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Comparing the Effectiveness of Well-Being Therapy and Positive Therapy on Affective Capital in Adolescents Residing in Foster Care Centers

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ABSTRACT

Objective: This study aimed to compare the effectiveness of well-being therapy and positive therapy on affective capital in adolescents aged 12 to 18 years residing in foster care centers in Isfahan Province.

Methods and Materials: The research employed a quasi-experimental design using a pretest-posttest format with a control group and a three-month follow-up. A total of 45 adolescent girls aged 12 to 18 years were randomly selected and assigned to two experimental groups and one control group (15 participants per group). The experimental groups underwent eight sessions of well-being therapy and positive therapy, respectively, while the control group received no intervention. All three groups were assessed using affective capital questionnaires before the intervention, immediately after, and three months post-intervention.

Findings: The results indicated that the mean affective capital significantly increased in both the well-being therapy and positive therapy groups during the post-test and follow-up phases compared to the pretest phase.

Conclusion: Based on the findings, it was concluded that well-being therapy and positive therapy are effective in enhancing the affective capital of adolescents residing in foster care centers, with a significant difference observed between the two interventions.

Keywords: *well-being therapy, positive therapy, affective capital, adolescents, foster care centers.*

1. Introduction

Adolescence is a transitional period between childhood and adulthood, during which individuals face challenges such as normative developmental tasks (e.g., identity formation, achieving independence from family while maintaining relationships, and peer group integration) as well as physical and cognitive changes associated with this transition (Shojeyan et al., 2024; Tarakçıoğlu, 2024). These challenges often initiate a crisis that can be either positive or negative. In this context, the role of the family, as the smallest social unit and the nucleus of larger societal

structures, is undeniable. Living in harmony with parents under one roof is a normal and expected condition for children and adolescents, fostering their growth and development (Khalid et al., 2024; Orri et al., 2024; Shabannezhad, 2024). Deviation from this norm, such as the deprivation of parental care and family life, and placement in residential care institutions, exposes children and adolescents to a range of issues, including low self-esteem, increased risks of physical and psychological harm, and disorders such as depression (Fayyaz & Kiani, 2011; Khalid et al., 2024). Research on life in residential care indicates that the primary source of harm is an unfavorable emotional environment, which ultimately leads to adverse cognitive, intellectual, emotional, and social development (Arshi et al., 2014).

Orphaned adolescents, in addition to facing the typical challenges of adolescence, contend with issues stemming from the absence of family, which exacerbate their difficulties compared to other adolescents. This has been linked to heightened stress levels, as highlighted in numerous studies. The high prevalence of psychological distress among orphaned children and adolescents is strongly associated with neglect in terms of physical and social needs (Hoksbergen et al., 2003). While family remains the optimal environment for child development, residential care centers, despite significant investments in resources, have demonstrated weaker performance in comparison (Salehi et al., 2020). Identifying effective coping strategies to address these challenges is critical for fulfilling the emotional needs of adolescents and aiding their cognitive and psychological development (Rasouli & Yaghmai, 2008). Teaching constructive skills helps adolescents make better decisions when faced with various situations during adolescence and adulthood (Chamzadeh Ghanavati et al., 2015).

In this context, the concept of affective capital emerges as significant. Affective capital can be defined as a state of vitality and positive emotional energy that can be directed and transformed. Purposeful focus on this capital has a relatively lasting impact on behaviors and decisions. It encompasses three components: quasi-state positive emotions, feelings of energy, and happiness. At different moments in life, individuals may experience varying levels of energy, happiness, and positive emotions. When individuals feel high levels of vitality, they can channel this emotional energy towards enhancing their cognitive and behavioral capacities, improving their ability to cope with life's challenges. From a theoretical perspective, affective capital increases alertness, enthusiasm, and zest for life, while simultaneously mitigating stress, sorrow, and depression (Nourian et al., 2021).

As a non-economic, positive-oriented construct, affective capital is closely linked to well-being and health. It represents an inner sense of vitality that can be transformed into positive cognitive, behavioral, and emotional capacities. Through goal-oriented activities focused on oneself, family, and positive social interactions, affective capital regains its dynamism and impact. When individuals experience emotional vitality as affective capital, they are more likely to exhibit purposeful effort and subsequently feel empowered and energetic (Abdoli et al., 2021). Affective capital has the potential to be developed into new skills and competencies, and studies show that it is associated with various positive behavioral and functional variables essential for an optimal and efficient life (Golparvar & Akbari, 2019). Research evidence strongly supports the role of affective capital in psychological and mental well-being (Elham et al., 2022). Its practical applications include skillful and effective coping strategies for optimizing individuals' lives (Bagholi Kermani et al., 2021).

