover uma mentalidade afiliativa nas CAR, que facilite a proximidade e conexão entre os diferentes agentes (cuidadores, colegas, chefias, jovens), tendo em vista um incremento da entreajuda e da qualidade de vida profissional dos cuidadores e a melhoria da prestação de cuidados às crianças e jovens.

Para estudar a eficácia do programa, foi conduzido um ensaio clínico aleatorizado por *clusters*, desenhado de acordo com *Consort 2010 statement: extension to cluster randomised trials* (Campbell et al., 2012). O ensaio clínico incluiu duas amostras, uma de cuidadores e outra de jovens em acolhimento. Foram analisados os efeitos do programa em diferentes indicadores individuais, interpessoais e organizacionais, indicados pela investigação como relevantes para assegurar a qualidade da prestação de cuidados neste contexto. A estabilidade das mudanças ao longo do tempo foi também avaliada, 3 e 6 meses após o término do programa (dependendo do estudo em causa). A avaliação dos diferentes tipos de indicadores foi realizada com recurso a métodos quantitativos e qualitativos de recolha de informação junto de diferentes informantes (i.e., cuidadores e jovens), narrados na primeira e na segunda pessoa (Mascaro et al., 2020).

Uma vez que, na Parte III da presente tese, foi apresentada uma discussão detalhada dos resultados da revisão sistemática e de cada estudo empírico, neste capítulo serão apresentadas uma síntese e uma discussão integrada dos principais resultados dos diferentes estudos incluídos nesta tese e dos seus contributos para a área do acolhimento de crianças e

jovens. Mais concretamente, serão apresentados os contributos dos trabalhos desenvolvidos para: (i) o estado da arte sobre programas dirigidos a cuidadores e focados na promoção da saúde mental e emocional nas CAR; (ii) a validação de medidas de autorrelato dirigidas a jovens em acolhimento sobre construtos associados à qualidade das relações estabelecidas com os cuidadores e ao clima emocional das CAR; (iii) o conhecimento científico sobre o papel das experiências de cuidados, calor e segurança no funcionamento psicológico dos jovens em acolhimento; (iv) o desenvolvimento e adaptação do programa de TMC-C; (v) os efeitos do programa de TMC-C nos cuidadores (compaixão, qualidade de vida profissional) de acordo com uma perspetiva avaliada na primeira e segunda pessoas; (vi) os efeitos do programa de TMC-C a nível interpessoal e organizacional (afiliação e clima emocional das CAR) de acordo com a integração da perspetiva dos cuidadores e dos jovens. Neste capítulo, serão ainda discutidas as potencialidades e limitações dos estudos realizados e apontadas recomendações para investigação futura nesta área. Por fim, serão destacadas as implicações deste projeto para as práticas e políticas de acolhimento.

1. Síntese e discussão integrada dos principais resultados

1.1 Revisão sistemática da literatura: Programas de treino/intervenção dirigidos a profissionais das casas de acolhimento com a finalidade de promover saúde emocional e mental no acolhimento residencial

Assegurar a qualidade da prestação de cuidados às crianças e jovens em CAR, requer conhecimento técnico e disponibilidade emocional dos cuidadores para compreender e estar em contacto com as histórias de vida potencialmente traumáticas das crianças e jovens de quem cuidam. Por esse motivo, diversos organismos em matéria de infância e juventude recomendam que seja facilitada formação especializada aos profissionais das CAR (FICE et al., 2007; NICE, 2015; ONU, 2010).

Neste seguimento, têm sido desenvolvidos programas com diferentes objetivos (e.g., Çatay & Koloğlugil, 2017; Pereira, 2009; Silva, 2013). Revisões sistemáticas da literatura procuraram sintetizar os contributos dos programas para a melhoria de indicadores de desenvolvimento das crianças em acolhimento (Hermenau et al., 2017), para as competências dos cuidadores (Eenshuistra et al., 2019) e para indicadores psicossociais dos cuidadores e dos jovens em acolhimento (Morison, 2018), não se debruçando especificamente sobre o efeito de programas com o objetivo de promover saúde emocional e mental nos cuidadores e nos jovens.

Apesar do estabelecimento de relações de qualidade ser central no trabalho diário efetuado nas CAR, o treino dos cuidadores não deve ser limitado ao desenvolvimento de

competências profissionais e interpessoais (Everson-Hock et al., 2011). O bem-estar dos profissionais deve ser protegido e promovido, sendo importante que o treino abranja também o autocuidado e a regulação emocional dos cuidadores (Lizano & Mor Barak, 2012; NCTSN, 2016; Steels & Simpson, 2017), aspeto este que não foi analisado nas revisões sistemáticas mencionadas.

A revisão sistemática da literatura apresentada no Capítulo 4 (Fostering emotional and mental health in residential youth care facilities: A systematic review of programs targeted to care workers; Santos et al., 2023c) sintetiza e analisa sistematicamente os programas de treino/intervenção dirigidos a profissionais que trabalham nas CAR, desenhados para promover a saúde emocional e mental nas CAR. Neste estudo procurou-se identificar o modelo de base dos programas e analisar os resultados obtidos em indicadores de saúde emocional e mental dos cuidadores e/ou dos jovens, bem como em indicadores associados à qualidade das relações interpessoais e do ambiente da CAR.

A revisão sistemática analisou os programas e respetivos resultados publicados em 17 estudos empíricos (publicados entre 2003 e 2021). Os resultados reproduziram, em parte, os resultados da revisão sistemática conduzida por Morison (2018). A maioria dos programas existentes é direcionado para o desenvolvimento de competências globais dos cuidadores, com o intuído de reduzir incidentes críticos e problemas de comportamento dos jovens (Barnett et al., 2018; Berridge et al., 2016; Donald, 2015; Hermenau et al., 2015; Hidalgo et al., 2016; Hurley et al., 2006; Izzo et al., 2016; Nunno et al., 2003; Schmid et al., 2020; Wahl, 2011). Apesar de alguns programas pretenderem, paralelamente, dar suporte aos cuidadores (Barnett et al., 2018; Griffing et al., 2021) e melhorar a sua regulação emocional e bem-estar (Hidalgo et al., 2016; Schmid et al., 2020; Vallejos et al., 2016), são poucos os programas que se direcionam especificamente para a promoção da saúde mental dos cuidadores (Griffing et al., 2021; Hidalgo et al., 2016; Schmid et al., 2020; Turner, 2017; Vallejos et al., 2016). Foram ainda poucos os programas que incorporaram competências de mindfulness (Griffing et al., 2021; Schmid et al., 2020; Turner, 2017) ou empatia (Donald, 2015; Silva & Gaspar, 2014), competências que são consideradas úteis para desenvolver consciência sobre os estados emocionais do próprio e dos outros (Singer & Lamm, 2009) e, por esse motivo, potencialmente úteis para a regulação emocional e prestação de cuidados neste contexto.

Alguns dos programas propunham ainda melhorar as dinâmicas sociais entre cuidadores e crianças ou entre membros das equipas, (Hidalgo et al., 2016; Izzo et al., 2016; van Gink et al., 2018; Wahl, 2011), mas nenhum incluiu indicadores associados ao ambiente/clima da CAR. Esta limitação da investigação foi também reportada em outras revisões sistemáticas (Hermenau et

al., 2017; Perry et al., 2020). Apesar de ser reconhecida a necessidade da criação de ambientes terapêuticos (Whittaker et al., 2016), os estudos realizados nesta área não disponibilizam evidência do impacto dos programas para o ambiente e clima das CAR.

Quanto à implementação dos programas, a maioria foi aplicado em formato de grupo, junto de profissionais com diferentes funções e profissões, o que parece ser uma boa prática tendo em vista a uniformização e coerência dos processos e das práticas de acolhimento (Bunting et al., 2019). Tanto na presente revisão sistemática, como em outras (Hermenau et al., 2017; Morison, 2018), menos de metade dos programas dispõem de manual, limitando a reprodução e integridade do tratamento.

Relativamente ao modelo conceptual dos programas, uma parte dos estudos incluídos neste trabalho não indicou informação clara a esse respeito. De acordo com a informação reportada, tal como foi também encontrado em outras revisões sistemáticas (Morison, 2018), os modelos teóricos agrupavam-se tendencialmente em torno das teorias do comportamento, da vinculação e/ou princípios orientados para o trauma. Se, por um lado, o foco no estabelecimento de relações seguras se encontra alinhado com recomendações internacionais para a criação de ambientes terapêuticos e informados no trauma (NICE, 2015; Steels & Simpson, 2017; Whittaker et al., 2016), por outro lado, o foco exclusivo na gestão comportamental poderá revelar-se limitador, visto que não responde plenamente às necessidades emocionais dos jovens (Luke et al., 2014). A abordagem teórica comportamentalista espelha o foco da maioria dos programas na gestão do comportamento observável, tendendo a menosprezar os problemas de internalização, também prevalentes no público-alvo das CAR (Granic, 2014; Hodgdon et al., 2013; Jozefiak et al., 2016). Além disso, o uso excessivo e descontextualizado de determinadas técnicas comportamentais (e.g., castigos) pode, por um lado, ativar memórias de experiências traumáticas e aumentar a desregulação da criança ou jovem (Bastiaanssen et al., 2014; Rijo et al., 2017) e, por outro, comprometer o estabelecimento da necessária relação de confiança com os cuidadores (Cimmarusti & Gamero, 2009; Hodgdon et al., 2013; Huefner & Ainsworth, 2021) .

No que diz respeito à contribuição dos programas para a melhoria da saúde emocional e mental dos cuidadores, dois programas indicaram uma redução dos níveis de stress (Schmid et al., 2020; Turner, 2017) e de *burnout* (Turner, 2017). No entanto, ambos os estudos apresentam limitações metodológicas que podem comprometer a generalização dos resultados (CRD, 2009; Kazdin, 2003). Programas não especificamente desenhados para este fim, não se revelaram eficazes na redução de problemas emocionais e de saúde mental dos cuidadores (Donald, 2015; Silva & Gaspar, 2014). Este resultado sugere que são necessárias intervenções

específicas para proteger e promover a saúde mental dos cuidadores. Com base na análise dos estudos incluídos nesta revisão sistemática, é possível destacar um conjunto de componentes comuns entre programa associados a melhores resultados ao nível da saúde mental dos cuidadores: (i) princípios baseados no trauma; (ii) componentes de autocuidado e estratégias de regulação emocional; (iii) práticas de meditação.

A maioria dos programas incluídos para análise no presente estudo pretende promover competências profissionais e interpessoais dos cuidadores com o intuito de reduzir incidentes críticos e problemas de comportamento. Os programas aparentam ser eficazes para esse fim. No entanto, a longo prazo, este tipo de abordagem tende a não promover alterações no funcionamento interno da criança ou jovem (Bastiaanssen et al 2012; Rijo et al., 2017). De facto, o foco excessivo no controlo comportamental, sem atender à satisfação das necessidades afetivas, emocionais e sociais da criança ou jovem, encontra-se associado a piores resultados da medida de acolhimento (Harder, 2018). As crenças da criança e jovem sobre si, os outros e o meio, são sustentadas por experiências traumáticas prévias, sendo necessárias novas experiências interpessoais significativas, baseados no cuidado e afeto, que as possam flexibilizar e alterar.

Neste sentido, alguns estudos analisaram o efeito dos programas em variáveis relacionais, indicando melhorias na relação entre cuidadores e crianças/jovens (Berridge et al., 2016; Cameron & Das, 2019; Donald, 2015; Hermenau et al., 2015; Hidalgo et al., 2016; Vallejos et al., 2016). No entanto, na maioria dos estudos, estas variáveis foram avaliadas com recurso a entrevistas, o que poderá ter distorcido os resultados devido à inclusão voluntária de participantes tendencialmente mais colaborantes (Júnior, 2022). Os estudos que recorreram a métodos mistos reportaram inconsistência entre os resultados qualitativos e quantitativos (Berridge et al., 2016; Donald, 2015; Vallejos et al., 2016).

Tal como em revisões sistemáticas prévias (Eenshuistra et al., 2019; Everson-Hock et al., 2011; Hermenau et al., 2017; Morison, 2018), os estudos incluídos na presente revisão sistemática apresentam limitações no desenho e metodologia (e.g., ausência de grupo de controlo e avaliação de *follow-up*), amostragem (e.g., amostras pouco representativas e limitadas a uma fonte de informação) e métodos de análise de dados (e.g., ausência de descrição dos procedimentos e de estatísticas inferências), podendo introduzir enviesamentos na leitura dos resultados, comprometer a validade interna e externa dos mesmos e a generalização dos resultados (CRD, 2009; Kazdin, 2003; Moher et al., 2010). É de salientar que uma parte dos estudos procurou integrar métodos de avaliação quantitativos e qualitativos. No entanto, algumas medidas não se encontravam validadas ou eram pouco fiáveis (Barnett et al., 2018;

Berridge et al., 2016; Cameron & Das, 2019; Griffing et al., 2021; Nunno et al., 2003; Schmid et al., 2020) e o método de análise de dados qualitativos não se encontrava devidamente descrito (Barnett et al., 2018; Berridge et al., 2016; Griffing et al., 2021; Hermenau et al., 2015; Nunno et al., 2003), dificultando a compreensão do tratamento de dados e a fiabilidade dos resultados obtidos. Acresce, ainda, que alguns estudos não forneceram qualquer informação relativamente aos jovens (Griffing et al., 2021; Osteen et al., 2018; Turner, 2017; van Gink et al., 2018), sendo pouco claro qual o real impacto da intervenção/treino dirigido aos cuidadores nos jovens acolhidos.

Deste modo, revela-se difícil emitir conclusões sobre os reais efeitos dos programas existentes, até que novos estudos passem a implementar metodologias mais robustas. De facto, esta e outras revisões sistemáticas de programas dirigidos a cuidadores do acolhimento residencial, apontam para uma escassez de ensaios clínicos aleatorizados e controlados neste contexto (Everson-Hock et al., 2011; Hermenau et al., 2017; Morison, 2018). Considerado que os ensaios clínicos são atualmente considerados o padrão de excelência (*golden standard*) para determinar a eficácia de uma intervenção (Hariton & Locascio, 2018), esta dificuldade poderá comprometer a qualidade das práticas de acolhimento e as tentativas de aproximação entre a ciência a esta área dedicada ao cuidado de uma população tão vulnerável, como são as crianças e jovens em perigo.

Em conclusão, os resultados da presente revisão sistemática da literatura, combinados com os resultados de outras revisões neste domínio, indicam que permanecem lacunas no que respeita aos programas de treino baseados em evidência, especificamente dirigidos para os profissionais das CAR com o objetivo de promover a saúde mental e emocional nesta resposta social. Este estudo reforça a necessidade de desenvolver programas que ajudem os cuidadores a atender às necessidades complexas das crianças e jovens em acolhimento, que não passem exclusivamente pelo controlo comportamental. Reforça ainda a necessidade de proteger e cuidar da saúde emocional e mental dos próprios cuidadores. É também destacada a necessidade de construir programas alicerçados em modelos teóricos sólidos, devendo a eficácia do programa ser devidamente testada com recurso a metodologias rigorosas de investigação, de forma a reforçar a ligação entre as práticas nas CAR e a ciência.

1.2 Validação de medidas de autorrelato para adolescentes

A investigação indica, de forma consistente, que o potencial terapêutico das CAR se encontra associado a fatores sociais e ecológicos (Costa et al., 2019; Graham & Johnson, 2021; Leipoldt et al., 2018; Leipoldt et al., 2019; Sellers et al., 2020; Sonderman et al., 2021; Strijbosch

et al., 2018; Wright et al., 2019). O estabelecimento de relações de qualidade entre crianças e cuidadores é fundamental para o desenvolvimento de competências emocionais, sociais e comportamentais da criança e do jovem (Huefner & Ainsworth, 2021; Wright et al., 2019). A qualidade dessas relações encontra-se positivamente associada ao sentimento de segurança reportado por crianças e jovens em CAR, que lhes disponibiliza um porto seguro para se apaziguarem e para lidarem com a adversidade, bem como uma base segura para o seu crescimento e projeto de vida (Briggs et al., 2012; Garcia Quiroga & Hamilton-Giachritsis, 2016; Jackson et al., 2019; Lecannelier et al., 2014; Sellers et al., 2020). Complementarmente, o clima das CAR, quando estruturado, estável e caloroso, tem sido apontado como um fator relevante para alcançar melhores resultados junto de crianças e jovens em acolhimento residencial (Costa et al., 2019; Lanctôt et al., 2016; Leipoldt et al., 2019; Sonderman et al., 2021).

Apesar da relevância atribuída aos fatores sociais e ecológicos mencionados, a investigação revela uma escassez de estudos de eficácia de programas que avaliem variáveis relacionais e relativas ao clima da CAR (Hermenau et al., 2017; Perry et al., 2020; Santos et al., 2023c). Quando investigada, a qualidade das relações entre cuidadores e jovens tem sido maioritariamente avaliada com recurso a entrevistas, o que pode introduzir enviesamento associado à seleção e desejabilidade social dos participantes (Júnior, 2022). A revisão sistemática da literatura mostrou também que são poucos os estudos de programas dirigidos a cuidadores que incluíram medidas de autorrelato dos jovens, enquanto recetores de cuidados (Santos et al., 2023c). Este procedimento traduz-se numa limitação da investigação atual, uma vez que é recomendado que a avaliação de variáveis desta natureza inclua perspetivas de múltiplos informantes (Leipoldt et al., 2019).

Considerando a natureza dinâmica das variáveis em estudo e o contexto ecológico de implementação, o ensaio clínico desenvolvido no âmbito do presente trabalho de investigação adotou uma abordagem de avaliação multimodal, segundo as recomendações constantes na literatura (Leipoldt et al., 2019; Mascaro et al., 2020; Van Dam et al., 2018). O ensaio clínico incluiu uma amostra de cuidadores (recetores do programa) e uma amostra de jovens em acolhimento residencial, enquanto informantes acerca de resultados do programa na qualidade das relações interpessoais e no clima da CAR.

Apesar de existirem escalas de avaliação desenhadas para avaliar o relacionamento interpessoal (e.g., Pais Ribeiro, 2011; Pierce et al., 1991) e o clima social das organizações (e.g., Leipoldt et al., 2018; Mathys et al., 2013; Strijbosch et al., 2014), as mesmas evidenciavam limitações de diversos tipos (e.g., medidas extensas) e/ou não se mostraram de particular relevância face ao modelo conceptual do programa que pretendíamos estudar. Além disso, a

TFC valoriza a forma como os indivíduos se sentiram ou sentem face ao comportamento dos outros, propondo avaliar a perspetiva e sentimentos do indivíduo em vez do comportamento manifesto em si (Gilbert, 2003). De facto, a investigação sugere que, por exemplo, problemas de saúde mental encontram-se mais fortemente associados com memórias de ausência de sentimentos de calor e segurança do que com a recordação de comportamento dos pais em si (Richter et al., 2009).

No ensaio clínico, importava-nos por isso, avaliar a perspetiva dos jovens relativamente ao clima da CAR onde residem e como se sentem na CAR (de Rivera & Paez, 2007), bem como a frequência com que sentem determinadas experiências afiliativas com os cuidadores das CAR. Para esse efeito, adaptaram-se duas escalas baseadas em construtos de relevância, previamente validadas para outras populações. Para avaliar o clima emocional, adaptou-se a Escala de Avaliação do Clima Emocional em Sala de Aula (EACESA; Albuquerque et al., 2021), medida que aplica o modelo integrativo proposto por Gilbert (2014) sobre o agrupamento de diferentes tipos de afeto em três sistemas de afeto evolucionários (i.e., ameaça, procura e afiliação/apaziguamento) ao clima de uma organização. Neste modelo, as experiências de cuidado, calor e segurança com os outros são *inputs* fundamentais para a ativação do sistema de afiliação/apaziguamento, relevante na regulação emocional dos indivíduos (Gilbert, 2010b; Hermanto & Zuroff, 2016). Interessava-nos, por isso, avaliar a perceção que os jovens em acolhimento apresentam sobre as experiências afiliativas com os cuidadores das CAR. No entanto, os instrumentos disponíveis para estudar este tipo de experiências restringem-se a uma retrospeção referente a memórias de infância (Richter et al., 2009). Neste sentido, adaptou-se a Escala de Memórias de Experiências Precoces de Cuidados e Segurança para Adolescentes (EMEPCS-A; Cunha et al., 2014; Vagos et al., 2017) para avaliar as experiências atuais (no presente) desta natureza, em adolescentes da população geral e em acolhimento residencial.

No Capítulo 5 são incluídos dois estudos empíricos (Estudo empírico I - Emotional Climate in Residential Care Scale for Youth: Psychometric properties and measurement invariance, Santos et al., 2023a; Estudo empírico II - Development and validation of the Current Experiences of Warmth and Safeness Scale in community and residential care adolescentes, Santos et al., 2021) de adaptação e validação de duas medida breves de autorrelato para jovens em acolhimento: Escala de Avaliação do Clima Emocional para Jovens em Acolhimento Residencial (ECRC-Y) e a Escala de Experiências Atuais de Cuidados e Segurança para Adolescentes (CEWSS-A).

Ambas as escalas mantiveram a estrutura fatorial das escalas originais e revelaram níveis adequados de consistência interna. Revelaram ainda validade de construto em relação a variáveis externas. A invariância do modelo de medida por sexo foi confirmada em ambas as medidas.

A Escala de Avaliação do Clima Emocional para Jovens em Acolhimento Residencial (ECRC-Y) baseia-se no modelo dos três sistemas de regulação do afeto de Gilbert (2014) e pretende avaliar como é que os jovens se sentem e percecionam o clima da CAR. A versão final é constituída por 14 itens, distribuídos pelos mesmos três fatores da escala original, tendo sido excluído um item ("Ansioso" do fator de emoções associadas à ameaça). A remoção do item foi baseada em indicadores estatísticos, linguísticos e teóricos, por se considerar que "Ansioso" poderá ser interpretado como "Entusiasmado", representando uma emoção do sistema de procura e não de ameaça, como sucedeu em outros estudos conduzidos com crianças e adolescentes (Eddy et al., 2011; Sousa et al., 2021). A estabilidade temporal desta escala foi fraca. Este resultado pode indiciar uma ameaça à fiabilidade da escala ou sugerir que a resposta à mesma foi influenciada pelas circunstâncias em que o preenchimento ocorreu ou pelo estado do humor do participante, sendo sensível a mudanças contextuais (de Vet et al., 2006). Este resultado poderá ser parcialmente explicado pelas características da amostra (i.e., jovens em CAR tendem a manifestar instabilidade emocional), mas também pode resultar da natureza do construto que se encontra a ser medido (Crocker & Algina, 1986), que tende a ser influenciado por fatores situacionais (Souverein et al., 2013; Strijbosch et al., 2018).

No que diz respeito à validade de construto em relação a variáveis externas, constatou-se que a dimensão de emoções associadas ao sistema de ameaça se relacionou negativamente com o afeto positivo e com experiências atuais de calor e segurança. Esta dimensão apresentou uma associação positiva com problemas internalizantes e externalizantes e também com afeto negativo. A dimensão de emoções associadas ao sistema de procura relacionou-se positivamente com o afeto positivo e com as experiências atuais de calor e segurança com os outros e, negativamente, com o afeto negativo e com problemas internalizantes. A dimensão de emoções associadas ao sistema de afiliação/apaziguamento relacionou-se positivamente com o afeto positivo e com experiências atuais de calor e segurança e, negativamente, com o afeto negativo e com problemas de internalização e de externalização. Quando comparadas as pontuações entre sexos, as raparigas reportaram sentir, na CAR, emoções associadas ao sistema de ameaça com maior frequência, comparativamente aos rapazes. Este resultado sugere que as raparigas tendem a percecionar o clima da CAR como mais ameaçador.

A Escala de Experiências Atuais de Cuidados e Segurança (CEWSS-A) foi validada para adolescentes da população geral e adolescentes em acolhimento residencial. Considerando as características da população a que se destina, o número de itens da escala foi reduzido, com base em critérios estatísticos e teóricos, de 21 para 12 itens, para evitar cansaço e desmotivação dos participantes (Stanton et al., 2002). A CEWSS-A revelou estabilidade temporal adequada nas duas amostras. A medida revelou-se positivamente associada com medidas de compaixão e de afeto positivo e inversamente associada com sintomas de ansiedade, depressão e stress, afeto negativo, desconexão com os outros e conflitos entre pares. A comparação de médias entre sexos e grupos, indicou que os rapazes reportaram significativamente mais experiências de cuidado e segurança comparativamente às raparigas. Como esperado, adolescentes em acolhimento residencial reportaram significativamente menos experiências de cuidado e segurança do que os pares da população geral.

Quando considerados conjuntamente, os resultados destes dois estudos sugerem que os construtos avaliados pelas duas escalas se encontram associados a indicadores de (des)ajustamento psicológico. Ambos se encontram alinhados com o modelo dos sistemas de regulação do afeto (Gilbert, 2014), correlacionando-se com medidas de afeto negativo e de afeto positivo no sentido esperado (Armstrong et al., 2021; Depue & Morrone-Strupinsky, 2005). Também de acordo com o modelo teórico de base, verificou-se que uma maior frequência de experiências atuais de cuidados e segurança com os outros, se encontrava positivamente associada a uma maior frequência na CAR de emoções associadas ao sistema de procura e ao sistema de afiliação/apaziguamento, e a uma menor frequência da experiência de emoções associadas ao sistema de ameaça. Estes resultados reforçam que o clima emocional é influenciado por fatores ecológicos (Souverein et al., 2013), salientando a necessidade de proporcionar experiências afiliativas de calor e segurança para a ativação do sistema de afiliação/apaziguamento e regulação de afeto negativo associado ao sistema de ameaça (Gilbert, 2014). Outros estudos na área do acolhimento, encontraram uma associação positiva entre o clima da CAR e qualidade das relações com os cuidadores (Strijbosch et al., 2018).

Numa outra perpetiva, estes resultados encontram-se também alinhados com a teoria da vinculação (Bowlby, 1982, 1988), parecendo indicar que quando os jovens se sentem apoiados e acarinhados pelos cuidadores, para além de disporem de um refúgio seguro que os apazigue, tendem também a sentir segurança e emoções energizantes que, conjuntamente, poderão facilitar uma base segura para se abrirem a novas aprendizagens e se envolverem em atividades úteis para a sua autonomia e projeto de vida (Briggs et al., 2012; Garcia Quiroga & Hamilton-Giachritsis, 2016; Irons & Gilbert, 2005; Jackson et al., 2019; Lecannelier et al., 2014;

Sellers et al., 2020). Considerando que este grupo tende a ser particularmente desmotivado (James et al., 2017), este resultado poderá trazer um novo *insight* para o delineamento de estratégias de intervenção e projetos educativos destes jovens (e.g., priveligiar atividades que favoreçam o estabelecimento de relações seguras com cuidadores de referência desde o início do acolhimento).

Tanto um clima emocional seguro, como as experiências atuais de cuidados e segurança com os cuidadores, se revelaram negativamente associadas quer a problemas de internalização, quer a problemas de externalização. Contrariamente, a perceção de um clima emocional de ameaça revelou-se positivamente associada aos referidos problemas. Estes resultados estão de acordo com as conclusões de outros estudos conduzidos no âmbito do modelo da TFC que encontram associações entre variáveis afiliativas e psicopatologia (Irons & Gilbert, 2005; Richter et al., 2009) e reforçam a relevância da integração de variáveis desta natureza no processo de acolhimento, tendo em vista a obtenção de melhores resultados (Costa et al., 2019; Graham & Johnson, 2021; Leipoldt et al., 2018; Leipoldt et al., 2019; Sellers et al., 2020; Strijbosch et al., 2018; Wright et al., 2019).

Os resultados destes estudos indicam ainda que as raparigas em acolhimento parecem apresentar maior vulnerabilidade comparativamente aos rapazes. Mais concretamente, as raparigas tendem a percecionar o clima da CAR como mais ameaçador, reportando maior frequência de emoções associadas ao sistema de ameaça naquele contexto, e tendem a percecionar menor frequência de experiências de cuidados e segurança com os outros. Esta tendência verifica-se também quando comparamos, entre rapazes e raparigas da população geral, a perceção relativa às experiências atuais de cuidados e segurança com os outros.

