Being the Instrument of Change

Staff Experiences in Developing Trauma-informed Practice in a Norwegian Child Welfare Residential Care Unit

Heine Steinkopf

Thesis for the degree of Philosophiae Doctor (PhD)
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List of abbreviations

ACE study	Adverse Childhood Experiences study
ADHD	Attention Deficit Hyperactivity Disorder
ARC framework	Attachment, Regulation, and Competency framework
Bufetat	The Regional Office for Children, Youth, and Family Affairs (Barne-ungdoms- og familieetaten)
Bufdir	The Directorate for Children, Youth, and Family Affairs (Barne-ungdoms- og familiedirektoratet)
CARE	Children and Residential Experiences
CBT	Cognitive Behaviour Therapy
CPP	Child Parent Psychotherapy
C-PTSD	Complex Post-Traumatic Stress Disorder
DSM	Diagnostical and Statistical Manual of Mental Disorders
ICD-11	International Classification of Diseases, 11th edition
MST	Multisystemic Therapy
NCTSN	National Child Traumatic Stress Network
NOVA	Norwegian Social Research Institute – Oslo Metropolitan University
NKVTS	Norwegian Centre for Violence and Traumatic Stress Studies
PTSD	Post-Traumatic Stress Disorder
RVTS-south	Regional Centre on Violence, Traumatic Stress, and Suicide Prevention Region south (Regionalt senter om vold, traumatisk stress og selvmordsforebygging region sør)
SAMHSA	Substance Abuse and Mental Health Services Administration
TF-CBT	Trauma-Informed Cognitive Behavioural Therapy
TIP	Trauma-Informed Practice
TIC	Trauma-Informed Care

Summary

The overall aim of this project is to contribute to the development of interventions that benefit children and adolescents in residential care. Research shows that this is a particularly vulnerable population, typically with histories of detrimental care and traumatic experiences, and which is institutionalised as an additional burden. Many of them display severe emotional, interpersonal, and behavioural problems. Meeting their needs in a residential care setting is challenging, and there has been a general call for models of care that can encompass the complexity of their life histories and problems and the institutional context.

Along with the growing understanding of the effects of developmental trauma, trauma-informed practice (TIP) has emerged as a theoretical framework guiding residential treatment and care. TIP was introduced in Norway around 2010 and has since become widespread, especially in child welfare settings. TIP is a theoretical framework or model, rather than a standardised or operationalised method, that must be operationalised within each concrete context. In Norway, TIP has mainly been based on the Three Pillars Model advanced by the Australian psychologist Howard Bath.

The objective of this project was to gain information on how Bath's TIP model was operationalised and experienced by staff at a child welfare institution for adolescents in Buskerud County, Norway. The institution was among the first in Norway to start operating in accordance with a TIP framework, starting with the implementation of Bath's Three Pillars model in 2014. The regional resource centre on violence, traumatic stress, and suicide prevention in southern Norway (RVTS-south) facilitated the implementation process. The qualitative research project this thesis is based upon was initiated as part of this process.

In the project, the following main research question was explored: how do staff in a residential care unit in Norway transform the TIP framework into practice, and how do they experience and reflect upon this practice? The project comprised three studies examining the research question from different angles with a qualitative

phenomenological research methodology. Over the course of six years, a total of 27 individual in-depth interviews were conducted with 19 informants. Data were analysed in accordance with the principles of thematic analysis, thematic network analysis, and narrative inquiry. The findings of the three studies are presented in three separate papers.

The focus of the first study (presented in Paper I) was how the TIP framework of Howard Bath was translated into concrete practices. Using thematic network analysis of data from interviews with all 19 informants, we identified three global themes: *self-awareness*, including self-reflection, other-regulation, and authenticity; *intended actions*, including building strength, building mentalisation skills, providing staff availability, setting safe limits, and collaborating with youth; and *organisational and cultural practices*, including having a commonly shared mindset, stability and routines, and cultural safety. We suggest that the described practices, in general, reflect shared ideas across TIP models and resonate with informants' training. However, some practices also seemed to be influenced by other, and perhaps partly conflicting perspectives. In particular, the results indicate confusion and the need for clarification regarding the roles of authenticity and boundary setting within TIP.

The second study (presented in Paper II) focused on prerequisites for staff members' capacity to maintain an emotionally regulated state when faced with disruptive emotional and behavioural expressions. Providing other-regulation through one's own emotional state is considered a core element of TIP. Using thematic analysis of data from interviews with 15 of the informants, we found that informants experienced their self-regulation capacity as depending on *critical self-reflection*, *self-acceptance*, being part of *a regulating work environment*, and *having a trustworthy theoretical model to be guided by*. The findings point to the importance of organisational cultures and procedures that encourage critical self-reflection and self-acceptance, which promote self-compassion and shame-resilience, and where investments are made to ensure staff identification with the chosen model of care.

The third study (presented in Paper III) explored informants' experiences with situations and interactions that could potentially threaten their capacity to maintain an emotionally regulated state. Data from interviews with eight of the informants were analysed using narrative inquiry, with an interest in how informants made sense of their experiences. We identified three major narrative themes: *Are we doing the right things?*, *My childhood issues surfaced*, and *Missing togetherness with trusted others*. The themes reflect that situations and interactions were seen as particularly challenging due to their complexity and confusing character, their potential to trigger painful childhood memories, and their potential to evoke fear of disconnection from colleagues. Findings were discussed in terms of what strain working within a TIP framework may imply for staff members – a strain that we suggest should be acknowledged and addressed at an organisational and structural level.

An overarching interpretation is that informants, in their ways of practicing TIP, experienced themselves as 'the instruments of change'. They engaged in a reflexive self-scrutinising endeavour, where they tended to attribute successes and failures in interactions with residents to factors within themselves. Although informants were generally in favour of working in accordance with TIP principles, the results revealed that working this way comes at a cost and may be deeply personally and emotionally challenging. Findings of the project point to the importance of acknowledging these costs and of establishing cultural and organisational practices that enable staff to endure the strain they face as the 'instruments of change'. This may include a particular focus on the management of shame by working with self-compassion, for example, by applying standardised procedures developed for this purpose.

To be able to face potentially dysregulating situations on a day-to-day basis, based on the project findings, the work environment should entail a culture of other-regulation, wherein cultural safety, transparency, and collegial support are emphasised. In addition, to be able to invest so much of themselves in their work, both personally and emotionally, staff would need an understanding of why they are doing it and confidence in the productivity of the approach. Additionally, based on project results, it is recommended that services practising or implementing TIP clarify to the greatest

possible extent what TIP is and what it is not, including a clarification of what is unique or generic to the model. Clarifying the role of authenticity and boundary setting within TIP might be of particular importance.

List of papers

Steinkopf, H., Nordanger, D., Stige, B., and Milde, A.M. (2020): How do staff in residential care transform Trauma-informed principles into practice? A qualitative study from a Norwegian child welfare context. *Nordic Social Work Research*.

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Steinkopf, H., Nordanger, D., Stige, B., and Milde, A.M. (2021): Experiences of becoming emotionally dysregulated. A qualitative study among staff in youth residential care. *Child and Youth Services*. https://doi.org/10.1080/0145935X.2021.1918541

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1.0 Introduction

1.1 Background

Children and adolescents in child welfare residential care are particularly vulnerable. Generally, they have been exposed to multiple adverse and/or traumatic experiences and suffered neglect or general detrimental care (Middleton, Bloom, Strolin-Goltzman, & Caringi, 2019). In addition to an arduous start of life, they have faced invasive child welfare measures, such as removal from home and institutionalisation, and experiences of loss and ruptures of relations with parents, siblings, other family members, and peers. Among the interventions available to child welfare, residential care is considered the last resort since other measures such as foster care are considered less invasive and are therefore preferred (Backe-Hansen, Bakketeig, Gautun, & Grønningsæter, 2011). Consequently, children and adolescents in residential care often have lived longer with detrimental care in the biological family, giving way to even more adverse experiences (Lehmann & Kayed, 2018). This group also typically displays the most severe emotional, behavioural, and interpersonal problems (Briggs et al., 2012).

Several recent reports have demonstrated concern regarding the quality of treatment and care in residential homes, especially for adolescents with challenging behaviours (Bufdir, 2018b; Fylkesmannen, 2019). In 2020, the Norwegian Child Commissionaire issued a report from residential care institutions based on interviews with adolescents and a review of documents and case papers, suggesting that child welfare authorities put too much weight on adolescents' behavioural problems, substance abuse, and association with crime, and too little on their experiences of detrimental care and neglect prior to placement. It was also reported that several institutions lacked coherent guiding frameworks or models (Norwegian Child Barneombudet, 2020). In addition, the child welfare system, in general, is continuously confronted with insistent demands for change and improvements and for the identification of new and better methods, models, and theoretical perspectives for guidance. These demands follow naturally from a system that operates in a complicated and controversial field, where decisions interfere with people's lives at a fundamental level (Fylkesnes, 2018). Historically, mechanisms and procedures for control and auditing may have been lacking or insufficient (Backe-Hansen, Bakketeig, Gautun, & Grønningsæter, 2011).

Although residential care is a last resort, there are also voices advocating for this kind of intervention, seeing it as a constructive pathway for adolescents with high resource needs (Whittaker et al., 2016). Whittaker and colleagues (2015) use the phrase 'therapeutic residential care', which '…involves the planful use of a purposefully constructed, multi-dimensional living environment designed to enhance or provide treatment, education, socialisation, support and protection to children and youth with identifies mental health of behavioural needs in partnership with their families and in collaboration with a full spectrum of community-based formal and informal helping resources' (p. 24).

This definition of residential care directs attention towards high-quality measures and interventions, highlighting every aspect of service delivery. However, there are several possibly conflicting definitions of what constitutes quality in residential treatment and care. Historically, there has been a lack of consensus on the critical elements. Harsh and punitive measures have been utilised, based on beliefs that adolescents with 'bad attitudes and behaviours' need to 'learn to behave' (James, 2011), but also emotion-based responses fuelled by anger, fear, or disgust (Anglin, 2002; Bath & Seita, 2018). The residential treatment and care context needs theoretical frameworks and models of care that can address the complex and demanding child welfare residential care context, and at the same time are perceived as sensible and meaningful by staff. Thus, the purpose of this thesis is to gather information that might contribute to the development of such frameworks and models of care.

The last two decades have seen a significant rise in awareness of the effects and long-term consequences of early traumatic and/or adverse childhood experiences (Felitti & Anda, 2010; Ford & Courtois, 2009). While these and other reports document that traumatic and adverse experiences are widespread in the general population, the prevalence of such experiences among children and adolescents in child welfare residential care is considerably higher (Briggs et al., 2012; Greger, Myhre, Lydersen, & Jozefiak, 2015; Kayed et al., 2015).

Following the realisation that children and adolescents in out-of-home placements, particularly those in residential care, have high exposure to trauma, neglect, and adversities, *trauma-informed* frameworks have emerged. These frameworks define guiding principles for interventions and care according to the presumed prevalence of traumatic and adverse experiences (Harris & Fallot, 2001b; SAMHSA, 2014). When exposure to trauma and neglect is acknowledged as central to the aetiology of children's problems, symptoms, and behaviours, it seems sensible that institutions and services be informed of, or sensitised to, these experiences and their consequences. The concept of trauma-informed practice (TIP) was initially formulated by Harris and Fallot (2001b) and has since become widespread. The term 'trauma-informed' refers to 'seeing all clients through a trauma lens', and reflects an understanding that the symptoms and behaviours presented by clients could be understood as expressions of underlying traumatic experiences (Bath, 2008b).

TIP initiatives and frameworks are inexorably tied to neurodevelopmental psycho-traumatology (Schore, 2003; Siegel, 2012; van der Kolk, 2014) and general developmental psychology (Trevarthen, 2009; Tronick, 2007). The merging of these fields has shaped the understanding of the effects of early traumatisation, particularly regarding the concept of 'regulation' (Nordanger & Braarud, 2017; Schore, 2003). The core effects of early traumatisation are related to dysregulation of emotions, thoughts, relationships, behaviour, and bodily processes (Ford & Courtois, 2009), meaning that the individual becomes very susceptible to and easily overwhelmed by stress. The contribution from developmental psychology relates to the concept of 'other-regulation' whereby the child, yet unable to self-regulate, is regulated by a significant other when distressed (Tronick, 2007). In other words, early trauma may lead to dysregulation and general regulation difficulties. This dysregulation needs to be other-regulated from the outside, since children and adolescents lack the internal capacity to self-regulate (Perry et al., 1995; Schore, 2003). Other-regulation consists of 1) sensory-motor activities, for example, rocking, hugging, soothing words or sounds, and walking together; 2) relational support, for example, physical proximity, gentle and kind words, adult presence, and tolerance; and 3) mentalisation, for example, talking about stressful situations and other self-reflective activities (Perry, 2009). Through these processes,

the child may internalise the mental state of the adult helper, and thus gradually develop their own self-regulation skills (Fonagy, 2004).

Although trauma-informed frameworks have become widespread, more knowledge is needed to decide whether they are sustainable alternatives to other frameworks or models (Rosten, 2020). Trauma-informed frameworks still miss conceptualisation and agreement on unique and essential features (Hanson & Lang, 2016), and their base of empirical evidence is insufficient (Berliner, Kolko, Hanson, & Lang, 2016).

Since TIPs are more general, theoretically guided frameworks or models rather than operationalised methods, they need to be conceptualised contextually. This opens the way for possible misunderstandings, misinterpretations, and disagreements (Donisch, Bray, & Gewirtz, 2016). Furthermore, the implementation of new theoretical frameworks, models, or metods does not occur in a vacuum, as staff typically have prior experience with several different frameworks and methods. The implementation of new frameworks does not erase prior knowledge and practices. Consequently, professional discourses are likely to coexist, making it complicated to see one framework as separate from another (Dusenbury, Brannigan, Falco, & Hansen, 2003).