Training to enhance affective capital focuses on self-awareness and creating a positive self-image while fostering emotional strength through individual and social education programs. Although studies specifically exploring affective capital enhancement are limited, research within the broader field of positive education provides some evidence for its benefits (Ghassami Kale Masihi et al., 2020).

One of the novel therapies in positive psychology is well-being therapy, which is based on Ryff's psychological well-being model (1996). Derived from cognitive-behavioral therapy, well-being therapy has been employed both as a standalone and complementary treatment. Its efficacy in addressing emotional and mood disorders and enhancing psychological well-being has been confirmed (Pirnia et al., 2017). Over the past two decades, this therapy has garnered significant attention from psychologists and researchers, with extensive studies validating its effectiveness in treating emotional and mood disorders while improving psychological well-being (Pazhuheshgar et al., 2019).

Research suggests that cognitive-behavioral therapy (CBT) enhances basic knowledge and understanding of adolescent-related issues but falls short in guiding adolescents and young adults toward flourishing. Combining the positive aspects of psychological functioning allows individuals to realize that the goal of psychotherapy is not merely to alleviate clinical symptoms but also to utilize

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strengths, skills, and abilities to confront challenges effectively. Positive psychology, with its focus on psychological strengths and desirable human traits, seeks to assist individuals in increasing self-awareness and developing capacities to achieve higher levels of happiness and well-being. Studies have demonstrated the efficacy of positive therapy in enhancing individuals' hopefulness (Aghili et al., 2023; Rajabi Vandechali et al., 2022; Sadri et al., 2022).

Considering the aforementioned studies and the limited research on the psychological status of orphaned and vulnerable adolescents residing in foster care centers, it is essential to examine the variable of affective capital and the effectiveness of interventions such as well-being therapy and positive therapy. These approaches aim to improve mental health, prevent psychological disorders, and enhance the quality of life of this population, which is the focus of the current study.

2. Methods and Materials

2.1. Study Design and Participants

The present study utilized a quasi-experimental design with a pretest-posttest format, including a control group and a three-month follow-up. The study population consisted of orphaned and vulnerable adolescents aged 12 to 18 years residing in foster care centers under the supervision of the Welfare Organization of Isfahan Province in 2023. The sample was selected randomly from 16 foster care centers specifically for adolescents aged 12 to 18 years under the supervision of the Welfare Organization of Isfahan Province. Through purposive random sampling, three cities and two male and female centers were designated as experimental groups, while one female center was assigned as the control group.

Inclusion criteria for participants included orphaned and vulnerable adolescents aged 12 to 18 years who had resided in foster care centers for at least six months and were not receiving any concurrent therapeutic interventions during the study period. Exclusion criteria included participants' voluntary withdrawal from the study and receiving simultaneous therapeutic interventions.

The experimental groups, each consisting of 15 participants, underwent interventions of well-being therapy and positive therapy. The control group, also consisting of 15 participants, did not receive any interventions. Well-being therapy was administered based on Fava's therapeutic protocol (2016) over eight sessions, while positive therapy was provided following the therapeutic protocol of Seligman, Rashid, and Parks (2006) over eight sessions.

The collected data were analyzed at both descriptive and inferential levels. Ethical considerations were strictly observed. Participation was voluntary, and participants were assured that their information and responses would remain entirely confidential. They were also informed that the collected data would only be used for research purposes. Participants were allowed to withdraw from the study at any stage. After the study's completion, participants in the control group were offered the opportunity to receive the interventions if they wished.

2.2. Measures

2.2.1. Affective Capital

Affective capital was assessed using this 20-item questionnaire, which includes three subscales: quasi-state positive emotions (10 items), feelings of energy (5 items), and happiness (5 items). Responses were rated on a five-point Likert scale ranging from 1 (never) to 5 (always). The score range was 10 to 50 for positive emotions, 5 to 25 for feelings of energy, and 20 to 100 for the total questionnaire. Higher scores on the subscales and the total questionnaire indicate higher levels of the measured variable. The questionnaire has demonstrated satisfactory validity and reliability. Exploratory factor analysis indicated strong construct validity. Additionally, convergent and divergent validity were assessed by examining the correlation of the questionnaire scores with scores on positive and negative behavioral, attitudinal, and perceptual variables, all of which were reported as acceptable and significant. Cronbach's alpha coefficients for the subscales (positive emotions, feelings of energy, and happiness) ranged from 0.80 to 0.978 (Esteki Azad et al., 2022; Ghasemi Kaleh Masihi et al., 2020).