Estes resultados podem dever-se a diferenças no processo de socialização entre rapazes e raparigas. O estabelecimento e manutenção de relações interpessoais é enfatizado no processo de socialização dos elementos do sexo feminino, podendo influenciar a perceção dos outros enquanto fonte de suporte e a escolha das estratégias de *coping* utilizadas pelos elementos dos dois sexos (Chow et al., 2014; Rueger et al., 2010). Enquanto as raparigas tendem a investir mais na procura de suporte, os rapazes tendem a envolver-se mais em comportamentos recreativos ou de evitamento face a problemas (Eschenbeck et al., 2007). Por este motivo, as raparigas podem tender a valorizar as relações de intimidade de diferente forma e a investir mais nos relacionamentos com os outros e, por isso, possuir uma perceção diferente destas relações (Gilligan, 1982). No acolhimento residencial, fatores como a rotatividade de colaboradores e de pares, bem como crenças do próprio sobre uma potencial rejeição, podem

interferir na perceção da disponibilidade e qualidade das relações com os outros (Chow et al., 2014; Lanctôt, 2020).

A diferente perceção de emoções associadas à ameaça no clima das CAR poderá encontrar-se associada também a diferenças de género na socialização, influenciando crenças em torno do que é culturalmente "expectável" e "aceitável" em termos da expressão emocional de homens e de mulheres (Chaplin & Aldao, 2013; Garside & Klimes-Dougan, 2002; Kirby & Kirby, 2017). Especificamente, rapazes que cresceram em ambientes hostis podem ter aprendido que expressar medo não é aceitável nem adaptativo, pois podem ser gozados, humilhados e excluídos, aprendendo a suprimir determinadas emoções (Chaplin & Aldao, 2013; Kirby & Kirby, 2017) ou a desenvolver formas alternativas para lidar com as mesmas, a fim de se protegerem (Paulo et al., 2020; Vagos et al., 2018). Este resultado não significa que rapazes e raparigas experienciam emoções com intensidades diferentes (Szentágotai-Tătar & Miu, 2016), mas sim que poderão utilizar estratégias de *coping* diferentes para lidar com as emoções na tentativa de as regularem (Paulo et al., 2020; Vagos et al., 2018).

Como era esperado, adolescentes da população geral reportaram sentir mais frequentemente experiências de cuidados e segurança com os outros, comparativamente aos adolescentes em acolhimento residencial. Este resultado poderá encontrar-se relacionado, pelo menos parcialmente, com o ambiente em que os adolescentes das duas amostras vivem atualmente (i.e., familiar vs residencial). Apesar dos esforços das CAR em simular um ambiente o mais familiar possível, devido ao rácio de cuidadores por criança/jovem, dificilmente os cuidados são prestados de forma individualizada de acordo com as necessidades de cada criança ou jovem, sendo prestados por múltiplos cuidadores, por vezes de forma inconsistente. Pelo mesmo motivo, os cuidados prestados são, sobretudo assistencialistas, descurando as necessidades emocionais e sociais das crianças e dos jovens (McCall & Groark, 2015). Concomitantemente, este resultado poderá também dever-se às experiências adversas prévias com a família em contexto de prestação de cuidados (e.g., violência e abuso) ou à ausência de cuidados, calor e afeto (Tahirović & Jusić, 2016; Vagos et al., 2017). Este tipo de experiências poderá ter comprometido o estabelecimento de padrões de vinculação seguros e o desenvolvimento do sistema de afiliação/apaziguamento, tornando mais difícil para estas crianças e jovens sentirem-se seguros com os outros, não percecionando e/ou não procurando cuidados compassivos (Gilbert, 2015). As dificuldades de ligação ao outro poderão aumentar a vulnerabilidade manifestada por estas crianças e jovens para desenvolverem dificuldades psicológicas e emocionais (Mota et al., 2016).

Em conclusão, quando pautada por calor, compreensão e segurança, a relação com os cuidadores das CAR poderá revelar-se uma experiência afiliativa relevante na ativação e estimulação dos sistemas de afiliação/apaziguamento e de procura dos jovens em acolhimento. A ativação destes sistemas poderá contribuir para a regulação do afeto negativo associado ao sistema de ameaça e dos problemas socioemocionais. Reconhecendo que o ser humano é um ser social, consideramos que tanto rapazes como raparigas apresentam as mesmas necessidades de calor, afeto e segurança com os outros. Estes estudos apontam, no entanto, para uma procura e utilização mais evidente pelas raparigas destas relações de suporte na gestão de dificuldades. Considerando que adolescentes do sexo feminino tendem a manifestar níveis mais elevados de psicopatologia do que adolescentes do sexo masculino (Bronsard et al., 2011; Campos et al 2019), estes resultados devem permitir refletir sobre a adequação das práticas e das intervenções em função do sexo dos utentes das CAR. Para rapazes e raparigas, o acolhimento residencial poderá ser uma oportunidade de experienciarem novas relações interpessoais num ambiente seguro (Mota et al., 2018), que poderá exercer um papel terapêutico na regulação do afeto e na sua recuperação (Bryson et al., 2017). Deste modo, estes estudos reforçam as recomendações relativas ao estabelecimento de relações estáveis e afetuosas entre cuidadores e crianças/jovens (FICE et al., 2007) e de um ambiente terapêutico nas CAR (Bailey et al., 2019; Lanctôt et al., 2016; Whittaker et al., 2016).

Os estudos apresentados do Capítulo 5 disponibilizam medidas breves de autorrelato destinadas a jovens em acolhimento e da população geral. Especificamente no domínio da investigação em acolhimento residencial, podem contribuir para avaliar a perspetiva do próprio, numa população para a qual existem poucas medidas validadas. Para a prática profissional, permitem dar voz ativa às crianças e jovens em acolhimento, de forma a compreender em que medida percecionam ter experiências de cuidados e segurança com os cuidadores e qual a sua perceção do clima emocional das CAR. Conjuntamente com a SSPS-A (Anexo D), também validada em coautoria pela autora desta tese, estas medidas podem contribuir para uma avaliação mais rigorosa e robusta da qualidade da prestação de cuidados nas CAR.

1.3 A relevância das experiências afiliativas no passado e no presente

O estudo empírico II (Santos et al., 2021) indicou que adolescentes em acolhimento percecionam ter menos experiências de cuidados e segurança com os atuais cuidadores, comparativamente aos pares da comunidade. O mesmo estudo indicou ainda que estas experiências se encontram, por um lado, positivamente associadas a variáveis protetoras, e por outro, negativamente associadas a problemas emocionais e de comportamento. Mais

concretamente, foi encontrada uma relação negativa de magnitude moderada entre experiências atuais de cuidados e segurança com sintomas de ansiedade e depressão. Problemas esses que, de acordo com a revisão sistemática da literatura (Santos et al., 2023c), e investigação conduzida nesta área (Fischer et al., 2016), tendem a ser negligenciados nas CAR, apesar de serem prevalentes em adolescentes em acolhimento (Bronsard et al., 2011; Jozefiak et al., 2016). Além disso, a adolescência é um período do desenvolvimento que envolve mudanças rápidas e profundas a diferentes níveis, durante o qual existe risco acrescido para o aparecimento de problemas de saúde mental, incluindo perturbações do humor e de ansiedade (Compas et al., 2017; Polanczyk et al., 2016; Rapee et al. 2019).

No que diz respeito à investigação em torno de variáveis afiliativas, enquanto a relação entre a vinculação estabelecida nos primeiros anos de vida e a psicopatologia futura tem sido amplamente estudada (Bowlby, 1988; Castilho et al., 2014; Irons et al., 2006; Mikulincer & Shaver, 2020; Siegel, 2015), o mesmo não se tem verificado em relação ao papel das experiências atuais de cuidados e segurança.

O estudo empírico III (Impact of early memories and current experiences of warmth and safeness on adolescents' psychological distress; Santos et al., 2023g), analisa o papel das memórias de experiências precoces e das experiências atuais de cuidado e segurança no desenvolvimento de sintomatologia de ansiedade e depressão, em adolescentes da comunidade e em acolhimento em CAR. Este estudo combinou uma abordagem focada na variável (análise de trajetórias) e uma abordagem focada no indivíduo (análise de perfis latentes), com o objetivo de tentar compreender se as experiências atuais de cuidados e segurança poderão ter um papel protetor face a sintomatologia depressiva e ansiosa em adolescentes, independentemente das memórias precoces sobre este tipo de experiências.

Resultados da abordagem focada na variável sugerem que, durante a adolescência, as memórias de experiências precoces de cuidados e segurança poderão ter um impacto variável em sintomatologia de ansiedade e depressão em adolescentes de diferentes grupos e sexo, dependendo da perceção que os mesmos revelam relativamente às experiências atuais de cuidados e segurança com os outros. Enquanto que as experiências atuais de cuidados e segurança aparentam desempenhar um papel protetor na saúde mental, a ausência de experiências desta natureza aparenta deteriorar a mesma.

Especificamente, os resultados da abordagem focada na variável sugerem que as memórias de experiências precoces de cuidados e segurança se encontravam negativamente e indiretamente associados a sintomatologia de ansiedade e depressão em rapazes e raparigas da população geral e a residir em CAR. Contrariamente a estudos prévios com variáveis

semelhantes, no presente estudo não se verificou uma relação direta entre as memórias precoces de cuidados durante a infância e problemas de saúde mental na atualidade (Mikulincer & Shaver, 2020; O'Donnell et al., 2017). Esta relação apenas ocorreu indiretamente quando mediada pelas experiências atuais de cuidados e segurança. Este resultado poderá, em parte, ser devido à medida utilizada para avaliar este tipo de experiências, que se reporta à memória de sentimentos e não a comportamentos objetivos em si (Downey & Crummy, 2021; Gilbert et al., 2003; Gilbert et al., 2006; Richter et al., 2009; Vagos et al., 2017).

A invariância do modelo delineado foi testada por grupo e por sexo, tendo sido encontradas diferenças em trajetórias e nas médias entre grupos e sexos. Resumidamente, os resultados encontrados corroboram os resultados de estudos prévios, reforçando que os adolescentes em acolhimento residencial são um grupo vulnerável, comparativamente àqueles que vivem com as suas famílias (Cousins et al., 2010; Fernández-Daza & Fernández-Parra, 2013; Greger et al., 2015). Relativamente às diferenças de sexo, enquanto que as raparigas tendem a reportar menos experiências atuais de cuidados e segurança do que os rapazes, os rapazes, por seu lado, tendem a manifestar menos sintomatologia ansiosa e depressiva do que as raparigas (Abad et al., 2002; Campos et al., 2019; Jozefiak et al., 2016; Rueger et al., 2014; Santos et al., 2021). Investigação prévia, também conduzida com amostras de adolescentes em acolhimento e da população geral, indica que os adolescentes em acolhimento percecionam ter uma rede de suporte mais reduzida, comparativamente a adolescentes da população geral (Singstad et al., 2020). O mesmo estudo indicou que o grupo de raparigas em acolhimento foi o grupo que reportou dispor de um menor número de pessoas de suporte. Assim, os adolescentes em acolhimento, e particularmente as raparigas, aparentam ter não só uma rede de suporte mais reduzida, mas também percecionar a mesma como menos calorosa, segura e cuidadora. De acordo com estudos prévios, a perceção de ausência de suporte, calor e afeto por parte das raparigas em acolhimento poderá dever-se também a crenças de desconexão e rejeição, associadas às experiências traumáticas vivenciadas (Lanctôt, 2020).

A abordagem focada no indivíduo identificou quatro perfis de adolescentes em acolhimento residencial com base nos níveis reportados de memórias de experiências precoces e de experiências atuais de cuidados e segurança. Um perfil apresenta níveis elevados das duas experiências afiliativas; um perfil com níveis elevados de memórias de experiências precoces de cuidados e segurança e níveis baixos de experiências atuais; um perfil com níveis baixos de memórias de experiências precoces de cuidados e segurança e níveis elevados de experiências atuais; um perfil com níveis reduzidos dos dois tipos de experiências afiliativas.

Como esperado, o perfil que apresenta maior vulnerabilidade para o desenvolvimento de sintomas depressivos e ansiosos, diz respeito aos adolescentes que percecionam menor frequência de memórias de experiências de cuidados e segurança e de experiências atuais dessa natureza. Isto significa que a contínua ausência de experiências afiliativas é fator de risco para o desenvolvimento de ansiedade e depressão na adolescência. O perfil referente a adolescentes que percecionam maior frequência de memórias de experiências, mas menor frequência desse tipo de experiências na atualidade na CAR, é o segundo com maior risco de desenvolvimento de sintomatologia. Já os adolescentes que percecionam menor frequência de memórias de experiências de cuidados e segurança, mas atualmente percecionam maior frequências dessas experiências com os cuidadores das CAR, apresentam menor vulnerabilidade para apresentar sintomatologia depressiva e ansiosa, do que os adolescentes do perfil anterior. Estes resultados sugerem que quando os cuidadores atuais não investem nos relacionamentos com os jovens, as consequências das experiências prévias de maus-tratos podem ser exacerbadas pela falta de experiências atuais de cuidados e segurança (Villodas et al., 2016).

Os resultados da abordagem centrada no indivíduo encontram-se alinhados com os resultados obtidos pela abordagem centrada na variável. Ambas reforçam o papel protetor das experiências de cuidados, calor e segurança ao longo da infância e da adolescência em relação ao desenvolvimento de sintomatologia de ansiedade e depressão (Irons & Gilbert, 2005; Kouros & Garber, 2014; Piña-Watson & Castillo, 2015; Rapee et al., 2019; Vagos et al., 2017). Destacam também que as experiências atuais de cuidados e segurança apresentam um papel protetor na saúde mental, mesmo perante a ausência de memórias desse tipo de experiências com os outros na infância (Rindlaub, 2015).

Apesar do maior investimento dos adolescentes nas relações com os pares e do seu progressivo movimento de autonomização em relação aos pais (Compas et al., 2017), o bem-estar mental do adolescente continua a depender de sentimentos de calor e segurança por parte de figuras significativas de prestação de cuidados, sejam elas os pais ou cuidadores das CAR. Enquanto figuras de suporte, pais, professores e cuidadores poderão ser agentes a incluir em intervenções mediadas com o intuito de promover a saúde mental e bem-estar dos adolescentes, podendo ajudar os mesmos a lidar com os desafios normativos desta fase de desenvolvimento e com situações de vida que envolvem emoções intensas.

Articulado com os estudos incluídos no Capítulo 5, este estudo sugere ainda vulnerabilidade associada ao sexo e ao grupo, que são necessárias atender na prática clínica e de acolhimento. Tal como descrito na literatura, no geral, as raparigas tendem a apresentar maior prevalência de sintomas de ansiedade e depressão (Abad et al., 2002; Campos et al., 2019;

Jozefiak et al., 2016), problemas esses que têm sido também associados a níveis reduzidos de suporte (Rueger et al., 2014). Reconhecendo que, face à adversidade, as raparigas tendem a procurar suporte emocional junto de outros significativos (Eschenbeck et al., 2007), familiares e cuidadores devem ser sensibilizados para identificar sinais de alerta e estarem disponíveis para prestar este tipo de apoio.

Tal como vastos estudos nesta área, os resultados deste estudo salientam que os adolescentes em acolhimento são um grupo particularmente vulnerável em termos de saúde mental (González-García et al., 2017; Greger et al., 2015; Jozefiak et al., 2016; Leloux-Opmeer et al., 2016; Luke et al., 2014; Magalhães & Calheiros, 2014; Mota et al., 2016; Tarren-Sweeney, 2008). Relacionamentos significativos, que forneçam calor, cuidados e segurança, parecem ser fundamentais para melhorar a saúde mental deste grupo, nomeadamente nos elementos do sexo feminino (Lanctôt et al., 2016). Este estudo reforça o papel terapêutico que os cuidadores das CAR podem assumir na recuperação psicológica dos adolescentes em acolhimento residencial (Jenney, 2020). Ao promover relações de proximidade e segurança, os cuidadores podem apoiar os adolescentes a reorganizarem os seus modelos internos, a utilizarem estratégias adaptativas para regular afeto negativo e lidarem melhor com situações do seu dia a dia. Este estudo reforça ainda que a prestação de cuidados nas CAR não pode assentar num modelo assistencialista, sendo necessário estabelecer relações significativas, calorosas e afetivas, bem como atender de forma individualizada às necessidades emocionais e sociais de cada criança e jovem. Além disso, a experiência crónica de insegurança prévia ao acolhimento é visível nas dificuldades de ligação ao outro manifestadas pelas crianças e jovens em acolhimento no geral (Crawford, 2006), e nas raparigas em particular (Lanctôt, 2020). Estas resistências poderão dificultar o estabelecimento de relações interpessoais seguras e de confiança com os atuais cuidadores. Por isso, revela-se importante que os cuidadores tenham uma visão compreensiva para com as dificuldades evidenciadas pelas crianças e jovens, de forma a gerirem as suas próprias expetativas e frustrações e adotarem uma intenção ativa e uma postura que facilitem o estabelecimento da relação (Sonderman et al., 2021). Para tudo isto, os cuidadores precisam de encontra-se emocionalmente disponíveis e regulados, para estar em contacto com o sofrimento carregado por estas crianças e jovens (Ferreira et al., 2020; Rindlaub, 2015; Sellers et al., 2020). Este estudo evidencia ainda a necessidade de qualificar e fornecer treino para que os cuidadores possam ser agentes efetivos de mudança e assim otimizar os resultados obtidos durante o processo de acolhimento (Garcia Quiroga & Hamilton-Giachritsis, 2016; Singstad et al., 2020).

Em conclusão, a integração dos resultados das duas abordagens metodológicas sugere que tanto as experiências precoces, como as experiências atuais de cuidados e segurança, apresentam um papel protetor na saúde mental dos adolescentes. Nos adolescentes em acolhimento residencial, as experiências atuais de cuidados e segurança parecem ter um papel protetor na saúde mental, mesmo quando as memórias desse tipo de experiências com os outros são parcas ou inexistentes durante a infância (Rindlaub, 2015). Os resultados deste estudo encontram-se também alinhados com as orientações internacionais para a qualidade do acolhimento (FICE et al., 2007), sendo recomendado que as CAR proporcionem relações estáveis e afetuosas às crianças e jovens.

1.4 Desenvolvimento, viabilidade e aceitabilidade do programa de TMC-C

A promoção de uma mentalidade afiliativa, na qual assenta a compaixão, tem sido associada à melhoria da prestação de cuidados em diversos contextos, com benefícios em termos de bem-estar para os recetores e prestadores de cuidados (Gilbert, 2019; Sinclair et al., 2021; Matos et al., 2022a). Este trabalho de investigação foi pioneiro na aplicação desta abordagem nas casas de acolhimento residencial de crianças e jovens, desenvolvendo e testado um programa de Treino da Mente Compassiva para Cuidadores (TMC-C), através da condução de um ensaio clínico aleatorizado por *clusters*.

O programa de TMC-C foi desenvolvido com base no modelo integrativo da compaixão desenvolvido por Gilbert e em práticas de treino da mente compassiva (2010b). Em sessões específicas foram também incluídos exercícios adaptados de outros programas baseados na compaixão, mindfulness e terapia da aceitação e compromisso (Hayes et al., 1999; Kabat-Zinn, 2003; Martins et al., 2020; Neff & Germer, 2013; Ribeiro et al., 2021). É sua finalidade a promoção de uma mentalidade afiliativa nos cuidadores que trabalham nas CAR. Ao cultivar os três fluxos da compaixão, o TMC-C pretende facilitar o desenvolvimento de relações de proximidade, calor e segurança entre cuidadores e crianças/jovens, bem como um ambiente seguro na CAR, variáveis associadas na literatura a melhor saúde mental e melhores resultados nas CAR (Costa et al., 2019; Graham & Johnson, 2021; Leipoldt et al., 2019; Santos et al., 2023g; Sellers et al., 2020; Silva et al., 2021; Sonderman et al., 2021; Strijbosch et al., 2018; Wright et al., 2019).

Sendo o TMC-C um programa novo, que procura implementar um modelo e práticas desenvolvidas e testadas noutros contextos a um contexto específico de prestação de cuidados, revelou-se necessário conduzir um estudo para testar a viabilidade dos procedimentos de avaliação e a aceitabilidade da versão experimental do TMC-C nas CAR. Este estudo recorreu a

metodologia mista e seguiu os critérios definidos por Bowen e colaboradores (2010) para estudos de viabilidade, cumprindo-se os critérios de implementação, praticidade, aceitabilidade, integração, resultados preliminares e adaptação. O estudo empírico V (Compassionate Mind Training for caregivers in residential youth care: Investigating their experiences through a thematic analysis) permitiu avaliar a aceitabilidade da versão final do programa.

Relativamente à implementação e praticidade, apesar dos constrangimentos associados ao funcionamento das CAR (e.g., trabalho por turnos, imprevisibilidade das rotinas), a implementação do protocolo de avaliação e do programa revelaram-se praticáveis, sucedendo de acordo com o planeado. A taxa de adesão ao TMC-C foi elevada. No entanto, a frequência semanal e a duração das sessões dificultaram a assiduidade na totalidade das sessões do programa por parte de alguns profissionais da equipa educativa, que trabalham por turnos e que asseguram diligências externas. Este tipo de constrangimento é comum na implementação de programas para cuidadores em contexto de acolhimento residencial (Brown et al., 2013; Griffing et al., 2021), revelando-se de difícil resolução uma vez que este contexto exige recursos contínuos que assegurem a prestação de cuidados e que deem resposta a diligências de carácter imprevisível. Por este motivo, os membros das equipas educativas são frequentemente impedidos de participar em formações (Brown et al., 2013; James et al., 2017), o que poderá limitar a adequação da prestação de cuidados, uma vez que estes profissionais são aqueles que prestam cuidados diretos às crianças e jovens (Sellers et al., 2020), sendo também aqueles que normalmente apresentam menor nível de formação especializada (Rodrigues & Barbosa-Ducharne, 2017; Seti, 2008; Steels & Simpson, 2017). Paralelamente, a investigação indica que o treino deve ser dirigido a todos os colaboradores para ter alcance organizacional (Bunting et al., 2019; Macdonald et al., 2012). Considerando que os programas baseados na compaixão envolvem pelo menos oito semanas de treino (Gilbert & Procter, 2006; Jazaieri et al., 2012b; Neff & Germer, 2013), e as complexidades e exigências deste contexto exigem treino, prática e reflexão conjunta, seria difícil reduzir de forma significativa a frequência e duração da intervenção. Para colmatar esta dificuldade e procurar incluir o máximo de profissionais na intervenção, no ensaio clínico, o recrutamento de participantes e o agendamento do horário das sessões foi realizado em consonância com as indicações do diretor técnico de cada CAR.

Em termos de aceitabilidade, os participantes revelaram-se satisfeitos com o programa, os seus conteúdos e exercícios experienciais e reconheceram a sua relevância para este contexto específico de prestação de cuidados. O carácter inovador do TMC-C foi destacado por disponibilizar estratégias de autocuidado para os cuidadores, bem como estratégias de atuação

e de intervenção com os jovens, ambas baseadas em práticas das terapias de terceira geração. A escolha do formato de grupo foi reforçada, por facilitar a criação de um espaço de partilha seguro de experiências e dificuldades comuns, facilitando a conexão e o sentido de humanidade comum entre os colegas, bem como o treino dos fluxos de dar e receber compaixão (Bates, 2005). Estes resultados vão ao encontro de outros estudos de programas baseados na compaixão aplicados noutros contextos (Arimitsu, 2016; Ashfield et al., 2021; Bratt et al., 2019; Condon & Makransky, 2020; Maratos et al., 2019).

Tal como em outros programas que incluem práticas contemplativas (Arimitsu, 2016; Lyddy et al., 2016), os participantes neste estudo também referiram dificuldades com determinadas práticas de meditação formal (e.g., *mindfulness*) e de imagética. Enquanto algumas dificuldades tenderam a esbater-se com a prática, os exercícios mais longos foram considerados especialmente exigentes para a maioria dos participantes, uma vez que não tinham experiência prévia de meditação. Na versão final do manual, os exercícios foram simplificados e encurtados.

Relativamente ao parâmetro da integração, os exercícios do programa foram aplicados, sobretudo, com a finalidade de regulação emocional do cuidador e com o fim deste adotar uma atitude compassiva na intervenção diária com os jovens. A concretização das práticas entre sessões foi, no entanto, reduzida, dificuldade também reportada em outros estudos (Arimitsu, 2016; Valley & Stallones, 2018). Considerando que a regularidade da prática entre sessões tende a exercer uma influência positiva nos resultados deste tipo de programas (Jazaieri et al 2013a; Maratos et al., 2019), no ensaio clínico reforçou-se a utilização de estratégias motivacionais para envolver os participantes na concretização das práticas entre sessões (Steindl et al., 2018). Não obstante, os resultados do grupo focal realizado no estudo de viabilidade indicaram potenciais benefícios do TMC-C para o cuidador, na relação entre cuidadores e jovens e na intervenção e ambiente da casa de acolhimento.

A aceitabilidade do programa e os benefícios reportados no grupo focal do estudo de viabilidade foram mais tarde reproduzidos e confirmados no estudo empírico V (Compassionate Mind Training for caregivers in residential youth care: Investigating their experiences through a thematic analysis). Mais concretamente no que diz respeito à aceitabilidade da versão final do programa de TMC-C, os participantes no estudo empírico V revelaram-se satisfeitos relativamente aos objetivos e características do programa, percecionaram a utilidade do mesmo, revelando uma atitude positiva face à sua implementação. Apesar de alguns participantes mencionarem que a frequência semanal do programa, por vezes, representava horas adicionais de trabalho, a aplicação do programa foi viável, verificando-se uma média de

participação de 10 sessões (em 12). O valor das atividades propostas entre sessões foi reconhecido, e apesar das dificuldades associadas às exigências da rotina diária, grande parte dos participantes referiu integrar no seu dia a dia pessoal e profissional os exercícios e aprendizagens realizadas nas sessões, sendo os mesmos aplicados a nível individual e coletivo (Liu & Smith, 2011).

Em conclusão, os resultados suportaram a viabilidade e a aceitabilidade do programa de TMC-C. O programa foi bem aceite, revelando-se adequado, tendo em conta as necessidades de intervenção deste contexto específico. Também os procedimentos de avaliação se revelaram viáveis e adequados, permitindo avançar para a execução do ensaio clínico de maior escala. Permitiu ainda ajustar a estrutura, metodologia e conteúdos do programa e antecipar dificuldades na implementação do ensaio clínico.

1.5 Efeitos do programa de TMC-C: Integração de resultados quantitativos e qualitativos relatados na primeira e segunda pessoa

Neste ponto serão sintetizados e discutidos, de forma integrada, os resultados do TMC-C derivados dos estudos empíricos apresentados no Capítulo 7, efetuados no âmbito do ensaio clínico, com recurso a metodologia quantitativa e qualitativa. Considerando que programas dirigidos a pais ou profissionais assistencialistas tiveram efeito indireto no recetor de cuidados (i.e., filhos e utentes, respetivamente; Bratt et al., 2019; Poehlmann-Tynan et al., 2020; Sinclair et al., 2016), no presente trabalho de investigação foram explorados os efeitos do TMC-C não só nos cuidadores como nos jovens em acolhimento, apesar destes últimos não terem sido diretamente intervencionados. Neste seguimento, neste ponto foi utilizada a abordagem proposta por Mascaro e colaboradores (2020) para avaliar o efeito da compaixão no próprio (primeira pessoa) e nos outros (segunda pessoa), combinando os resultados quantitativos e qualitativos. De acordo com Mascaro e colaboradores (2020), relatos na primeira pessoa referem-se a uma perspetiva autorreferencial relativamente à experiência subjetiva de manifestações da compaixão no próprio (e.g., pensamentos, sentimentos e motivação compassiva); relatos na segunda pessoa referem-se a uma perspetiva interpessoal relativamente a manifestações e comportamentos compassivos na perspetiva do recetor.

1.5.1 Efeitos do programa de TMC-C em variáveis individuais dos cuidadores

1.5.1.1 Variáveis associadas à compaixão

Os três fluxos da compaixão foram treinados no TMC-C com o intuito de fomentar a resposta às necessidades dos outros, sem negligenciar as necessidades do próprio, de modo a

evocar, de forma balanceada, comportamentos de dar e receber apoio (Hermanto & Zuroff, 2016). Os resultados dos estudos IV (Compassionate mind training for caregivers of residential youth care: Early findings of a cluster randomized trial; Santos et al., 2022), V (Compassionate Mind Training for caregivers in residential youth care: Investigating their experiences through a thematic analysis; Santos et al., 2023d) e VI (Fostering an affiliative environment in residential youth care: A cluster randomized trial of a Compassionate Mind Training Program for Caregivers enrolling youth and their caregivers; Santos et al., 2023e) sugerem que o programa TMC-C se revelou eficaz na promoção dos três fluxos da compaixão.