Against this background, the research project behind this thesis was initiated at a residential care unit for adolescents in Buskerud, in the south-eastern part of Norway. This institution requested the implementation of a TIP program from the regional resource centre on traumatic stress (RVTS-south) in 2013. As a pioneer program in Norway, RVTS-south found it important to combine the implementation process with a qualitative research procedure, collect information on how staff at the institution translated the TIP principles into practice, and investigate how they reflected upon the model.

1.2 Aims, objectives, and research questions

The overall aim of the project was to contribute to the development of models of care[1] that are beneficial to children and adolescents in residential care. Since TIP has become a widespread framework to guide the care provided by child welfare residential care facilities, our objective was to gather information about how staff working in such a context experienced, understood, and reflected upon the practice. Such information is relevant for institutions and services that are in the process of instituting a TIP framework and may provide important insights for future TIP implementation efforts.

Correspondingly, the overall research question for the project was: *How do staff in a residential care unit in Norway transform the TIP framework into practice, and how do they experience and reflect upon this practice?*

As stated above, TIP emphasises the staff's self-regulation abilities. Therefore, we were interested in exploring staff's experiences and practices related to this aspect of the framework. This interest is reflected in the more specific research questions chosen for the three studies included in this thesis as follows:

1) How do staff in this particular residential child welfare unit in Norway transform TIP principles into practice? (Paper I)
2) What are staff's perceptions of what it takes to stay regulated when working with adolescents? (Paper II)?
3) What characterises situations, contexts, and interactions that elicit or threaten to elicit emotional dysregulation among staff? (Paper III).

1.3 Overview of the thesis

This thesis consists of seven chapters. Chapter 2 provides an outline of the theoretical background and context of the study, starting with a description of the field of residential treatment and care in the Norwegian child welfare system, followed by an

[1] In this thesis the term 'models of care' is used as synonymous with theoretical frameworks and models that guide the work and inspire concrete methods and interventions.

outline of current knowledge of the prevalence of trauma and neglect among children and adolescents in residential care. Chapter 3 presents the development of the traumatology field, with an introduction to post-traumatic stress disorder (PTSD) diagnoses; PTSD (APA, 1980) and Complex PTSD (C-PTSD) (ICD-11, 2020). Here, emphasis is on the field's foundation in neurobiology and developmental psychology. Next, the regulation concept and the emergence of trauma-informed practice are described. Lastly, the Three Pillars TIP model of Howard Bath is presented. In Chapter 4 I present the institution studied and the TIP implementation model, before I give an overview of the diversity of theoretical perspectives and models of care within the residential care field. In Chapter 5, the ontological, epistemological, and methodological perspectives that guide the choice of procedures and analyses are described, along with a presentation of the specific work connected to each of the three studies. To the end of Chapter 5, quality of the research process along with ethical considerations are addressed. In Chapter 6, the thesis results are presented by providing a brief outline of the results of each of the three studies. In Chapter 7, I discuss the most salient findings against the background of relevant research and suggest some practical implications for residential treatment and care. Suggestions for further research are presented as well. The last sections of Chapter 7 address the challenges and benefits of my roles in the project and wind up in a brief conclusion.

2.0 Children and adolescents in the child welfare system

2.1 Residential treatment and care for children and adolescents

In Norway, 1111 children resided in child welfare residential care by the end of 2018, approximately eight per cent of all children that were under custody by the child welfare system (Bufdir, 2020). The number of similar children in foster care was 11,812 (Statistics Norway, 2020). At the same time, 45,587 children received help from child welfare while remaining in their homes (Ibid.). These numbers illustrate the general policy of the child welfare system; out-of-home placements are less preferred than home-based interventions (Lehmann & Kayed, 2018). There has been a slight decline in the use of residential institutions over the last ten years and a corresponding increase in the use of foster care. Compared to ten years ago, there has been a trend towards applying foster care for younger children. The use of foster care over residential care reflects that residential care is considered the least preferred child protection measure (Backe-Hansen et al., 2011). A consequence is that out-of-home placements (especially residential care) occur late in childhood, which increases the potential risk of harm to the child due to inadequate or insufficient care, abuse, or traumatic experiences (Lehmann & Kayed, 2018).

Child welfare residential care in Norway is organised into four categories of homes: 1) acute, short-term placements; (2) homes for adolescents with substance abuse problems; (3) homes for adolescents in need of care with no apparent behavioural or addiction problems for whom foster care is exhausted or not available for some other reason, and 4) homes for adolescents with primary behavioural difficulties. Category 4, placements based on behavioural problems, is further divided into the sub-categories 'high' or 'low', referring to the expected persistence and severity of the youths' behaviour problems (Bufdir, 2020). Placements may be either coercive or voluntary (Barnevernloven, 1992).

Placement criteria have no reference to trauma, neglect, or history of adversities. When children are placed in custody in Norway (regardless of the type of placement), the reasons are broadly 'quality of care', which involves parental inadequacies of some

kind, while placements of adolescents are more often based on behaviours such as deviancy, substance abuse, school dropout, or crime (Backe-Hansen, Højer, Sjöblom, & Storø, 2013).

2.2 Youth in residential care: Histories of adverse experiences

As noted above, youth in residential care generally have a history of adverse experiences prior to placement in an institution. Since residential treatment is considered a problematic option, other measures have often been tried for some time, such as various in-home interventions and placement in foster care (Backe-Hansen et al., 2011). Consequently, they often have a longer history of exposure to detrimental care and traumatic incidents than other children/adolescents in the child welfare system (Lehmann & Kayed, 2018). Additionally, placement in institutions in Norway is often justified by the youths' behaviours rather than their needs; youth with serious conduct problems are often assigned to institutions with an understanding that they need measures and interventions that are not available in less restrictive environments, such as foster care (Backe-Hansen, Madsen, Kristofersen, & Hvinden, 2014). These considerations indicate that adolescents in residential care are particularly vulnerable to exposure to trauma and neglect.

A national survey conducted by the Norwegian Social Research Institute (NOVA) showed a prevalence of 11% of severe sexual assault and eight per cent of severe physical violence from parents in a sample of high school students (Stefansen & Mossige, 2007). Another report by the Norwegian Centre for Violence and Traumatic Stress Studies (NKVTS) revealed a lifetime prevalence of rape in Norwegian women of 9.4%. In this study, severe physical violence from parents was reported by 5.1% of the informants, whereas 30.3 % reported experiencing 'less severe' parental violence (Thoresen & Hjemdal, 2014). A more recent study from NKVTS among 9,240 Norwegian 12-16 years olds revealed a similar tendency. Here, five per cent reported severe physical violence from parents, while six per cent reported experiences of sexual abuse by an adult, most often by someone other than close family members (Hafstad & Augusti, 2019). A study by Heiervang et al. (2007) found an estimated prevalence of childhood maltreatment of eight per cent in the general Norwegian population.

Even though exposure to adversities is common in the general population, the prevalence is considerably higher in the residential care population. Greger et al. (2015) investigated maltreatment and adversities prior to placement in a sample of adolescents in residential care and identified the following categories of maltreatment prior to placement: general household dysfunction (66.7%), victim of physical violence within the family (54.4%), sexual abuse (37.6%), and witnessing violence (38.4%).

Among international studies, Briggs and colleagues (2012) studied trauma exposure and functional impairment among young people in residential treatment and care, drawing upon data from the National Child Traumatic Stress Network (NCTSN) database. They also found a high prevalence of exposure to adversities, with the categories of emotional abuse (67.6%), traumatic loss (62.1%), and impaired caregiver (60.0 %) as the most frequently reported. Domestic violence (58.3%) was also frequently reported. On average, each youth reported exposure to 3.8 types of traumatic incidents. 92% of the youth reported experiencing multiple traumatic events prior to entering residential care (Ibid.).

2.3 Consequences of adverse experiences

Dovran et al. (2012) conducted a systematic literature review of traumatic events and posttraumatic symptoms among children and adolescents in out-of-home placements. From the studies included in the review, they concluded that 'most of the children and adolescents living in out-of-home placements have complex trauma histories and complex posttraumatic stress reactions' (page 29). However, this report does not distinguish between residential care and foster care.

Kayed et al. (2015) found a high prevalence of psychiatric disorders among children and adolescents in Norwegian residential care; 76.2% received at least one diagnosis listed in the fourth revision of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), with a very high comorbidity rate (Jozefiak et al., 2016). For example, typically, those with behaviour problems also had more emotional problems. They also

found greater impairments of physical health, lower self-esteem, and poorer peer relationships than the general population (Kayed et al., 2015).

The study by Briggs et al. (2012) presented similar findings: a high prevalence of functional impairment with behavioural problems (80.3%), attachment problems (70%), substance use problems, suicidal ideation (30%), criminal activity (30.3%), and self-injurious behaviours (28.4%) as some of the highest-ranking categories. They also found a dose-response relationship between the number of trauma exposures and indicators of functional impairment severity.

2.4 A landscape of shifting theoretical perspectives

The last 30 years have seen increased efforts to improve the quality of public services in both child welfare and mental health in general and in residential treatment and care in particular (Andreassen, 2003). The concept of 'evidence-based methods' emerged during the 1990s and was subsequently followed by an increased emphasis on cognitive-behaviourally (CBT) oriented models like Multisystemic Therapy (MST) (Henggeler & Schaeffer, 2016) and the institutional model MultifunC (Bengtsson & Jakobsen, 2009). Evidence-based practices comprise a tendency towards the standardisation and operationalisation of methods. This is also a pronounced ambition for the Directorate for Children, Youth and Families (Bufetat, 2019) and the Directorate for Health (Helsedirektoratet, 2020). Before the shift to cognitive-behaviour-oriented approaches, residential treatment in Norway was generally influenced by psychodynamic, attachment-oriented models of care (Larsen, 2018). Hence, since there are methodological differences between these two models, discussions and disagreements have surfaced (Reime, 2018). Also, bio-medical (Shah & Mountain, 2007) and behaviour analytic (Isaksen & Karlsen, 2018) perspectives have had some influence on residential care, even though they are more represented in mental health services and the care of individuals with mental disabilities.

According to Reime (2016), there are currently two competing overarching discourses in Norwegian residential care, one of 'techno-science' and one of 'indeterminacy'. The techno-science discourse upholds the idea that it is possible to develop universal and

effective methods for treatment and care that can be standardised and used by all in accordance with the general understanding of evidence-based practice. CBT may be considered to be embedded in a techno-science discourse. On the other hand, the indeterminacy discourse carries the understanding that methodological pluralism, contextualisation, and professional autonomy are preferable to control and standardisation.

Hence, the field of residential treatment and care is affected by a history of changing and somewhat competing models of care. Within the TIP field itself, scholars are holding an ongoing internal discussion of standardisation, operationalisation, and conceptualisation in general. There is a consensus that the trauma-informed perspective is relevant and required (Atwool, 2019; Cutuli, Alderfer, & Marsac, 2019; Levenson, 2017). At the same time, there is a growing demand for a uniform conceptualisation and operationalisation so that providers and agencies will know that they are delivering TIP (Hanson & Lang, 2016). Donisch et al. (2016) conducted a qualitative study among service providers within child welfare, juvenile justice, mental health, and education systems, which revealed that many frontline workers were confused about what interventions were appropriate according to TIP, despite expressing a positive attitude toward TIP principles. In Norway, a report among child welfare institutions revealed that many of them told to work in accordance with the TIP framework, and at the same time there were substantial differences in how they interpreted the concepts and in how it was practised (Bufdir, 2018a). Against this background, there may be a need for a more unified conceptualisation and operationalisation of TIP, one that applies to professionals within all child-serving institutions.

3.0 The field of traumatology

3.1 From single to complex trauma

Research on how childhood trauma, neglect, and other adversities impact brain development and mediate many physical, psychological, and social problems later in life has provided new and important insights. In contrast to many traditional aetiological models, trauma theories propose that the origins of many physical, psychological, and social disorders lie in the direct and indirect exposure to external traumatogenic agents (Bloom & Farragher, 2011).

Studies of war veterans, mainly American soldiers returning from Vietnam during the 1960s and 70s, contributed significantly to the modern understanding of psychological trauma (Horwitz, 2018). The experiences of these veterans paved the way for the introduction of the DSM-III diagnosis of post-traumatic stress disorder (PTSD) in 1980 (APA, 1980), along with a growing understanding that traumatic incidents have the potential to cause severe psychological problems. Criteria for the diagnosis included re-experiencing of the traumatic events, avoidance of reminding thoughts and memories of the events, and persistent perception of threat, often leading to hypervigilance (Ibid.).

Parallel to the development of the PTSD diagnosis, research efforts within the trauma field have gradually brought attention to childhood adverse experiences as an even more significant threat to public health. In particular, the San Diego based Adverse Childhood Experiences (ACE) study (Felitti & Anda, 2010) contributed to this understanding. The ACE study is longitudinal, with more than 17000 participants. It explored the relationship between childhood adversities such as exposure to domestic violence, sexual and physical abuse, emotional and physical neglect, and household dysfunction, and negative outcomes in adulthood, such as impaired physical and mental health, substance abuse, and social malfunction (Ibid.) The study showed that up to 50% of the non-clinical population had experienced one or more of the different types of adversities. It further showed a dose-response relationship between the number of types of adversities experienced in childhood and negative outcomes in adulthood on all health and functional parameters measured (Ibid.).

Observing the impacts of childhood sexual abuse from a clinical viewpoint, Judith Herman pointed out the limitations of the PTSD diagnosis to capture the long-term and global impacts of these kinds of trauma (1992). She saw far more complex problems, which she found to call for an expanded diagnosis called Complex PTSD. Along the same lines, Leonore Terr (1990) suggested a distinction between two different types of traumatic exposure: Type 1 and Type 2, where Type 1 refers to a single-event exposure, while Type 2 refers to repeated and prolonged exposure, normally with onset in early childhood. Other commonly used terms to describe Type 2 trauma are 'complex trauma' (Ford & Courtois, 2009), 'developmental trauma' (van der Kolk, 2014), and 'relational trauma' (Schore, 2003). Type 2 traumas are found to have considerably more global consequences than Type 1 traumas, since the exposure repeatedly occurs and most often at a very young age and, to a larger extent, impacts normal brain development (Teicher, Samson, Anderson, & Ohashi, 2016).