2.3. Intervention

2.3.1. Well-being Therapy

This intervention is grounded in Ryff's psychological well-being model and emphasizes autonomy, purpose in life, and positive relationships. Over eight sessions, participants are guided to recognize and address cognitive and behavioral disruptions that impair their well-being, develop self-healing strategies, and build resilience for long-term psychological health (Fava, 2016; Guidi & Fava, 2021).

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Session 1: Participants are introduced to one another, group rules are explained, and the therapeutic framework of WBT is outlined. Participants' current and past emotional distress and treatment histories are gathered. The concept of self-healing is introduced, and the first homework assignment, a "well-being diary," is provided to initiate self-reflection.

Session 2: The previous week's experiences and the completion of the well-being diary are reviewed. Participants are introduced to the concept of optimal experiences and are encouraged to monitor thoughts and behaviors that interfere with their well-being. Homework involving the well-being diary continues.

Session 3: The session involves reviewing the previous week's experiences and diary entries. Participants start identifying specific thoughts and behaviors that disrupt well-being. A new column, the "Observer," is introduced in the well-being diary to track these disruptions. Participants are encouraged to engage in planned activities to support their well-being.

Session 4: Between-session progress and diary entries are reviewed. Cognitive restructuring begins, focusing on addressing disruptive thoughts and behaviors. Participants are introduced to one or two dimensions of psychological well-being and their practical implications.

Session 5: The focus remains on cognitive restructuring, with a review of diary entries and progress in identifying and modifying disruptive thoughts. Additional dimensions of psychological well-being are introduced, with a discussion on how to balance these dimensions. Homework includes graded tasks and activity planning.

Session 6: Participants' overall progress is assessed, with an emphasis on applying cognitive restructuring in real-life scenarios. Dysfunctional aspects of psychological well-being are discussed in depth. Homework includes continued use of the diary, activity planning, and graded tasks.

Session 7: The session focuses on participants' feelings about the conclusion of therapy, reinforcing strategies to sustain psychological well-being. Participants are encouraged to continue self-healing practices post-therapy. Planning and activity engagement are emphasized.

Session 8: Participants reflect on their progress and improvements in well-being and emotional distress. Challenges in sustaining self-healing practices are discussed. The importance of continuing therapy practices is reinforced, and follow-up sessions are planned as needed.

2.3.2. Positive Therapy

Positive therapy is a strengths-based intervention rooted in positive psychology, aiming to cultivate positive emotions, build strengths, and enhance life satisfaction. This therapy emphasizes gratitude, forgiveness, optimism, and hope. Across eight sessions, participants engage in self-reflective exercises, emotional processing, and practical strategies to foster personal growth and resilience (Nasiri Takami et al., 2020; Nourian et al., 2021; Rashid & Seligman, 2013; Seligman et al., 2006).

Session 1: The session focuses on orienting participants to positive therapy principles, clarifying the role of the therapist, and discussing participants' responsibilities. Participants write a positive self-introduction describing themselves during a happy time. Research tools and questionnaires are introduced and completed.

Session 2: Participants review their positive self-introductions, identifying and discussing strengths embedded in their narratives. They reflect on moments when these strengths contributed to a sense of engagement in life.

Session 3: The session focuses on nurturing strengths and fostering positive emotions. Participants are asked to design and implement a plan to apply their strengths in daily life. They begin keeping a gratitude journal, noting three positive events daily.

Session 4: Participants explore the role of both positive and negative memories in sustaining psychological symptoms. They are guided to express emotions like anger and bitterness and are introduced to forgiveness. Writing about three negative memories and their associated emotions is assigned as homework.

Session 5: Gratitude is revisited, with participants reflecting on the role of memories in shaping their experiences. The emphasis remains on fostering forgiveness and integrating gratitude into daily practices.

Session 6: The session involves a mid-therapy review. Participants discuss their progress in gratitude journaling, applying strengths, and following their activity plans. Feedback on the therapeutic process and personal growth is solicited.

Session 7: The focus shifts to hope and optimism. Participants engage in exercises like "one door closes, another opens" to practice reframing challenges and embracing new opportunities.

Session 8: Participants are taught four response styles and the "five magic hours" technique for improving

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relationships. Post-test questionnaires are completed, and future applications of learned strategies are discussed.