Imediatamente após o programa (Santos et al., 2022), tal como em outros estudos desta natureza (Sommers-Spijkerman et al., 2018), os participantes no TMC-C revelaram mudanças de baixa magnitude em termos da compaixão e não revelaram mudanças significativas na autocompaixão. Estas variáveis alcançaram mudanças significativas e de maior magnitude, passado 6 meses da intervenção (Santos et al., 2023e). Após a conclusão do programa, observou-se, no entanto, uma redução significativa dos medos associados aos três fluxos da compaixão no grupo de intervenção (Santos et al., 2022). Em alternativa, os participantes do grupo de controlo aumentaram de forma significativa os medos da compaixão relativamente a receber compaixão dos outros e à autocompaixão. Estudos que envolvem intervenções baseadas na compaixão sugerem que redução dos medos da compaixão prediz melhorias associadas aos programas noutras variáveis, como autoapaziguamento e redução do stress (Fox et al., 2020), como verificámos noutro estudo do presente trabalho de investigação (Santos et al., 2023f). Este resultado sugere que os medos da compaixão parecem ser a primeira variável alvo de mudança num programa desta natureza.

No que diz respeito à compaixão em relação aos outros, curiosamente, no estudo qualitativo que decorreu após a intervenção (Santos et al., 2023d), alguns participantes afirmaram que anteriormente ao programa já reconheciam ser detentores de uma motivação intrínseca para cuidar dos outros, percecionando maior mudança nos outros dois fluxos da compaixão (autocompaixão e de receber compaixão dos outros, nomeadamente dos colegas). Considerando a função exercida pelos participantes, a existência prévia de uma motivação compassiva para cuidar de pessoas que experienciem sofrimento seria expectável, tendo sido encontrados resultados semelhantes noutros estudos com profissionais de áreas associadas à prestação de cuidados (Beaumont et al., 2017; Orellana-Rios et al., 2017; Sinclair et al., 2021). Este resultado pode explicar, em parte, os resultados do estudo empírico IV (Santos et al., 2022), no qual o grupo de intervenção evidenciou apenas um ligeiro aumento da compaixão em relação aos outros após a implementação do programa, incremento esse que aumentou de magnitude

em *follow-up* (Santos et al., 2023e). Para além da sensibilidade ao sofrimento, uma resposta compassiva requer que o indivíduo desenvolva competências que permitam ajudar e apaziguar a pessoa em sofrimento (Gilbert, 2010a; Goetz et al., 2010). De facto, no estudo qualitativo, os participantes referiram que o TMC-C contribuiu para aumentar atributos compassivos, tais como a sensibilidade ao sofrimento e a empatia, bem como competências compassivas, referindo ainda que aplicaram as mesmas nas práticas diárias de prestação de cuidados. Alguns exemplos relatados prendiam-se com a tentativa de ouvir e compreender os jovens, comunicar e atuar de forma compassiva, recorrer ao modelo dos três sistemas de regulação do afeto para compreender as situações do quotidiano da CAR e guiar as práticas. Três meses após a intervenção (Santos et al., 2023f), 92.9% dos participantes referiu que continuou a aplicar as aprendizagens do programa no seu dia a dia e, após 6 meses, 78.6% referiu manter essas práticas. Apesar da compaixão pelos outros ser um valor presente na sociedade portuguesa, associado à tradição judaico-cristã, sendo por isso descrita como intrínseca e facilmente aplicável (Moses, 2002), o conjunto destes resultados sugere que enquanto motivação e mentalidade, a compaixão carece de tempo e de prática para ser cultivada (Gilbert, 2014; Jazaieri et al., 2013; Savari et al., 2021).

O mesmo se aplica de forma mais acentuada no que diz respeito à autocompaixão, fluxo onde os medos, bloqueios e resistências tendem a ser mais exacerbados, revelando-se por isso mais difícil de promover (Beaumont et al., 2021; Germer, 2009; Gilbert et al., 2011; Savari et al., 2021; Scarlet et al., 2017), particularmente nesta população, que tende a privilegiar as necessidades dos outros em detrimento das suas (Figley, 2002). Neste âmbito, é de salientar que o uso recorrente da autocrítica, como estratégia para evitar falhas ou impulsionar melhoria, sucesso e estatuto, assume-se como um dos medos específicos, que tende a inibir a autocompaixão (Gilbert et al., 2011). A resistência para reduzir a autocrítica foi referida por alguns participantes no estudo qualitativo, o que poderá ajudar a compreender a inexistência de diferenças significativas entre os grupos na medida de atitude autocrítica no estudo empírico VI (Santos et al., 2023e). Outros estudos com programas da mesma natureza mencionaram também dificuldades em obter mudança ao nível do autocriticismo (Beaumont et al., 2016b; Gilbert & Procter, 2006; Maratos et al., 2019; Matos et al., 2022a; Sansó et al., 2017; Savari et al, 2021). Como uma representação mental cognitivo-afetiva estável e duradoura, a autocrítica pode precisar de uma prática mais contínua e consistente para ser reduzida (Low et al., 2020).

Mais especificamente no que respeita a autocompaixão, gostaríamos de salientar que, no estudo qualitativo, o destaque foi sobretudo colocado no reconhecimento, por parte dos cuidadores, do papel da autocompaixão na melhoria da prestação de cuidados e no bem-estar

do cuidador. De facto, a frase "para cuidar dos outros, preciso de cuidar de mim primeiro", poderia ter sido outro título para este programa de intervenção nas CAR. Estes resultados são consistentes com a teoria de mentalidades sociais de Gilbert, espelhando a dinâmica interativa entre os fluxos da compaixão (Gilbert, 2010a). Tal como em estudos anteriores (e.g., Beaumont et al., 2016b), apesar de não existirem mudanças na atitude autocrítica, são visíveis diferenças significativas entre grupos, com uma ligeira tendência de aumento da autocompaixão no grupo de intervenção em *follow-up* (Santos et al., 2023e). Este resultado poderá indicar que apesar dos bloqueios à autocompaixão inerentes ao próprio trabalho, organizações e educação vigente na sociedade atual (Dutton et al., 2014; Gilbert et al. 2011; Kirby et al., 2019; Sinclair et al., 2021), o despertar para a necessidade de cuidar do próprio e o envolvimento em comportamentos de autocuidado (e.g., maior atenção ao equilíbrio entre a vida profissional e pessoal, envolvimento em atividades de prazer) mencionados no estudo qualitativo (Santos et al., 2023d), poderão fomentar uma mudança progressiva de mentalidade ao longo do tempo, com benefícios para a saúde mental do cuidador, tal como encontrado no estudo empírico VII (Santos et al., 2023f).

Considera-se relevante destacar que, por contraste, o grupo de controlo apresenta um decréscimo progressivo da compaixão em relação aos outros e da autocompaixão ao longo do tempo (Santos et al., 2023e), o que, a longo prazo, poderá comprometer não só a qualidade de vida dos cuidadores, como a qualidade da prestação de cuidados. Investigação prévia com profissionais assistencialistas sugere que a ausência de treino e de oportunidade de reflexão em grupo pode limitar uma prestação de cuidados compassiva (Curtis, 2013; Sinclair et al., 2016). Este resultado sugere que o TMC-C, para além de promover uma mentalidade mais compassiva, pode ter um efeito amortecedor na deterioração da motivação compassiva ao longo do tempo, seja ela dirigida aos outros ou ao próprio. Este resultado vai ao encontro dos resultados de investigação conduzida com profissionais assistencialistas que trabalham noutros contextos (e.g., profissionais de saúde; Beaumont et al., 2016b; Bjerknes & Bjørk, 2012). Estes resultados podem merecer particular atenção, pois a investigação junto de profissionais de áreas assistencialistas refere que fatores individuais (e.g., stress), interpessoais (e.g., conflitos com colegas) e organizacionais (e.g., sobrecarga de trabalho e burocracias excessivas), características deste tipo de profissões, pode interferir e bloquear uma prestação de cuidados compassiva (Crawford et al., 2014; Dutton et al., 2014; Figley, 2002; Kirby et al., 2019; Sharkey & Sharples, 2003; Sinclair et al., 2016).

1.5.1.2 Qualidade de vida profissional e saúde emocional e mental

Tal como em outros estudos com programas baseados na compaixão (Andersson et al., 2022; Irons & Heriot-Maitland, 2020; Kirby et al., 2017; Matos et al., 2017; Matos et al., 2022a; Sansó et al., 2017), os estudos empíricos V (Compassionate Mind Training for caregivers in residential youth care: Investigating their experiences through a thematic analysis; Santos et al., 2023d) e VII (The effects of the Compassionate Mind Training for Caregivers on professional quality of life and mental health over time: A cluster randomized trial in residential youth care; Santos et al., 2023f) sugerem benefícios do TMC-C ao nível da regulação emocional, redução de afeto negativo e sofrimento, e aumento do bem-estar geral.

No estudo qualitativo (Santos et al., 2023d), os participantes referiram encontrar-se mais conscientes das suas emoções e mais tolerantes e hábeis na gestão das mesmas, tendo reportado uma redução de comportamentos reativos e impulsivos. Este resultado é de grande relevância para a prática diária das CAR, uma vez que a desregulação emocional e comportamental dos cuidadores aumenta o risco de interações pautadas por coação e de modelamento de estratégias de *coping* menos apropriadas (Winstanley & Hales, 2014). Para além de terem reportado estar mais tolerantes face a afeto negativo, como culpa ou stress, os cuidadores reportaram um aumento de afeto positivo associado ao sistema de afiliação/apaziguamento. No geral, estes resultados vão ao encontro dos resultados quantitativos do estudo empírico VII (Santos et al., 2023f), que indicou efeitos significativos do TMC-C para a redução de sintomas de *burnout*, depressão e ansiedade. Neste último, a avaliação de *follow-up* revelou que os sintomas de *burnout*, depressão e ansiedade tenderam a diminuir ao longo do tempo, o que poderá estar associado ao progressivo incremento dos fluxos da compaixão, nomeadamente da compaixão pelos outros, para além do final da implementação do programa. Contrariamente à investigação prévia, este resultado sugere que não só a autocompaixão, mas também a compaixão pelos outros, poderão estar associadas a menores níveis de *burnout*, sintomatologia depressiva e ansiosa (Beaumont et al., 2016b; Lopez et al., 2018; Neff, 2003a). Estes resultados sugerem que adotar uma perspetiva compassiva face ao sofrimento dos outros parece aumentar a tolerância face ao sofrimento e reduzir o afeto negativo por parte do cuidador quando exposto ao sofrimento das pessoas de quem cuida, protegendo a sua saúde mental, sem comprometer a humanização dos cuidados prestados (Halpern, 2003). Estes resultados alinham-se com a evidência de estudos da área das neurociências, que mostram que a compaixão é essencial para manter a autorregulação emocional do cuidador e a distinção “eu-outro” de forma a tolerar e não absorver o sofrimento

do utente, contribuindo assim para a prevenção de problemas emocionais (Klimecki, 2015; Singer & Klimecki, 2014).

Considerando a relevância de fatores interpessoais e organizacionais para o desenvolvimento de sintomas de *burnout* em contexto de acolhimento residencial (Leake et al., 2017; Lizano & Mor Barak, 2012; Steinlin et al., 2017), as melhorias evidenciadas ao nível do *burnout* poderão ser também, em parte, devidas à maior abertura para receber compaixão dos outros, nomeadamente dos colegas (Santos et al., 2022, 2023d), reforçando o potencial valor deste programa em formato grupal.

No que diz respeito ao grupo de controlo, os participantes tenderam a manter os mesmos níveis de *burnout* e de depressão ao longo do tempo, mas os níveis de ansiedade deterioraram. Em consonância com os resultados do estudo empírico VI (Santos et al., 2023e), este resultado sugere que, face às exigências deste contexto específico de intervenção, quando os cuidadores não recebem qualquer treino ou intervenção, os níveis de ansiedade tendem a aumentar com o tempo. Quando a ansiedade é sentida de forma crónica, poderá evoluir para quadros de *burnout* (Maslach et al., 2001), síndrome que é comum em colaboradores desta área e que se encontra associado a deterioração da qualidade da prestação de cuidados e ao aumento da rotatividade de colaborações, o que poderá comprometer a estabilidade necessária nas CAR (Barford & Whelton, 2010; Sinclair et al., 2021). Este resultado reforça a necessidade de fornecer treino e suporte contínuo aos profissionais das CAR.

Para além do que temos vindo a discutir, não podemos deixar de referir que o estudo ocorreu durante o primeiro ano da pandemia. As medidas de saúde pública decretadas e o desconhecimento em torno da doença poderão ter agravado as exigências de trabalho neste contexto e, consequentemente, ter acentuado os níveis de ansiedade dos profissionais do acolhimento residencial (Carvalho et al., 2022; Ravens-Sieberer et al., 2020; Whitt-Woosley et al., 2022), que também foram profissionais essenciais de primeira linha. Neste âmbito, os nossos resultados indicam que os níveis de ansiedade associados à pandemia reportados pelos participantes do grupo de controlo foram significativamente mais elevados do que os reportados pelos participantes no programa. Para além disso, os participantes no TMC-C reconheceram que o programa foi útil para os ajudar a lidar com as contingências associadas à pandemia e com as crianças e jovens durante os períodos de confinamento. Este resultado vai ao encontro de outros estudos acerca do papel protetor da compaixão na saúde mental durante a pandemia (Matos et al., 2022b).

Embora os resultados qualitativos indiquem que os cuidadores percecionam sentir níveis menos elevados de stress e níveis mais elevados de motivação para o trabalho, os

resultados quantitativos não indicam diferenças estatisticamente significativas entre os grupos nestas variáveis. Outros programas desta natureza obtiveram resultados semelhantes (Delaney, 2018; Jazaieri et al., 2013; Matos et al., 2022a; Pfaff et al., 2017; Potter et al., 2013). Neste âmbito, é importante referir que, contrariamente a programas como o *Mindfulness-Based Stress Reduction* (MBSR; Kabat-Zinn 1990), especificamente desenhado para reduzir o stress, o objetivo central de programas baseados na compaixão passa pela promoção de uma motivação compassiva, para tolerar e aceitar o sofrimento como parte da condição humana, em vez de evitar o mesmo. O foco deste tipo de intervenções foca-se na ativação de áreas cerebrais associadas à afiliação e afeto positivo, em vez da intervir diretamente na redução do afeto negativo em si, assumindo que estados emocionais associados ao sistema de afiliação/apaziguamento poderão regular o afeto negativo. Deste modo, com o TMC-C pretende-se que os cuidadores possam prestar cuidados de qualidade, e lidar com as exigências usuais deste contexto, sem serem constantemente absorvidos por afeto negativo (Hofmeyer et al., 2020; Klimecki, 2015). Para além disso, alguns estudos indicam que neste contexto específico é expectável algum nível de stress profissional, encontrando-se o mesmo associado a níveis mais elevados de envolvimento e compromisso na prestação de cuidados (Jordan et al., 2009; Silva et al., 2021). Tal como noutros programas dirigidos a profissionais assistencialistas (Brinkborg et al., 2011; Pfaff et al., 2017), o TMC-C também não se revelou eficaz a reduzir o stress traumático secundário. Este resultado poderá ser devido às baixas pontuações de stress traumático secundarias encontradas na presente amostra, indicando um aparente efeito de chão.

No geral, os resultados que temos vindo a discutir resultantes dos efeitos do TMC-C vão ao encontro dos resultados da investigação efetuada acerca da eficácia de programas baseados na compaixão, que revela que esta abordagem é eficaz na redução de problemas de saúde mental ao longo do tempo (Ferrari et al., 2019; Irons & Heriot-Maitland, 2020; Matos et al., 2022a). Neste sentido, os resultados deste trabalho de investigação sugerem que a aplicação de uma abordagem focada na compaixão nas CAR, poderá ser uma resposta adequada às necessidades evidenciadas na literatura para a escassez de programas que promovam e protejam a saúde mental dos profissionais que trabalham nas CAR (Santos et al., 2023c).

1.5.2 Efeitos do programa de TMC-C em variáveis interpessoais e organizacionais

O programa de TMC-C foi desenvolvido com a finalidade de promover uma mentalidade afiliativa nos cuidadores, com o intuito de facilitar experiências interpessoais de calor e segurança às crianças e jovens e um ambiente seguro na CAR onde residem. Este trabalho de investigação combinou a perspetiva dos cuidadores (grupo intervencionado) e dos jovens

(recetores indiretos), de modo a compreender se o potencial aumento de uma motivação compassiva, reportada pelos cuidadores, seria percecionada pelos jovens de quem cuidam, ao nível da relação interpessoal e das práticas de prestação de cuidados no acolhimento. Neste sentido, os resultados do VI (Fostering an affiliative environment in residential youth care: A cluster randomized trial of a Compassionate Mind Training Program for Caregivers enrolling youth and their caregivers; Santos et al., 2023e) que integra uma amostra de jovens acolhidos nas casas onde o programa foi implementado, reforçam os resultados do estudo empírico V (Compassionate Mind Training for caregivers in residential youth care: Investigating their experiences through a thematic analysis; Santos et al., 2023d), sugerindo que, no geral, o programa TMC-C se revelou eficaz no estabelecimento de relacionamentos de proximidade, calor e segurança, e de um clima emocional mais seguro para quem trabalha e vive nas CAR.

1.5.2.1 Resultados relatados pelos cuidadores

Tal como descrito noutros estudos (Crocker & Canevello, 2017; Kelly & Dupasquier, 2016), o aumento da compaixão e da autocompaixão revelaram-se associados a níveis mais elevados de proximidade e segurança na relação com os outros (Santos et al., 2023e). Mais concretamente, os resultados indicaram que após o programa, os cuidadores do grupo de intervenção se sentiam mais seguros, próximos e ligados aos outros, resultado que se manteve seis meses após a intervenção (Santos et al., 2022, 2023e). Este resultado foi também destacado no estudo qualitativo (Santos et al., 2023d), tendo sido descrita maior facilidade de comunicação entre colegas, confiança e coesão de grupo, havendo, por exemplo, mais facilidade na solicitação de ajuda entre colegas. De acordo com estudos prévios (Gilbert et al., 2009), o facto de os colaboradores percecionarem maiores níveis de compaixão por parte dos colegas, poderá ter diminuído não só o receio de ser criticado, assim como a perceção do outro como uma potencial ameaça, aumentando o sentimento de segurança para aceitar e pedir apoio aos outros. Nas CAR, esta capacidade de reconhecer as próprias limitações e pedir ajuda é fundamental para quebrar ciclos interpessoais disfuncionais entre cuidadores e jovens e prevenir escaladas comportamentais, bem como o *burnout* e desgaste das equipas (van Gink et al., 2018). As melhorias na afiliação aos outros, e particularmente entre colegas, foram destacadas em estudos com programas baseados na compaixão implementados noutros contextos de trabalho (Maratos et al., 2019; Pinard et al., 2020). Este resultado é consistente com o proposto pela Teoria das Mentalidades Sociais de Gilbert (2010a), demonstrando que a compaixão é dinâmica e interativa, podendo facilitar que os indivíduos se tornem mais sensíveis

não só à manifestação de sofrimento, mas também a sinais de calor e cuidados dos outros, aumentando comportamentos recíprocos de entreajuda e de suporte (Armstrong et al., 2021).

A investigação indica, ainda, que o apoio dos colegas se associa a um clima organizacional positivo (Sedivy et al., 2020), o que vai ao encontro dos resultados obtidos referentes às melhorias da perceção do clima emocional na CAR (Santos et al., 2022, 2023e). Mais especificamente, após o programa, cuidadores do grupo de intervenção percecionaram que o clima da CAR se tornou significativamente mais seguro e menos ameaçador (Santos et al., 2022). Estes resultados foram também reportados no estudo qualitativo (Santos et al., 2023d) e mantiveram-se seis meses após a intervenção (Santos et al., 2023e). Estes resultados são bastante relevantes, tanto ao nível da equipa, como a nível organizacional, uma vez que a falta de apoio entre colegas tem sido reportada como fator de stress entre cuidadores (Del Valle et al., 2007; Santos et al., 2023a) e a cultura de medo (Brown et al., 2018; Seti, 2008) poderá tender a sobreativar o sistema de ameaça dos cuidadores, deixando os mesmos mais reativos e menos disponíveis para serem compassivos. Um clima seguro e afiliativo oferece as condições necessárias para estabelecer na CAR um ambiente promotor de cuidado, onde os cuidadores possam ser agentes de segurança tranquila não só para as crianças e jovens, mas também para os colegas que se sintam mais sobrecarregados ou desregulados (van Gink et al., 2018). Deste modo, um clima seguro e afiliativo poderá facilitar na equipa maior abertura para aprender e corrigir erros, facilidade na gestão de situações inesperadas e emocionalmente exigentes e envolvimento com o trabalho (Bakker & Demerouti, 2017; Cosley et al., 2010; Sedivy et al., 2020). De facto, resultados do estudo qualitativo sugerem maior eficácia das equipas e maior qualidade na prestação de cuidados (Santos et al., 2023d). Os participantes reportaram partilhar uma linguagem comum, baseada no modelo teórico do programa, bem como uma maior coerência nas práticas entre colaboradores. Este conhecimento parece ter permitido que a intervenção passasse de meramente intuitiva, para inerentemente intencional, e tornando-se, de acordo com os participantes, mais adequada, compassiva, assertiva e eficaz (Santos et al., 2023d). De acordo com os resultados do mesmo estudo, o TMC-C parece ter sido particularmente útil para gerir situações de crise. De acordo com os participantes, as estratégias aprendidas durante o programa terão contribuído para evitar escaladas comportamentais, tendo sido reportada a redução de penalizações e de contenções físicas nas práticas de acolhimento (Santos et al., 2023d).

Em paralelo à redução de práticas pautadas por coação, penalização e contenção física, foi relatada maior tolerância, proximidade e expressão de afetos em relação às crianças e jovens (Santos et al., 2023d). De acordo com a literatura, o estabelecimento de relações desta natureza

é fundamental para alcançar melhores resultados nas CAR (Leipoldt et al., 2019; Silva et al., 2021; Sonderman et al., 2021). Para além disso, este resultado merece especial destaque, uma vez que a investigação indica que práticas disciplinares autoritárias e punitivas continuam a ser comuns nas CAR (Hermenau et al., 2014), sendo por isso necessário promover estratégicas alternativas a que os cuidadores devam e possam recorrer. Os resultados deste trabalho de investigação indicam que é possível melhorar as práticas de acolhimento, sem recorrer exclusivamente a estratégias comportamentais, investindo no estabelecimento de relacionamentos de proximidade, calor e segurança com as crianças e jovens. O TMC-C oferece às CAR uma nova abordagem para as práticas de acolhimento residencial, respondendo às lacunas evidenciadas na revisão sistemática apresentada no Capítulo 4 desta tese (Santos et al., 2023c), que sugere que grande parte dos programas existente é focado em modelos fundamentalmente comportamentais.

Relativamente ao grupo de controlo, verificaram-se flutuações relativamente a sentimentos de proximidade e ligação ao outro, tendo-se observado uma diminuição dessa variável no momento de avaliação correspondente à pós-intervenção e um aumento em *follow-up* (Santos et al., 2023e). Contrariamente aos participantes no TMC-C, os cuidadores incluídos no grupo de controlo não manifestaram mudanças na sua perceção do clima emocional em termos de segurança e afiliação, mas reportaram um aumento significativo de emoções associadas ao sistema de ameaça em *follow-up*. Enquanto este resultado é facilmente compreendido enquadrado nas exigências adicionais associadas à pandemia (Parry et al., 2022), a oscilação no sentimento de proximidade e segurança foi inesperado.

Segundo as sugestões constantes em investigação prévia (Lilius et al., 2008; Dutton et al., 2014; Mascaro et al., 2020), pode-se considerar que globalmente os resultados obtidos a nível interpessoal (e.g., melhoria dos relacionamentos interpessoais) e organizacional (e.g., linguagem e modelo comum, clima emocional) sugerem que, o TMC-C contribuiu para que as casas de acolhimento se tornassem residências mais compassivas e afiliativas para os colaboradores. Ao sentirem-se mais seguros no seu trabalho em equipa, e pessoalmente mais equilibrados e disponíveis, os cuidadores poderão disponibilizar uma base segura e um porto seguro às crianças e jovens, que lhes permita usufruir do suporte que necessitam para minimizar os danos associados às experiências adversas a que foram expostas no passado e ultrapassar os obstáculos desenvolvimentais normativos com que se deparam no presente (Huefner & Ainsworth, 2021).

1.5.2.2 Efeitos (indiretos) do programa nos jovens em acolhimento residencial

O estudo empírico VI (Fostering an affiliative environment in residential youth care: A cluster randomized trial of a compassionate mind training program for caregivers enrolling youth and their caregivers; Santos et al., 2023e), incluiu o autorrelato de jovens acolhidos nas CAR em estudo, e reforça os resultados autorreportados pelos cuidadores. Mais concretamente, os resultados deste estudo indicam que, após o programa, os jovens das CAR onde o TMC-C foi implementado percecionaram maior tranquilidade e segurança no clima da CAR e sentiram maior proximidade e ligação aos outros. No entanto, este efeito não se manteve no *follow-up*, seis meses após a intervenção, tendo regredido para níveis prévios. Por um lado, este resultado pode indicar que o TMC-C não teve impacto suficiente na consolidação das práticas compassivas, de forma a manter a atuação dos cuidadores após a aplicação do programa. No entanto, poderá também espelhar, pelo menos em parte, o impacto das medidas de saúde públicas associadas à pandemia, que se faziam sentir durante a avaliação de *follow-up,* que poderão ter condicionado a aplicação contínua e consistente das aprendizagens do programa.

Mais especificamente, após a intervenção, as mudanças na compaixão manifestadas através de comportamentos de maior escuta, compreensão, não julgamento e proximidade por parte dos cuidadores, tal como descritos no estudo qualitativo (Santos et al., 2023d), poderão ter sido percecionadas pelos jovens como maior disponibilidade e responsividade dos cuidadores. De facto, no estudo qualitativo, os cuidadores mencionaram que, após o programa, alguns jovens revelavam uma atitude menos defensiva e reativa às suas atitudes e intervenções, o que poderá ser indicador de maior segurança na relação com os outros. Investigação conduzida nesta área sugere uma forte relação entre a perceção da criança relativamente à qualidade dos relacionamentos com os cuidadores e o sentimento manifesto de segurança (Sellers et al., 2020). Estes resultados sugerem que a participação no programa de TMC-C pode contribuir para melhorar a qualidade das relações entre cuidadores e jovens. No entanto, durante a pandemia, que coincidiu com a recolha de dados em *follow-up*, comportamentos afiliativos de proximidade, contacto físico e manifestação de sinais não verbais de tranquilidade e segurança, passaram a não ser recomendados, representando mesmo sinal de eventual ameaça (e.g., toque, abraço, uso obrigatório de máscara). Paralelamente, as equipas das CAR passaram a trabalhar em espelho, estando ausentes das CAR por períodos mais longos de tempo. Inclusivamente, alguns cuidadores ficaram de baixa, por necessidades de apoio à sua família. Para suprimir a ausência desses colaboradores, as CAR viram-se obrigadas a contratualizar temporariamente novos colaboradores, que não receberam o TMC-C. Por um

lado, mudanças ao nível do *staff* podem comprometer a implementação de um novo modelo e de novas práticas devido à falta de consistência entre membros da equipa (Durlak & Dupre, 2008; James, 2017; van Gink et al., 2018). Paralelamente, a falta de sessões de reforço e de supervisão poderão ter dificultado a reflexão individual e coletiva em torno das práticas e ter comprometido a transferência das mesmas para o contexto diário da CAR. Por outro lado, os jovens em acolhimento são particularmente sensíveis a perdas e a inconsistência na prestação de cuidados. A ausência da sua figura de referência ou a alteração de comportamento/atitude da mesma devido à pandemia, poderá ter sido sentida como uma nova perda ou abandono, potenciando medos prévios de receber compaixão dos outros por parte dos jovens. De acordo com a investigação, o medo de receber compaixão dos outros encontra-se associado à falta de sentimentos de segurança e proximidade com os outros, o que é particularmente acentuado em pessoas que não tiveram oportunidade de desenvolver o sistema de afiliação/apaziguamento devido a ausência de relações de infância pautadas por calor e segurança parental ou cujas figuras parentais eram ameaçadoras, como é o caso de grande parte das crianças e jovens em acolhimento (Gilbert, 2014; Gilbert et al., 2011; Kirby et al., 2019; Kelly et al., 2012; Kelly & Dupasquier, 2016; Naismith et al., 2019a). No estudo qualitativo (Santos et al., 2023d), os medos, bloqueios e resistências dos jovens relativamente às novas práticas de acolhimento e postura compassiva dos cuidadores foram também nomeados (e.g., manifestações de estranheza e desconfiança face às novas práticas e atitudes dos cuidadores). A oscilação encontrada nos resultados quantitativos, poderá indicar que a perceção de maior proximidade e ligação aos outros reportada após a intervenção poderia estar a contribuir para uma abertura dos jovens à compaixão, registando-se, no entanto, um retrocesso devido à alteração das rotinas, práticas e padrões de relacionamento associados às medidas de saúde pública da pandemia.