Currently, the International Classification of Diseases (ICD-11) features two diagnoses explicitly linked to psychological trauma: PTSD and Complex PTSD (C-PTSD). Criteria for C-PTSD highlight exposure to events or series of events that are prolonged or repetitive, typically domestic violence or sexual or physical abuse. Symptoms include those listed in the PTSD diagnosis together with problems with affect regulation, diminished beliefs about oneself, feeling worthless or defeated, feelings of shame, guilt, or failure, and difficulties in sustaining relationships and feeling close to others. Additionally, impairments in personal, familial, social, educational, occupational, or other important areas of functioning are included. Hence, the diagnostic system has adapted the early distinction between Type 1 (PTSD) trauma and Type 2 (C-PTSD) (ICD-11, 2020; Terr, 1990).

3.2 Developmental trauma

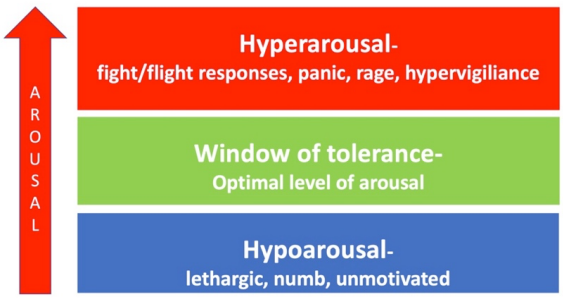
As stated above, the concept of complex trauma refers to chronic, prolonged or repeated exposure to traumatic stressors. Siegel, 2012; Schore, 2012; Perry, 2006). The term 'developmental trauma' (van der Kolk, 2014) has been applied for these kinds of exposure to emphasise that these stressors occur during development and disturb normal brain development. These children are often recognised in child protection and

mental health services not by the traditional PTSD diagnosis, but as impulsive and antisocial (Courtois, 2006) or with conduct disorder (Lyttle & Brodie, 2007), along with anxiety, depression, ADHD, and attachment disorder (Ackerman, Newton, McPherson, Jones & Dykman, 1998).

Several studies have explored the impact of severe adversities and psychological trauma on the developing brain. These include alterations in the corpus callossum, hippocampus, amygdala, and several structures in the prefrontal cortex (De Bellis, 2001; Pechtel, Lyons-Ruth, Anderson, & Teicher, 2014; Shonkoff, 2016; Teicher, Anderson, & Polcari, 2012; Teicher et al., 2016; van der Kolk, 2014). These changes to the brain serve to reduce the capacity to regulate stress responses and sensitise brain areas involved in eliciting stress responses. Stress responses may be either *hyper-reactions* involving the mobilisation of the fight/flight/freeze system, or *hypo-reactions*, involving activation of the systems of physical immobilisation or submission (Porges, 2007). Consequently, the person is primed for danger. Neutral stimuli that have become associated with traumatic events easily trigger both hyper- and hypoarousal responses, causing sudden shifts to the survival mode (LeDoux, 2015; Porges & Furman, 2011).

The window of tolerance (Siegel, 2012) is a widely used metaphor for understanding the heightened sensitivity of the stress-response system (see Figure 1 below).

Figure 1. The Window of Tolerance



Adapted from Siegel (1999).

The middle part of the window illustrates a zone of optimal arousal, in which the individual can relate to others in a meaningful and attentive way and is able to learn, concentrate, and focus. The hyperarousal state above the window may imply reactions such as impulsivity, acting-out, aggression or running away. In this zone, typically, children will be perceived as challenging, troublesome, or even hostile. The hypoarousal state below the window may imply numbness, passivity, feelings of emptiness, or helplessness. In this zone, children will often be perceived as lazy, apathetic, lacking in concentration, or without initiative, seemingly without a will of their own. Children or adolescents with histories of repeated adverse experiences often have a narrow window, causing rapid shifts to either hyper- or hypoarousal (Nordanger & Braarud, 2017).

In many cases, the functional display of these neurobiological alterations involves poor emotion regulation, distrust towards others (attachment issues), sensorimotor problems, altered cognitive functions such as memory problems, aggression, self-harm, trauma enactment, difficulties with attention and focus, planning and learning, low self-esteem, poor self-awareness, feelings of powerlessness, and shame and guilt (Cicchetti, 2013; Cook et al., 2005; Ford & Courtois, 2009). Other psychological problems include feelings of being shut off from society, lack of connection (van der Kolk, 2014), feeling that the world is fundamentally unsafe, and loss of hope for the future (Cozolino & Siegel, 2010; Yule, 1999). The pervasiveness of these consequences is striking.

In sum, repeated exposure to adverse experiences in childhood, trauma, neglect, or less pronounced negative experiences have a profound impact on the developing brain. Some of the most pervasive effects relate to the capacity to regulate emotions, thoughts, bodily reactions, and social relations, labelled 'general dysregulation' (Ford & Courtois, 2009). Consequently, trauma treatment comprises a robust regulatory component, helping the individual stay inside the window of tolerance (Siegel, 2012).

3.3 Self- and other-regulation

The neurobiological underpinnings of the regulation concept are described above. During the acute phase of the stress response, the person has reduced access to the cognitive and thinking areas of the brain, leading to dysregulated responses that lack conscious control (Perry, 2009). All people experience dysregulation, but people with a history of trauma, especially prolonged childhood traumatic experiences, are affected in three ways: 1) their neuroendocrine stress response is more easily activated 2) their stress response is activated by seemingly neutral stimuli, and 3) their stress responses are prolonged compared to non-affected populations (Siegel, 2012). In terms of the 'window of tolerance' described above, their windows are narrower, they slip more easily out of the window, and it is more difficult for them to find their way back into the window.

New-born babies have a very limited ability to self-regulate. Such skills are learned through the process of other-regulation, in which the adult caregiver recognises the emotional stress of the child and soothes her. Normally, this is done through somatosensory (rocking, stroking, hugging), sensorimotor (walking, jumping), and vocal (calming sounds and words) activities, allowing the child to internalise the regulated state of the adult (Fonagy, 2004). Repeated cycles of being emotionally upset, followed by calming interventions by the caregivers, provide a foundation for learning self-regulation that may last into adulthood (Schore, 2003; Tronick, 2007). This need for other-regulation endures even when we get older. In times of crisis, we seek out others, primarily attachment figures, for support and emotion regulation (Bath & Seita, 2018).

When children and adolescents lack the capacity to self-regulate, they become dependent on others to regulate them. Consequently, the main task for adult caregivers in the environment of children and adolescents with such problems is to *regulate others* (Nordanger & Braarud, 2017; Trevarthen, 2009). As discussed above, children and adolescents who have experienced childhood adversities such as trauma and neglect are prone to becoming more easily dysregulated than peers not exposed to childhood adversities, and we know that children and youth in residential care have a high probability of being traumatised (Kayed et al., 2015). Their likelihood of reacting with

behavioural problems and uncontrolled emotional displays is equally high (Briggs et al., 2012).

In this project, the term 'other-regulation' is used instead of 'co-regulation'. In the TIP literature, the term 'co-regulation' is more commonly used (Bath, 2015; SAMHSA, 2014). The term 'other-regulation' originates in the works of Russian psychologist Lev Vygotsky and was adapted by researchers who were interested in the early mother-child dyadic relationship (Wertsch, 2008). As suggested by Tronick (2007), we find that other-regulation emphasises adult responsibility, while the term co-regulation implies a transactional understanding of the parent/child interaction, in which the adult and child mutually co-regulate each other (Sameroff, 2009). In this sense, the term co-regulation puts part of the responsibility of the interaction on the child. In the residential care context, an explicit focus on adult responsibility is crucial, which is why we consistently stick to the term other-regulation[2].

The ability to other-regulate a child or an adolescent depends on the adult's capacity to maintain emotional self-regulation. The inherent nature of these caregiver/child interactions and encounters is challenging for adults' self-regulation, since the child is often emotionally dysregulated (Bath & Seita, 2018). The adult is easily 'contaminated' by the child's emotional state and may become dysregulated him- or herself, in which case the whole other-regulation 'project' falls apart. Hence, it is essential to consider prerequisites for maintaining emotional self-regulation among those caring for a child.

3.4 Trauma-informed practice (TIP)

As outlined above, the background for the trauma-informed perspective was the growing awareness of the prevalence and implications of childhood trauma and neglect in all clinical populations and contexts, child welfare, mental health systems, juvenile justice, homelessness services, and education systems (Hopper, Bassuk, & Olivet, 2010).

[2] In Paper III, we use the term 'co-regulation' instead of 'other-regulation' upon request from the editor of the journal.

The developmental trauma perspective described above is the most significant contribution to TIP (Bath & Seita, 2018).

Harris and Fallot (2001b) introduced the term 'trauma-informed', making a distinction from 'trauma-specific'. 'Trauma-specific' refers to specialised treatment, which includes individual, group, or family therapy, aiming specifically to ameliorate post-traumatic symptoms through therapeutic interventions such as cognitive restructuring or exposure therapy (Fallot & Harris, 2005). 'Trauma-informed', on the other hand, refers to systems or services that have integrated an understanding of psychological trauma in all aspects of service delivery. In this sense, 'trauma-informed' involves a shift of culture, perhaps even a shift of paradigm in how we understand human nature as well as human injury and recovery (Middleton et al., 2019).

Trauma-informed models or frameworks can be roughly divided into two categories: 1) system-level models with overarching ideas as governing principles, and 2) referral models, which emphasise screening for trauma symptoms and referrals to evidence-based therapy interventions (Donisch et al., 2016). The fundamental axiom uniting all trauma-informed frameworks is 'to see the child through a trauma lens' (Harris & Fallot, 2001b), implying an understanding that all clients may have experienced traumatising events in the past, and that their present symptoms may be a consequence of this exposure. Some frameworks highlight this as a fundamental principle, while others address it is more implicitly. The overarching trauma-informed principles suggested by Harris and Fallot (2001a) include the following: 1) safety, 2) trustworthiness, 3) choice, 4) collaboration and 5) empowerment. There are some variations across trauma-informed literature regarding these overarching principles and their labelling and how many are listed. The table below shows the selection of principles suggested by influential stakeholders[3]:

[3] I use the term 'stakeholder' as synonymous with all parties who participate to the development of theoretical frameworks and models within the TIP field and to those who implement and evaluate such practices.

Table 1. A selection of TIP stakeholder principles

Model, Stakeholders	**Main Principles**
The ARC framework (Hodgdon, Kinniburgh, Gabowitz, Blaustein, & Spinazzola, 2013)	1) Attachment; strengthening caregiving system 2) Regulation; identifying, understanding, tolerating and managing internal experience 3) Competency; increasing choice and empowerment, developing narratives around key life experiences
Sanctuary Model (Bloom, 2005)	1) Safety 2) Emotion (management) 3) Loss (dealing with) 4) Future (prepare for)
Domestic violence programs (Wilson, Fauci, & Goodman, 2015)	1) Establishing emotional safety 2) Restoring choice and control 3) Facilitating connections 4) Supporting coping 5) Responding to identity and context 6) Building strength
Consensus model (SAMHSA, 2014)	1) Safety 2) Trustworthiness and transparency 3) Use of peer support 4) Collaboration and mutuality 5) Empowerment, voice and choice 6) Consideration for cultural, historical and gender issues
Homelessness programs (Hopper et al., 2010)	1) Trauma awareness 2) Emphasis on safety 3) Opportunities to rebuild control 4) Strengths-based (resource-oriented)
Trauma-Informed Oregon (Yatchmenoff, Sundborg, & Davis, 2017)	1) Restore power; choice, empowerment, strengths, skill-building 2) Create safe context; physical safety, trustworthiness, choice, transparency, predictability, clear and consistent boundaries 3) Build self-worth; relationships, respect, compassion, mutuality, collaboration, acceptance
The Three Pillars model (Bath, 2015)	1) Safety; physical, emotional, social, cultural 2) Connections; close relationships, connected to societal institutions

	3) Coping; other-regulation (co-regulation), skill-building, mentalisation

The trauma awareness component is explicit in the list of Hopper, Bassuk, and Olivet only. The principles of the Substance Abuse and Mental Health Services Administration (SAMHSA) were developed through a consensus process. SAMHSA organised a group of national experts on trauma and traumatology, trauma survivors, former patients who had been recipients of treatment and care, practitioners from various related fields, researchers, therapists, and policymakers. Together, this group developed a working document that was posted on the SAMHSA website for public feedback, where it received 20,000 comments. After a review and refinement of the work done, the principles listed above were presented as the core concepts of TIP (SAMHSA, 2014). This is also the most cited list of principles. The six principles listed by Wilson et al. (2015) were the product of a similar process, derived from a systematic review of key documents describing TIP applied in the domestic violence field. The Sanctuary Model and the ARC model provide more detailed descriptions of the program components. They aim at single organisations with a more coherent framework and have a more explicit focus on organisational culture (Bloom, 2005; Hodgdon et al., 2013). They address all levels of organisational functioning, with detailed guidelines and principles for practice, but with a more therapeutic orientation than models aimed at general system delivery. These models, along with the equally comprehensive therapeutically oriented CARE (Holden et al., 2010)(not listed above), have a level of operationalisation that abridges empirical evaluation (Forrest et al., 2018).

All these models aim at system-level variables to integrate trauma understanding into all parts of the organisation or system responsible for service delivery. This includes staff in every part of the organisation, including receptionists and cleaning personnel (SAMHSA, 2014). They focus on cultures, environments, and conditions for change rather than on specific therapeutic interventions, although therapeutic interventions are considered valuable and called for (Bath & Seita, 2018).