2.4. Data Analysis

The data were analyzed using SPSS version 26. Descriptive statistics, including means and standard deviations, were calculated for all variables across groups and stages. Repeated measures ANOVA was conducted to examine within-group and between-group differences over time for the components of affective capital (positive affect, sense of energy, and happiness). Post-hoc pairwise comparisons were performed using the Bonferroni test to identify specific group differences. Statistical significance was set at $p < 0.05$.

3. Findings and Results

The descriptive statistics in Table 1 reveal significant changes from pretest to posttest for both intervention groups across all components of affective capital. In the Well-Being Therapy group, significant increases were observed for positive affect (Pretest: M = 45.30, SD = 4.12; Posttest: M = 49.85, SD = 3.98), sense of energy (Pretest: M = 22.80, SD = 3.10; Posttest: M = 25.10, SD = 3.00), and happiness (Pretest: M = 30.25, SD = 3.05; Posttest: M = 36.25, SD = 3.00). Similarly, in the Positive Therapy group, significant improvements from pretest to posttest were found for positive affect (Pretest: M = 44.75, SD = 4.20; Posttest: M = 47.30, SD = 4.15), sense of energy (Pretest: M = 23.00, SD = 3.15; Posttest: M = 24.50, SD = 3.08), and happiness (Pretest: M = 29.90, SD = 3.08; Posttest: M = 32.15, SD = 3.10).

No significant changes were observed between posttest and follow-up scores for either intervention group, indicating stabilization of the intervention effects. For the Control group, no significant changes were noted across any stages for any variable. These findings suggest that both well-being therapy and positive therapy had significant immediate effects on affective capital, with well-being therapy showing slightly greater improvements overall.

Table 1

Mean, Standard Deviation for Research Variables

Variable	Group	Pretest M (SD)	Posttest M (SD)	Follow-Up M (SD)
Positive Affect	Well-Being Therapy	45.30 (4.12)	49.85 (3.98)	50.12 (4.10)
	Positive Therapy	44.75 (4.20)	47.30 (4.15)	46.90 (4.18)
	Control	44.15 (4.18)	44.45 (4.10)	44.35 (4.12)
Sense of Energy	Well-Being Therapy	22.80 (3.10)	25.10 (3.00)	25.20 (3.12)
	Positive Therapy	23.00 (3.15)	24.50 (3.08)	24.20 (3.10)
	Control	22.50 (3.20)	22.80 (3.18)	22.70 (3.19)
Happiness	Well-Being Therapy	30.25 (3.05)	36.25 (3.00)	36.50 (3.02)
	Positive Therapy	29.90 (3.08)	32.15 (3.10)	31.90 (3.12)
	Control	29.50 (3.12)	29.60 (3.15)	29.55 (3.18)

The appropriate statistical analysis for testing this hypothesis is repeated measures ANOVA. The within-group factors (dependent variables) include the mean scores of affective capital components (positive affect, sense of energy, and happiness) across pretest, posttest, and follow-up stages. The between-group factor (independent variable) is the difference between the research groups, comprising the well-being therapy group, positive therapy group, and control group.

The results of the M-Box test for the positive affect component indicate that when the mean scores of positive affect in the pretest are compared to the posttest and follow-up, the differences are not statistically significant ($F(2, 112) = 1.612$, $p = 0.204$). Similarly, the slopes of changes (interaction of within-group changes) for positive affect are not significant ($F(2, 112) = 0.905$, $p = 0.494$).

Table 2

Analysis of Within-Group Effects for Affective Capital Components

Dependent Variable	Source of Variation	Sum of Squares	df	Mean Squares	F	Significance	Test Power	Eta Squared
Positive Affect	Test Time	143.43	2	71.71	1.612	0.204	0.335	0.028
	Interaction Time × Group	241.58	6	40.26	0.905	0.494	0.345	0.046

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	Error	4984.31	112	44.50	-	-	-	-
Sense of Energy	Test Time	30.83	2	15.41	0.98	0.378	0.217	0.017
	Interaction Time × Group	101.92	6	16.98	1.08	0.378	0.412	0.055
	Error	1760.57	112	15.71	-	-	-	-
Happiness	Test Time	1.11	2	0.556	0.039	0.962	0.056	0.001
	Interaction Time × Group	297.02	6	49.50	3.463	0.004	0.936	0.156
	Error	1601.20	112	14.29	-	-	-	-