No grupo de controlo, verificou-se a tendência oposta em relação às variáveis afiliativas mencionadas. Na avaliação pós-intervenção, os jovens reportaram um decréscimo na perceção do sentimento de proximidade e ligação aos outros e de emoções associadas ao sistema de apaziguamento e segurança no clima da CAR. No entanto, foram reportadas melhorias nestas variáveis durante o *follow-up*. Estes resultados revelam-se de difícil interpretação. Uma possível explicação pode prender-se com as alterações de rotina durante os confinamentos. Com o fecho das escolas e promulgação de confinamento geral, as crianças e jovens passaram a estar mais tempo na CAR, na companhia dos cuidadores e dos pares. Este maior contacto diário poderá ter otimizado a oportunidade de criar mais espaço relacional e consequentemente estreitar relacionamentos (Pinheiro et al., 2022). De facto, o último relatório CASA (ISS, 2022) indica que

as crianças e jovens em acolhimento reportaram maior proximidade e ligação aos pares e cuidadores das CAR durante a pandemia. Neste sentido, as alterações na rotina decorrentes da pandemia de Covid-19 poderão ter sido percecionadas pelos jovens das CAR do grupo de controlo como um ganho relacional, contrariamente aos jovens das CAR do grupo de intervenção, que foram expostos a uma mudança afiliativa na CAR após o programa, e que por isso poderão ter sentido as alterações associadas às medidas de saúde pública e respetivos confinamentos como uma perda relacional e afetiva (Santos et al., 2023e).

No global, os resultados do TMC-C relativos à perceção dos jovens revelaram-se de difícil interpretação, pois apesar das melhorias reportadas pelos jovens após o treino dos cuidadores, os resultados de *follow-up* não permitem emitir conclusões sólidas sobre os efeitos do TMC-C relativamente à promoção de relações e ambientes seguros para as crianças e jovens. Revela-se assim necessário efetuar mais estudos, fora do contexto de pandemia, para testar os reais efeitos do programa nas variáveis referidas.

De acordo com orientações internacionais para acolhimento terapêutico (Whittaker et al., 2016), os resultados do estudo qualitativo sugerem que este programa para cuidadores poderia ser um complemento a programas de intervenção psicológica dirigidos aos jovens, podendo contribuir para otimizar os processos e práticas nas casas de acolhimento residencial.

2. Potencialidades, limitações e recomendações para investigação futura

Uma vez que as potencialidades, limitação e recomendações para investigação futura de cada um dos estudos incluídos nesta tese se encontram descritos, de forma detalhada, em cada estudo empírico presente na parte III da tese, nesta secção serão destacadas as principais potencialidades e limitações do presente trabalho de investigação, bem como recomendações para investigação futura.

2.1 Potencialidades dos estudos

O presente trabalho de investigação apresenta potencialidades, a nível teórico e metodológico, que atestam a sua relevância e inovação para o avanço do conhecimento científico na área do acolhimento residencial e para o reforço do elo entre ciência e as práticas de intervenção nas CAR.

Em primeiro lugar, ao disponibilizar um programa sustentado por um modelo teórico sólido e evidência científica, este trabalho de investigação respondeu a uma necessidade expressa na literatura, e percecionada pela investigadora no decorrer da sua experiência profissional, referente à escassez de programas para proteger e cuidar da saúde emocional e

mental dos cuidadores. Paralelamente, o programa prossupõe tornar a prestação de cuidados mais compassiva e ajustada às necessidades emocionais e sociais das crianças e jovens em acolhimento. A inovação e o duplo objetivo deste programa foram destacados pelos participantes nos grupos focais do estudo de viabilidade e no estudo empírico V (Compassionate Mind Training for caregivers in residential youth care: Investigating their experiences through a thematic analysis; Santos et al., 2023d). A taxa de adesão ao programa e a sua difusão em casas de acolhimento na Galiza e na região Autónoma da Madeira podem também ser entendidos como reconhecimento dessa mesma necessidade e aceitabilidade do programa. Importa destacar que este foi o primeiro trabalho de investigação a aplicar a abordagem focada na compaixão para o acolhimento residencial de crianças e jovens em perigo, disponibilizando a todos os profissionais da CAR um modelo teórico sólido para compreender e intervir face ao sofrimento expresso não só pelas crianças e jovens, como pelos próprios cuidadores. Assim, o TMC-C revela ser um programa inovador, com impacto ao nível da qualidade de vida profissional dos cuidadores, coesão e funcionamento das equipas e qualidade da prestação de cuidados a um grupo particularmente vulnerável.

Em segundo lugar, este trabalho de investigação procurou ultrapassar algumas das limitações metodológicas reportadas nas revisões sistemáticas da literatura referentes a programas dirigidos a profissionais da área da proteção de crianças e jovens, nomeadamente do acolhimento residencial. Especificamente, este trabalho de investigação implicou a realização de um ensaio clínico aleatorizado por *clusters*, num contexto social vulnerável, onde os estudos experimentais são escassos. Os ensaios clínicos aleatorizados e controlados são considerados o padrão de excelência metodológico para determinar a eficácia de intervenções, por possibilitarem produzir evidência com mínimo enviesamento (Hariton & Locascio, 2018). Além disso, os estudos conduzidos no âmbito do ensaio clínico foram desenhados e reportados de acordo com a extensão das normas CONSORT 2010 para ensaios clínicos aleatorizados por *clusters* (Campbell et al., 2012), de forma a descrever detalhadamente e com transparência os procedimentos metodológicos e os resultados obtidos. Com a mesma finalidade de transparência e de modo a permitir a reprodução dos estudos por investigadores independentes, foram também utilizadas nos estudos incluídos nesta tese normas internacionais como o PRISMA (Page et al., 2021), COREQ (Tong et al., 2007) e a TIDieR (Hoffmann et al., 2014). Tanto o ensaio clínico como a revisão sistemática foram registados previamente à sua execução, respetivamente em ClinicalTrials.gov (Identifier: NCT04512092) e PROSPERO (Identifier: CRD42021254783). Outra potencialidade metodológica prende-se com o processo de avaliação, que combinou múltiplos informantes (i.e., cuidadores e jovens) e o

recurso a diferentes metodologias (e.g., quantitativa e qualitativa) para avaliar variáveis de interesse a nível individual (e.g., compaixão, qualidade de vida profissional), interpessoal (e.g., proximidade e ligação aos outros) e organizacional (e.g., clima emocional da CAR), de forma a obter uma abordagem compreensiva e multidimensional sobre os efeitos do programa. A avaliação de *follow-up* permitiu avaliar a evolução e estabilidade de mudança até seis meses após o término do programa. Os instrumentos de avaliação de autorrelato integrados no protocolo de avaliação encontravam-se adaptados e validados para a população portuguesa. Face à especificidade do modelo teórico e da população em estudo, foram inclusivamente adaptadas e validadas três medidas de autorrelato para jovens em contexto de acolhimento residencial (Santos et al., 2021, 2023a; Miguel et al., 2022), que serviram de indicadores para os estudos empíricos III (Impact of early memories and current experiences of warmth and safeness on adolescents' psychological distress) e VI (Fostering an affiliative environment in residential youth care: A cluster randomized trial of a Compassionate Mind Program for Caregivers enrolling youth and their caregivers). Estes instrumentos permitiram incluir a perspetiva dos jovens em acolhimento, enquanto recetores da prestação de cuidados, relativamente a variáveis de interesse fundamentais nesta área e pouco exploradas em investigação prévia de validação de programas, como o sentimento de segurança e proximidade com os outros e o clima emocional na CAR. O processo de avaliação permitiu recolher e integrar informação relatada na primeira e na segunda pessoa, consoante o papel dos participantes enquanto prestadores ou recetores de compaixão, permitindo compreender a relação entre estados internos (motivação compassiva) e comportamento observável (práticas de acolhimento).

Em terceiro lugar, este trabalho de investigação disponibiliza um manual de intervenção, sustentado por um quadro teórico sólido e evidência científica relativamente à sua eficácia. O manual permite, por um lado, a aplicação desta intervenção em outros estudos e, por outro, facilita o treino de profissionais para aplicação do programa noutras regiões e territórios.

Em quarto lugar, o trabalho desenvolvido disponibiliza instrumentos de autorrelato adaptados e validados para jovens em acolhimento residencial, que permitem dar voz às crianças e jovens em acolhimento e auscultá-las sobre a sua perceção acerca das relações estabelecidas com os cuidadores e acerca do clima emocional da CAR.

Em quinto lugar, todos os estudos empíricos incluídos neste projeto respeitam os princípios éticos e deontológicos da investigação em psicologia. Os procedimentos de investigação dos estudos transversais e longitudinais respeitam os princípios éticos da Declaração de Helsínquia de 1964 e suas emendas posteriores, o código de ética da APA e o da Ordem dos Psicólogos Portugueses.

Por último, os estudos constantes nesta tese encontram-se alinhados com os direitos das crianças (e.g., direitos de participação) constantes na Convenção Universal dos Direitos da Criança (ONU, 1989) e orientações internacionais para Cuidados Alternativos a Crianças (ONU, 2010), com as Normas para o Acolhimento de Crianças Fora da sua Família Biológica na Europa (Quality4Children, FICE et al., 2007), com os princípios do consórcio internacional para acolhimento terapêutico (Whittaker et al., 2016), com as orientações da OMS para intervenções destinadas à promoção e prevenção da saúde mental dos adolescentes (HAT Guidelines, OMS 2020), com normas do *National Center for Child Traumatic Stress* (NCTSN, 2016) e do Plano de Ação da Garantia para a Infância 2022-2030 (Resolução do Conselho de Ministros n.º 3/2023, Diário da República, 1ª série, nº 12, 17 de janeiro).

2.2 Limitações dos estudos e recomendações para futura investigação

Este trabalho de investigação apresenta também algumas limitações que importam referir e considerar na interpretação dos resultados. As limitações mencionadas, indicam sugestões que podem ser alvo de atenção de modo a poderem ser ultrapassadas em futuros estudos.

Relativamente à revisão sistemática da literatura, as principais limitações prendem-se com a fraca qualidade metodológica dos estudos incluídos para análise e respetiva heterogeneidade de variáveis em estudo, o que impediu a realização de uma meta-análise. A definição inconsistente de acolhimento residencial encontrada nos estudos de diferentes países poderá ter produzido algum enviesamento. Tendo por base as limitações encontradas, procurou-se ultrapassar as mesmas no desenho de investigação implementado no ensaio clínico conduzido no âmbito deste trabalho de investigação.

Relativamemte ao estudo empírico III (Impact of early memories and current experiences of warmth and safeness on adolescents' psychological distress), importa referir que o mesmo foi conduzido com recurso exclusivo a instrumentos de autorresposta. Apesar dos instrumentos utilizados se encontrarem validados, o recurso exclusivo a este tipo de instrumentos pode conduzir a enviesamentos no preenchimento (e.g., o viés de recordação/memória, desejabilidade social, fadiga da resposta, dificuldades de compreensão ou perda de interesse). Paralelamente, este tipo de medidas pode levantar problemas associados à variância partilha entre as medidas e a natureza transversal dos dados limita inferências de causalidade entre as variáveis em estudo (Maxwell & Cole, 2007). Para procurar ultrapassar esta limitação, o estudo III combinou uma abordagem centrada na variável com uma abordagem focada no indivíduo, que conjuntamente fornecem uma compreensão sobre como as variáveis

variam intra e inter indivíduos (Mervielde & Asendorpf, 2000). Não obstante, estudos futuros devem recorrer a um desenho longitudinal para confirmar a causalidade e direcionalidade das associações encontradas no estudo transversal.

Os procedimentos do ensaio clínico apresentaram também algumas limitações que importa referir. Em primeiro lugar, apesar da aleatorização ter ocorrido depois da avaliação pré-intervenção, não foi possível, por carência de recursos, manter completamente anónimo o grupo de pertença dos participantes no estudo para os avaliadores. A ausência de grupo de controlo ativo dificultou a ocultação do tipo de intervenção pelos grupos. Segundo, e ainda relativamente ao processo de avaliação do ensaio clínico, apesar do esforço em envolver múltiplos informantes e metodologias, é importante referir que tanto a informação recolhida através de medidas de autorrelato, como por via de grupos focais, encontra-se sempre sujeita a enviesamento derivado da desejabilidade social. Neste sentido, uma possibilidade para estudos futuros seria o recurso a medidas menos suscetíveis à desejabilidade social, como por exemplo, medidas psicofisiológicas para avaliar os efeitos do programa em correlatos psicofisiológicos associados à regulação emocional dos cuidadores e dos jovens (e.g., variabilidade do ritmo cardíaco; Sousa et al., 2023), bem como indicadores comportamentais associados ao desgaste emocional (e.g., número de baixas e *turnover*). Sendo a manifestação comportamental da compaixão uma componente não abrangida ou totalmente não contemplada pelos questionários de autorrelato seria importante incluir indicadores adicionais a partir dos quais se possa inferir manifestação de comportamentos compassivos, como a avaliação das práticas de prestação de cuidados, tais como observação direta, registos de ocorrências disciplinares, medidas reparadoras e contenções físicas. Apesar do recurso a alguns destes indicadores ter sido inicialmente pensado, a inexistência de um registo uniforme entre as casas de acolhimento impediu que fossem utilizados dados desta natureza. De modo a não aumentar a sobrecarga dos cuidadores com procedimentos adicionais de investigação, abdicou-se destes indicadores. Ainda dentro deste assunto, a manifestação da compaixão ao nível da organização é outro indicador também pouco explorado na investigação publicada (Mascaro et al., 2020). Estudos futuros deverão procurar integrar mais variáveis organizacionais, incluindo, por exemplo, a perspetiva de terceiros (i.e., pessoas não envolvidas na dinâmica de dar e receber compaixão, que observem o funcionamento e comportamento verbal e não verbal do grupo). Neste sentido, recomenda-se que investigação futura avalie o efeito do programa de TMC-C em indicadores de práticas de prestação de cuidadores (e.g., observação de comportamentos compassivos, frequência de medidas de reparadoras e contenções físicas), e em indicadores organizacionais,

com recurso a diferentes metodologias de recolha de dados (e.g., observação direta ou realização de grupos focais com jovens em acolhimento).

Terceiro, e relativamente à intervenção, gostaríamos de referir que foi assegurado o primeiro nível de integridade do tratamento (i.e., existência de um manual estruturado, treino do dinamizador, monitorização da aplicação do programa; Perepletchikova, 2011). O programa foi aplicado pela primeira autora do manual, de acordo com o mesmo. Foi também adaptada uma grelha de avaliação de outros programas baseados na compaixão, que foi preenchida pela própria dinamizadora após as sessões. A falta de recursos limitou a robustez da avaliação de integridade do tratamento (e.g., envolvimento de avaliadores externos). Quarto, contrariamente ao previsto, devido à pandemia, não foi possível oferecer sessões de reforço aos participantes no programa. Estudos futuros devem incluir a avaliação estandardizada de implementação do programa realizada por avaliadores externos e oferecer sessões de reforço ou supervisão, de forma a compreender se os ganhos associados ao programa podem ser otimizados ao longo do tempo.

Quinto, e no que diz respeito à análise estatística dos dados colhidos no ensaio clínico, o tamanho da amostra limitou a utilização de estatísticas mais robustas (e.g., modelos de crescimento latente, modelos multinível) para análise de dados longitudinais e que permitissem controlar variáveis organizacionais, que podem ter influência nos resultados (e.g., nº de utentes por CAR, cultura organizacional). Para além disso, uma vez que não foi possível obter as medidas dos participantes que desistiram do estudo no pós-intervenção e no *follow-up*, não foi possível seguir o princípio *intention-to-treat analysis*, que inclui todos os participantes nas análises, mesmo aqueles que não frequentaram um número mínimo de sessões (80%) ou aqueles que desistiram da intervenção (Hariton & Locascio, 2018). Optou-se por realizar análises de acordo com o princípio do *per-protocol analysis*, comparando os participantes do grupo de intervenção que completaram mais de 60% do programa com os participantes do grupo de controlo nas variáveis em estudo. Por motivos associados ao tamanho de amostra, não se seguiu a recomendação referente à inclusão de sujeitos que frequentassem no mínimo 80% das sessões do programa. Análises realizadas segundo o princípio *per-protocol analysis* podem enviesar os resultados, na medida em que participantes que aderem melhor à intervenção podem estar mais motivados para a mesma. Neste sentido, para reforçar a informação acerca da eficácia do TMC-C, recomenda-se que estudos futuros possam reproduzir este estudo com uma amostra alargada de casas de acolhimento, utilizando o princípio da *intention-to-treat analysis* e procedimentos estatísticos de tratamento de dados mais robustos (e.g., modelos de crescimento latente, Duncan & Duncan, 2009). Estudos futuros deveriam também estudar o

impacto do programa num contexto pós-pandemia, para investigar a estabilidade dos resultados em *follow-up*. Uma vez que as avaliações dos estudos realizados ocorreram durante o confinamento, revelou-se difícil isolar o efeito da pandemia e das medidas dela decorrentes nos resultados do ensaio clínico realizado. Por último, estudos futuros devem também investigar os mecanismos subjacentes à mudança e as variáveis moderadoras do efeito do programa, que ficaram por testar no presente ensaio clínico.

3. Implicações para as práticas e políticas de acolhimento

Os trabalhos de investigação apresentados no âmbito da presente tese oferecem contributos relevantes para as práticas e políticas de acolhimento, com potencial impacto social. De um modo global, os resultados reforçam as orientações relativas ao estabelecimento de relações estáveis e afetuosas entre cuidadores e crianças/jovens (FICE et al., 2007), à criação de um ambiente seguro e terapêutico nas CAR (Bailey et al., 2019; Donald, 2015; Lanctôt et al., 2016; Whittaker et al., 2016), e à necessidade de fornecer suporte e formação especializada a todos os profissionais que trabalham nas CAR (FICE et al., 2007). As implicações a seguir apresentadas traduzem uma reflexão em torno da literatura consultada ao longo do presente trabalho de investigação, os resultados obtidos nos estudos constantes nesta tese e a experiência pessoal e profissional da autora enquanto investigadora e técnica no acolhimento residencial.

O estudo empírico III (Impact of early memories and current experiences of warmth and safeness on adolescents' psychological distress) indica que os jovens em acolhimento reportam não só menos experiências precoces de calor e segurança, como experiências atuais dessa natureza, quando comparados com adolescentes da comunidade. De acordo com este estudo, as experiências afiliativas de calor e segurança na infância e na adolescência exercem um papel protetor face ao desenvolvimento de sintomatologia de ansiedade e depressão durante a adolescência. Este estudo destaca o papel preponderante das experiências atuais de calor e segurança, mesmo face à ausência desse tipo de experiências na infância. Estes resultados reforçam o quem sido apontado pela literatura, no sentido de fortalecer a rede de suporte dos adolescentes em geral e, em específico, dos adolescentes em acolhimento, que tende a ser mais reduzida (Degner et al., 2014; Rindlaub, 2015). Estudos prévios indicam que os adolescentes em acolhimento identificam os cuidadores das CAR, a família e os amigos como fontes de suporte social (Ferreira et al., 2020), devendo os mesmos ser envolvidos no planeamento de atividades e intervenções decorrentes do processo individual de acolhimento. Tendo em vista o aumento da sua rede de suporte, os jovens devem ser envolvidos em atividades de lazer na comunidade

e a manutenção de contactos regulares com a família ou com figuras significativas deve ser efetuada, tanto quanto for adequada e possível.

Estes resultados vão também ao encontro do referido na literatura sobre a importância do papel dos profissionais das CAR, enquanto agentes ativos e afiliativos no processo de acolhimento. Deste modo, os cuidadores devem ser valorizados, devendo ser considerados agentes terapêuticos e envolvidos no processo de acolhimento como tal. Esta mudança pressupõe alterações conceptuais e estruturais nas CAR. Em primeiro lugar, os modelos educativos das CAR devem passar a priorizar o estabelecimento de relações seguras entre cuidadores e jovens, em vez de se centrarem exclusivamente na gestão de rotinas e no controlo do comportamento (Levin, 2009; Moses, 2000). Neste âmbito, é imprescindível entender a necessidade básica de segurança, não como uma proteção face à ameaça e ao perigo externo (e.g., violência, maus-tratos), mas como um estado de segurança tranquila, associada à ativação do sistema de afiliação/apaziguamento. Se analisarmos a intervenção baseada na promoção dos direitos e proteção da criança/jovem nas CAR à luz do funcionamento e motivos evolucionários do modelo dos sistemas de regulação do afeto (Gilbert, 2010a), identificamos que os objetivos de intervenção se encontram fundamentalmente centrados na proteção face ao perigo (i.e., afastamento de situações de perigo), associada ao sistema de ameaça, e na ativação do sistema de procura, considerando o estabelecimento de rotinas diárias, o foco no desempenho académico e o envolvimento em atividades extracurriculares. O espaço e tempo reservados na rotina diária da CAR para a estimulação do sistema de afiliação/apaziguamento das crianças e jovens encontra-se num plano secundário, sendo, no entanto, a ferramenta-chave consistentemente destacada na literatura para facilitar a intervenção e recuperação emocional das crianças e jovens acolhidas nas CAR (Pinheiro et al., 2022; Sellers et al., 2020). Investigação realizada com crianças e jovens em acolhimento indica que as mesmas valorizam cuidadores que se revelam disponíveis, compreensivos e atenciosos, persistentes face a dificuldades, e que disponham de tempo para conviver de forma relaxada (Moore et al., 2018). A voz das crianças e jovens em acolhimento indica uma necessidade expressa de procura de relações de suporte, afeto e segurança, que vai ao encontro do proposto pelo modelo acima mencionado, destacando que tanto o sentimento de proteção face ao perigo, como o sentimento de segurança tranquila, são necessários para que a criança/jovem se possa sentir segura e disponível para investir no seu projeto de vida. A qualidade das relações estabelecidas e o sentimento de segurança daí resultante, poderão favorecer a transição da criança ou jovem para o meio natural de vida, independentemente do seu projeto de vida ser o retorno à família ou a sua autonomização. As figuras de referência da CAR podem disponibilizar um porto seguro para

alavancar este processo de transição. A saída da CAR não deve ser entendida como uma perda ou abandono, mas como um acontecimento necessário ao processo de desenvolvimento, no qual é permitida a manutenção dos laços de vinculação e assegurado o suporte necessário, através da criação de estruturas de apoio e acompanhamento após a saída da CAR (Pinheiro et al., 2015, 2018).

Em segundo lugar, a prestação de cuidados deve ser individualizada, de forma que os cuidadores possam compreender e responder às necessidades emocionais e sociais de cada criança ou jovem (Magalhães & Calheiros, 2017). Idealmente, cada criança/jovem deveria ter um cuidador de referência, que tenha recebido treino específico para auxiliar o processo de recuperação física e psicológica da criança/jovem, através do estabelecimento de uma relação segura num ambiente seguro, estável e terapêutico (Campos et al., 2019; Sellers et al., 2020). Para que isto se torne viável, são necessárias mudanças na contratualização de profissionais, que deve passar pelo aumento do número de cuidadores por criança/jovem, devendo os mesmos ser devidamente selecionados (e.g., avaliação da motivação, estado psicológico e compaixão) e treinados (Garcia Quiroga & Hamilton-Giachritsis, 2016, 2017). Paralelamente, o estabelecimento de relações de qualidade e de confiança consistentes deve ser prioritário relativamente às tarefas burocrática e administrativas, que normalmente ocupam grande parte do tempo das equipas e limitam o tempo disponível dos cuidadores para estar em contacto com as crianças e jovens e para investir no estabelecimento de relações interpessoais de qualidade e na prestação de cuidados compassivos (Coady, 2014; Crawford et al., 2014; Degner et al., 2010; Jenney, 2020; Pinheiro et al., 2022).

Especificamente no que diz respeito à qualificação dos profissionais das CAR, e considerando a elevada incidência de problemas de saúde mental entre as crianças e jovens em acolhimento, os profissionais devem receber apoio apropriado e treino específico face às exigências dos utentes que quem cuidam. Programas especializados poderão facilitar uma abordagem que permita compreender e atender às necessidades físicas, sociais e emocionais das crianças, fornecer estratégias alternativas de relacionamento e regulação emocional e comportamental. Sendo este um contexto de trabalho emocionalmente exigente, a qualificação de profissionais deveria contemplar ainda suporte e treino de competências de regulação emocional do próprio cuidador, para otimizar o seu papel na promoção de saúde mental nas CAR e atender às suas próprias necessidades emocionais perante situações de frustração, perda ou trauma, frequentes neste contexto. Estas recomendações encontram-se alinhada com orientações da ONU para prestação de cuidados alternativos a crianças (ONU, 2010), com os princípios do consórcio internacional para acolhimento terapêutico (Whittaker et al., 2016), com

as orientações da OMS para intervenções destinadas à promoção e prevenção da saúde mental dos adolescentes (HAT Guidelines, OMS 2020), com normas do *National Center for Child Traumatic Stress* (NCTSN, 2016) e também com o recentemente criado Plano de Ação da Garantia para a Infância 2022-2030 (Resolução do Conselho de Ministros n.º 3/2023, Diário da República, 1ª série, nº 12, 17 de janeiro).

Relacionado com o ponto anterior, a revisão sistemática da literatura (Fostering emotional and mental health in residential youth care facilities: A systematic review of programs targeted to care workers) indica, no entanto, que os programas existentes não respondem de forma eficaz às necessidades evidenciadas no terreno. Os resultados indicam que a maioria dos programas de treino/intervenção direcionados para cuidadores das CAR têm como objetivo diminuir problemas de comportamento das crianças e jovens e incidentes críticos decorrentes nas CAR, não contemplando problemas de regulação emocional dos jovens ou problemas de internalização associados aos maus-tratos e ao trauma, e muito menos no que respeita a problemas de regulação emocional e de saúde mental dos cuidadores. Os poucos programas existentes para estes fins são sustentados por metodologias de investigação pouco robustas, que limitam a evidência empírica dos mesmos.