Some stakeholders, however, link TIP with evidence-based treatment and define the 'trauma-informed' component as the availability of specific trauma treatment based on formal screening of trauma symptoms. One such example is the Massachusetts Child Trauma Project (Bartlett et al., 2016). This is a state-wide trauma-informed project aimed at assessing trauma-related disorders, such as PTSD, with standardised measures for all children entering the child welfare system. The standardised trauma assessment provides a background for referrals to evidence-based treatments, such as trauma-focused cognitive behavioural therapy (TF-CBT) (Cohen et al., 2016) or child-parent psychotherapy (CPP) (A. F. Lieberman, Van Horn, & Ippen, 2005). Program goals are formulated as follows: 'a) improve identification and assessment of children exposed to complex trauma, b) build mental health services to deliver trauma-specific, evidence-based treatments and practices in community agencies serving child welfare involved children, c) increase referrals of children to trauma treatment, and d) increase caregivers' awareness and knowledge of child trauma' (Bartlett et al., 2018, p. 111). The program aims to direct attention towards the availability and smooth functioning of specific evidence-based treatments. Thus, the model conceptualises 'trauma-informed' more in terms of evidence-based trauma treatment than the above-mentioned original system- and culture-oriented models (Harris & Fallot, 2001a; Wilson et al., 2015).

3.5 The Three Pillars Model

TIP entered the scene in Norway through Howard Bath's article 'The three pillars of trauma-informed care' (Bath, 2008b). Bath has revised his approach over the years. In 2015, he changed the title to 'The three pillars of trauma-wise care: Healing in the other 23 hours' (Bath, 2015), and in 2018 once more to 'The three pillars of transforming care' (Bath & Seita, 2018), this time leaving out reference to 'trauma' in the title. Initially, the three pillars were 'Safety', 'Relations', and 'Regulation'. In the 2015 paper, he changed 'Relations' into 'Connections', and 'Regulation' into 'Coping'. Both changes reflected a need for expanding and nuancing the concepts; 'Connections' contain not only close individual relationships, but are expanded to connection to social groups and societal structures (e.g. sports, church and choirs). In the revised version, regulation (and other-regulation) is described as one form of 'coping' along with other strategies such as mentalisation and cognitive restructuring (Bath & Seita, 2018). The decision to

elude the use of 'trauma' in the latest model title is explained by his realisation that the trauma concept had become 'fashionable' and was at risk of being watered out and losing its content (Bath, 2017).

Bath's TIP-model is not a therapeutic approach per se, but the model suggests therapeutic strategies that can be carried out by those who are close to children and adolescents, such as teachers, pre-school teachers, parents, foster parents, and residential care staff. The model endorses that much of the healing from trauma occurs in the natural environment rather than in formal therapy sessions (Briere & Scott, 2014). It is neither a comprehensive model of care nor an overall program design with assessment, staffing, or implementation procedures. Hence, it is not an outline for organisational change, as is the case for the Sanctuary Model and the ARC framework mentioned above.

As with all TIP models, Bath's Three Pillars model builds upon neuroscience, which highlights the pervasive impact of trauma and neglect on the developing brain. However, Bath also emphasises insights from resilience research, directing attention to the therapeutic power of everyday interactions with caring adults (Masten, 2001). He argues that healing from trauma depends largely on the natural environment and less on formal therapy sessions. Focus is '…on positive, thoughtful engagement with children and young people where they live, learn, and play' (Bath & Seita, 2018, location 141).

The model identifies three core needs of children and youth who have been exposed to forms of complex trauma: The need to feel safe; the need for healthy connections with caring adults, with the normal community, and with one's cultural roots; and the need for adaptive coping strategies to manage both challenging external circumstances and internal dysregulation, with specific emphasis on co-regulation (other-regulation). The core needs are addressed through the three pillars:

1) The first pillar is *safety*. Safety is viewed as the most pressing need and the most crucial aspect of developing and providing good mental health. Safety is

fundamental to recovery, to reach a point where others can be trusted, and to be able to relax both the body and brain. Bath divides the safety category into four domains:

a) Physical safety: Refers to a protective physical environment. Residential care staff have rotating shifts, new residents come and go, peers may be abusive, or in other ways act in a way that is destabilising.
b) Emotional safety: Refers to how thoughts, feelings, and wishes are acknowledged, accepted, and respected. Are children and adolescents allowed to express their feelings, is the negative affect accepted without responding with hostility? Emotional safety refers to acknowledging the pain of the inside child and the pain-based behaviour of the outside child.
c) Relational safety: Involves adults repeatedly, consistently, and relentlessly demonstrating their trustworthiness. They need to be open, honest, and reliable and demonstrate with actions that they mean what they say.
d) Cultural safety: Is his or her cultural identity acknowledged and respected? Adults need cultural competence, cultural sensitivity, and humility. Cultural aspects may involve food, music, clothing, cultural festivals, religion, or issues that concern gender.

2) The second pillar is *connections*. Fractured or impaired connections with those who would normally provide protection and nurture, often leading to a fundamental breach of trust, are common consequences of complex traumatic experiences. There is also often a sense of alienation from peers, schools, and other vital community structures. This pillar, then, involves building or restoring healthy connections, ranging from emotionally satisfying relationships and attachment-oriented interpersonal engagement to engagement in normative community activities.
3) The third pillar is *coping*. This pillar refers to the need to be able to deal with inner turmoil as well as challenging external realities. As described above, complex trauma involves general regulation problems, including the regulation of emotions, behaviours, thoughts, social relations, and bodily responses. Many traumatised children develop maladaptive and harmful strategies to regulate their emotions, such as substance abuse or self-harm. Such strategies, which for many are attempts to escape states of emotional dysregulation, often become a problem in themselves. Initially, Bath named this pillar 'emotion regulation', highlighting co-regulation

(other-regulation) as the primary task for adults to help children and youth establish self-regulation (Bath, 2008a, 2008b). Later, he extended the pillar to include learning self-help strategies such as verbal emotion management and narration to make sense of painful experiences (Bath, 2015).

In collaboration with Diana Boswell, Bath developed a trainer's manual that provides both a curriculum and a training procedure (2016). They define the following global aims of the training: 'To positively transform the way care providers understand and respond to the children and young people in their care', and 'to promote the development of trauma-sensitive care environments that provide sanctuary and that enable healing, personal growth and positive relationships' (Ibid., introduction, page vi). In addition to describing the three pillars, the trainers' manual commits to the following insights from neuroscience and trauma theories (Bath & Boswell, 2016, pp. vi-vii):

- 'To outline the case for understanding early adversity and its developmental impacts
- To provide descriptions and definitions of the types of trauma to which children and young people in special care arrangements often have been exposed to
- To identify the key principles of brain development and the multiple impacts on the brain of exposures to adversity and trauma
- To provide care providers with an overview of the key tenets of trauma theory linking the theory with the developmental experiences of many children in 'special needs' settings
- To describe how the key tenets of trauma theory relate to our understanding of attachment and attachment problems
- To provide an overview of the research findings on the developmental and behavioural outcomes of exposure to relational trauma'.

4.0 The site of the study

4.1 The child welfare residential facility

The chosen site for the doctoral project was a child welfare residential facility in southern Norway. The institution's physical environment is an ordinary residential building that could have been the home of a standard Norwegian family, situated in a quiet suburb in a small city with approximately ten thousand inhabitants.

The institution is state-owned reserved for adolescents aged 13–18 who have experienced detrimental care (formerly known as an F3-category institution) (Bufdir, 2020). The criteria for placement in this kind of institution are, in principle, not related to behaviour or substance abuse problems. However, many residents also display such problems. During the project period, staff were commonly exposed to violence and severe threats from adolescents, and there were suicide attempts and episodes of serious self-harm among the residents. In the context of the project, placement criteria also included known histories of traumatic experiences. There is no predetermined length of stay at the institution, but adolescents typically would stay there for approximately one year. The institution has rooms for four residents at the same time.

To the best of our knowledge, this institution was the first in Norway to implement a trauma-informed model of care. The competence program started in December 2013 and continued until the spring of 2019. For this institution, like many other institutions in Norway in later years, the implementation of TIP represented a shift from prior adherence to cognitive-behavioural methods (Andreassen, 2003; Armelius & Andreassen, 2007; Ogden, Christensen, Sheidow, & Holth, 2008).

4.2 The implementation process

For the implementation part of the project, program components described by Fixsen et al. (2009) were used as a template, involving pre-service training, continuous supervision and coaching, a system for evaluating staff performance, and management support.

The competence program was developed and implemented by RVTS-south. The program started with five full-day training components. Due to staff turnover, shorter versions of these sessions were regularly repeated throughout the program to ensure that the principles were known among all staff. All staff members received a full day of supervision every six weeks. In supervision, staff discussed daily life challenges at the institution and how TIP principles should be understood and translated into practice.

The program curriculum was primarily based on Howard Bath's model, as described above. It continued with sessions about the development, structure, and functioning of the brain and the nervous system, focusing on the stress-response system (Hart, 2008). Within this topic, Perry's (1999) concepts of the 'The use-dependent brain' and 'state-dependent functioning', as well as MacLean's (1990) model of 'The triune brain' were central. The triune brain is a metaphor that divides the brain into three parts: the reptilian, the limbic, and the thinking brain (prefrontal cortex). The metaphor organises other-regulation activities, where sensorimotor activities are directed towards the reptilian brain, relational support towards the limbic brain, and words and mentalisation towards the thinking brain. Against this theoretical background, the impacts of early exposure to maltreatment and neglect were discussed in terms of disturbed development, in accordance with the concept of 'developmental trauma' (van der Kolk, 2014).

Across topics, the Window of Tolerance (confer above) was used as a model to understand both the adolescent's developmental needs and their emotional and behavioural challenges. The concepts of regulation, self-regulation, and other-regulation were used consistently, with a focus on regulating emotions rather than behaviours. Efforts were made to ensure an attitude marked by understanding, empowerment, and collaboration. Ample time was given to the understanding of emotions and to discuss strategies to contain, confirm, and regulate adolescents' emotions. Throughout the project period, informants were encouraged to reflect on their own reactions and responses and to be aware of how youth behaviour could trigger their own emotional reactions. Discussions during supervisions often concerned how staffs' ways of communicating, including their body language, could be picked up by the youth and lead

to emotional reactions or even serve as triggers of traumatic memories. There was a continuous encouragement to try to 'look behind' the overt behaviours and consider what could be the underlying emotions, and to be conscious about avoiding re-traumatisation.

Topics were generally organised in accordance with their relevance to the three pillars in Bath's model, which represented the main program structure (e.g., attachment was addressed in relation to 'safety', while other-regulation was addressed in relation to 'coping'). See Table 2 for an overview of the program progression.

Table 2. TIP competence program

Stage 1	**Stage 2**	**Stage 3**	**Stage 4**
Anchoring the program in the organisation, securing leadership commitment, signing contracts	2-day TIP-training. Plenary sessions, mainly in the form of lectures.	2+1 day TIP workshop. Focus on organisational learning and cultural practices to promote the program. Exercises and group discussions around TIP principles (see above).	One full day of supervision every 6th weeks. Supplementary training sessions and workshops.

5.0 Method

5.1 General methodology

The overarching research question in this project concerns how a TIP framework is transformed into practice and how its fundamental principles are *experienced and reflected upon* by staff in residential care. The research question calls for a qualitative methodology since the focus is on lived experiences and perceptions (Bryman, 2016). 'Methodology', as used here, does not refer to the specific methods that are applied but to how the chosen methods are justified in relation to the purpose and objectives of the study (Carter & Little, 2007).

The field of qualitative research is characterised by a diversity of research traditions and methodologies, but most originate from a constructivist view of knowledge, with a common ground in their emphasis on interpretative actions in constructing knowledge (Holstein & Gubrium, 2016), in accordance with the constructivist view of both reality and science. According to Giddens (1984), what we see as 'truth' or 'reality' are in fact results of social interaction between individuals and social groups. This implies that social reality does not exist as such, but is actively constructed from experiences and conversations, rather than being unearthed or discovered (Berger & Luckmann, 1971). In this project, constructivism refers somewhat less radically to how knowledge about social phenomena is constructed through an interpretative process involving the researchers, the informants, and their contexts (Alvesson & Sköldberg, 2017). In classic phenomenology, as formulated by Husserl, research is basically a study of lived experience, the study of the world as lived by a person, rather than of the world isolated from the person (Laverty, 2003). Husserl also suggested that to be able to observe precisely, one has to 'bracket' past knowledge about the phenomena at hand, whereby one can regard the phenomena more precisely (Giorgi, 1997).

Hermeneutically oriented scholars, such as Hans-Georg Gadamer, object to the notion that it is possible to seal off prior knowledge of a phenomenon (Laverty, 2003). An epistemology that combines phenomenology and hermeneutics is therefore called for. Alvesson and Sköldberg (2017) suggest 'reflexive interpretation' as an overall frame of

reference for qualitative research. Reflexive interpretation combines perspectives from both empiricism and constructivism but acknowledges the situatedness of the research context. The epistemological position of this project is based on this understanding.

Binder, Holgersen, and Moltu (2012) have, within a context of interview-based psychotherapy research, described how this epistemology integrates the explorative nature of phenomenology with the interpretative character of hermeneutics. They describe a tension between phenomenological discovery or disclosure and hermeneutic interpretation and proceed to define the following three principles to guide their research methodology (Binder et al., 2012): '1) Access to the explorative phenomenological dimension is a prioritised ideal that guides the accomplishment of research within a self-reflexive recognition that can only be partially achieved. 2) Meaning is not given to be objectively found, but it is co-created between two persons in the research interviews and also between the researcher and the data in the analyses. 3) The objective of developing theoretical knowledge and professional understanding from research participants' experiences necessarily involves acts of interpretation from the researcher's perspective' (p. 106).

5.2 Choice of data collection method

In line with the overview above, the project aimed to access the informant's subjective ideas and understanding while recognising that the data, in fact, result from a dialogic process between them and the researcher during the interviews. This position implies that the analyses are also largely affected by the researchers' preunderstanding and preconceptions, emphasising the need for reflexivity throughout the process (Alvesson & Sköldberg, 2017) (see Section 5.6).