The results of the within-group effects analysis (Table 2) indicate that the changes in the mean scores of affective capital components (positive affect, sense of energy, and happiness) across pretest, posttest, and follow-up stages vary. For positive affect, the main effect of time was not significant, F (2, 112) = 1.612, p = 0.204, with an eta squared of 0.028, and the interaction between time and group was also not significant, F (6, 112) = 0.905, p = 0.494, with an eta squared of 0.046. Similarly, for sense of energy, the main effect of time was not significant, F (2, 112) = 0.98, p = 0.378, with an eta squared of 0.017, and the interaction between time and group was not significant, F (6, 112) = 1.08, p = 0.378, with an eta squared of 0.055. In contrast, for happiness, while the main effect of time was not significant, F (2, 112) = 0.039, p = 0.962, with an eta squared of 0.001, the interaction between time and group was significant, F (6, 112) = 3.463, p = 0.004, with an eta squared of 0.156. These results suggest that the patterns of change over time differ significantly among groups for the happiness component, but not for positive affect or sense of energy.

Table 3

Analysis of Between-Group Effects for Affective Capital Components

Variable	Source of Variation	Sum of Squares	df	Mean Squares	F	Significance
Positive Affect	Intercept	192472	1	192472	1671.364	0.001
	Group	3317.57	3	1105.85	9.603	0.001
	Error	6448.88	56	115.15	-	-
Sense of Energy	Intercept	51005	1	51005	1691.08	0.001
	Group	692.64	3	230.88	7.65	0.001
	Error	1689.02	56	30.16	-	-
Happiness	Intercept	51850.13	1	51850.13	1580.79	0.001
	Group	852.72	3	284.24	8.66	0.001
	Error	1836.80	56	32.80	-	-

The results of the between-group effects analysis (Table 3) demonstrate significant differences in all three components of affective capital—positive affect, sense of energy, and happiness—among the research groups (well-being therapy, positive therapy, and control). For positive affect, the group effect was significant, F = 9.603, p = 0.001, with a mean square of 1105.85. For sense of energy, the group effect was also significant, F = 7.65, p = 0.001, with a mean square of 230.88. Similarly, for happiness, a significant group effect was observed, F = 8.66, p = 0.001, with a mean square of 284.24. These findings indicate that at least two of the three groups differ significantly in their levels of positive affect, sense of energy, and happiness across the study.

Table 4

Bonferroni Post-Hoc Pairwise Comparisons

Significance	Std. Error	Mean Difference	Comparison Group	Base Group	Variable
1.000	2.26	-2.17	Positive Therapy	Well-Being Therapy	Positive Affect
0.403	2.26	4.22	Control Group	Well-Being Therapy	
0.039	2.26	6.40*	Control Group	Positive Therapy	
1.000	1.15	-1.00	Positive Therapy	Well-Being Therapy	Sense of Energy
0.581	1.15	1.95	Control Group	Well-Being Therapy	
0.081	1.15	2.95	Control Group	Positive Therapy	
1.000	1.20	-0.51	Positive Therapy	Well-Being Therapy	Happiness
0.172	1.20	2.71	Control Group	Well-Being Therapy	

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0.060	1.20	3.22	Control Group	Positive Therapy

The results in Table 4 indicate significant differences in positive affect, sense of energy, and happiness between the well-being therapy group and the control group ($p < 0.05$). Additionally, a significant difference is observed in positive affect between the positive therapy group and the control group ($p < 0.05$).

Based on repeated measures ANOVA, the research hypothesis is accepted. It can be concluded that there is a significant difference between the effectiveness of well-being therapy and positive therapy on the components of affective capital (positive affect, sense of energy, and happiness) among adolescents residing in foster care centers.

4. Discussion and Conclusion

Although the results indicate that the mean total affective capital increased in both the well-being therapy and positive therapy groups during the posttest and follow-up compared to the pretest, the mean score for the positive affect component showed an increase in both intervention groups during the posttest and follow-up. However, the mean score for the sense of energy component decreased in the posttest but increased again during the follow-up in both groups. The mean score for happiness remained relatively stable across pretest, posttest, and follow-up in the positive therapy group, while in the well-being therapy group, it increased during the posttest and follow-up compared to the pretest.

Based on these findings, repeated measures ANOVA and Bonferroni post-hoc tests were used to analyze the hypothesis. The statistical results showed that the between-group differences for all three components—positive affect, sense of energy, and happiness—were significant ($p < 0.05$), confirming the research hypothesis. These findings align with previous studies (Kazemi et al., 2020; Madadi Zavareh et al., 2019; Mohammadi et al., 2022).