Alinhado com orientações internacionais para acolhimento terapêutico (Whittaker et al., 2016), o presente trabalho de investigação disponibiliza às casas de acolhimento um programa baseado num modelo teórico sólido e com evidência empírica. A promoção de uma mentalidade afiliativa, operacionalizada através do Treino da Mente Compassiva para Cuidadores (TMC-C), pretende ampliar o foco de atuação das CAR, frequentemente criticadas por se direcionarem maioritariamente para proteção da criança face a situações de perigo e provisão assistencialista de recursos, para a promoção de um ambiente seguro, facilitador de segurança emocional e afiliativa, necessária à recuperação psicológica da criança (Sellers et al., 2020). De acordo com os resultados obtidos nos estudos empíricos do ensaio clínico, o TMC-C fornece um modelo de compreensão sobre o funcionamento da mente humana, facilitando a compreensão sobre como as experiências adversas previamente vivenciadas condicionam o funcionamento atual da criança/jovem, bem como sobre as estratégias de regulação emocional pouco adaptativas utilizadas pelos mesmos, que espelham um modo de sobrevivência associado ao trauma. Esta compreensão sobre as causas da desregulação emocional e comportamental permite, aos cuidadores, a identificação dos “gatilhos” mais comuns e disponibiliza diretrizes de atuação e de intervenção consistente entre os membros da equipa, no sentido de responderem de forma mais adequada e construtiva aos comportamentos manifestados pelos jovens, evitando escaladas comportamentais, e diminuindo a resistência dos jovens à prestação de

cuidados. Adicionalmente, a atuação consistente e ajustada da equipa face aos comportamentos disruptivos das crianças e jovens poderá ajudar estes a aprenderem estratégias alternativas para lidar com a ativação emocional associada ao sistema de ameaça, contribuindo para expandir a sua capacidade de autoapaziguamento e controlo interno, diminuindo a necessidade de contenção externa. Deste modo, as práticas de acolhimento poderão ser melhor fundamentadas, mais consistentes e mais alinhadas com as necessidades emocionais e sociais dos jovens. Paralelamente, o programa permite apoiar um melhor funcionamento das equipas. O relacionamento interpessoal entre colegas é um fator importante no trabalho em contextos de prestação de cuidados (Aarons & Sawitzky, 2006). Promover um olhar compassivo entre colegas é fundamental para reduzir as ameaças interpessoais e aumentar o sentimento de segurança e comportamentos de apoio nas próprias equipas. A nível individual, o TMC-C permite obter maior nível de consciência sobre as próprias emoções e conhecimento acerca de formas adaptativas para regular as mesmas, diminuindo a frequência de comportamentos reativos baseados nas emoções, que podem comprometer as relações estabelecidas com os jovens. O TMC-C ajuda também os profissionais a refletirem sobre as suas necessidades enquanto cuidadores, e a atenderem às mesmas de forma a proteger a sua saúde mental, podendo potencialmente vir a contribuir para a redução de baixas e *turnover*. No seu conjunto, destacamos que a finalidade deste programa assenta na melhoria da qualidade das relações afiliativas entre cuidadores (figuras de referência) e jovens e entre os membros das equipas, pretendendo facilitar um ambiente mais seguro para todos os elementos das CAR através da promoção de uma mentalidade afiliativa. Um ambiente acolhedor, afiliativo e seguro é um pré-requisito para a criação de ambientes terapêuticos e para melhores resultados nas CAR (Sonderman et al., 2021), podendo otimizar as intervenções psicológicas individualizadas oferecidas às crianças e jovens, e facilitar a mudança da perceção que as mesmas poderão ter vindo a desenvolver ao longo da vida sobre si, os outros e o mundo. Gostaríamos de destacar que, considerando o trauma e psicopatologia associada ao mesmo, este tipo de abordagem pretende complementar as intervenções especializadas dirigidas às crianças e jovens (e.g., psicoterapia, aconselhamento), e não substituir as mesmas.

Considerando as recomendações da literatura, bem como as exigências associadas ao trabalho neste contexto, para alcançar melhores resultados, recomenda-se que o TMC-C seja aplicado a todos os profissionais da CAR, sem restrições relativas à função exercida (Henshall et al., 2018; McEwan et al., 2020). Salienta-se, no entanto, que tornar o treino obrigatório poderá ser contraproducente junto de profissionais mais resistentes a este tipo de abordagens (Sinclair et al., 2021), devendo a participação ser encorajada, mas não forçada. De acordo com a nossa

experiência e com recomendações da literatura (Dutton et al., 2014; James et al., 2017; Sinclair et al., 2021), o envolvimento dos diretores técnicos é fundamental para a adesão e envolvimento do grupo à prática e manutenção de uma mentalidade afiliativa no local de trabalho.

A sustentabilidade das aprendizagens e das práticas do programa na CAR é relevante para alcançar consistência na intervenção e manutenção dos resultados alcançados. A literatura indica que o *turnover* é uma ameaça comum à aplicação e manutenção de novos modelos e práticas baseadas em evidência neste contexto (Aarons & Sawitzky, 2006; James, 2017; Ogden & Fixsen, 2015; Steinlin et al., 2017). Deste modo, recomenda-se que os psicólogos das CAR possam receber formação no TMC-C para poderem vir a aplicar o programa junto de novos colaboradores.

De modo a manter os ganhos alcançados com o treino, recomenda-se ainda que seja fornecida supervisão às equipas para facilitar que o modelo e as práticas do TMC-C sejam transferidas e aplicadas de forma efetiva (Curry et al., 2005; Liu & Smith, 2011). Mais especificamente, uma supervisão continuada poderá: (1) facilitar apoio contínuo às equipas; (2) apoiar a transferência das aprendizagens e integração das mesmas na prática diária; (3) criar oportunidade de reflexão individual e coletiva sobre o modelo e aplicação do mesmo às práticas de acolhimento; (4) monitorizar pontos fortes e dificuldades na prática e delinear estratégias para ultrapassar as mesmas; (5) facilitar a leitura de casos com base no modelo teórico com o intuito de delinear estratégias de intervenção; (6) estabelecer e manter hábitos promotores de saúde mental na rotina da CAR, tanto para jovens, como para cuidadores. Investigação na área do acolhimento sobre aplicação de práticas baseadas em evidência sugere ainda que a sustentabilidade das práticas se encontra associada à avaliação positiva dos resultados de implementação do programa e ao comprometimento das direções com o mesmo (Groark & McCall, 2011; James et al., 2017; Rivard et al., 2005). Neste sentido, uma cultura colaborativa, com apoio das direções das CAR, facilitará a ocorrência de mudanças estruturais que apoiem a implementação das aprendizagens e competências aprendidas no programa de TMC-C.

Para além de um programa de treino para os profissionais das CAR, o presente trabalho de investigação disponibiliza também várias escalas de autorrelato para adolescentes em acolhimento, que permitem a avaliação de construtos de relevância de acordo com o modelo de base do programa. Estes instrumentos poderão contribuir para avaliar a qualidade da prestação de cuidados nas CAR, nomeadamente no que diz respeito ao sentimento de segurança em cada CAR, ao relacionamento estabelecido com o cuidador e à perceção do clima emocional da CAR, contribuindo para informar as organizações sobre eventuais melhorias a efetuar.

No que diz respeito às políticas públicas, consideramos que as mesmas deveriam contemplar um maior investimento nas organizações sociais de proteção à infância. O papel dos profissionais das CAR merece e deveria ser valorizado e reconhecido. Os profissionais deveriam ser devidamente selecionados e treinados, e o seu bem-estar mental protegido. O investimento na melhoria da prestação de cuidados e intervenções das CAR poderá ter benefícios para as crianças e jovens, para o Estado e para a sociedade em geral. De acordo com a Comissão de Análise Integrada da Delinquência Juvenil e Criminalidade Violenta (CAIDJCV, 2023), mais de 50% dos jovens com medida tutelar educativa de internamento em centro educativo (art.º 17º da Lei n.º 166/99, de 14 de setembro) viu previamente executada uma medida de promoção e proteção de acolhimento residencial. Estudos de *follow-up* de jovens que passaram pelo acolhimento indicam que estes são um grupo relativamente vulnerável para pobreza, baixas qualificações, parentalidade precoce, falta de habitação e de emprego (Cameron et al., 2018; Purtell et al., 2021), o que pode contribuir a sua exclusão social e para a manutenção de ciclos intergeracionais de maus-tratos infantis. Revela-se por isso importante quebrar este ciclo e fornecer experiências alternativas, reparadoras e terapêuticas às crianças de hoje e do amanhã.

Importa referir que o programa desenvolvido e testado no âmbito do presente trabalho de investigação se encontra registado como marca da Universidade de Coimbra e tem sido objeto de transferência de saberes para a comunidade. Mais concretamente, o manual do TMC-C encontra-se traduzido em Castelhano e o programa foi aplicado em casas de acolhimento da Galiza, em Espanha. O TMC-C encontra-se também a ser aplicado em todas as casas de acolhimento da Região Autónoma da Madeira. A transferência de saberes ocorreu através de uma prestação de serviços externos da Unidade de Psicologia Clínica Cognitivo-Comportamental à IGAXES (Galiza) e de outra, contratualizada com o Instituto da Segurança Social da Madeira (IP-Ram), no âmbito da qual se realizou formação a técnicos para aplicação do programa e sessões de supervisão durante a implementação do mesmo. A avaliação de resultados da implementação do programa na Região Autónoma da Madeira encontra-se atualmente em curso.

4. Conclusão

Este trabalho de investigação procurou reforçar o elo entre a investigação científica e a práticas das casas de acolhimento residencial de crianças e jovens, respondendo à necessidade reportada na literatura ao nível da qualificação dos profissionais deste setor social. Esta tese compila vários estudos que procuram prover conhecimento científico, um modelo de intervenção fundamentado em evidência e materiais de avaliação e intervenção testados e

validados, que apoiem e qualifiquem a prestação de cuidados a crianças e jovens a viver em acolhimento, ao abrigo da medida de promoção e proteção de acolhimento residencial.

O presente trabalho de investigação reconhece e valoriza o papel dos cuidadores no processo de acolhimento das crianças e jovens. Os profissionais das casas de acolhimento apresentam um papel ativo, afiliativo e terapeutico priviligiado na vida destas crianças e jovens, devendo, por isso, beneficiar de condições de trabalho que lhes garantam os recursos materiais, técnicos, sociais, emocionais e financeiros adequados às suas funções.

Os resultados dos estudos empíricos apresentados no âmbito desta tese indicam que o Treino da Mente Compassiva para Cuidadores (TMC-C-) é um programa viável e eficaz na promoção de uma mentalidade afiliativa no acolhimento residencial. O programa demonstrou capacidade de ajudar os cuidadores a desenvolver uma mente mais compassiva. Resultados quantitativos e qualitativos indicam que os efeitos do TMC-C ocorrem aos níveis: (1) individual, no desenvolvimento de competências socioemocionais dos cuidadores que podem contribuir para a proteção da sua qualidade de vida e saúde mental; (2) interpessoal, contribuindo para uma maior proximidade e ligação aos outros entre cuidadores e jovens e entre colaboradores; (3) organizacional, contribuindo para uma prestação de cuidados mais compassiva e coerente entre a equipa e um ambiente mais seguro na CAR para cuidadores e jovens. Os resultados revelam ainda que os ganhos observados nos cuidadores do grupo de intervenção foram mantidos 6 meses após o término do programa. Destaca-se que as mudanças relatadas pelos cuidadores foram percecionadas pelos jovens residentes nas CAR do grupo de intervenção, com impacto positivo ao nível do sentimento de proximidade e ligação aos outros e na perceção de segurança e afiliação no clima emocional da CAR, imediatamente após o programa. Adicionalmente, os resultados mostram que, quando não é oferecido treino, os cuidadores tendem a deteriorar a motivação compassiva (dirigida aos outros e ao próprio), bem como indicadores de qualidade de vida profissional e de saúde mental, podendo comprometer a qualidade da prestação de cuidados. Deste modo, o TMC-C poderá constituir-se como um programa útil na formação especializada das equipas das CAR, recomendando-se que possa orientar a intervenção e supervisão neste contexto.

Globalmente, este trabalho de investigação procurou contribuir para melhorar a qualidade das práticas de prestação de cuidados e fornecer um modelo de intervenção baseado em evidência, que possa contribuir para uma maior eficiência e qualidade da medida de acolhimento residencial. Os seus *outputs* estão articulados com as orientações para os Cuidados Alternativos de Crianças (ONU, 2010) e para o acolhimento terapêutico (Whittaker et al., 2016), bem como com as recomendações nacionais constantes na Lei de Proteção de Crianças e Jovens

em Perigo. Esperamos que os resultados deste trabalho de investigação possam informar decisões políticas, práticas e processos de acolhimento, tendo em vista a adequação e otimização da prestação de cuidados face às necessidades das crianças e jovens, tornando as casas de acolhimento em residências compassivas e afiliativas, onde as crianças e jovens se sintam emocionalmente seguros para integrar e acomodar as experiências do passado, possam crescer com as experiências oferecidas no presente e projetar-se, de forma confiante e segura, no futuro.

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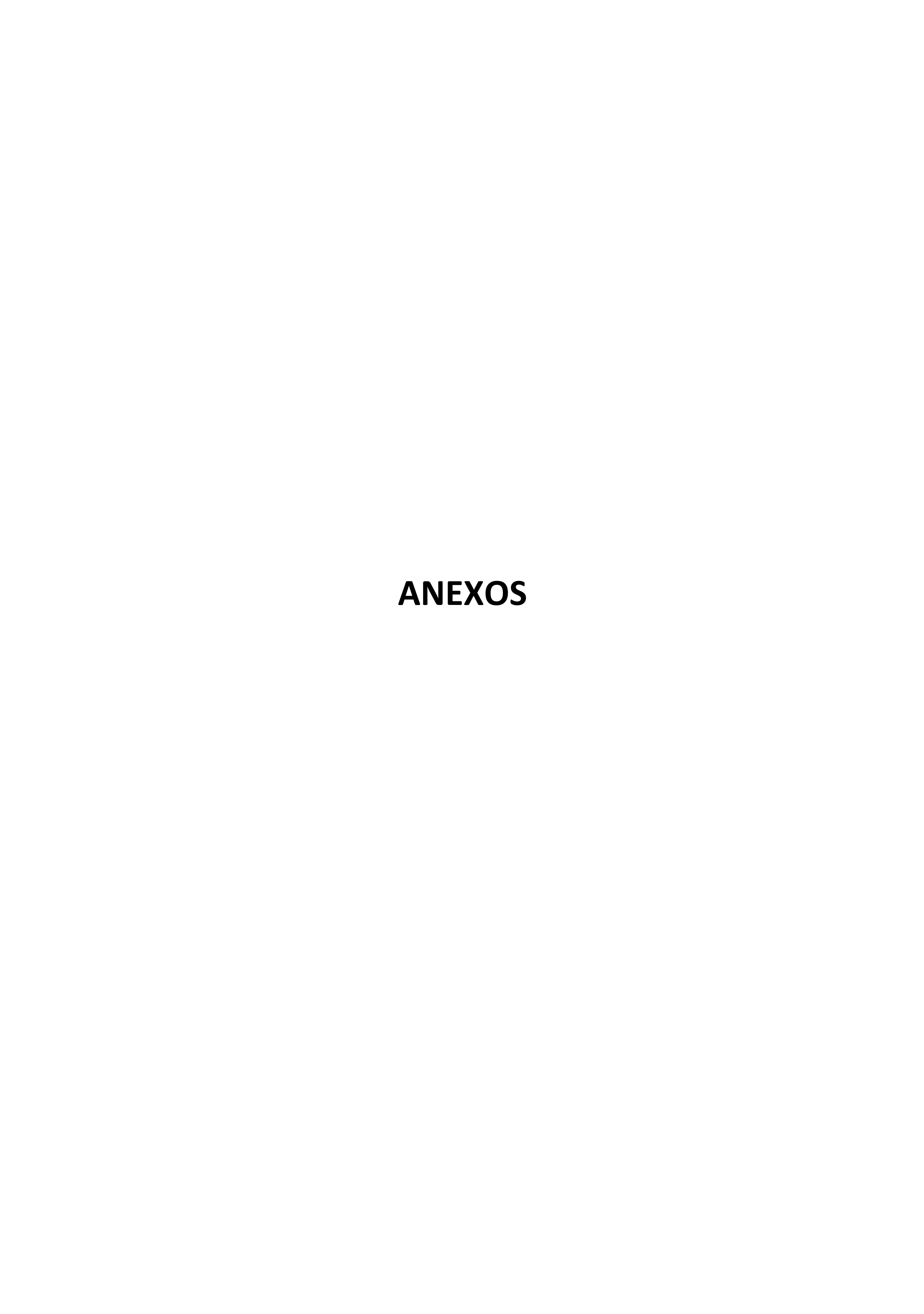


ANEXOS

ANEXO A

EXCERTO DO PROGRAMA DE TREINO DA MENTE COMPASSIVA PARA CUIDADORES

TMC-C

Manual do Programa de Treino da Mente Compassiva para Cuidadores de Jovens em Acolhimento Residencial

Manual do dinamizador

Laura Santos

Daniel Rijo

Maria do Rosário Pinheiro

sessão

Sistema de Tranquilidade
“Verde Apaziguador”

. Sessão 6

Resumo da Sessão

A Sessão 6 é iniciada com o exercício de aterragem de treino da mente compassiva "Sorriso compassivo". A fim de manter a continuidade entre as sessões, realiza-se uma breve síntese dos conteúdos da sessão anterior. Abre-se espaço para a partilha das experiências com o desafio semanal para a prática compassiva, sendo solicitado a cada participante que preencha a ficha de avaliação do nível de concretização da sua prática semanal (Formulário de Check-in).

A exploração do tema da Sessão 6 é iniciada com a visualização de imagens potencialmente ativadoras do Sistema de Afiliação e Apaziguamento (neste programa denominado por sistema de tranquilidade, sistema verde). Este exercício pretende explorar o funcionamento, outputs (i.e., emoções, respostas fisiológicas e comportamentais) e função deste sistema de regulação do afeto. Os/as participantes são convidados/as a refletir sobre a atuação do sistema verde nas suas vidas e possíveis formas de o estimular. Realiza-se o exercício de imaginação "Lugar seguro", como exemplo, de uma prática para estimular a ativação deste sistema. É introduzida a Mentalidade Afiliativa e explorada a sua relevância no contexto de acolhimento residencial. Para o efeito, é explicado o papel da vinculação no desenvolvimento, maturação e funcionamento do sistema de tranquilidade e analisado o funcionamento dos sistemas de regulação de afeto dos jovens em acolhimento, atendendo às suas experiências de vida e eventuais necessidades básicas não atendidas. Realiza-se uma leitura da intervenção no âmbito da promoção e proteção de jovens, com recurso à distinção entre os conceitos de "safety" (estar protegido face a ameaças) e "safeness" (sentimento de tranquilidade segura). Salienta-se ainda a importância da promoção de uma tranquilidade segura entre a equipa de cuidadores, a fim da mesma ser modelada e estimulada nos jovens. Neste sentido, realiza-se o exercício "Palavras do coração" para cultivar a afiliação entre participantes.

Para preparar o check-out da sessão, realiza-se uma síntese das aprendizagens fundamentais. Os/as participantes são convidados/as a realizar uma reflexão sobre a aplicação das aprendizagens da sessão na sua vida pessoal/profissional, ao trabalho diário na casa de acolhimento e em/na relação aos/com jovens. Abre-se espaço para partilha de reflexões individuais. O grupo deverá selecionar uma ou duas ideias-chave para registar no Muro da Compaixão. De seguida, o desafio semanal para a prática compassiva é lançado, sendo reforçada a ideia de que tal como treinamos o nosso corpo, é importante treinarmos as nossas mentes.

A sessão é avaliada pelos/pelas participantes, através do preenchimento de um formulário de avaliação da satisfação, aprendizagens e suas transferências (Formulário de Check-out). A música compassiva de um dos/das participantes é escutada durante o preenchimento do formulário. Para terminar a sessão, os/as participantes são convidados/as a realizar um exercício de ativação do Sistema de Tranquilidade: "Respiração Tranquila".

Objetivos da sessão

- Compreender o funcionamento e respostas do sistema de tranquilidade
- Compreender a relação entre a vinculação e o sistema de tranquilidade
- Identificar estratégias de ativação do sistema de tranquilidade
- Estimular a imagem do lugar seguro
- Reconhecer a importância da mentalidade afiliativa no sistema de acolhimento
- Reconhecer a necessidades de calor e segurança dos jovens

Material

- Quadro e/ou flipchart
- Canetas para o quadro de cor azul, verde e vermelha
- Apresentação em Powerpoint
- Computador
- Projetor
- Postal souvenir da Austrália "para mais tarde recordar e treinar"

Tabela 6 – Sumário da Sessão 6

Preparativos para a viagem/sessão	Exercícios
	Breve exercício de aterragem para o/a dinamizor/a
Check-in	
1 Aterragem na sessão	• Sorriso compassivo
2 Revisão da sessão anterior	• Sumariar: Vantagens e desvantagens das respostas do sistema de procura (comportamentais, emocionais, cognitivos)
3 Partilha da prática semanal	• Preenchimento do Formulário de check-in • Partilha de experiências com o desafio semanal para a prática compassiva: Os meus votos
Exploração do tema	
4 Sistema de tranquilidade	• Imagens que nos tocam
5 Estimular o sistema de tranquilidade	• O que normalmente me ajuda a acalmar? • Lugar seguro
6 Mentalidade afiliativa no acolhimento residencial	• Mentalidade afiliativa • Qual a cor da mente dos nossos jovens? • Palavras do coração
Check-out	
7 Resumo da sessão e aplicação prática	• Sumariar as aprendizagens fundamentais da sessão e refletir sobre a aplicação das mesmas (Cuidador, Jovens, Casa de acolhimento) • Escrever uma ideia-chave da sessão no Muro da Compaixão
8 Desafio para a prática compassiva	• Entregar postal souvenir com o desafio semanal para a prática compassiva: Expressar tranquilidade
9 Avaliação da sessão e escuta da música compassiva	• Preenchimento do Formulário de check-out • Partilhar e escutar uma música compassiva
10 Descolagem da sessão	• Respiração tranquila

Check-in

1 Aterragem na sessão

O/a dinamizador/a dá a boas-vindas aos/às participantes e agradece pela sua presença na Sessão 6. A sessão é iniciada com um exercício de aterragem de treino da mente compassiva.

Sorriso compassivo

(Adaptado do programa Compass)

Bem-vindos/as à sessão de hoje de Treino da Mente Compassiva para Cuidadores. Como é habitual, vamos começar a nossa sessão com um exercício para treinar a nossa mente. Neste exercício vamos tentar observar as nossas sensações corporais, pensamentos e emoções à medida que alteramos a nossa expressão facial.

I. *Sentem-se de forma confortável, mantenham as vossas costas direitas e coloquem os vossos pés bem assentes no chão. Se se sentirem confortáveis, podem escolher fechar os vossos olhos ou, se preferirem podem fixá-los num ponto do chão à vossa frente.*

II. *Comecem por focar gentilmente a vossa atenção no vosso rosto. Como está o vosso rosto, neste momento? Identificam algum ponto de tensão ou notam o vosso rosto relaxado? O objetivo é apenas observar… O que notam na vossa testa? Nos vossos olhos? No vosso nariz? Nas vossas bochechas? No vosso queixo? Expandam a vossa atenção e notem que sensações se encontram no vosso corpo.*

III. *Agora, foquem gentilmente a vossa atenção na vossa respiração…. Notem a forma como o ar entra e sai do vosso corpo… tomem consciência das diferentes sensações associadas a cada inspiração e a cada expiração… podem até notar a pausa que existe entre a inspiração e a expiração…*

IV. *Agora, convido-vos a colocar um pequeno sorriso no vosso rosto. Coloquem uma expressão facial amigável, como se estivessem com alguém de quem gostam. Mantenham essa expressão facial amigável, esse ligeiro sorriso, por alguns segundos… Não se preocupem se se sentirem embaraçados/as, por vezes isso pode acontecer. Se a vossa mente começar a comentar este exercício ou se vaguear para outro lado, reparem nisso e voltem a focar-se gentilmente no exercício, observando o vosso sorriso, novamente. Procurem imaginarem-se a olhar para vocês próprios/as e observem o vosso rosto neste momento, o que veem?*

V. *Mantendo esse sorriso, notem que sensações estão no vosso corpo. Que sensações apareceram quando fizeram o sorriso? Que emoções surgiram? Que pensamentos passaram pela vossa mente?*

VI. *Para terminar, convido-vos a colocar uma expressão facial que vos seja confortável e tranquilizadora. Pode ser o sorriso ou não, desde que seja uma expressão que vos deixe tranquilos/as, confortáveis, seguros/as... Convido-vos a fazer algumas respirações mais profundas e lentas… foquem-se no momento presente… permitam-se sentir esta experiência no aqui e agora… Quando se sentirem prontos e/ou prontas podem abrir gentilmente os vossos olhos e concluir este exercício.*

2 Revisão da sessão anterior

O/a dinamizador/a convida o grupo a sumariar a informação da sessão anterior, assegurando que as aprendizagens fundamentais são sintetizadas.

Antes de avançarmos para a sessão de hoje, vamos recapitular os pontos principais da sessão anterior. Gostava de perceber como estão a lidar com as novas aprendizagens e se as mesmas se aplicam no vosso dia a dia.

Aprendizagem fundamental da sessão anterior:

Vantagens e desvantagens do sistema de procura

Questões sugeridas:

- **O que se recordam da última sessão?**
- **O que gostariam de destacar?**

Tópicos para a síntese:

- O sistema de procura permite-nos manter o foco nas nossas motivações e valores, sendo uma forma possível de nos ajudar a lidar com as dificuldades associadas ao sistema de defesa-ameaça.
- Contudo, o sistema de procura pode apresentar também alguns “perigos”. Quando ativado por excesso, pode levar-nos a um estado de busca constante e consumo excessivo de recursos (i.e., procurar, fazer, alcançar). Quando se encontra diminuído, o sistema de procura pode desencadear falta de energia e de motivação para alcançar objetivos ou mesmo espoletar sintomatologia depressiva.

É distribuída a cada participante uma ficha de avaliação do nível de concretização do desafio semanal para a prática compassiva (Formulário de Check-in). Cada participante deve colocar o código pessoal que se encontra no seu cartão de embarque.
Após o preenchimento da mesma, o/a dinamizador/a avalia se os/as participantes realizaram a tarefa de transferência da aprendizagem, qual o contexto da sua aplicação e possíveis dificuldades encontradas na concretização da tarefa e das práticas semanais.

Tarefa de Transferência da Aprendizagem: Os meus votos

Transformar os valores nucleares em votos e repetir mentalmente esse voto diariamente.

Quais foram as vossas experiências com a prática semanal?

E com a realização desta tarefa?

Exploração do tema

O/a dinamizador/a apresenta os objetivos da sessão ao grupo (projetar em powerpoint)

4 Sistema de tranquilidade

A exploração do tema da sessão inicia com um exercício experiencial. Este exercício pretende gerar algum nível de ativação do sistema de tranquilidade, de forma a explorar o seu funcionamento, outputs (emoções, pensamentos, tendências de ação) e função. A sua ligação à vinculação deverá ser abordada.

Exercício experiencial

Imagens que nos tocam

Os/as participantes são convidados/as a visualizar um conjunto de imagens (disponíveis em powerpoint – sessão 6) e a notar o que as mesmas espoletam no seu corpo e mente. As imagens foram selecionadas de forma a ativar sensações e emoções do sistema de tranquilidade. Os outputs deste sistema são explorados de acordo com os exemplos enunciados pelos/pelas participantes, sendo destacadas ideias-chave sobre a sua origem e função. Para auxiliar o exercício, o/a dinamizador/a pode desenhar o esquema do modelo dos três sistema de regulação do afeto no quadro e completar o mesmo com as respostas dos/das participantes.

Vamos visualizar um conjunto de imagens. Peço-vos que observem atentamente cada uma delas. À medida que visualizam cada imagem, peço-vos que tentem colocar-se na situação representada e procurem notar que sensações surgem no vosso corpo, quais os pensamentos que vos vêm à cabeça e qual a tendência para ação.

Questões auxiliares:

- *Em que situações este sistema se ativa?*
- *Que emoções surgem?*
- *Que tipo de pensamentos ou memórias surgem?*
- *Qual a expressão facial das pessoas retratadas nas imagens? E postura corporal?*
- *Como temos tendência para agir?*
- *Que função terá este sistema na vida humana?*

Ideias a reter:

Ideia-chave 1: Origem na vinculação

O sentimento de segurança é estimulado desde o nascimento, através da interação estabelecida entre a criança e o(s) seu(s) cuidador(es).
Dada a vulnerabilidade da cria humana à nascença, a vinculação tem como função a proteção da criança. Nascemos sem capacidade para nos alimentar ou defender, dependemos de um cuidador que nos proteja e nutra. Este para além de proporcionar os cuidados básicos, quando atende às necessidades da criança com calor e afeto, tende a promover um sentimento de conforto e segurança. Assim, a vinculação molda as nossas interações sociais, regula as nossas emoções e influência a forma como os nossos sistemas de regulação do afeto se desenvolvem.

Por exemplo, uma criança com um estilo de vinculação segura, mais facilmente recorda sentimentos e memórias de calor e afeto durante a vida, que a ajudarão a equilibrar e a regular os sistemas afetivos através de autoapaziguamento e segurança.

Ideia-chave 2: Dá-nos um sentimento de segurança

O sistema de tranquilidade estimula um comportamento de desaceleração e calma, fornecendo um sentimento de tranquilidade e segurança. Esta segurança não diz respeito à procura de proteção, com a finalidade de ficar a salvo, associado ao modo de defesa-ameaça (safety). A segurança (safeness/tranquilidade segura) do sistema de tranquilidade está associada ao estado de contentamento. Permite-nos relaxar e enfrentar os riscos, explorar, crescer e desenvolver. Quando os seres humanos se sentem seguros são mais criativos na resolução de problemas e adoptam comportamentos mais pró-sociais.