In this project, the choice was to conduct individual semi-structured in-depth interviews (Kvale and Brinkmann, 2009) with all informants. The choice was guided by the interest in how the staff members understood and 'translated' the TIP concepts, undisturbed by other staff members' interpretations. Semi-structured interviews are effective in gaining insight into people's subjective understanding of reality and usually

provide rich descriptions (ibid.). Furthermore, we wanted to have informants' narratives instead of, for example, participant observation, since narratives through conversations, as suggested by Berger and Luckmann (1971), are the most important means of maintaining, modifying, and reconstructing social reality. Conversations (interviews) as sources of information thus correspond with the overall phenomenological-hermeneutical position outlined above.

Qualitative research studies are often described as iterative, in the sense that questions and intentions are cultivated and changed as the studies progress (Barbour & Barbour, 2003). In this study, data were collected in three different waves according to the following flexible and needs-based criterion: information was collected when we wanted new input and new perspectives (Bryman, 2016). Our primary interest in the early phases of the project was to obtain descriptions of trauma-informed practice, that is, how the principles were translated into concrete practice. While obtaining these data, our attention was drawn towards self-regulation as a prerequisite for other-regulation, which provided the background for the second wave of interviews. Subsequently, we became aware of the importance of insight into situations and contexts that challenged staff's capacity to maintain an emotionally regulated state, which became the focus of the third wave of interviews.

5.3 Informants

Informants were all staff available at the time of the interviews. The sample comprised 19 staff members, 12 women and seven men. The mean age was 41.7 years (men, 47.3, women, 38.9). The age range was 24 to 65 years. Sixteen of the informants had ten years or more experience in social welfare, education system, or health services, while three had less than two years of experience with relevant services. As a consequence of interviewing only staff on duty, 13 informants were interviewed once, six were interviewed twice, and two were interviewed all three times. In the table below, all participants are presented with regard to their gender, education, age, and the paper to which they contributed:

Table 3. Informants' gender, education, age, and paper contributions

Gender	**Education**	**Age**	**Paper**
Female	Social worker	47	I
Female	Social worker	39	I, II, III
Male	Occupational therapist	39	III
Female	Social worker	48	II
Female	Social worker	43	I, III
Female	Social worker	38	I, II, III
Female	Social worker	40	II
Female	Teacher	40	I
Male	Social worker	65	I, III
Female	Student	24	III
Male	Social worker	49	I
Female	Pre-school teacher	40	I
Female	Nurse	37	I, II
Female	Social worker	43	I
Female	Police officer (other)	28	III
Male	Corrections officer (other)	47	I
Male	Social worker	50	I, III
Male	Other	30	II
Male	Occupational therapist	46	II

5. 4 Data collection procedures

The first wave of interviews took place in May 2015, the second in April 2016, and the third in June 2018. The total number of interviews was 27; eight were interviewed during the first wave, 11 during the second wave, and eight during the third wave. We developed an interview guide (see below) for each interview wave. As explained above, the interviews were semi-structured. Interviews were conducted in a way that invited informants to present their descriptions as coherent narratives. The qualitative

research interview is a narrative practice (Riessman, 2008), producing stories with unique positions and identities. We wanted informants to present free narratives but within the thematic scope of the research questions.

All interviews were conducted by me[4] at the institution, with four exceptions: two were carried out using Skype, one in a quiet room in a café, and one in a quiet room in an office located elsewhere. Each interview lasted between 25 and 56 minutes (mean, 39 min). Interviews were recorded and transferred to an encrypted, separate hard drive. The interviews were transcribed into Word documents. I transcribed the interviews from the first two waves, while the eight interviews from the third wave were translated by a professional aide. I verified these transcriptions by listening to the tapes while simultaneously reading the transcripts. The month of interview waves, number of informants in each wave, mean duration of each interview, and papers in which the interviews were included are presented in the table below. All interviews were conducted before starting the process of writing the material.

Table 4. Interviews as a function of date, number of informants, mean duration, and paper contribution

	Month of interviews	**Number of Informants**	**Mean duration (min)**	**Paper**
1. Interviews	May 2015	8	40.2	I, II
2. Interviews	April 2016	11	44.8	I, II
3. Interview	June 2018	8	39	I, III

5.3.1 Interview guides

We developed an interview guide for each interview wave. Some basic questions were the same across the three waves. However, in accordance with the interpretative

[4] All concrete procedures were performed by the author of this thesis, referred to with the pronoun 'I' or 'me'. Discussions, reflections and overall decisions were collaborative and referred to with the pronoun 'we'.

process described above, themes and questions were added as new issues to explore arose (Denzin & Lincoln, 2018).

The first wave of interviews focused on staff's perceptions of adolescents' needs, their understanding of the TIP model, and staff qualifications derived from the TIP model (with emphasis on being a regulating other). Focus was also on their understanding of what is needed to execute the TIP model on the level of organisational culture and organisational structures. In the second wave, interest shifted more towards an emphasis on self-regulation. The third wave was more specific to situations and contexts that were perceived as particularly challenging for self-regulation (see Appendix 3 for the complete guide). Table 5 shows the main themes for the interview guides for each interview wave.

Table 5. Interview guides, main themes for each interview wave

First interview, May 2015	The kids you are working with; how do you see their troubles? What do they need to develop well? What general staff qualifications are needed in residential care work? What staff qualifications are needed for a TIP practice? What is needed to be a regulating other? Recount an event/situation that describes, in your view, good work and bad work?
Second interview, April 2016	After two years with TIP, tell me about the model How would you describe the model? How does it differ from other models? How do you see your own personal values compared to TIP practice? What general staff qualifications are needed in residential care work? What staff qualifications are needed for a TIP practice? What is needed to be a regulating other? Tell me about your day-to-day practice. How would you evaluate the TIP model?
Third interview, June 2018	What general staff qualifications are needed in residential care work? What staff qualifications are needed for a TIP practice? Tell me about your typical other-regulation strategies Tell me about a situation where other-regulation failed

	What was it about the situation, the context, or the interactions that made self-regulation difficult?

5.4 Data analysis

Data analysis in a project of this kind cannot be separated from the different phases of the process: preparations and planning, data collection, drawing conclusions, and writing up the results (Bryman, 2016). The project period lasted approximately six years, during which hypotheses, data, and interpretations of data were continuously discussed, scrutinised, criticised, written up, or dismissed according to the epistemological model we chose (Alvesson & Sköldberg, 2017; Binder et al., 2012).

5.4.1 Paper I

For the first study, we chose an explorative thematic analysis because we wanted to identify all themes that occurred across the data material. To meet the challenges of reflexivity and transparency, we chose a systematic network analysis (Attride-Stirling, 2001) as the analytic tool. The procedure involves utilising thematic networks where the process from codes to higher-order themes is visualised and through which the process from text to interpretation (the hermeneutic progression) is disclosed (Ibid.). The analysis consisted of six steps. As in all thematic analytic procedures, the first step included reducing the data through a coding process. I read through the texts several times to become familiar with the material. I then coded the texts into segments based primarily on the research question but also on salient issues that arose from the texts. During the second step, themes identified from the coded text segments were reviewed and refined together with the research team. The third step involved constructing thematic networks by selecting the basic themes, deciding on the organising themes, and deducing the global themes.

Table 6 below, extracted from Paper I, provides an example of the procedure. In this example, we found 'self-awareness' to be an adequate global theme, comprising three organising themes: 'self-reflection', 'authenticity', and 'other-regulation'. Steps four, five, and six involved describing and exploring the networks, to summarise them, and finally interpreting the patterns, which we did in writing the paper.

Table 6. Thematic network analysis: Global theme of self-awareness

Codes	Basic Themes	Organising Themes
Be conscious of your responses Word own thoughts and feelings Be conscious of own emotions First look at myself (yourself) Evaluate my trustworthiness	Reflect on own thoughts, emotions, and reactions Be self-conscious Reflect on responses from the youth	Self-reflection
Keep your heart on your sleeve Show who you are Display own emotions Show affection Tune in to the youth Show own reactions Stay present in the moment	Stay close, be attentive Allow yourself to be affectionate Display normal, real emotions Stay with the youth in what is difficult	Authenticity
Say you are sorry Be calm and laid-back Find your own safe place Appear calm and non-threatening Avoid further triggering Sit down to appear non-threatening	Be humble Seek own calm Identify and avoid triggering of affect	Other-regulation

5.4.2 Paper II

For the analysis in Paper II, we applied the more traditional explorative thematic analysis described by Braun and Clarke (2006). The process involved six analytic steps.

1) Reading through the transcriptions thoroughly several times to gain an overall impression and become familiar with the text.

2) Initial coding of possible meaningful units.

3) Search for themes across the codes.

4) Close review of themes together with the research team.

5) Defining and labelling of themes through iterative discussions in the research team.

6) Writing up the report as part of Paper II.

Braun and Clarke (2019), in a later commentary, discuss the reflexive components of this strategy, given that several researchers are involved in the process. The codes were subjected to discussions within the research team and elaborated into themes in dialogue. The revision of the themes was an iterative, collective process involving the five authors of the paper. The final categorisation into organising themes was the product of thorough reflections and discussions within the research team.

5.4.3 Paper III

For the study presented in Paper III, we decided on a narrative analysis. The research question was 'What characterises situations, contexts, and interactions that elicit, or threatens to elicit, emotional dysregulation among staff in this particular Norwegian residential child welfare unit?' Originally, we attempted thematic analysis across the interview data. During the initial process of reading through the texts, we were inspired by the emotional energy of the informants' descriptions. The research team recommended a narrative analytic approach to give justice to the emotional and storytelling energy embedded in the texts. This choice was further justified by the narrative entry to the interview situation, as described above. Narratives provide meaning and coherence to life experiences, as well as an understanding of practices as consequences of discourses (Bruner, 1986; Ricœur, 1992). The way events and experiences are described will decide future actions and understandings (Riessman, 2008). Therefore, a narrative lens made it possible to view staff as involved in constructing various representations and positions of themselves, their co-workers, the youths, and the workplace as part of their self-regulation project.

The chosen narrative inquiry was based on Riessman's (2008) thematic approach, implying structuring the analyses around the content of the stories rather than around their linguistic properties or sequential composition. In addition, the research question invited a focus on the content, not the form of the informants' descriptions. I reread the texts applying the categorical content mode of reading texts (Lieblich, Tuval-Mashiach, & Zilber, 1998), involving four steps to direct the analysis. First, I selected subtexts involving reading through interviews to identify sections of the texts directly related to the research question. At this stage, I identified 29 narrative excerpts. Then, I continued

to define content categories, whereby the narrative excerpts identified during the first step were categorised into seven broader categories related to the research question. The third step was to sort these categories into themes. From this point, the process involved the entire research team. The seven categories were assigned to three themes. We chose excerpts for each theme that captured its essential content and meaning (Kvale & Brinkmann, 2009). The last step of the process was to draw conclusions from the results, which involved elaborating on the content in each theme to paint a picture of how staff positioned themselves narratively in relation to the question of emotional dysregulation.

5.5 Ethical considerations

The project was reported to both the Norwegian Centre for Research Data (NSD, reference: 57112) and the Norwegian Regional Committee for Medical and Health Research Ethics (REK). NSD approved the study procedures, while REK concluded that their approval was unnecessary because the project collected data from a non-clinical sample. (See Appendix 1). All informants signed a letter of consent (see Appendix 2).

Formal permissions do not reduce the importance of continuous ethical considerations. The sample was relatively small, and all informants were recruited from the same institution. Even though informants were informed of the theoretical possibility of being identified and still consented to participate, the risk of identification remains an issue. Paoletti (2014) argues that the interview, being a social situation, is influenced by the knowledge that total anonymity is not possible and that responses might be softened or moderated accordingly. The ethical perspective thus concerns not only the risk of being identified but how this risk may have influenced informants' responses. Other aspects of the interview situation are also potentially problematic; the interviewer is a specialist psychologist, adding to the power imbalance already present in the researcher-informant relationship (Kvale & Brinkmann, 2009). The next section discusses the importance of reflexivity in reducing possible biases due to such factors.

Furthermore, during the early phases of the implementation process, the institution suffered from leadership instability and at the same time experienced a significant 'wave' of sick leaves. There were times when we wondered if the implementation process was too demanding or if the TIP model put too much strain on staff, contributing to burnout or fatigue. We decided to include questions about this in the interview guide, and I will return to this topic in the Discussion section.

5.6 Quality of the research process

Barbour and Barbour (2003) hold that measures by which research is evaluated must correspond with the epistemic nature of the research itself. Qualitative researchers use different languages and terminologies when discussing quality, which reflects different epistemological positions (Alvesson & Sköldberg, 2017). Still, many researchers within qualitative research agree with the importance of considering trustworthiness and transferability when evaluating qualitative research (e.g., Creswell, 2014; Kvale & Brinkmann, 2009). These concepts are also subject to interpretation and depend on the reader's interests, understanding, and knowledge of the subjects studied (Kvale & Brinkmann, 2009). Malterud (2001) suggests that research is a '…reflective process for development of knowledge that can somehow be contested and shared' (p. 483). Against this background, Stige et al. (2009) proposed an evaluation framework that contains an *agenda* rather than checklists or criteria, EPICURE, which emphasises reflexivity as the basic premise. The letters in the acronym represent engagement, processing, interpretation, critique, usefulness, relevance, and ethics. With this acronym, they argue for a shift of attention in research evaluation, from an orientation towards rules, to reflexive dialogue. Even if the concepts were not developed to directly respond to the challenges of trustworthiness and transferability, they provide a useful background for the discussion.