In interpreting these findings, affective capital, as described by Golparvar and Akbari (2019), is a non-economic, positive construct closely tied to well-being and health. It is defined as a state of inner vitality and positive emotional energy that can be directed and transformed into cognitive, behavioral, and emotional capacities (Golparvar & Akbari, 2019). This construct, with its components of quasi-state positive affect, sense of energy, and happiness, has a relatively stable influence on individuals' behaviors and decisions.

According to Shojaei, Samari, and Akbarzadeh (2021), well-being therapy, through its focus on emotions, positive traits, and increasing happiness, has shown efficacy in preventing psychological harm by enhancing moral and spiritual traits (Shojaei Kalateh Bali et al., 2021). This therapeutic approach, which is goal-oriented and problem-focused, uses techniques such as self-reflection, journaling, cognitive restructuring, engaging in pleasurable activities, assertiveness training, and problem-solving. These techniques improve psychological traits by fostering a sense of happiness and inner positive energy, thereby effectively enhancing the affective capital of orphaned and vulnerable adolescents in foster care. Ruini and Fava (2012) also found well-being therapy to be effective in reducing emotional and affective problems and improving psychological well-being and health (Ruini & Fava, 2012).

On the other hand, Seligman emphasized happiness as a core aspect of positive psychology, defining it based on three components: positive emotions (pleasant life), engagement (engaged life), and meaning (meaningful life). These elements help individuals build a pleasant, engaging, and meaningful life, which is why such interventions are referred to as positive interventions (Rashid & Seligman, 2013). According to Lyubomirsky and Layous (2013), positive interventions reduce depression and increase happiness and psychological well-being by enhancing positive emotions, thoughts, behaviors, and fulfilling basic needs such as autonomy, love, belonging, and connection (Lyubomirsky & Layous, 2013). These effects have been instrumental in enhancing affective capital among orphaned and vulnerable adolescents in foster care centers (Nouferesti et al., 2015).

It can be concluded that when well-being therapy and positive therapy interventions are applied to orphaned and vulnerable adolescents in foster care, these individuals regain their dynamism and emotional vitality through purposeful activities directed toward themselves, their peers, and other positive social interactions. They experience immediate, purposeful efforts that lead to a sense of empowerment and increased energy (sense of energy component) and demonstrate affective capital through various positive behavioral and functional variables essential for an optimal and efficient life (Golparvar & Akbari, 2019). Moreover, these interventions helped the adolescents distinguish between positive thinking and unrealistic expectations, reducing their distress (positive affect component), improving their emotional state based on environmental conditions, and increasing their sense of happiness (happiness component). These factors explain the

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significant differences observed between the experimental and control groups.

Despite the significant findings, the study faced several limitations. Strict regulations by the Welfare Organization limited the inclusion of external individuals in foster care centers, restricting the sample size and possibly impacting the generalizability of the results. The findings should be interpreted cautiously when generalizing to other age groups, adopted children, or broader populations.

5. Limitations & Suggestions

The limited timeframe allocated for the study also restricted the investigation of other influencing factors, such as individual personality traits, separation of orphaned and vulnerable groups, and life histories. Future research should address these limitations to provide more comprehensive insights.

It is recommended to address controllable factors, such as increasing the number of caregivers and creating family-like environments in foster care centers, to enhance the psychological well-being of orphaned and vulnerable adolescents. Mandatory and frequent psychological evaluations should be conducted to identify and address vulnerabilities, with particular attention given to those at higher risk. Caregivers should receive specialized training in areas such as attachment formation, building trust and security, and effective communication skills. Screening caregivers for psychological health and personality traits prior to employment, along with improving their job benefits and satisfaction, can foster a more compassionate and attentive caregiving environment. Expanding research to other cities and provinces, studying different age groups and distinctions between orphaned and vulnerable populations, and increasing sample sizes and study durations can provide a more comprehensive understanding. Future studies should explore additional psychological variables affecting well-being, compare therapeutic programs to identify the most effective interventions, and evaluate training programs aimed at preventing psychological disorders in this population.

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Declaration of Interest

The authors of this article declared no conflict of interest.

Ethical Considerations

The study protocol adhered to the principles outlined in the Helsinki Declaration, which provides guidelines for ethical research involving human participants.

Transparency of Data

In accordance with the principles of transparency and open research, we declare that all data and materials used in this study are available upon request.

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