Ideia-chave 3: Dupla função

Quando o sistema de tranquilidade está ativo permite que a pessoa esteja focada no momento presente, permitindo obter uma sensação de relaxamento e/ou segurança para explorar o meio. Ou seja, quando o nosso sistema verde está ativo podemos estar num modo passivo, associado a atividades de relaxamento ou num modo ativo, a redirecionar a atenção para explorar o meio.

Ideia-chave 4: Ajuda-nos a restabelecer o equilíbrio

O sistema de tranquilidade é o “antídoto natural” para regular o funcionamento, não só do sistema de defesa-ameaça, como também do sistema de procura.

Promove a desativação das emoções (raiva, medo, tristeza) e comportamentos (agressão, luta ou fuga) do modo ameaça, oferecendo outros recursos para lidar com as adversidades.

Pode também desligar as necessidades de procurar, fazer, alcançar e adquirir, associadas ao sistema de procura.

5 Estimular o sistema de tranquilidade

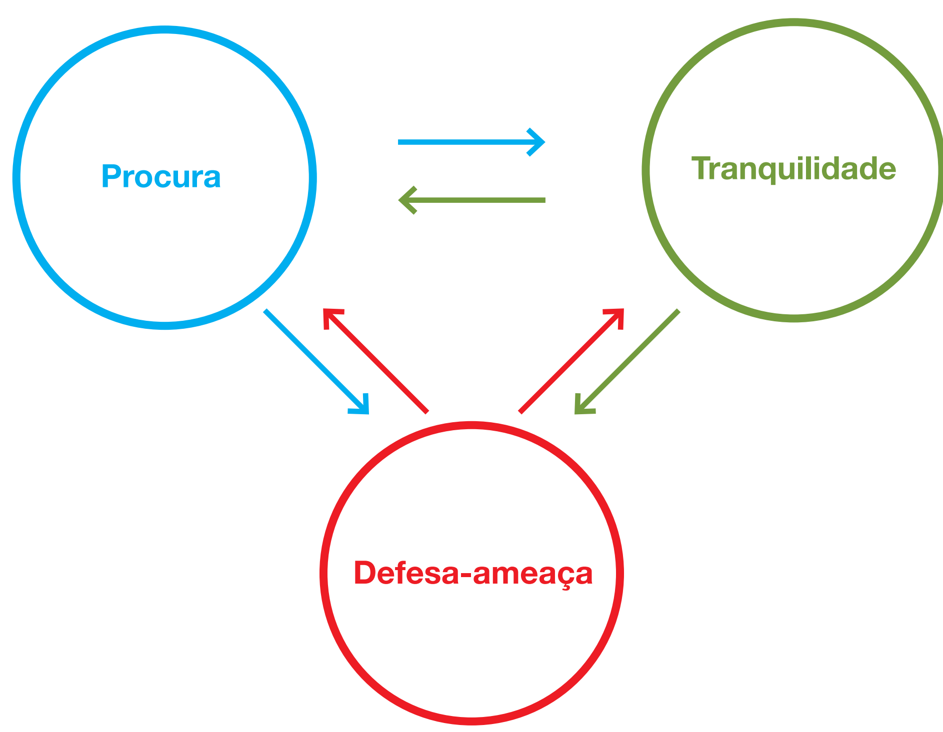
Neste ponto, pretende-se que os/as participantes identifiquem estratégias adaptativas e desadaptativas que as pessoas normalmente utilizam para se acalmar ou relaxar. De seguida, são abordadas estratégias que permitam a ativar o sistema de tranquilidade. O exercício “Lugar Seguro” é realizado, como exemplo, de uma prática para ativação e estimulação do sistema de tranquilidade.

O que normalmente me ajuda a acalmar?

O/A dinamizador convida os/as participantes a listar cinco atividades ou ações que os/as ajudem a relaxar ou acalmar. De seguida, os/as participantes são convidados/as a partilhar as suas estratégias e a identificar a que sistema de regulação do afeto pertencem as mesmas. O mesmo exercício é realizado em relação às estratégias de apaziguamento, mais frequentemente, utilizadas pelos/pelas jovens em acolhimento. Para auxiliar o exercício, o/a dinamizador/a pode registar no quadro as estratégias referidas com a cor do sistema a que poderão estar associadas.

Convido-vos a fazer uma lista do vosso top 5 de atividades que vos ajudam a acalmar ou a relaxar.

- *Quando estamos ansiosos ou stressados, o que é que normalmente nos ajuda a acalmar ou relaxar? Contudo, por vezes as estratégias que utilizamos para tentar relaxar nem sempre são as mais saudáveis.*
- Que estratégias é que as pessoas normalmente usam para se acalmar ou relaxar que podem não ser tão positivas/saudáveis?
  (e.g., fumar, consumir álcool, compras excessivas, comer em demasia, ingerir alimentos doces, isolar-se, etc.).
- E os nossos jovens? A que tipo de estratégias normalmente recorrem? (e.g., automutilação, tabaco, consumo de substâncias, isolamento, etc.)
- Serão estratégias associadas ao sistema de tranquilidade? Ou aos sistemas de defesa-ameaça ou procura?



Como vimos, a proximidade aos outros poderá ativar o sistema verde. Imaginem uma criança pequena a chorar. Qual das seguintes respostas vos parece ser mais útil?

a) *Os pais ameaçam a criança e dizem em tom ríspido e autoritário para parar de chorar.*

b) *Os pais abraçam a criança e conversam com ela calmamente.*

O sistema de tranquilidade está associado à vinculação. Quando o sistema de ameaça se encontra ativo e a criança revela desconforto ou stress, a figura de vinculação/cuidador tenta tranquilizar a criança através de proximidade, calor e afeto (e.g., pegar ao colo, embalar). Desta forma, a criança começa a aprender a apaziguar-se e a tranquilizar-se. Estar em contacto com outras pessoas, com as quais estabelecemos relações baseadas no carinho e afeto, pode também ajudar-nos a sentirmo-nos mais calmos.

Deste modo, para manter a nossa ligação aos outros, o sistema de tranquilidade é sensível a determinados sinais verbais e não verbais. Conseguem identificar alguns desses sinais?

Com que tom de voz é que costumamos falar para os bebés? É naturalmente calmo e tranquiliza-os, o mesmo funciona para os mais crescidos.

- *Expressão facial (sorriso)*
- *Toque*
- *Tom de voz*

Quando um jovem entra para a vossa casa de acolhimento e vos conhece, o que acham que o/a vai fazer sentir relativamente mais seguro/a?

- *Como seria a vossa expressão facial?*
- *Qual seria o vosso tom de voz?*

É importante ganharmos consciência das nossas expressões faciais, do nosso tom de voz e postura corporal, utilizando sinais verbais e não verbais que revelem interesse, cuidado e bondade, e que facilitem a ativação do sistema de tranquilidade dos outros.

E se esses sinais têm capacidade de promover essa ativação nos outros, podem também ser úteis se os utilizarmos em relação a nós próprios. Se reconhecemos que todos nós temos uma parte crítica, capaz de ativar o nosso sistema vermelho, será que não teremos também uma parte compassiva que permita ativar o nosso sistema verde quando precisamos? Esse é o rumo da nossa viagem. Cultivarmos o nosso Eu compassivo, não só em relação aos outros, mas também em relação a nós mesmos/as. Para isso, podemos aprender formas de ativar o nosso sistema de tranquilidade. Para além dos sinais verbais e não verbais de que falámos, podemos também estimular o nosso sistema de tranquilidade através de exercícios de respiração e de imaginação.

Para compreendermos melhor o poder daquilo que estimulamos na nossa mente, peço-vos que imaginem a seguinte situação: fechem os vossos olhos. Imaginem que acabaram de acordar. Antes de se irem preparar para ir para o trabalho, dirigem-se à vossa cozinha. Abrem o frigorífico e pegam num limão. Tiram uma faca da gaveta e cortam o limão ao meio. De seguida pegam numa das metades do limão e dão-lhe uma dentada.

O que sentiram no vosso corpo?

O que criamos na nossa mente estimula diferentes sensações e emoções no nosso corpo. Se um limão tem essa capacidade, outras coisas que imaginamos também podem ter um impacto poderoso em nós. Se pensarmos em coisas tristes que aconteceram no passado, em alguém de que não gostamos, ou quando somos autocríticos, tudo isto se reflete em reações físicas no nosso corpo.

Por isso, ao longo da nossa viagem, vamos aprender alguns exercícios que nos podem ajudar a estimular na nossa mente e corpo reações do sistema verde. Vamos começar por criar o nosso local seguro.

Lugar seguro

(Adaptado de Gilbert, 2010)

Vamos tentar criar na nossa mente um sítio que nos proporcione um sentimento de segurança e tranquilidade. Não segurança, no sentido de estarmos protegidos de algo perigoso, mas um lugar onde somos livres para explorar, divertirmo-nos ou relaxarmos, se quisermos. Esta é uma forma de ativarmos o nosso sistema de tranquilidade. Não se preocupem se as imagens que surgirem não forem totalmente nítidas, a intenção não é criar imagens fotográficas. Com a prática, esta competência tem tendência a melhorar. Se as vossas mentes vaguearem e se distraírem, já sabem que isso é natural. O importante é a intenção de ativar o sistema de tranquilidade e não atingir nenhum estado em particular.
Antes de começarmos, gostaria que pensassem como seria o vosso lugar seguro. Algumas pessoas têm uma ideia definida acerca de como é esse lugar, outras não. Que sítio vos faz ou faria sentirem-se seguros/as? Pode ser um lugar real ou imaginário, construído por vocês. Tentem fazer o exercício como se fossem um artista a pintar um quadro pela primeira vez, experimentando diferentes tonalidades até encontrarem a que gostam mais. Pode, por exemplo, ser uma praia, um campo próximo de um riacho, uma cascata ou um sítio que vos seja familiar. Se for esse o caso, tentem não utilizar lugares associados a memórias dolorosas. O importante é que esse sítio vos faça sentir seguros/as e confortáveis.

I. *Encontrem uma posição confortável, mantenham as costas direitas, poisem as vossas mãos sobre o vosso colo e coloquem os vossos pés bem assentes no chão. Permitam-se ter uma expressão facial gentil. Podem escolher fechar os vossos olhos ou fixá-los num ponto do chão à vossa frente, se for mais confortável.*

II. *Comecem por fazer algumas respirações mais profundas e lentas… Tentem percecionar o vosso corpo como um todo... Notem, onde se sentem mais leves e onde sentem mais peso… sintam os vossos pés em contacto com o chão… notem que sensações estão no vosso corpo.*

III. *Agora, foquem a vossa atenção na vossa respiração… notem o ar a entrar e a sair do vosso corpo… notem cada inspiração e cada expiração…. Notem o vosso corpo a abrandar…*

IV. *Quando se sentirem preparados e/ou preparadas, tragam à vossa mente um lugar que vos transmita calma, paz, segurança… Um lugar seguro e confortável… Pode ser uma divisão acolhedora da vossa casa ou de outra casa ou um espaço tranquilo ao ar livre, como uma praia calma ou uma floresta… pode ser também um lugar imaginário, como flutuar nas nuvens… Qualquer lugar onde se sintam seguros e/ou seguras e em paz… Quando vos surgir uma imagem desse lugar, mesmo que seja vaga ou pouco nítida, tentem observar onde estão. Estão ao ar livre ou no interior de alguma casa? Que cores existem nesse lugar? Que sons existem nesse lugar? Que cheiros existem nesse lugar? Que sensações sentem no vosso corpo?*

V. *Se não surgir nada ou se notarem que a vossa mente está a vaguear, direcionem a vossa atenção para a vossa intenção de criar um lugar seguro…*

VI. *Existe mais alguém ou algum animal nesse lugar? Ou estão sozinhos/as? Esse lugar é o espaço criado e escolhido por vocês… um lugar onde se podem sentir seguros e/ou seguras… um lugar onde podem ser vocês mesmos/as… um lugar que vos aceita exatamente como vocês são…*

VI. *Permitam-se desfrutar estar nesse lugar especial… Notem como esse lugar vos acolhe de forma calorosa… Notem como ele vos oferece segurança e conforto… Desfrutem dessas sensações… Agradeçam por esta experiência… Permitam-se ter uma expressão facial gentil, com um sorriso amigável no vosso rosto…*

VI. *Quando se sentirem preparados e/ou preparadas, deixem que essa imagem saia gentilmente da vossa mente e direcionem a vossa atenção para a vossa respiração… Quando se sentirem confortáveis podem abrir gentilmente os vossos olhos e regressar ao momento presente, ao aqui e agora.*

Sugestão de questões para explorar o exercício:

- O que sentiram? Que emoções surgiram ao longo deste exercício?
- Descobriram alguma coisa nova ou curiosa sobre vocês?
- Surgiu alguma dificuldade na realização deste exercício?

Este exercício permite-nos treinar a nossa mente, exige prática. Não é um exercício destinado a evitar momentos ou emoções difíceis ou para nos distrairmos, mas para conseguirmos trazer algo tranquilizador à nossa mente. É um exercício que nos permite ativar o nosso sistema de tranquilidade, sistema que pode criar a segurança que precisamos na nossa vida e particularmente no nosso trabalho.

6 A Mentalidade afiliativa no acolhimento residencial

O/a dinamizador/a introduz e explora a mentalidade afiliativa através de um exercício de imaginação. A fim de explorar a sua importância no contexto de acolhimento residencial, analisa-se o funcionamento dos sistemas regulação de afeto dos jovens em acolhimento e identificam-se as necessidades de intervenção com base na regulação dos mesmos. É destacado que devido às suas experiências de vida, grande parte dos/das jovens que se encontra em acolhimento pode não ter crescido num meio promotor de experiências afiliativas, de cuidado e segurança, necessárias para o desenvolvimento do sistema de tranquilidade. Assim a ativação do mesmo pode encontrar-se comprometida. Neste sentido, reforça-se a ideia de que para além da proteção é necessária a promoção de um ambiente seguro, promotor de experiências de cuidado, calor e segurança, onde os jovens possam aprender a regular as suas emoções e a florescer. Para dar resposta às necessidades de calor e segurança dos/das jovens é salientado o papel de relevo da regulação emocional dos próprios cuidadores, quer individualmente, quer enquanto equipa.

Mentalidade afiliativa

A ativação do sistema de tranquilidade assenta numa mentalidade afiliativa ou de prestação de cuidados.

Para compreendermos melhor o que isto implica, peço-vos por favor que fechem gentilmente os vossos olhos e imaginem um momento em que estavam profundamente motivados/as para ajudar alguém, sentiam-se genuinamente interessados no bem-estar dessa pessoa e fizeram aquilo que podiam naquele momento para a ajudar.

- ***Em que é que estão focados/as?***
- ***O que vos dá entusiasmo?***
- ***O que é que vos faz sentir ameaçados/as?***
- ***Como é que veem as outras pessoas?***
- ***Como é que se comportam com as outras pessoas?***
- ***Como é que acham que as outras pessoas vos veem e se relacionam com vocês?***
- ***Quando se sentirem prontos e/ou prontas podem abrir os vossos olhos e concluir este exercício.***

O exercício é explorado em torno das respostas dos/das participantes em relação às perguntas colocadas durante o exercício de imaginação.

Exemplo:

Motivação: cuidar/prestar cuidados

Pensamento: focado no bem-estar e crescimento

Emoção: calor, tranquilidade, afeto positivo

Comportamento: construir e manter relações de suporte, revelar interesse pelo outro, responder às necessidades

Notem como a mentalidade afiliativa vai organizar o que se passa na nossa mente e no corpo. E de uma forma bastante diferente da mentalidade competitiva.

Quais as consequências associadas a este tipo de mentalidade?

A nossa profissão exige cuidar dos outros, outros esses que passaram por situações difíceis, potencialmente traumáticas, e que por isso continuam a manifestar mal-estar e sofrimento. Faz-vos sentido o desenvolvimento deste tipo de mentalidade no acolhimento residencial?

Qual a cor da mente dos nossos jovens?

Os/as participantes são convidados a escolher um/uma jovem com quem trabalham e a desenhar os seus sistemas de regulação do afeto. O/a dinamizador/a incentiva os elementos do grupo a partilhar a sua interpretação do caso. A partilha de grupo tem como objetivo explorar as necessidades de calor e segurança dos jovens e a adequação da intervenção com a finalidade de facilitar a ativação do seu sistema de tranquilidade. O exercício deve conduzir ao reconhecimento da importância da mentalidade afiliativa no acolhimento residencial.

Vamos analisar os sistemas de regulação do afeto dos jovens com quem trabalham e procurar compreender quais são as suas necessidades. Peço-vos que pensem num ou numa das jovens com quem trabalham e desenhem os seus sistemas de regulação de afeto de acordo com a proporção que cada um poderá exercer na vida desse ou dessa jovem.

- *Os 3 sistemas estão equilibrados? Qual o maior?*
- *Que impacto é que isso tem nele/nela? Que tipo de emoções e comportamentos manifesta? E que impacto é que isso tem nos outros?*
- *A maioria dos/das jovens com quem trabalham cresceu num meio que estimulou maioritariamente qual dos sistemas reglação do afeto?*
- *O sistema de tranquilidade poderá encontrar-se comprometido?*

Grande parte dos/das jovens com quem trabalhamos passaram por experiências de negligência e maus-tratos, muitas vezes perpetradas pelas figuras de vinculação. Experiências precoces adversas, como o abuso, negligência, abandono, rejeição e criticismo estão associadas à ativação do sistema de defesa-ameaça. Desde muito cedo que estes/estas jovens aprenderam a estar focados/as na sua própria proteção e sobrevivência. Aprenderam que pedir ajuda aos outros não é útil, e poderá ser mesmo ameaçador.

Tendem, por isso, a ter dificuldade em desenvolver relações de proximidade, ligação e segurança com os outros. Este modo de funcionamento cria-lhes grandes dificuldades, não só a nível interpessoal, mas também a nível intrapessoal. Por outro lado, dada a instabilidade das relações precoces com as figuras de vinculação, estes/estas jovens podem não ter tido oportunidade de estimular o sistema de tranquilidade. Assim, apresentam dificuldade em regular as emoções difíceis associadas ao sistema de defesa-ameaça.

- *Ao olharem para os desenhos que fizeram dos três sistemas de regulação do afeto do/a jovem em que pensaram, qual ou quais poderão ser as necessidades dele/dela?*

Exemplos de necessidades desenvolvimentais não satisfeitas: segurança, proteção, pertença, validação emocional, autonomia proporcional à idade, limites impostos pelos cuidadores, experiências de calor e afeto.

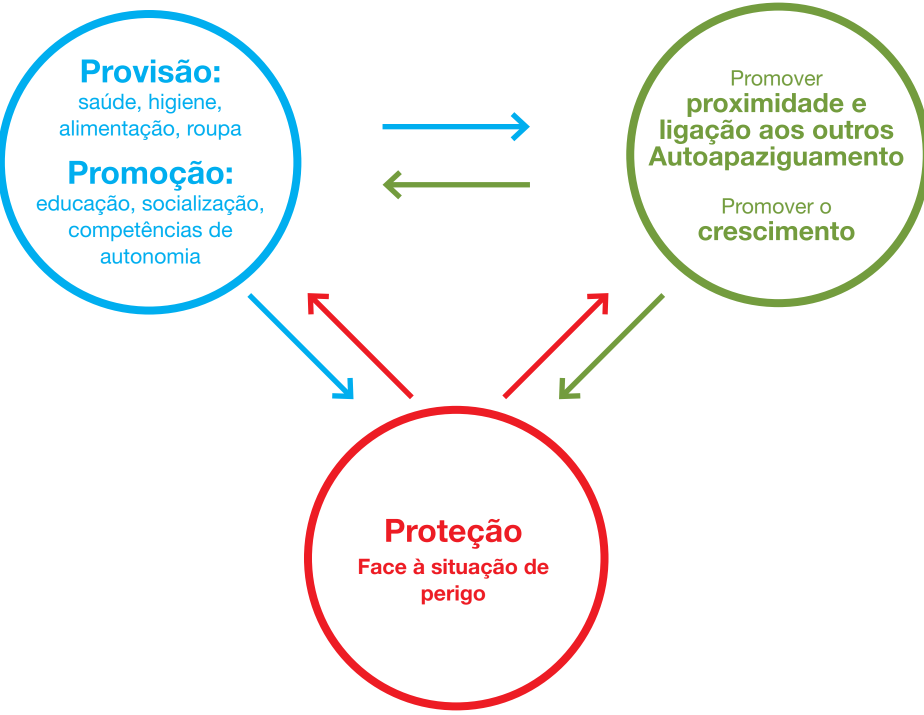
- *Que ações estão na base de uma intervenção que tem como finalidade a promoção e proteção dos jovens?*

Proteção: manter os jovens afastados do perigo (sistema de defesa-ameaça).

Provisão: saúde, higiene, alimentação e outros recursos necessários ao seu desenvolvimento (sistema de procura).

Promover a educação e a socialização: ir à escola, tirar um curso, regras e limites, ensinar competências de autonomia para a vida (sistema de procura).

- *Que sistemas estamos a estimular/trabalhar?*
- *Será que estamos a promover uma segurança associada à proteção da ameaça (sistema de defesa-ameaça) ou uma segurança tranquila (sistema de tranquilidade)?*
- *Como podemos ajudar os jovens a estimular o sistema de tranquilidade?*
- *Como podemos melhorar o ambiente da casa de acolhimento, a fim de proporcionar uma segurança tranquila aos jovens que favoreça o seu crescimento?*



Sabemos que o calor e a proximidade aos outros podem ajudar a regular/apaziguar as emoções difíceis. A ligação e relação estabelecida com os/as jovens é fundamental para os/as ajudarmos a desenvolver formas de estimular o sistema de tranquilidade e a regular os seus sistemas afetivos. As pessoas sentem-se mais seguras e tranquilas, quando sentem que são ouvidas, validadas e compreendias.

Para isso, também nós (cuidadores) precisamos de nos sentir seguros/as no nosso local de trabalho.

Que fatores vos fazem sentir seguros/as no vosso trabalho?

Entre os vários fatores que referiram, a ligação aos colegas e segurança sentida nessa relação é bastante importante. É mais fácil sentirmo-nos seguros/as, se sentirmos que as pessoas à nossa volta gostam de nós, nos valorizam e se importam connosco. A mentalidade afiliativa tem um grande impacto sobre a nossa capacidade de reduzir os sentimentos de ameaça, sem termos de recorrer demasiado ao sistema de procura.

Por isso, estamos aqui a trabalhar juntos/as, para reforçar a vossa coesão, enquanto grupo e para que se sintam mais seguros/as.

Palavras do coração

Imaginem que estão chateados ou chateadas com alguma coisa no trabalho e chega a hora da troca de turno. O que acontece no vosso corpo e que sentimentos surgem se:

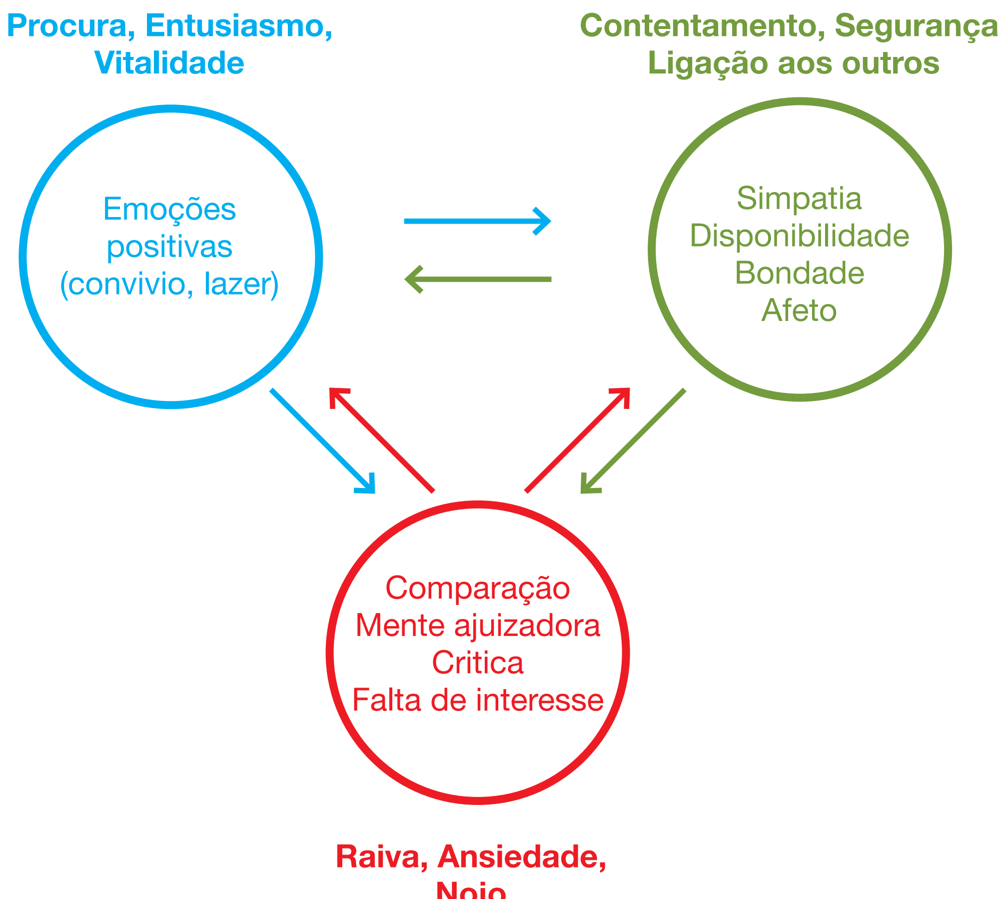
a) *Os vossos colegas ou chefe forem críticos com vocês?*

b) *Os vossos colegas ou chefe não revelarem interesse?*

c) *Os vossos colegas ou chefe se mostrarem preocupados, validarem o que estão a sentir, demonstrarem compreensão e vontade de vos apoiar?*

A nossa capacidade para nos tranquilizarmos está associada à simpatia e disponibilidade dos outros, enquanto que o criticismo e a falta de interesse estimulam mais facilmente o sistema de defesa-ameaça.

Uma vez que a nossa mente é naturalmente ajuizadora, normalmente, quando nos relacionamos com os outros é fácil ativarmos o sistema de defesa-ameaça, nosso e dos outros (porque nos comparamos ou porque criticamos constantemente). Por outro lado, quando sentimos emoções positivas nas nossas relações, estas estão muitas vezes associadas ao sistema de procura. É importante treinarmos a ativação do nosso sistema de tranquilidade nas nossas relações com os outros.



Assim, pensando nos desafios do vosso trabalho diário na Casa, peço-vos que escrevam uma frase de apoio ou um voto para o colega que está ao vosso lado direito. Algo simples, não é necessário ser algo muito pessoal. O objetivo é que todos/as vós possam desejar algo ou expressar apoio a um/uma colega e receber também uma frase com essa intenção. Depois de redigirem a vossa frase, entreguem a mesma ao/á vosso/a colega para que ele/ela a possa ler e guardar.

Sugestão de questões para explorar o exercício:

- *Como se sentiram ao ler as frases?*
- *Ler essa frase alterou de alguma forma as vossas emoções neste momento?*
- *Que sensações surgiram no vosso corpo ao lerem a frase?*
- *O que vos apeteceu fazer?*
- *Como é que se sentiram ao ouvir o/a colega a falar sobre o modo de como as palavras que vocês lhe dirigiram o/a fez sentir? Que impacto isso teve em vocês?*

O funcionamento de uma equipa com uma mentalidade afiliativa é como o voo dos bandos de aves migratórias, como os gansos, cisnes ou flamingos (voo em forma de V). Esta forma de voo organizada e coesa ajuda as aves do bando a conservarem energia, o que aumenta a resistência do bando para fazer viagens mais longas e difíceis. Para além disso, a ave que vai à frente, quando se sente cansada, é substituída. As aves que vão atrás grasnam para encorajar as aves que vão à frente. Quando uma ave adoece ou fica ferida, e por isso tem de abandonar o grupo, outros elementos da formação acompanham-na para a ajudar e proteger. Apoio e encorajamento dos colegas é fundamental face às dificuldades.

A compaixão está enraizada nesta mentalidade afiliativa, que assenta na criação de uma base segura e investimento nos outros, a fim de promover o seu bem-estar e desenvolvimento. Na próxima sessão vamos aterrar na Compaixão.