5.6.1 Trustworthiness

The first part of the EPICURE acronym, EPIC (engagement, processing, interpretation, and self-critique), refers to the development of solid narratives that describe the entire research process. Engagement involves the researcher's motivation, involvement, and understanding. These aspects are discussed in Section 5.6.3. Processing refers to how

the empirical material is dealt with, which is described in detail in Sections 5.2–5.5. In Paper I, thematic network analyses are presented in tables to show the progress (Attride-Stirling, 2001). The context for residential care in Norway, with an emphasis on the history of emerging theoretical frameworks, is provided above (Sections 2.1–2.4), along with descriptions of the informants and the institution (Sections 4.0 and 5.3). These descriptions may enhance the authenticity and precision of the process (Creswell, 2014). Furthermore, the interview guide was designed with unleading, open-ended questions to allow for unstructured and comprehensive narrative responses. The complete interview guide is available in Appendix 3. The interviews from the first wave were scrutinised with regard to how the questions were framed and followed up in order to avoid leading and closing questions. We identified some questions that seemed to create confusion among informants, e.g., 'Tell me about your personal philosophy that guides your work with children and youths' and 'Can you relate your choice of work to experiences in your life?' Both questions were removed from the interview guides used in the second and third waves. Interpretation (the 'I' in EPIC) is relevant to the above discussion but also relates to the reflexivity of preunderstandings, challenges of bias in the interpretation of the data, and the double-hermeneutic situation during interviews (Giddens, 1984). These topics are discussed in more detail below (Section 5.6.3) along with some aspects of critique, which, as the 'C' in the EPIC-acronym, refers to both self-and social critique.

5.6.2 Transferability

The second part of the EPICURE acronym, CURE (critique, usefulness, relevance, and ethics) relates primarily to requirements for the project's usefulness for practice and future research, hence the reference to transferability. Here, both self-and social critiques are important topics I will return to in the section below (5.6.3). Usefulness refers to how and if the findings of the study, as well as the research process itself, are useful for practical life or research. Usefulness relates to the overarching research question of the project and is discussed in detail in the Discussion section, particularly in the sections on practical implications (Sections 7.3.1–7.3.5) and implications for research (Section 7.3.6). Likewise, relevance (the 'R' in the acronym) refers to the project's relevance, how it may contribute to the development of a field, in this case the

field of residential care, and how it relates to prior research and the established knowledge base of the field. These issues are primarily discussed in the Introduction, particularly Sections 2.0 (Children and adolescents in the child welfare system) and 3.0 (The field of traumatology). Ethics (the 'E' in CURE) refers to how the general ethical perspective was dealt with throughout the project. These issues were addressed in Section 5.5 (Ethical considerations) and in Section 7.4 (Being the instrument of research).

5.6.3 Reflexivity

Reflexivity is essential for all aspects of EPICURE (Stige et al., 2009). Reflexivity implies having a conscious and analytic distance to own preconceptions and attitudes and how they may interfere with the research process (Malterud, 2001). Alveson and Sköldberg (2017) note that there is double nature to the term 'reflexive' compared to the term 'reflective'. They see reflexivity as a multi-dimensional and interactive process that involves empirical data, interpretations, cultural and contextual circumstances, and reflections on the self, language, and authority. Reflective, on the other hand, is a narrower and more one-dimensional concept. The researcher influences the process and is influenced by the process, from constructing the overall frame of reference, the choice of research questions, the construction of the interview guide, and the interaction with informants, through the analyses, and even through the writing of the results (Cho & Trent, 2006). The researcher must be aware of the assumptions underlying the research process and how these assumptions may interfere with every aspect of the data processing (Baarts, Tulinius, & Reventlow, 2000).

Finlay (2002) offers a typology of different ways of being reflexive. Among these are *introspection,* in which the researcher engages in a critical self-dialogue, *intersubjective reflection*, the research team explores the research relationships in a self-reflective way, and *reflexivity as mutual collaboration*, where the researcher enrols the participants as co-researchers. In reflexivity as *social critique*, aspects of the power imbalance between the researcher and participants are addressed. These typologies are used as background to account for the preconceptions and biases below:

The self-critique involved in the narrative process involves some of the experiences and practices that have impacted me in my role as a clinical psychologist. I have learned and practised several different methods, including cognitive behaviour therapy (Beck & Beck, 2011), system and family therapy (Johnsen, Sundet, & Torsteinsson, 2000), narrative therapy (White & Epston, 1990), emotion-focused therapies (Monsen & Monsen, 2000), and more specific trauma-related therapies (Fisher, 2017). Over the years, I have become less interested in specific methods and more interested in the relational aspects of the therapeutic process. I have been influenced by insights from psychotherapy research (Duncan, Miller, & Hubble, 1999; Norcross & Lambert, 2018; Wampold & Imel, 2015), which highlight the relational aspect in all kinds of psychological treatment and human encounters, along with an understanding of the pervasive importance of early child development for adult life wellbeing (Hundeide, 2003; Trevarthen, 2009; Tronick, 2007). The relationship factor in psychotherapy and social work has become a fundamental interest for me since I experience that the ongoing search for evidence-based methodologies is downplaying this relationship. Being a dominant preconception on my part, it may have affected the way I conducted the interviews and could likely influence the analytic process. I may subconsciously have overlooked responses that favour technical, instrumental, or structural interventions and practices. Due to my background as a clinical psychologist, I was easily distracted by the informants' narratives, and at times deviated from the interview guide. This likely strengthened the narrative character of the interviews but may also have reduced the relative standardisation of the interview situation (Kvale & Brinkmann, 2009). Still, I wanted to be open-minded and prepared for 'the unexpected' that might occur in the informants' narratives.

Furthermore, I was involved in the implementation of the TIP model at the institution. As stated by Stige et al. (2009), 'In qualitative research in which the researcher has a personal involvement, his or her experience and subjectivity becomes part of the study. For the researcher's situatedness not to become a negative bias where preconceptions are confused with findings, a convincing level of reflection is required. The value of qualitative research, therefore, relates to reflexivity in the sense of regarding the nature and impact of the engagement. Sensitivity of and reflection on the researcher-as-

instrument is thus asked for' (p. 1508). During the six-year period of the project, I supervised the staff on a six-week schedule. Consequently, I developed a friendly relationship with many staff members. On the one hand, due to the closeness of the relation, informants may have felt that they could not convey negative or critical opinions. On the other hand, closeness could also provide access to more in-depth information (Hammersley & Atkinson, 2007). According to the typology of *introspection,* I have tried to keep these considerations in mind as a continuous internal dialogue (Finlay, 2002).

Finlay's (2002) typology of *social critique* draws attention to the power imbalance between researchers and participants. As a specialist psychologist, I was positioned in the role of status and dominance. When reflecting upon this and listening to the recorded interviews, I noticed that I stuttered, started, stopped, and restarted questions more than I would do in other contexts. As it seemed, I tried to downplay my power position by giving an impression of not finding the right words, fumbling, and being inarticulate. I was also often self-ironic, commenting on my memory deficits and clumsiness. These strategies may or may not have reduced the power imbalance but were consistent throughout all interviews and became part of the research situation.

The above-mentioned threats to the trustworthiness of the analytic process were discussed extensively within the research team, providing reflexivity as *intersubjective reflection* (Finlay, 2002). The team consisted of academics with varied backgrounds: two clinical psychologists (one specialised in child and adolescent psychology, the other in clinical adult psychology), one professor of music therapy, and one sociologist with a special interest in practice evaluation. One psychologist was primarily oriented towards quantitative research methodology, while the others were experienced qualitative researchers. The diverse backgrounds of the team were of great value in challenging preconceptions and identifying possible biases. Research questions, data gathering procedures, interview guides, and coding, interpretations, and categories were discussed, both in group meetings and in one-to-one supervision encounters, providing a type of investigator triangulation (Patton, 1980).

Feedback on the process and on preliminary findings was also gathered at several different research fora where the project was presented: the Regional Centre for Child and Youth Mental Health and Child Welfare in Bergen (RKBU-vest), at different fora as part of the PhD education (mid-term evaluation, course in qualitative methodology, research fellow gathering), and the Research Group on Dialogical Practice at the Agder University College. Also, I established a local forum with experienced colleagues (psychologists, social workers, and sociologists) at my workplace RVTS-south, where I presented results, analyses, and reflections and received feedback and critique regularly. Another form of researcher triangulation was accomplished through presenting preliminary findings and research methodology at national and international conferences. To meet the typology of *reflexivity as mutual collaboration*, we used member checking (Lincoln & Guba, 1985) or respondent validation (Torrance, 2012), involving presenting and discussing preliminary findings and interpretations with the informants. This was practised throughout the project in combination with regular supervision sessions.

6.0 Results

The Results section summarises the findings of the three project studies. Table 7 provides a brief overview of the studies, analyses, procedures, and results.

Table 7. Overview of the studies in the project.

	Paper I	**Paper II**	**Paper III**
Title	How do staff in residential care transform Trauma-Informed principles into practice? A qualitative study from a Norwegian child welfare context.	Prerequisites for maintaining emotion self-regulation in social work with traumatised adolescents. A qualitative study among social workers in a Norwegian residential care unit.	Experiences of becoming emotionally dysregulated. A qualitative study of staff in youth residential care
Research question	How are TIP principles based on the Three Pillars Model transformed into practice in a residential care unit for adolescents in Norway?	What are social workers' perceptions of what it takes to stay regulated in interactions with adolescents in their institution?	What factors characterise situations, contexts, and interactions that elicit or threaten to elicit emotional dysregulation among staff in this particular Norwegian residential child welfare unit?
Number of Informants	19 staff members	15 staff members	8 staff members
Method of data collection	Semi-structured in-depth interviews	Semi-structured in-depth interviews	Semi-structured in-depth interviews
Analysis	Thematic network analysis (Attride-Stirling, 2001)	Thematic analysis (Braun & Clarke, 2006)	Narrative inquiry (Riessman, 2008)
Results	Three global themes, with subsequent organising themes: 1) Self-awareness 2) Intended actions 3) Organisational and cultural practices	Four themes: 1) Critical self-reflection 2) Self-acceptance 3) A regulating work environment 4) Having a trustworthy theoretical model to be guided by	Three narrative themes: 1) Are we doing the right things? 2) My childhood issues surfaced 3) Missing togetherness with trusted others

6.1 Paper I: How do staff in residential care transform Trauma-Informed principles into practice? A qualitative study from a Norwegian child welfare context

This study explored how the Three Pillars Model was translated into practice in this specific residential care context. The study drew upon data collected through all three waves of interviews (2015, 2016, and 2018), and included 19 informants and 27 interviews. We found that informants' descriptions of practices were sorted into three global themes: *self-awareness*, *intended actions*, and *organisational and cultural practices* (see Table 7 above). Within the global theme of *self-awareness*, informants described self-reflection, authenticity, and other-regulation as salient themes. Within the global theme of *intended actions*, they emphasised five themes: building strength, actively stimulating mentalisation, providing staff availability, setting safe limits, and collaborating with the youth. Within the global theme of *organisational and cultural practices*, informants drew attention to having a shared mindset, ensuring stability and routines, and ensuring cultural safety. In general, informants' operationalisation of the TIP model corresponded with the training in the Three Pillars frameworks as well as with major contemporary TIP models. We further discussed if their descriptions were specific to TIP, or if they could be representative of other collaborative or relationally oriented models of care. We suggest that the critical self-reflection and other-regulation themes could be unique and essential characteristics of TIP, as one could argue that they had an active focus on underlying emotions or trauma-related experiences rather than on overt behaviours in interactions with youth. Furthermore, we discussed the potential contradiction in the informants' emphasis on both other-regulation and authenticity, and a somewhat unclear idea among informants regarding the role of boundary setting within TIP. We also suggested that the relatively low level of standardisation of Howard Bath's TIP model served to enhance commitment and sense of responsibility among staff.

6.2 Paper II: Prerequisites for maintaining emotion self-regulation in social work with traumatised adolescents. A qualitative study among social workers in a Norwegian residential care unit

This study focused on informants' descriptions of what they saw as important prerequisites for maintaining an emotionally regulated state. The study drew upon data collected through the first two waves of interviews (2015 and 2016), and included 15

informants and 19 interviews. Within the description of prerequisites for emotional self-regulation, we identified four major themes: *critical self-reflection*, *self-acceptance, a regulating work environment*, and *having a trustworthy theoretical model to be guided by.* Within the theme of critical self-reflection, informants emphasised the importance of knowing oneself, being able to distinguish between their own emotions and reactions and those of the youth. Within the theme of *self-acceptance*, they focused on being able to confront their own feelings of shame connected to perceived shortcomings and failures. Within the theme of *a regulating work environment*, they emphasised cultural safety through predictability, collegial support, and transparency; within the theme of *having a trustworthy model to lean on*, informants thematised the importance of having a theoretical model that helps them to understand the youths' complex problems and the dynamics of challenging interactions in their everyday practice. We argue that the findings illustrate the importance of encouraging critical self-reflection and self-acceptance through self-compassion and shame-resilience procedures at the cultural and organisational level in institutions of residential care. Derived from informants' experiences of needing a trustworthy model to lean on, we pointed to the importance of ensuring identification with the chosen framework among staff.

6.3 Paper III: Experiences of becoming emotionally dysregulated. A qualitative study of staff in youth residential care

The study presented in Paper III explored situations, interactions, and contexts that were particularly challenging to informants' self-regulation. The study drew upon data collected during the third wave of interviews in 2018, which included eight informants and eight interviews. We extracted three narrative themes that were representative of situations and interactions contributing to emotional dysregulation: *Are we doing the right things?, My childhood issues surfaced*, and *Missing togetherness with trusted others*. The first theme involved highly complex situations that informants found difficult to make sense of, while the second theme involved situations where collegial support was perceived as missing. The third theme involved situations or interactions in which emotionally upsetting memories were triggered. We suggest that adherence to the Three Pillars TIP Model implies more emotional strain for staff than many other models of care. Based on informants' experiences, we also argued that it might be legitimate at the workplace to focus on the staff's own adverse childhood experiences, as these may

contribute to emotional dysregulation when triggered by the adolescents. Finally, we discussed the potentially dysregulating complexity informants told they have to face, which speaks to the importance of acknowledging just complexity as an innate characteristic of child welfare residential work.

7.0 Discussion and conclusion

The overall aim of the research project was to contribute to the development of interventions that are beneficial to children and adolescents in residential care. Since TIP has become a widespread framework to guide the care provided by child welfare residential care units, the overarching research questions addressed how staff working in such a context transformed TIP into practice, and how they experienced and reflected upon this practice. The discussion is organised into three sections, where the first two address the two parts of the overarching research question. The third section discusses the implications of the findings for residential care units adhering to TIP principles, as well as for those in charge of their training.

7.1 From principles to practice

As described above, TIP frameworks outline overarching principles for care rather than operationalised methods (see Section 3.4). This goes for Howard Bath's model as well, which is built around the three pillars of *safety* (physical, emotional, social, and cultural), *connections* (close relationships and belongingness to a social group), and *coping* (i.e. capacity to manage stress and regulate emotions) (Bath, 2015; Bath & Seita, 2018). The principles need to be transformed into concrete actions and interventions by those who do the actual work and those who supervise the TIP implementation processes. One of the main objectives of the project, captured by the first part of the main research question, was to explore how informants transformed the principles into practice in their specific context.

7.1.1 TIP in informants' 'translation'

First, analyses of informants' descriptions suggest that they transformed TIP into a certain kind of *self-awareness.* Within this theme, informants conveyed that, to them, TIP implied a certain kind of self-reflection, that is, a willingness to evaluate themselves, their intentions, values, actions, reactions, and roles in interactions with youths. As one of the informants put it (paper 1); 'I have become more conscious about how I affect the youth's behaviour. And how I understand them'. Moreover, they mentioned practising authenticity in terms of a willingness to leave their professional role and display normal

reactions and emotions like 'love' and 'sincerity', but also 'anger' and 'frustration'. Further, much emphasis was placed on practising other-regulation: staying calm, having a non-threatening appearance, and being humble and open to apologising to the youth. One informant described a situation in which an adolescent cut herself with a glass shard. Instead of being oriented towards damage reduction, calling for help or scolding the youth, the informant simply sat down and expressed concern.

For informants, practising TIP also implied some *intended actions*. It implied efforts to build the adolescents' strength by focusing on their resources, encouraging mastery, and skill-building. One informant reflected on the issue as follows (Paper I): 'When I think about those I know who have improved their situation, I think it was correlated with a positive focus, and we were able to identify their resources, they were released'. Intended actions were also involved in actively encouraging adolescents to mentalise on their own emotions, thoughts, reactions, and motives that were triggered in everyday interactions. Further, informants conveyed that TIP should imply a practice of making oneself available to the youth, both in terms of physical proximity and emotional availability, even when the adolescents communicate rejection or distance. Moreover, informants translated TIP into intended actions of collaborating with rather than restricting the youth, sometimes even allowing coping efforts commonly seen as unacceptable. For example, instead of imposing a consequence on an adolescent who had been stealing knives from the kitchen, one informant negotiated a solution in which the adolescent was allowed to keep one knife on the condition of refraining from stealing others. As the fifth category of intended actions, informants emphasised the practice of setting safe boundaries for adolescents. It was, however, described in terms of communicating safety and adult responsibility, as illustrated by this quote: 'Some say I'm too kind... I set limits, but it is about how you do it. To do this in a way that makes the adolescent understand that we set limits because we care about them.'

Lastly, according to informants' descriptions, they translated TIP into a set of *cultural practices*. One such practice was to nurture a shared mindset and common understanding among staff, particularly with regard to the theoretical framework inspiring the practical interventions. One informant explained that '(...) if you work

together with someone who lacks understanding of the model, or with someone with a different attitude towards the adolescents, then I have seen that things escalate immediately (...)'. Informants also stressed the importance of a cultural practice of stability and routines related to predictability when it came to turnovers, sick leaves, leadership, and the use of temporary staff. Finally, informants pointed to the importance of a practice of cultural safety. To most informants, TIP should focus on transparency and collective self-reflection, which inspired mutual trust among staff. Here, staff also stressed the importance of openness, e.g., 'Especially since we need to have this openness, you need openness among your colleagues (...) to be able to express all issues, weaknesses, and strengths (...)'.

Generally, the practice informants emphasised make sense against the background of their training in the Three Pillars Model. The model entails safety, connections, and coping as overarching guiding principles, along with the other training components outlined in Section 3.4. The concrete situations described by the informants are comparable to case examples and vignettes provided by Bath and Seita (2018). Informants' descriptions also express ideas shared by influential TIP stakeholders. As shown in Section 3.4, Table 1, guiding principles such as strength building, emotion management, empowerment, collaboration, building trust, supporting transparency, and creating a safe context were commonly described, along with a focus on relationships and connections. Cultural and organisational factors such as mutual trust, transparency, and safety are also frequently referred to in the TIP literature (Bloom, 2005; Hodgdon et al., 2013; Hopper et al., 2010; SAMHSA, 2014; Wilson et al., 2015; Yatchmenoff et al., 2017).

7.1.2 A distinct approach, or just distinct wording?

Even though the informants' descriptions make sense in light of both their training and TIP literature, the question briefly discussed in Paper I needs further elaboration: Are the practices informants describe unique to TIP, or would they convey the same descriptions of their practice independently of their TIP training? Might the practices that staff describe as well reflect perspectives and inspiration other than TIP? The informants were generally experienced professionals who had worked for a long time in

various residential care settings (mean age: 41.7 years). Many had prior education and training in different theoretical models. Within the self-awareness theme, informants focused primarily on themselves as instruments of change. Here, the influence of mindfulness-oriented traditions (Binder, 2014), sensorimotor psychotherapy (Fisher, 2019) and interpersonal neurobiology (Siegel, 2012) may be in play. All these traditions emphasise the importance of self-awareness for human wellbeing. Both mindfulness and sensorimotor interventions-focus on becoming conscious of bodily processes such as breathing, muscle tone, and posturing. It is postulated that such awareness may produce calm and relaxation and contribute to therapeutic change (Binder, 2014; Fisher, 2019). Siegel describes how self-reflection is a necessary part of becoming an integrated person, which implies the ability to negotiate between internal processes of chaos and rigidity (Siegel, 2010, 2012). He suggests practising awareness of sensory experiences (sight, taste, touch, smell, hearing), emotions, thoughts, internal bodily processes, and connectedness to other people (Siegel, 2010).

The self-awareness theme also resonates with a psychodynamic perspective that emphasises transference and counter-transference as important mechanisms in therapeutic work (Tuber, 2008). Heiman (1950) referred to counter-transference simply as *feelings the therapist experiences towards the patient*. She describes these feelings as one of the most important tools the therapist has, providing information about the patient's 'unconscious' life world. There is a striking similarity between the counter-transference concept and the self-awareness theme expressed by the informants, particularly illustrated by the quote above; '…I am increasingly aware of how *my emotions* are a source of information'. As noted by Larsen (2018), residential treatment in Scandinavian countries since the 1950s was strongly influenced by psychodynamic thinking.

Likewise, the kind of 'intended actions' described by the informants, such as building strength and skills and encouraging mastery, would likely be acknowledged by most theoretical perspectives in the mental health field. They resonate with the salutogenesis concepts of Aaron Antonovsky (1979), the resilience concept (Masten, 2001), or the more general field of positive psychology (Gillham, 2000). These elements have also

been identified within modern relational pedagogy (Crownover & Jones, 2018; Spurkeland, 2011). Likewise, stimulating mentalisation, emphasised by informants, is also relevant to other perspectives, since verbalising experiences and inner sensations is a common therapeutic practise (Cohen, Mannarino, Kliethermes, & Murray, 2012; Yule, 1999). The positive effects of the labelling of emotions are also empirically supported (M. D. Lieberman et al., 2007).

Focus on organisational culture is also common in child welfare and not unique to TIP. Larsen (2018), who has greatly influenced residential care in Norway, highlights organisational culture as the prime agent of change in residential care. Implementation research also emphasises cultural and managerial practices, such as procedures, structures, culture, and climate, as important areas for consideration to ensure successful implementation of new methods or practices (Fixsen et al., 2009). Although Fixsen refers to the implementation of evidence-based and operationalised programs, these considerations are equally important for less standardised TIP approaches (Tullberg & Boothe, 2019; Tullberg, Kerker, Muradwij, & Saxe, 2017; Yatchmenoff et al., 2017).

May the reason why informants described few practices unique to TIP, be that TIP actually has few unique features? Hanson and Lang (2016) in their critical article on trauma-informed practices address the same question: is TIP just good, ordinary institutional care with nothing new or unique to offer? On the other hand, based on Waltz et al. 's (1993) model for evaluating the distinctiveness of therapeutic interventions, in Paper I, we argued that the organising themes of self-reflection and other-regulation bear some features that may be specific and unique to TIP. These themes may be manifestations of what being 'trauma-informed' means: seeing behind youth's behavioural expressions, with a strengthened awareness of their prior life experiences and how they may act out in the daily social interactions. While these concepts may make sense within any model focusing on relationships and collaborative care, they may reflect something more specific when applied in the context of TIP.

7.1.3 In the crossroads between discursive influences

As evident from the above, being staff at the child welfare residential unit means working at a crossroads between many discursive influences. These varying influences may also lead to disagreements, misunderstandings, or misinterpretations. A multitude of theoretical perspectives may be represented in education and training programs for this group of professionals. In informants' descriptions, we could also see how exposure to various discursive influences could cause confusion and frustration. As described in Section 2.4, one of the most influential models in Norwegian child residential care during the last 20 years has been CBT (Andreassen, 2003; Bengtsson & Jakobsen, 2009). Behaviour analytic models, though more popular within the care for the mentally disabled, have also been influential (Isaksen & Karlsen, 2018). As shown in Paper I, some informants clarified that setting boundaries should be an essential and explicit part of TIP. One informant described that in the early phases of the implementation process, staff became 'trauma-blind', in the sense of becoming afraid of setting boundaries in case it would trigger traumatic memories or cause re-traumatisation. Hence, this theme might reflect a 'negotiation' between TIP and the previous behaviourally oriented perspective. Some informants described this negotiation as a source of insecurity and frustration, which could eventually lead to misunderstandings and disagreements among staff.

It might be fair to say that TIP takes a clear stance against ideas that unwanted behaviours must be met with a consequence in order for learning to occur. Such an understanding may also be influenced by cultural, implicit understandings like 'bad behaviours must be punished', or 'if you give them a finger, they take the whole hand' (Bath & Seita, 2018). According to Hodgdon and colleagues (2013), the international trend in residential care has focused on teaching staff who have been led 'to understand behaviours through a medical "lens" and have been trained to extinguish behaviours' (page 683), referring to both a medical and a behaviour analytic discourse. Thus, the insecurity of setting boundaries may be related to the coexistence of discourses with different methodological orientations.

At the same time, being insecure about when and how to set boundaries may also reflect vague TIP conceptualisation regarding this issue. As described above, TIP models emphasise collaboration and understanding (see Table 1), and are concerned with avoiding that painful relational experiences from adolescents' past are being reproduced in their interactions with staff. TIPs also denounce correctional programs that use restraints and isolation as interventions, and are concerned about avoiding punitive responses from adults (Anglin, 2002; Bath & Seita, 2018). These factors may contribute to an understanding that adolescents should be met with collaboration in all situations, or that problematic behaviours always stem from the re-enactment of traumatic experiences.

Similarly, informants' emphasis on the importance of authenticity may reflect colliding influences from psychodynamic or humanistic perspectives. As presented in Paper I, informants reported both other-regulation and authenticity as essential components of TIP, both as part of the global theme of self-awareness. Other-regulation was typically described in the following way: 'Well, you know, it is about maintaining calm first and foremost, and then, try to be present, try to talk, reach out, and try to appear calm and at ease. I usually sit down and try to show a sincere interest in what is happening to the youth. I try to communicate in a calm way and try to make the youth feel safe'. At the same time, informants stressed the importance of being authentic – to display genuine feelings and be a 'real' person rather than keeping a professional distance. 'Love and sincerity' were frequently mentioned terms, but authenticity could also imply expressing anger and frustration. One informant told to have yelled at an adolescent and described how the emotional outburst had contributed to building trust.

Authenticity, originating in humanistic psychology (Rogers, 2004) and defined within a psychodynamic discourse (Tuber, 2008), is less addressed in the TIP literature. The nearest reason is that authentic responses may include emotionally dysregulated responses as well. Feeling anger and screaming to someone might be authentic but might quickly escalate stress and conflict and contradict other-regulation endeavours.

Such apparent inconsistencies may reflect the complex discursive influences that staff are exposed to. At the same time, they may reflect the complexity of the residential care work in itself, where some situations require calm and some measure of emotional distance, while other situations call for authenticity and sincerity (Rolvsjord, Gold, & Stige, 2005). As suggested in Paper I, it may also be that these strategies target different needs in adolescents; calmness may be called for in situations of fear or stress, while authenticity may relate to more long-term investment in a healthy relationship. Corresponding to our informants' descriptions, authenticity might also be an adequate operationalisation of other components of TIP, such as relational safety, predictability, or trust.

7.1.4 Summing up the section

As discussed in this section, informants transformed TIP into a certain kind of *self-awareness,* some *intended actions,* and into a set of *organisational* and *cultural practices*. In large, their 'translation' of TIP principles into practice make sense against the background of their training as well as shared ideas among different TIP models. However, informants' descriptions indicate that they operate at a crossroads between numbers of discursive influences. Some described practices might not be fully compatible with or are less resolved within TIP. Among issues to resolve within a TIP framework might be the roles of authenticity and other-regulation, as well as how collaboration and understanding go together with boundary setting. The most unique features of TIP, communicated by informants, may be embedded in the themes of *other-regulation* and *self-reflection*.

7.2 Being the instrument of change

In the section above, I discuss how informants transformed TIP into practice, as the first part of the research question invited to. Here, I will focus on the second part, which was how informants experienced and reflected upon adhering to TIP-principles in their work. The following quote may be illustrative of their experiences and reflections.

> *What the youth do to us is information. We need to look into ourselves, not only attribute what happens to something inside the youth or in their context. I must be conscious about myself and my vulnerability, even more when I see it (my reactions, what happens to me) as a practical tool.*

The quote from Paper I illustrates what I see as a consistent pattern across all interview waves: a constant reflexivity among informants with regard to sources of own emotions and reactions, and with regard to how factors within oneself influence interactions and the adolescents' responses and functioning. It seems fair to suggest that the essence of how informants experienced and reflected upon TIP can be understood as a sense of *being the instrument of change*.