Check-out

7 Resumo da sessão e aplicação prática

O/a dinamizador/a convida o grupo a refletir sobre as aprendizagens fundamentais da sessão e a realizar uma síntese da mesma, aplicando ou relacionando essas aprendizagens a três níveis: relativamente ao próprio, aos jovens e ao contexto da casa de acolhimento. Para o efeito, cada participante deve redigir no seu diário de bordo uma reflexão ou aplicação prática das aprendizagens da sessão para cada nível. De seguida, realiza-se uma partilha grupal. Um/uma participante deve registar as principais conclusões do grupo no Muro da Compaixão.

Para iniciarmos o check-out da nossa viagem de hoje, vamos verificar que souvenirs levamos na nossa bagagem/mala de mão compassiva. Vamos tentar perceber que utilidade as aprendizagens desta sessão podem ter nas nossas vidas, no nosso trabalho, nos jovens e em/na relação aos nossos/nossas jovens.

Aprendizagem fundamental das Sessão 6:

- **Reconhecer a importância do sistema de tranquilidade na regulação dos sistemas de afeto**

- *O que acharam mais interessante?*
- *Reconheceram a função do sistema de tranquilidade?*
- *Qual o impacto que o desenvolvimento de uma mentalidade afiliativa poderia ter no ambiente de uma casa de acolhimento residencial?*

Peço-vos que desenhem no vosso diário de bordo o seguinte triângulo. Procurem refletir como as aprendizagens de hoje podem ser aplicadas relativamente a cada um dos elementos do triângulo.

Eu

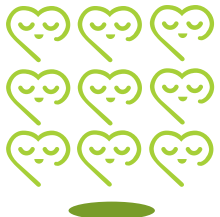
O que vos poderá ser útil?

Jovem

O que gostariam de ensinar aos jovens?

Casa de acolhimento

- *Como podemos aplicar estas aprendizagens na nossa vida? Em termos pessoais e profissionais? E relativamente aos jovens? O que gostariam de lhes ensinar?*



- *Que conclusão ou conclusões da sessão de hoje podemos registar no nosso Muro da Compaixão? Quem se voluntaria para colocar o tijolo de hoje no nosso Muro da Compaixão?*

Tópicos gerais para a síntese:

- A vinculação é fundamental para a maturação do cérebro, bem-estar e regulação emocional.
- A ativação do sistema de tranquilidade está associada a um estilo de vinculação segura e a sentimentos de segurança. Este sistema promove regulação emocional e capacidade para lidar de forma adaptativa com o meio à nossa volta.
- O sistema de tranquilidade é ativado por sinais verbais e não verbais de afiliação (e.g., revelar interesse, bondade, cuidado) e está associado a sentimentos de calor, segurança, ligação aos outros e bem-estar.
- Tem um papel importante na regulação do sistema de defesa- ameaça o do sistema de procura, ajudando-nos a restabelecer o equilíbrio emocional.
- Contudo, por vezes este sistema encontra-se menos desenvolvido, sendo necessário estimulá-lo (e.g., através de exercícios de respiração e de imaginação).
- Devido ao contexto hóstil onde cresceram, grande parte dos jovens em acolhimento pode não ter tido oportunidade de vivenciar de forma consistente experiências afiliativas de cuidado e segurança com pessoas significativas. Deste modo, a ativação do seu sistema de tranquilidade pode encontrar-se comprometida.

Exemplos de aplicação das aprendizagens ao contexto do Acolhimento:

- Uma intervenção com a finalidade de proteção e promoção requer a efetiva proteção do perigo, e igualmente, a possibilidade de os jovens residirem num ambiente promotor de segurança, onde possam crescer e regular as suas emoções, com figuras responsivas que atendam às suas de afeto, calor e segurança.

- A atuação dos cuidadores da Casa de Acolhimento deverá ajudar os jovens a restabelecer o equilíbrio dos seus sistemas de regulação de afeto. A prestação de cuidados deve centrar-se na promoção de experiências de calor e segurança que permita ao jovem sentir-se seguro, numa postura não defensiva, mas de abertura, curiosidade e exploração.
- É importante criarmos um ambiente seguro na equipa.
- O desenvolvimento de uma mentalidade afiliativa na Casa de Acolhimento é importante para que os jovens possam se sentir seguros e florescer.

Postal Souvenir

8 Desafio semanal para a prática compassiva

Fotografia gentilmente cedida por João Boavida.

O/a dinamizador/a relembra a importância de realizar uma prática regular e consistente e lança o desafio semanal para a prática compassiva (tarefa de transferência da aprendizagem da sessão). É entregue a cada participante o postal souvenir da presente sessão, com a descrição da tarefa a realizar entre as sessões (Postal da Austrália – Anexo).

O treino da mente, como todos os treinos, implica uma prática regular e continuada. Por isso, ao longo da semana relembro a importância de escolherem uma hora e local para treinarem a vossa mente. Podem utilizar os áudios dos exercícios que realizamos na sessão de hoje. O souvenir desta sessão é um postal da Austrália, de onde são nativos os Coalas, um bom exemplo de um mamífero que cuida das suas crias para que as mesmas possam desenvolver-se e sobreviver enquanto são incapazes de o fazer sozinhas.

Ao longo desta semana, convido-vos a reforçar a vossa ligação aos outros, de forma a fortalecer o Sistema de Tranquilidade, o vosso e o dos outros.

Tarefa de Transferência da Aprendizagem:

Expressar tranquilidade

Na vossa interação com as outras pessoas (por exemplo com os jovens ou colegas) prestem atenção ao vosso tom de voz, à vossa expressão facial e postura corporal, tentando ajustar os mesmos de acordo com o funcionamento do sistema de tranquilidade.

Para isso podem também praticar os exercícios do sorriso compassivo, lugar seguro e respiração tranquila que realizámos na sessão de hoje.

9 Avaliação da sessão e escuta de música compassiva

O/a dinamizador/a distribui a ficha de avaliação da sessão (Formulário de check-out – Anexo) a cada participante e relembra o processo de preenchimento da mesma. Para assegurar o anonimato, cada participante deve colocar o código pessoal que se encontra no seu cartão de embarque.

Durante o preenchimento do formulário de check-out, é colocada a música compassiva partilhada por um dos/as participantes. Se assim o desejar, o/a participante pode partilhar com o grupo o motivo da escolha da sua música compassiva. O/a dinamizador/a deve agradecer pela partilha efetuada.

10 Descolagem da sessão

Respiração tranquila (Adaptado de Gilbert, 2010 – Soothing breathing rhythm)

Antes de irmos embora, vamos realizar um exercício de respiração, que nos pode ajudar a equilibrar os nossos sistemas e a fortalecer o sistema de tranquilidade. Se reparem, quando estamos em modo de ameaça, a nossa respiração torna-se mais superficial e rápida. Ao diminuirmos o ritmo da nossa respiração, isso pode-nos ajudar a ficarmos mais calmos/as e tranquilos/as. Assim, aprender a abrandar o ritmo da nossa respiração é um passo importante no treino da nossa mente. O exercício "Respiração tranquila" pode ajudar-nos a acalmar, quando sentimos stress, ansiedade ou raiva.

I. *Encontrem uma posição confortável na vossa cadeira, mantenham as costas direitas e o peito aberto. A vossa cabeça e pescoço devem estar alinhados com a vossa coluna… Permitam que os vossos ombros descaiam e que as vossas mãos descansem sobre o vosso colo. Sintam os vossos pés bem assentes no chão… Podem escolher fechar os vossos olhos ou fixá-los num ponto do chão à vossa frente.*

II. *Agora, foquem a vossa atenção na respiração. Façam algumas respirações mais profundas e lentas… À medida que respiram, notem o ar a entrar pelo nariz… a encher os vossos pulmões… a descer até à barriga, a permanecer aí por um instante, e depois a percorrer o caminho inverso até sair pela boca… Levem o tempo que precisarem… Inspirem lentamente, contando até 3… Mantenham o ar dentro de vocês, contando até 3… e expirem, contando até 3… aguardem 3 tempos e respirem novamente… vamos respirar ligeiramente mais devagar e mais profundamente do que o habitual… Foquem a vossa atenção na sensação de abrandamento do vosso corpo e da vossa mente… notem como é sentir essa sensação… do corpo a abrandar e da mente a abrandar… Notem a vossa respiração e descubram o ritmo que for mais confortável e tranquilizador para vocês… a ideia é focarem-se na sensação de abrandar e acalmar…*

III. *É como se entrassem no ritmo calmo do vosso corpo… Notem a respiração a descer em direção à vossa barriga… Reparem como a vossa barriga se move suavemente à medida que respiram… E depois notem o ar a mover-se em direção à vossa boca para sair… À medida que encontram o vosso ritmo, notem e foquem-se na sensação de abrandamento interior com cada expiração. Notem como o vosso corpo responde à respiração, com este ritmo que o acalma e apazigua.*

IV. *Quando notarem que a vossa mente está a vaguear, tragam-na gentilmente de volta para a respiração… Para se concentrarem, tentem inspirar pelo nariz e expirar pela boca… é diferente da forma como normalmente respiramos… Quando expirarem, façam-no lenta e suavemente, como um balão que se esvazia aos poucos e poucos... Foquem-se particularmente na expiração e no ar a sair pela vossa boca, com um ritmo estável.*

V. *Para terminar este exercício, felicitem-se por terem realizado esta prática, que contribuiu para o treino da vossa mente. Quando se sentirem prontos e prontas, podem abrir os vossos olhos e concluir este exercício.*

Obrigada pela vossa presença e pelas partilhas efetuadas. Que possam ter uma boa semana!

ANEXO B

FICHAS DE AVALIAÇÃO DESENVOLVIDAS NO ÂMBITO DO PROGRAMA DE TREINO DA MENTE COMPASSIVA PARA CUIDADORES

Formulário de Check-in

Nº da sessão: ___________________ **Código pessoal:** _________________________

Por favor, responda às seguintes questões, assinalando com uma cruz (X) a sua resposta

	Nunca	Poucas vezes	Algumas vezes	Muitas vezes	Sempre
No seu dia a dia costuma recordar o que foi falado na sessão anterior?					
Aplicou na sua rotina pessoal as aprendizagens realizadas na última sessão?					
Aplicou na sua rotina profissional as aprendizagens realizadas na última sessão?					
Durante a semana teve oportunidade de realizar os exercícios práticos (áudios)?					
Durante a semana realizou a tarefa de aplicação prática?					
Sentiu que as suas novas práticas e aprendizagens tiveram impacto nas crianças e jovens?					

Espero que a viagem de hoje possa ser do seu agrado!

Sessão 6 Sistema de Tranquilidade "Verde Apaziguador"

Aprendizagem fundamental da sessão ✓ Reconhecer a importância do sistema de tranquilidade na regulação dos sistemas de afeto

Data:_______________________________ Código pessoal:_______________________

Por favor, pense na sessão de hoje e responda às seguintes questões. A sua opinião é muito importante. Obrigada.

Quanto se sente insatisfeito/a ou satisfeito/a com a sessão de hoje?

Em relação...	Muito Insatisfeito/a	Insatisfeito/a	Indiferente	Satisfeito/a	Muito Satisfeito/a
Ao tempo de duração da sessão					
Aos recursos usados na sessão					
Aos exercícios realizados					
À interação entre a dinamizadora e o grupo					
À participação do grupo na sessão					
À minha participação na sessão					
No geral, fiquei					

Qual o seu grau de desacordo ou acordo em relação a cada afirmação?

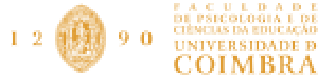
Nesta sessão...	Discordo Muito	Discordo	Não discordo, Nem concordo	Concordo	Concordo Muito
Fiz aprendizagens relevantes					
Compreendi o funcionamento e respostas do sistema de tranquilidade					
Compreendi a relação entre a vinculação e o sistema de tranquilidade					
Identifiquei estratégias de ativação do sistema de tranquilidade					
Desenvolvi a imagem do lugar seguro					
Reconheci a importância da mentalidade afiliativa no sistema de acolhimento					
Reconheci as necessidades de calor e segurança dos jovens					
O que falámos na sessão é aplicável no meu dia a dia pessoal					
O que falámos na sessão é aplicável à minha atividade profissional					
Durante a semana...					
Sinto-me capaz de aplicar o que aprendi na sessão					
Comprometo-me a realizar a prática semanal					
Comprometo-me a realizar a tarefa: Expressar tranquilidade					

Descreva qual/ais o/s aspeto/s que mais gostou nesta sessão.

Descreva qual/ais o/s aspeto/s que menos gostou nesta sessão.

Sugestões

Tenha uma boa semana!



Grelha de Observação

Sessão 6 Sistema de Tranquilidade "Verde Apaziguador"

Casa de Acolhimento: ____

Participante	Relaciona-se com o grupo	Colabora com o/a dinamizadora	Realiza os exercícios propostos	Participa na discussão dos exercícios/temas	Revela atingir os objetivos da sessão	Revela ter realizado a aprendizagem fundamental da sessão	Realizou a tarefa de TAF

Legenda: TAF – tarefa de transferência da aprendizagem fundamental

Escala de avaliação:
1 - Nada/Não revela
2 = Muito pouco/Revela muito pouco, abaixo do mínimo necessário
3 = Algum/Revela o mínimo necessário
4= Muito/Revela substancialmente
5= Totalmente/Revela totalmente

Comentários/Observações:

Aprendizagem Fundamental da sessão:

Tarefa de Transferência da Aprendizagem Fundamental:

Avaliação da sessão pelo dinamizador (Nível de concretização dos objetivos propostos):

O/A dinamizador/a: Data:

ANEXO C

MURO DA COMPAIXÃO

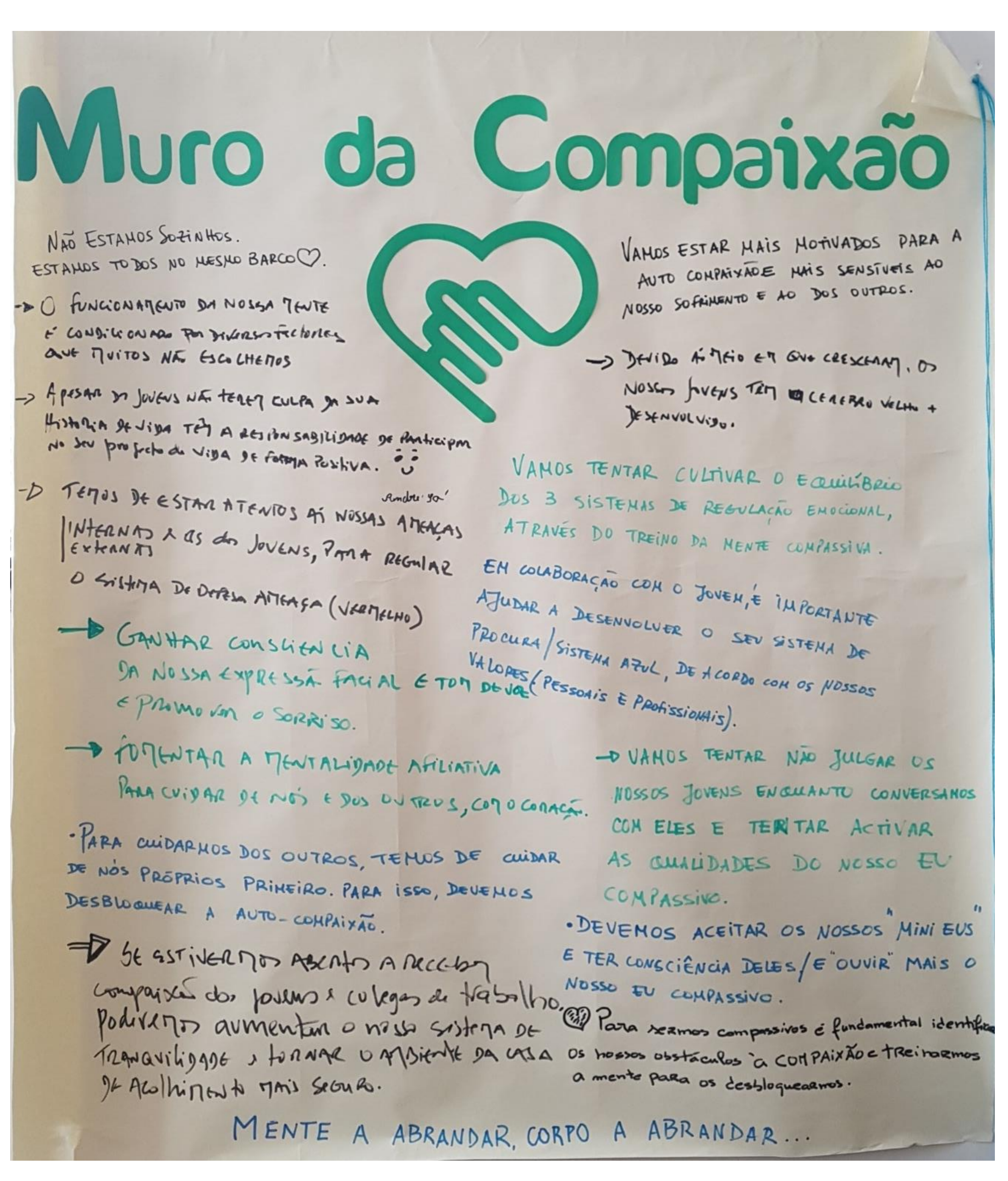


Figura 1. *Muro da Compaixão da CAR que participou no estudo de viabilidade*

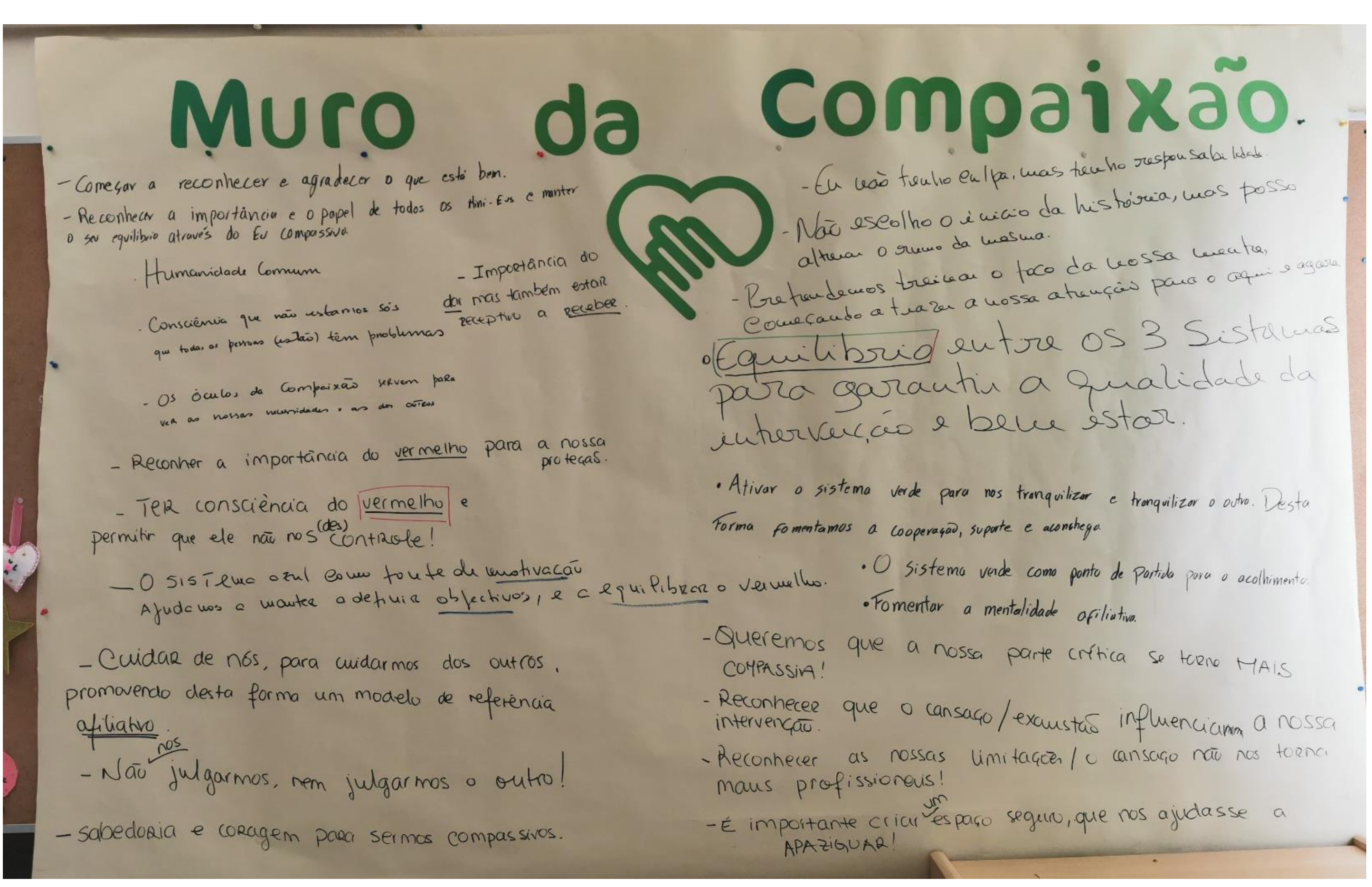


Figura 2. *Muro da Compaixão de uma CAR que participou no ensaio clínico*

Figura 3. *Muro da Compaixão de uma CAR que participou no ensaio clínico*

ANEXO D | ESTUDO EMPÍRICO

DIMENSIONALITY AND MEASUREMENT INVARIANCE OF THE SOCIAL SAFENESS AND PLEASURE SCALE IN ADOLESCENTS FROM COMMUNITY AND RESIDENTIAL YOUTH CARE

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Dimensionality and measurement invariance of the Social Safeness and Pleasure Scale in adolescents from community and residential youth care

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Abstract

Objective: Social safeness has been proposed as the individual's perception of the social world as being warmth and soothing. The lack of social safeness has been suggested as a transdiagnostic socio-emotional vulnerability for several mental health difficulties. To date there was no study addressing experiences of social safeness in adolescents. This study aims to validate and study the psychometric properties of the Social Safeness and Pleasure Scale to Portuguese adolescents from community and residential care homes.

Method: A total of 731 Portuguese adolescents from community and residential youth care homes participated on this study. The community sample was composed of adolescents recruited from regular schools (208 boys; 224 girls). The residential youth care sample was composed of adolescents placed in residential care homes (145 boys; 154 girls). A confirmatory factor analysis was conducted, and measurement invariance investigated.

Results: A one-factor solution presented a good fit across all samples and proved to be invariant (configural, metric, scalar and strict measurement invariance). Moreover, internal consistency values were excellent for all samples ($\alpha > .93$) and evidence for construct validity in relation to external variables was found. Means comparisons revealed significant differences between all tested groups. Community adolescents reported higher social safeness in comparison to the adolescents placed in residential care. Within both samples, boys scored higher in the SSPS-A when compared to girls.

Conclusions: These findings provide evidence on the SSPS-A validity and its use across diverse adolescent samples.

Keywords: adolescents; measurement invariance; positive affect; residential youth care; social safeness.

Introduction

The way people establish close relationships is a key interpersonal process linked to psychological adjustment across life span (Gilbert, 2009; Krebs, 2015). For this reason, Gilbert and colleagues (2009) developed a scale assessing how people report positive/pleasurable feelings in social situations, such as warmth, acceptance and connectedness with others. However, to date, no such scale is adapted to adolescence. Then, this work aims to adapt Social Safeness and Pleasure Scale for adolescents (SSPS-A) resorting two Portuguese samples – adolescents from community and residential youth care homes.

The evolution of group living, and conspecific cooperation has been one of the major questions addressed by evolutionary psychology (Buss, 2015; Krebs, 2015). The advantages of living together in groups include protection, resource sharing, and opportunities for breeding. Considering these biosocial advantages, all group living animals need to solve the challenges of living in close proximity to each other. These include how and who to compete appropriately with (Gilbert, 2004; Buss, 2015), how and with whom to invest and share (Krebs, 2015) and how to stay close enough to each other to operate as a group (Gilbert, 2004, Buss, 2015). This means that in certain social contexts individuals fight-flight systems are deactivated enabling conspecifics to "feel safe enough" so that they can relax (e.g., social play) (Gilbert, 2004). However, groups can also be defiant, rejecting or competitive of those whom they perceive as not fitting the group norm (Sznycer et al., 2018), leading to tension or defensive strategies that trigger disconnection, exclusion or submission. Experiencing disconnection, a sense of non-belonging, external shame and feeling unsafe in social groups is strongly linked to mental health problems (Cacioppo et al., 2014; Gilbert, 2009).

Considering the challenges associated to group living, humans prosper when successfully match the biosocial goals with the appropriate social strategies. Neuroscientific evidence underpins a multicomponent model of affect that can structure and coordinate our emotions, physiological correlates and behaviors. Three different types of affect have been proposed: negative affect relates to a neurohormonal response by sympathetic nervous system and hypothalamic pituitary adrenocortical axis (Mascaro & Raison, 2017), and two types of positive affect, one oriented to rewards and associated to dopaminergic correlates and another system focused in securing goals and endorphin-based states of contentment, connectedness and peaceful well-being (Depue & Morrone-Strupinsky, 2005). Social safeness is conceptualized as a by-product of this later positive affect system (Gilbert, 2015) and derives in part from attachment theory (Bowlby, 1973; Cassidy & Shaver 2016). Gilbert (2015) suggested that the mechanisms that evolved to facilitate close attachments and offer infants the experience of a

secure base, became recruited to form a more general affect system from which emerges a specific type of affect acknowledged as social safeness (e.g. feelings of safeness, warmth, contentment). Therefore, it is relevant to distinguish social safeness from other constructs also related to the need for connection, such as attachment itself and social support.

According to Bolby (1973) attachment theory is based on the premise that infants' early caregiving experiences build the foundation for internal working models, in other words, mental representations of self and others. Therefore, attachment style is grounded on a set of beliefs, rules, and expectations for interacting in close relationships (Gillath et al., 2009). By comparison, social safeness is exclusively focused on the mood that social connection generates (e.g., safe, secure, warm, content) without any cognitive framework that has been activated (Armstrong et al., 2021; Gilbert, 2010; Gilbert et al., 2009). Whereas attachment focus on relationships with attachment figures (e.g., parents, romantic partners, friends), social safeness is theorized to be sensitive to a variety of non-attachment sources, such as acquaintances and strangers alike (Armstrong et al., 2021; Gillath et al., 2009). Within the topic of attachment, it also seems relevant to briefly address the notion of felt security. Felt security has been conceptualized as the main goal of attachment behavioral system and also a mediator for adaptive behavior (Bolby, 1973; Sroufe & Waters, 1977). As social safeness is theorized in-the-moment affect (e.g., feeling of warm security) it might be conceptualized as the affective component of the felt security, extended beyond attachment contexts (Armstrong et al., 2021). In what concerns social support, it has been defined as the perception or beliefs about the extent to which others are reliable and/or available to provide assistance or emotional support (Armstrong et al., 2021; Cohen & Wills, 1985). Thus, social support is mostly perceived as a cognitive construct whereas social safeness is more affective in nature (Kelly et al., 2012).

To evaluate the extent to which individuals report positive/pleasurable feelings in social situations, such as feelings of warmth, acceptance and connectedness with others, Gilbert and colleagues (2009) developed the Social Safeness and Pleasure Scale. A single factor structure for this scale was reported in the original study (Gilbert et al., 2009). Regarding the internal consistency of the scale, previous studies reported excellent Chronbach's alpha, ranging from 0.91 (Gilbert et al., 2009) to 0.96 (Kelly & Dupasquier, 2016). Gender comparisons were conducted only by Kelly and colleagues (2012), with adult women reporting higher social safeness than men.

Research has been suggesting that social safeness plays an important role on mental health. On the one hand, positive associations were found between social safeness and self-esteem (Kelly et al., 2012), secure attachment (Kelly et al., 2012), life satisfaction (Satici et al.,

2016), as well as physical and psychological wellbeing (Marta-Simões, et al., 2022). On the other hand, social safeness revealed to be negatively associated with insecure attachment (Kelly et al., 2012), avoidant, paranoid, and borderline personality traits (Kelly et al., 2012), depressive (Kelly et al., 2012; Matos et al., 2015; Alavi et al., 2017) and anxiety symptoms (Gilbert et al., 2009), and also with eating disorder symptoms (Ferreira et al., 2018). In addition, its transdiagnostic relevance could be inferred through the role social safeness has revealed in mediating the relationship between early emotional trauma and depressive symptoms (Matos et al., 2015).

Previous literature also demonstrated that lower levels of social safeness were associated with an increased experience of shame (Gilbert, 2009), self-criticism (Kelly el al., 2012) and lower levels of self-compassion (Akin & Akin, 2015; Kelly et al., 2016).

First, shame can be defined as a painful self-conscious emotion, usually triggered in social contexts when someone is aware they are being seen negatively by others. It evokes a cognitive component of being different, unattractive, or inadequate and a behavioral component that includes the desire to hide, avoid eye contact, or engage in submissive behavior (Gilbert, 2007; Sedighimornanii, 2018). Interpersonal consequences of shame have been consistently demonstrated. Previous studies showed that shame is associated with the tendency to socially withdraw, to hide and to inhibit social interactions (Haidt, 2003; Wilson et al., 2006). Also, individuals with higher levels of shame are likely to feel more socially anxious and less safe when interacting with others (Gilbert, 2010).

Second, self-criticism involves feelings of inferiority, diminished self-worth and self-condemnation (Gilbert et al., 2004). Previous studies have found a negative association between social safeness and self-criticism (Gilbert et al., 2008; Kelly et al., 2012). Self-criticism was also found to predict a decrease in positive affect and low willingness to interact (Bareket-Bojmel et al., 2011) and a lower sense of social connectedness with others (Rice et al., 2006). Poorer interpersonal outcomes are associated with lower social safeness, including being colder and more distant towards others (Deng et al., 2019), withhold self-disclosure (Bareket-Bojmel & Shahar, 2011), and avoiding seeking social support (Richardson & Rice, 2015).

Finally, social safeness has also been linked to higher levels of self-compassion (Akin & Akin, 2015; Kelly & Dupasquier, 2016). Self-compassion involves being kind, caring and understanding towards oneself when experiencing feelings of suffering (Neff, 2003). Previous studies demonstrated interpersonal consequences associated with self-compassion. It has been theorized that self-compassion helps to reduce the sense of threat and distress, facilitating feelings of connectedness and warmth that characterize social safeness (Gilbert et al., 2009; Kelly et al., 2016). Also, self-compassion fosters interpersonal trust (Crocker & Canevello, 2008),

facilitates compromising solutions when interpersonal conflicts arise (Yarnell & Neff, 2013), and it relates with more pleasurable emotions of safeness in social situations (Carvalho et al., 2019).

Forming and maintaining healthy social relationships with others (i.e., romantic and friendships) is one of the most relevant developmental tasks to be accomplished during adolescence (Nelson et al., 2005; Steinberg, 2010). Particularly, research findings have consistently indicated that poor quality relationships, which means the sense of disconnection and the struggle to feel safe and soothed with/by others, is associated to negative mental health outcomes in adolescents (Boele et al., 2019; Rapee et al. 2019; Wang et al., 2018). Considering the relevance of assessing social safeness during adolescence, the present study aimed to investigate the psychometric properties of the Social Safeness and Pleasure Scale in adolescents. This work also explores social safeness across two samples, i.e., adolescents from community and residential care settings. Previous research stated that early experiences of warmth and nurturance may shape the experience of felling connected, safe, and reassured in later social relationships (Gilbert et al., 2009). Residential care placements commonly occurs after history of maltreatment (e.g., neglect or abuse) (Indias et al., 2019) and adolescents placed in residential youth care homes report fewer current experiences of warmth and safeness (Santos et al., 2021). Thus, feelings of connectedness, reassurance and safeness with others may be impaired. In addition to being protected from threat (removed from dangerous and toxic environments), adolescents in residential care need to feel safe and secure, in order to heal and thrive. Therefore, a psychometric valid measure to assess social safeness during adolescence and in this specific population will be useful both for research as well as for practical purposes.

This study's main goal is to adapt and validate the Social Safeness and Pleasure Scale to Portuguese adolescents, both from the community and from residential care settings. In accordance with the SSPS original measurement model (i.e., unidimensional measurement model) (Gilbert et al., 2009), a total score for the scale was expected to be confirmed. Measurement invariance was explored between the two samples (adolescents from the community and from residential care homes) and between gender within each sample. Lower social safeness is expected to be reported by adolescents placed in residential care settings, in comparison to normative peers. Finally, construct validity in relation to external variables was also investigated. Considering previous findings, positive associations between social safeness and self-compassion (Akin & Akin, 2015; Kelly et al., 2016) were expected to be found, as well as negative associations with both shame (Gilbert, 2009) and self-criticism (Kelly el al., 2012).

Method

Participants

To explore the dimensionality of the SSPS-A, a total sample of 731 Portuguese adolescents were recruited, with ages ranging from 14 to 18 years old (*M* = 15.60, *SD* = 1.26). The total sample was composed of 432 community adolescents and 299 adolescents recruited from residential care homes (RCH). For the complete sample, boys (*M* = 15.54, *SD* = 1.22) and girls (*M* = 15.66, *DP* = 1.29) had similar mean ages (t(729) = -1.267, *p* = .206), and were evenly distributed by socioeconomic status (SES; $\chi2(2)$ = 1.267, *p* = .531).

Within the community sample (208 boys and 224 girls), regarding age, no significant differences were found between boys (*M* = 15.33, *SD* = 1.17) and girls (*M* = 15.51, *SD* = 1.28; t(430) = -1.539, *p* = .125). Moreover, there were no gender differences regarding years of education (t(430) = -1.620, *p* = .106; for boys *M* = 9.72, *SD* = 1.08 and for girls *M* = 9.90, *SD* = 1.18) and SES distribution ($\chi2(2)$ = 2.371, *p* = .306).

The RCH sample was composed of 145 boys and 154 girls, and no gender differences were found for age (t(297) = -.200, *p* = .842; for boys *M* = 15.83, *SD* = 1.23 and for girls *M* = 15.86, *SD* = 1.29) and SES distribution ($\chi2(2)$ = .677, *p* = .713). Nonetheless, girls (*M* = 9.20, *SD* = 1.59) presented slightly more years of education than boys (*M* = 8.79, *SD*= 1.65; t (297) = -2.142, *p* = .033).

Adolescents from RCH (*M* = 15.85, *SD* = 1.26) were significantly older than the adolescents of the community sample (*M* = 15.43, *SD* =1.23; t(729) = -4.539, *p* < .001). Also, adolescents from RCHs had completed significantly less years of education (t(729) = 7.942, *p* < .001; for the community sample *M* = 9.81, *SD* = 1.13; for the RCH adolescents *M* = 9.00, *SD* = 1.63). Gender distribution was similar between the two samples ($\chi2(1)$ = .009, *p* = .926) although the RCH adolescents presented lower SES when compared to the community sample ($\chi2(2)$ = 36.06, *p* < .001).

To explore construct validity in relation to external variables, a subsample of the community sample (n = 227; 119 boys and 108 girls) also answered a set of self-report measures in addition to the SSPS-A (see measures section). The subsample had on average 15.86 (*SD* = 1.06) years old (for boys *M* = 15.80, *SD* = 1.04 and for girls *M* = 15.93, *SD* = 1.08), and no gender differences were found regarding age (t(225) = -.906, *p* = .366). Additionally, no gender differences were found for years of education (t(225) = -1.836, *p* = .068) or SES distribution ($\chi2(2)$ = 5.711, *p* = .058). Information concerning the demographic characteristics of the samples is presented in Table 1.

Table 1. *Demographic Characteristics' of the Samples and Subsample*

	Gender		Age		Socioeconomic status			School Years
	Male	Female	Male	Female	Low	Medium	High	
Complete sample	353 (48.3)	378 (51.7)	15.54 (1.22)	15.66 (1.29)	425 (58.1)	227 (31.1)	21 (2.9)	9.48 (1.42)
Community sample	208 (48.1)	224 (51.9)	15.33 (1.17)	15.51 (1.28)	233 (53.9)	178 (41.2)	15 (3.5)	9.81 (1.13)
RCH sample	145 (48.5)	154 (51.5)	15.83 (1.23)	15.86 (1.30)	192 (64.2)	49 (16.4)	6 (2.4)	9.00 (1.63)
Subsample	119 (52.4)	108 (47.6)	15.80 (1.04)	15.93 (1.08)	144 (63.4)	64 (28.2)	19 (8.4)	9.50 (1.01)

Note. Information for gender and socioeconomic status are presented as n (%); information for age is presented as M (SD). Socioeconomic status (SES) was measured by parents' professions, considering the Portuguese professions classification. Examples of professions in the high SES group are judges, higher education professors, or MDs; in the medium SES group are nurses, psychologists, or school teachers; and in the low SES group are cleaning staff or undifferentiated workers.

Procedures

Prior to data collection, this study was approved by a national ethics committee and all participants were informed of the study participation's voluntary nature.

Participants of the community sample were recruited from schools of the center region of mainland Portugal and four sports/recreational groups based on convenience. Both schools and institutional boards were asked to signal adolescents between 14 and 18 years old. Verbal consent was asked from participants and a written informed consent was also requested from parents/legal guardians. The participants' selection also obeyed the following exclusion criteria: 1) cognitive impairment, 2) use of medication for psychiatric symptoms/disorders; 3) being under psychiatric or psychotherapeutic intervention in the past two years. All community adolescents completed the Social Safeness and Pleasure Scale. Within the total community sample, 227 participants also answered the Self-Compassion Scale, the Other as Shamer Scale and the Forms of Self-Criticizing/Attacking & Self-Reassuring Scale. Data was collected during class time in the presence of the researcher. The order of presentation within the self-report protocol was counterbalanced to prevent sequential presentation interference in the results.

For the RCH sample, adolescents were recruited from 34 Portuguese residential care homes. Participants signaled by RCHs' professionals as presenting cognitive impairment were excluded. Eligible participants, aged between 14 and 18 years old, were also explained the voluntary nature of their participation. Verbal informed consent was obtained. Additionally, informed consent was also obtained from the legal guardians. Data was collected in small groups in RCHs, also with the presence of the researcher.

Measures

***Social Safeness and Pleasure Scale* – Adolescent version (SSPS-A; Gilbert et al., 2009; Portuguese adolescent version by Castilho et al., 2015)**

The SSPS-A is a unidimensional self-report questionnaire, composed of 11-items. It assesses how people experience positive/pleasurable feelings in social situation, which is a way to evaluate how people subjectively interpret their social world as safe, soothing and warm (e.g., "I feel a sense of warmth in my relationships with people"). Participants rate each item using a five-point scale (1 = almost never to 5 = almost all the time); so, the total score of SSPS-A range from 11 to 55. In the original study, the SSPS achieved very good internal consistency (α = .91; Gilbert et al., 2009). The adolescent version was adapted from the adult Portuguese version, cultural issues, age appropriateness and semantic equivalence across languages was maintained by not altering the item's original content.

Other as Shamer Scale Brief (Goss et al., 1994; adolescent Portuguese version (OASB-A) by Cunha et al., 2017)

The OASB-A is an 8-item, self-report scale, that assess external shame, i.e., the subject's perception of being negatively judged by others (e.g., "I think that other people look down on me"). Participants rate each item on a five-point scale (0 = never to 4 = always). In the Portuguese version for adolescents, the internal consistency value was .92 (Cunha et al., 2017). Good internal consistency values were also found in a sample of male young offenders placed in juvenile detention facilities (α = .89; Vagos et al., 2016). In the present study, the internal consistency value for the scale in the community sample was .92.

The Forms of Self-Criticizing/Attacking & Self-Reassuring Scale (FSCRS; Gilbert et al., 2004; Portuguese version by Castilho et al., 2013)

The FSCRS is a 22-item self-report questionnaire that assesses self-reassurance (e.g., "I am able to care and look after myself") and two forms of self-criticism: inadequate self, which focuses on a sense of personal inadequacy (e.g., "I am easily disappointed with myself") and hated self, which assesses the desire to hurt or persecute the self (e.g., "I have become so angry

with myself that I want to hurt or injury myself"). Items are answered using a five-point scale (0 = not at all like me to 4 = extremely like me). The scale original version showed Cronbach alphas of .90 for inadequate self and .86 for hated self and self-reassurance (Gilbert et al., 2004). In the Portuguese version, internal consistency was .89, .72 and .87 for the nonclinical sample and .91, .82 and .81 for the clinical sample, for inadequate self, hated self and reassured self, respectively (Castilho et al., 2013). In the present study, for the community sample, internal consistency values were .88 for the inadequate self and self-reassurance and .79 for the hated self.

Self-Compassion Scale – Adolescent version (SCS-A; Neff, 2003; Portuguese adolescent version by Cunha et al., 2015)

The SCS-A is a self-report measure composed by 26 items that assesses self-compassion. The scale has a total score that represents self-compassion, and six subscales (Self-Kindness; Self-Judgment; Common Humanity; Isolation; Mindfulness; Over-Identification), and its items are rated using a five-point scale (1 = almost never to 5 = almost always). In the original version (Neff, 2003) the total score showed very good internal consistency ($\alpha = .92$) and the six subscales ranged from .75 to .81. In the Portuguese adolescent version, the total score had an internal consistency of .88 and the six subscales ranged from .70 to .79 (Cunha et al., 2015). In the present study, for the community sample, the total score of the scale achieved very good internal consistency ($\alpha = .91$) with the six subscales ranging from .70 to .81.

Data analysis

For the Confirmatory Factor Analyses (CFA) procedures, Mplus v7.4 (Muthén & Muthén, 2015) software was used. First, data normality was tested, showing a non-normal distribution for the total sample (K-S = .090, $p < .001$), for the community sample (K-S = .096, $p < .001$) and for the residential youth care sample (K-S = .079, $p < .001$). Therefore, the Maximum Likelihood Robust estimator (MLR) was used for the CFA procedures. Hu and Bentler (1999) guidelines were followed to assess the CFA model fit indices: the comparative fit index (CFI; ≥.95 for good, ≥.90 for acceptable), the Tucker-Lewis index (TLI; ≥.95 for good, ≥.90 for acceptable), the root mean square error of approximation (RMSEA; ≤.06 for good, ≤.08 for acceptable) with its 90% confidence interval (CI) and the Standardized Root Mean Square Residual (SRMR) ≤ .09. Moreover, the quality of the items was analyzed through their loadings. Following Hair and colleagues (2009) guidelines, loading values should be equal or higher than 0.50.

To reliably perform mean comparisons between groups, the best fitting model of the SSPS-A across samples was tested for both gender and group (community sample vs residential youth care sample) invariance. Therefore, configural invariance (meaning that the same

measurement model fits for all groups), metric invariance (adds the constraint that the factor loadings must be similar across groups), scalar invariance (adds to the previous constraint the new one of similar intercepts across groups) and strict invariance (adds the constraint of similarity of items' uniqueness across groups) were sequentially tested in all samples. Following Chen's (2007) guidelines, when assessing quality of model fit indexes across increasingly constrained models, $\Delta CFI \leq -.01$ combined with either $\Delta RMSEA \leq .015$ or $\Delta SRMR \leq .03$ should be observed.

The IBM SPSS Statistics 22 software was used for internal consistency computation and for the analyses of construct validity, using the Spearman product-moment correlation coefficient. Mean comparison between groups were also explored using the Mann-Whitney test, considering the non-normal distribution of the data, and effect sizes were calculated using the *r* statistic, dividing z scores by the root of N ($r = Z / \sqrt{N}$).

Results

Evidence based on internal structure

The original study assessing the factorial structure of Social Safeness and Pleasure Scale (Gilbert et al., 2009) proposed a higher-order factor referring to the scale total score (the scale's eleven items converged into a single higher order factor representing social safeness). This original measurement model was tested across all samples and acceptable to good model fit indices were found, showing a well-defined measurement model in the total, community, and residential youth care samples (see Table 2).

The items' loading values for all samples are displayed in Table 3. Across all samples, loading values showed to be above the reference value (.50) and were considered good representations of the construct they were supposed to measure. Additionally, internal consistency values were excellent across all samples, demonstrating that items are working in concert to assess the construct under study.

Table 2. *Fit indicators for CFA analyses and Configural Invariance Analyses of the Social Safeness and Pleasure Scale in both the community and forensic samples*

	χ2	df	RMSEA	90% CI for RMSEA	CFI	TLI	SRMR
Complete sample	173.097	44	.063	0.054;0.073	.960	.951	.029
Male participants	121.406	44	.071	0.056;0.086	.946	.932	.038
Female participants	96.891	44	.056	0.041;0.072	.972	.965	.028
Community sample	160.817	44	.078	0.066;0.092	.944	.930	.034
Male participants	114.869	44	.088	0.068;0.108	.928	.910	.041
Female participants	103.152	44	.077	0.058;0.097	.949	.936	.038
RCH sample	89.684	44	.059	0.041;0.076	.968	.960	.031
Male participants	71.731	44	.066	0.036;0.093	.954	.943	.045
Female participants	58.805	44	.047	0.000;0.076	.983	.979	.029

Note. χ2 values were always significant at $p < .01$, df: degrees of freedom for Chi-Square, RMSEA: root mean square error of approximation, CI for RMSEA: confidence interval for RMSEA, CFI: comparative fit index, TLI: Tucker-Lewis index, SRMR: standardized root mean square residual.

Table 3. *Loading and Internal Consistency Values for the SSPS-A (for the complete sample; for the total community sample, and community sample by gender; for the total RCH sample, and RCH sample by gender)*

	Complete sample			Community sample			RCH sample		
	Total	Male	Female	Total	Male	Female	Total	Male	Female
SSPS-A	α = .94	α = .93	α = .95	α = .94	α = .93	α = .94	α = .94	α = .93	α = .95
1 I feel content within my relationships	.69	.67	.69	.68	.68	.66	.70	.65	.72
2 I feel easily soothed by those around me	.73	.69	.75	.73	.73	.72	.71	.64	.78
3 I feel connected to others	.82	.80	.82	.80	.79	.79	.83	.80	.84
4 I feel part of something greater than myself	.64	.60	.66	.60	.59	.59	.67	.60	.72
5 I have a sense of being cared about in the world	.81	.78	.83	.80	.82	.79	.80	.73	.86
6 I feel secure and wanted	.86	.84	.87	.84	.83	.86	.87	.85	.87
7 I feel a sense of belonging	.82	.81	.82	.82	.82	.82	.81	.79	.82
8 I feel accepted by people	.84	.84	.83	.84	.85	.83	.84	.83	.84
9 I feel understood by people	.81	.78	.83	.81	.77	.82	.81	.79	.84
10 I feel a sense of warmth in my relationships with people	.75	.72	.77	.76	.71	.79	.74	.72	.75
11 I find it easy to feel calmed by people close to me	.71	.70	.72	.75	.74	.74	.67	.64	.69

Note. All loading values were significant at $p < .001$. The items are presented in its original versions (Gilbert et al., 2009); for complete versions of the items in their Portuguese adolescent version please contact the corresponding author.

Measurement invariance

As regards measurement invariance between the community and residential youth care samples, the same measurement model fitted the two samples (see Table 2), demonstrating configural invariance. Thus, metric, scalar and strict measurement invariance were tested. Findings showed metric (ΔRMSEA = -.003; ΔCFI = -.001; ΔSRMR = .007), scalar (ΔRMSEA = -.001; ΔCFI = -.003; ΔSRMR = .003) and strict (ΔRMSEA = .004; ΔCFI = -.010; ΔSRMR = .020) invariance between these samples.

Next, since configural invariance was already achieved in all samples (see Table 2), between gender measurement invariance was also tested in the complete sample, in the community sample and in the residential youth care sample. For all samples, metric (ΔRMSEA = -.003, ΔCFI = .000, ΔSRMR = .006 for the complete sample; ΔRMSEA = -.004, ΔCFI = .000, ΔSRMR = .014 for the community sample; ΔRMSEA = -.003, ΔCFI = -.000, ΔSRMR = .012 for the residential youth care sample), scalar (ΔRMSEA = -.002, ΔCFI = -.002, ΔSRMR = .003 for the complete sample; ΔRMSEA = -.003, ΔCFI = -.002, ΔSRMR = .003 for the community sample; ΔRMSEA = -.003, ΔCFI = -.000, ΔSRMR = .000 for the residential youth care sample) and strict (ΔRMSEA = -.003, ΔCFI = .001, ΔSRMR = .013 for the complete sample; ΔRMSEA = -.005, ΔCFI = .002, ΔSRMR = .022 for the community sample; ΔRMSEA = -.001, ΔCFI = -.001, ΔSRMR = .014 for the residential youth care sample) measurement invariance were found.

Finally, measurement invariance between the community and residential youth care sample was investigated, for each gender individually (i.e., community male adolescents vs residential youth care male adolescents; community female adolescents vs residential youth care female adolescents). Configural invariance was already established across these samples (see Table 2), thus allowing metric, scalar and strict measurement invariance testing. Evidence for metric (ΔRMSEA = -.004, ΔCFI = -.001, ΔSRMR = .007 for boys; ΔRMSEA = -.003, ΔCFI = -.001, ΔSRMR = .016 for girls), scalar (ΔRMSEA = -.002, ΔCFI = -.003, ΔSRMR = .001 for boys; ΔRMSEA = -.001, ΔCFI = -.002, ΔSRMR = .003 for girls) and strict (ΔRMSEA = .002, ΔCFI = -.009, ΔSRMR = .021 for boys; ΔRMSEA = .002, ΔCFI = -.006, ΔSRMR = .018 for girls) invariance were also found.

Measurement invariance analyses procedures revealed that the same measurement model fitted all samples. Additionally, these analyses revealed the similarity of the items' loadings, intercepts and uniqueness across all samples. Thus, the SSPS-A proved to be invariant and reliable mean comparisons were further conducted between samples.

Mean comparisons in the Social Safeness and Pleasure Scale

When comparing the community and the adolescents at RCH, significant differences were found and results showed that adolescents from the community scored higher in the SSPS-

A, when compared to the residential youth care sample ($z = -3.726$, $p < .001$, $r = .14$), with a small effect size.

Gender differences were also explored in the complete sample, in the community sample and in the residential youth care sample. Across all these samples, male adolescents scored higher in feelings of social safeness when compared to female adolescents: $z = -4.452$, $p < .001$, $r = .17$ for the complete sample; $z = -4.186$, $p < .001$, $r = .20$ for the community sample; $z = -2.229$, $p = .026$, $r = .13$; all comparisons with small effect sizes.

Finally, comparisons between community and residential youth care adolescents were performed for males and females separately. As regards to males, boys from the community sample scored higher in the SSPS-A, when compared to males from the residential youth care sample ($z = -3.173$, $p = .002$, $r = .17$), with a small effect size. Regarding females, girls from the community sample also scored higher when compared to girls from the residential youth care sample ($z = -2.309$, $p = .021$, $r = .12$), with a small effect size. All mean scores, by sample, are presented in table 4.

Table 4. *Means and standard deviations for the SSPS-A by samples*

	M	SD
Complete sample	3.73	.83
Male participants	3.87	.78
Female participants	3.60	.85
Community sample	3.84	.75
Male participants	3.99	.72
Female participants	3.70	.76
Residential youth care sample	3.57	.91
Male participants	3.70	.84
Female participants	3.45	.95

Note. M = mean. SD = standard deviation

Construct validity in relation to external variables

Significant associations were found between the SSPS-A and all tested external variables (see Table 5). The SSPS-A was negatively associated with external shame. Concerning self-criticism and self-reassurance, social safeness was negatively associated with the Inadequate and Hated forms of self-criticism and positively associated with self-reassuring.

Finally, social safeness showed to be associated with self-compassion. Positive associations were found between feelings of social safeness and the positive dimensions of self-compassion – Self-Kindness, Common Humanity and Mindfulness; and negative associations were found between the SSPS-A and the negative dimensions of the SCS-A – Self-judgment, Isolation, and Over Identification.

Table 5. *Correlation values between the Social Safeness and Pleasure Scale in the community sample and the OASB-A, FSCRS-A and SCS-A*

	OASB-A	FSCRS			SCS-A						
		Inadequate Self	Hated Self	Reassured Self	SCS-A Total	Self-Kindness	Common Humanity	Mindfulness	Self-judgment	Isolation	Over Identification
SSPS - A	- .632**	-.478**	-.421**	.628**	.508**	.402**	.261**	.347**	-.386**	-.467**	-.376**

Note. OASB-A: Other as Shamer Scale Brief – Adolescent version, FSCRS - A: The Forms of Self-Criticizing/Attacking & Self-Reassuring Scale, SCS-A: Self-Compassion Scale – Adolescent version.

** $p < 0.01$

Discussion

The Social Safeness and Pleasure Scale was developed to assess the individual's warmth, secure and reassuring affiliative experiences with others. To date, this construct had not been studied in adolescents, despite the relevance of quality relationships for psychological functioning within this specific developmental period (Boele et al., 2019; Rapee et al. 2019; Wang et al., 2018).

The present study aimed to investigate the SSPS adolescent (SSPS-A) version and its psychometric properties in a sample of community adolescents, as well as in a sample of adolescents placed in residential care homes. The one-factor solution model presented good fit indices and good internal consistency values across all samples. Measurement invariance was supported for SPSS-A. Hence the SPSS-A seems an appropriate measure validly representing the warmth and reassuring affective experience with significant others in community adolescents as well as in adolescents placed in residential youth care settings for both genders.

Results showed significant differences in self-reported feelings of social safeness between samples. As expected, adolescents placed in residential care homes, when compared to adolescents from the community, reported lower feelings of soothing, warmth and connection within their social network.

This finding is consistent with previous research. Care placement commonly occurs after severe direct and/or indirect forms of maltreatment in their household (Indias et al., 2019) compromising early experiences of nurturance and emotional warmth. Furthermore, residential care frequently represents the loss of attachment figures, repeated moving placements, a less home-like environment, less individualized caregiving and fewer current experiences of warmth and safeness (Li et al., 2017; Santos et al., 2021), endorsing a sense of disconnection and rejection from others and stimulating a threat-focus. When one's social world becomes unsafe, individuals are more prone to resort to defensive emotional and behavioral strategies, such as wanting to attack, hide, conceal or submit to others (Gilbert, 2009). Consequently, struggling to feel safe and soothed by others has been suggested as a transdiagnostic vulnerability (Gilbert et al., 2009).

Differences between gender were found in both samples, with boys (from the community and residential care homes) reporting higher frequency of social safeness feelings than girls. In existing research, only Kelly and colleagues (2012) tested for gender differences concerning social safeness, and findings showed that adult women reported higher levels of social safeness in comparison with men. The present study did not replicate the same finding. However, one study found that both girls from community and residential care facilities tend to perceive lower frequency of current caring experiences than boys (Santos et al., 2021). Hence, it is understandable that they might feel less social safeness as well. It has also been reported that girls tend to experience fewer closer relationships (Crosnoe et al., 2008) displaying more preoccupation over the quality of such friendships (Leadbeater et al., 1999). However, contradictory findings emphasize the importance of conducting future research on gender-differences relating the perception of social safeness across the lifespan.

As hypothesized by Gilbert (2015), reduced distress may be a by-product of social safeness. Then, not surprisingly, adolescents with greater levels of social safeness presented higher levels of self-compassion and self-reassurance, and lower levels of external shame and self-criticism. Besides the interpersonal aspect of social safeness, these associations support the value of a relevant intrapersonal aspect of feeling (or not) connected and cared by others, with a feasible impact on psychological adjustment. Indeed, these findings highlight the role of social safeness as a transdiagnostic vulnerability factor, which is in line with previous research (Gilbert et al., 2009).

The cross-sectional nature of this study does not allow for robust conclusions about the stability of participants' feelings of safeness in social relationships. Future research should explore the scale test-retest reliability. Once social safeness is developmentally based, future

research should also include longitudinal designs and implications across life span should be explored. Future research should also explore the SSPS-A in clinical research and practice, specifically with adolescents placed in residential care homes. Considering that out-of-home placement occurs after experiences of maltreatment (e.g., abuse or neglect), which may have consequences in establishing and maintaining healthy social relationships, it would be relevant to access the extent to which social safeness is responsive to intervention efforts.

Therefore, social safeness seems to be a relevant construct within such a vulnerable population as adolescents placed in residential care homes. First, SSPS-A allows to explore the social safeness construct itself but also to study possible associations with other important variables, especially to identify factors that might mitigate the perception of perceiving others as not trustworthy nor a source of warmth and reassurance. Second, SSPS-A also highlights the importance of delivering interventions targeting social safeness, in order to promote strategies able to derive more soothing and warmth from adolescents' significant relationships."

Finally, this research supports the use of SSPS-A in adolescents, providing the clinician and the researcher with an empirically validated measure to address social safeness in a developmental stage in which this construct seems to play a major role in behavior and emotion regulation.

Compliance with Ethical Standards

Ethical approval: All procedures performed in this study were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards.

Informed consent: Informed consent was obtained from all individual participants included in the study.

Conflicts of Interest: All authors declare having no conflict of interests.

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