7.2.1 A reflexive endeavour

The reflexivity on themselves as the instrument of change involved how they reacted and responded to the youth, and how they perceived that their reactions and responses influenced the youths in either positive or negative ways. Seeing the three studies of the project through such a lens, one may say that such reflexivity was represented all across. As presented in Paper I, when describing their perceptions of central practices within a TIP framework, informants conveyed statements like: 'show affection', 'show who you are', 'display your own emotions', 'keep your heart on a sleeve', and 'tune in to the youths'. They stated that staff need to be authentic, able to self-reflect, honest and transparent, willing to collaborate with the youth, and being a person who 'radiates safety'. Within the self-reflection and other-regulation themes, they emphasised reflexivity in terms of scrutinising their own motivations, reactions, emotions, and actions. It also involved reflections on youths' motives, motivations, and internal processes.

Likewise, as presented in Paper II, when informants described prerequisites for being able to regulate their emotions, they put the responsibility on themselves and their work environment, rather than on external factors such as characteristics of the adolescents or their behaviour. They emphasised reflexivity around their own emotions

and thoughts and around their own ways of handling failure and shame, and pointed to the importance of a work environment and a model to lean on that made them feel safe and represented a source of other-regulation. The same self-centred reflexivity was evident in their descriptions of situations and contexts perceived as threatening to self-regulation, as presented in Paper III. Here, for example, they referred to how youth's behaviour and interactions with youth sometimes triggered adverse childhood memories, and how these memories became the source of emotional dysregulation. However, instead of putting the blame on the youth's behaviour, they described struggles with handling these situations in terms of their own needs and vulnerabilities: how perceived lack of support from colleagues cradled insecurity and frustration, and how the complexity of day-to-day situations was a source of emotional unrest.

7.2.2 'Like coming home', but at a cost

Informants were generally favourable towards TIP, with reference to how the model corresponded with their core values and basic beliefs about how to treat the adolescents and facilitate change. One of the informants said, 'I feel that my personal values correlate with the TIP values. I feel this is right for me. That is why I don't apply for jobs at more behaviourally oriented facilities.' Another said that 'It is like coming home', and '… now I can do what I feel is right'. As described in Paper II, informants emphasised the theme 'Having a trustworthy model to lean on' as a prerequisite for emotional self-regulation, implying that they considered the TIP model 'trustworthy' and suitable for making sense of ambiguous situations, e.g. 'I remember a kid standing in the laundry room; she was about to faint when I came in and got her. Later, I went with her to a police inquiry where it was revealed that in her prior history, she had been raped by someone in a laundry room. It is interesting to see how things are connected.' The context was the informant and the youth collaborating on making sense of the symptoms (fainting). In this situation, trauma theory informed the understanding that the laundry room triggered suppressed memories of severe adversities in the youth's past. This understanding helped the informant provide meaningful support to the youth and gave her a sense of doing the right things.

Although informants generally expressed to be fond of working within a TIP framework, their position as instruments of change undoubtedly implied costs as well. In Paper III, we suggested that TIP frameworks may involve more emotional strain for staff than other approaches. One of the informants said, '… you have to make yourself so vulnerable, to allow all this to play out', implying that the TIP framework encourages staff to endure more expressions of pain and turbulent emotions from the youth than other models do. Staff in residential care are subjected to numerous stressors, as described in Paper III, regardless of the model or approach they adhere to. Such stressors include adolescents' challenging behaviours and non-compliance, aggression, suicide attempts, self-harm, runaways, or symptoms that provoke confusion (Bath & Seita, 2018; Hodgdon et al., 2013; Loughrey, Jackson, Molla, & Wobbleton, 1997). Studies indicate that residential care staff run a higher risk of burnout, secondary trauma, and compassion fatigue than comparable professional groups (Kind, Eckert, Steinlin, Fegert, & Schmid, 2018; Lakin, Leon, & Miller, 2008; Seti, 2008; Tullberg & Boothe, 2019).

In the TIP context, this stressful environment may be reinforced by the experienced need to be 'authentic' (see above). Authenticity calls for emotional reactivity. Staff cannot shut down their emotions or avoid emotional engagement. They have to 'embrace vulnerability' (Brown, 2015), identify the emotions of the adolescents, and respond in a genuine and respectful way. One informant expressed it as follows: 'The emotions I experience are information of their life-world. I am increasingly aware of how my emotions are a source of information. And you should not see it as negative to be afraid or feel insecure; these emotions are information about what the youth is going through' (Paper I). The quote illustrates an emotional investment seen as necessary to be able to respond adequately to adolescents' initiatives. Another informant expressed the need for emotional commitment by saying, 'I think that, in order to promote good health, you need to have some abilities that relate to … love and sincerity. (…) I believe it contributes to something healthy for the youth when we allow ourselves to become unconditionally fond of them. Not just say it, but make it visible, show them that you love them' (Paper I).

Informants also described costs in terms of coming in contact with painful experiences from their own past. As presented in Paper III, informants expressed that contexts and situations that triggered such memories were among the most stressful ones. We labelled this narrative theme 'My childhood issues surfaced'. The theme involved narratives of feeling inferior and stories of past fearful situations. When these memories were triggered, they caused strong emotional reactions. One informant said, 'I come from a family where knowledge and mastery were cherished and…I have always felt that I was less competent and had less knowledge than others. So, when I encounter these kids who are… 'know-it-all's', it is not a nice label, but they trigger something inside me, something from my own family'. Hence, according to informants' descriptions, TIP encourages the identification and confrontation of such adverse memories. This may, at least in a short-term perspective, be emotionally challenging. One of the informants said, 'You need to focus on yourself, almost be egoistic. You must be curious about yourself, how you react, and be honest about your own emotions and vulnerabilities. And you need to be willing to share it with your colleagues'.

Being the instrument of change implies having to face complex day-to-day situations with the youths by means of oneself rather than by means of a standardised protocol. Under the theme 'Are we doing the right things' presented in Paper III, informants pointed at this complexity as a common source of stress and frustration. One informant even questioned whether TIP, due to its complexity, is achievable as a guiding framework, since it is so demanding for both staff and organisation; '… with all kinds of personalities and value-systems present … it's easy to say that we have a trauma-informed cultural climate, and that we are a generous organisation … that we are appreciative of each other and so on, that we believe in everybody's good intentions … it's not always like that in reality'. As discussed above, TIP calls for an understanding of what lies behind the youths' immediate expressions, which necessarily implies reflecting and negotiating on interventions. This is an arduous and complex enterprise, and even more so since the approaches and interventions are not self-evident or pre-programmed. Complex situations are by their nature unpredictable. They instigate insecurity, often resulting in frustration and demand for interventions that give

apparent predictability and order, an urge to make complex situations less complex (Van Beurden, Kia, Zask, Dietrich, & Rose, 2013).

7.2.3 Summing up the section

Considering the interview material as a whole, informants' descriptions of how they practised TIP seemed to reflect that they saw themselves as the primary instrument of change, highlighting their own self-reflective and emotion-regulation skills as the means for care. Informants described a self-scrutinising focus wherein they were looking within themselves for reasons for escalating or emotionally demanding encounters with adolescents. Informants were generally in favour of the TIP model, but also conveyed that the practice involved personal and emotional strain, particularly related to how being the instrument of change involved dealing with complex situations with only oneself as the 'tool'. During encounters with adolescents, for some, painful childhood memories were evoked. Some costs of TIP were related to conflicting views on boundary setting, and other complex situations wherein the 'correct' line of action was difficult to find. Informants stated that within TIP, to be able to stand against the forces of adolescents' strong expressions, they needed to have trust in the model of care.

7.3 TIP's way forward

In the sections above, I have discussed the two parts of the research question: how TIP was transformed into practice, and how the informants experienced and reflected upon this practice. In this section, I will discuss the possible implications of these findings for practice and research in the field of TIP.

The location for this particular project, the residential child welfare unit in Buskerud County, was chosen because it was a 'pioneer' institution – to the best of our knowledge, the first to explicitly change their approach to a TIP framework. Since then, TIPs have continued to spread across a number of Norwegian services for children and adolescents, particularly within the child welfare system. Today, all five RVTSs in Norway run a number of TIP programs. At RVTS-south, the centre in charge of the TIP implementation studied, the framework has been adjusted to and implemented in a

variety of contexts outside the child welfare system as well, including mental health services, kindergartens, schools, refugee services, and the police (RVTS-south, 2020). On assignment from Bufdir, RVTS-south designed the TIP awareness program 'Handlekraft', implemented in all child welfare institutions in Norway (Bræin, Andersen, & Simonsen, 2017).

So, what have we learned from the project that can inform the work of services applying, or planning to apply, a TIP approach, or of services engaged in TIP competence building? The project is in the position of providing valuable information about these questions. The study presented in Paper I provides information on what might get 'lost in translation' when TIP principles are to be put into practice in a residential care context. The study presented in Paper II addressed what informants experienced as prerequisites for being able to adhere to the TIP 'ideal' of maintaining an emotionally regulated state in their interactions with the adolescents, while the study presented in Paper III addressed the characteristics of situations, contexts, and interactions where maintaining such a state was experienced as particularly challenging.

7.3.1 Maintaining 'the instrument'

The most important lesson learned from informants is the importance of caring for staff as individuals in this work, acknowledging the cost of 'being the instrument' and investing in 'maintaining' this instrument. Informants made us aware of the personal and emotional costs of trying to adhere to the principles of TIP. In line with other reports from residential care contexts (Hodgdon et al., 2013; Kind et al., 2018; Lakin et al., 2008; Seti, 2008), they described a stressful environment at the institution and a work evoking personal vulnerabilities. The literature addressing the cost of such work has focused on secondary traumatisation, burnout, or compassion fatigue. Anglin's (2002) study of nine residential homes in Canada may be a reminder of how important it is to focus on the costs of such work. He observed that staff tended to respond with punitive and hostile actions when they were emotionally stressed by adolescents. The importance of such a focus is supported by psychotherapy research as well, such as studies indicating that factors related to the therapist or the therapeutic relationship

count more for the outcome than the therapist's theoretical and methodological orientation (Duncan et al., 1999; Miller, Hubble, Chow, & Seidel, 2013; Wampold & Imel, 2015).

Findings from the project may imply that to enable staff to manage this kind of work, a focus on their own history of adverse or distressing experiences should be an integrated structural routine at the workplace. It may be considered unprofessional to display one's own private emotional life in a work context, as reflected in the concept of 'professional distance'(Goldstein, 2001). This concept is still relevant, even though a number of reports have both criticised and problematised it along with reflections on concepts to the other end of the relationship continuum such as 'love' (Green, Gregory, & Mason, 2007; Neumann, 2012; Thrana, 2016; Unhjem, Hem, & Vatne, 2018). However, the 'professional distance' concept relates primarily to the therapist-client relationship and may not be equally applicable to the more symmetrical staff-staff relationships referred to by the informants of this project. Theories of supervision also warn against being too personal or displaying emotional reactions in a professional context (Handal & Lauvås, 2014). Still, as staff need to maintain emotional self-regulation in order to be effective agents of change, and as self-reflection and self-acceptance may facilitate their self-regulation, taking on such 'self-disclosing' cultural practice may still be appropriate. In my view, regular supervision sessions might provide the most suitable frame for such a practice.

According to Tullberg and Boothe (2019), practices seen as essential for an agency or an institution in child welfare should not be left as an individual responsibility but anchored at the organisational level. In the following sections, we suggest some models of organisational anchoring of self-disclosure and ways to deal with interfering childhood memories.

7.3.2 Addressing shame and self-compassion

Informants' shared experiences indicate that 'maintaining the instrument' should include a focus on managing shame. Informants reported feeling shame in situations

involving rejection, as illustrated by the quote from Paper II: 'Rejection is tough. (...). Then I feel I'm not coping with the situation, and I feel shame.' Another typical shame-inducing situation reported was connected to feelings of not being up to it in situations of failure, as expressed in this quote: 'She said the girl was very angry with me following the previous weekend. At first, I felt resentment towards my colleague, who pinpointed my mistakes. It was very uncomfortable. Then I had to reflect on why I felt so uncomfortable. I realised I felt shame that I had not handled the situation well...' (Paper II). Several informants reported the feeling of shame as a highly distressing emotion, which is relevant for self-regulation.

Paper II describes strategies informants reported as beneficial for their self-regulation, such as critical self-reflection and self-acceptance. The organising theme of critical self-reflection consisted of exploring their own emotions, reactions, and motivations faced with the expressions and behaviours of both adolescents and fellow staff members. To our informants, self-reflection involved self-acceptance, particularly acceptance of the shame that typically accompanies feelings of inadequacy, doing wrong, doing too little, or not being able to provide the attention and support the adolescent needed. Against this background, we would suggest that promoting critical self-reflection and self-acceptance should be considered a crucial aspect of 'maintaining the instrument', not only as a means to prevent fatigue or burnout among staff.

Brown and colleagues (2011) have suggested a formalised procedure acknowledging such a stance: the *shame resilience curriculum*. Brown defines shame as 'the intensely painful feeling or experience of believing we are flawed and therefore unworthy of love and belonging' (Brown, 2007, p. 5). In her research, shame is connected to feelings of rejection, failure, feeling like an outsider, and being exposed. The connection between shame and emotional dysregulation has been well established (e.g., Binder et al., 2019). The shame resilience curriculum is a structured way to encourage self-reflection on how one's own adverse experiences may interfere with work-related tasks. It is a 12-session psychoeducational program designed for groups aiming to reduce feelings of blame, fear, and disconnection. Each session consists of a didactic component, either on a digital platform or through a facilitator, followed by exercises and processing

individually or in groups. The procedure also includes the widely used self-compassion scale, which measures self-kindness, the feeling of connectedness to other humans, and mindfulness (Neff, 2003). Such formalised procedures may facilitate the building of an organisational culture that serves to strengthen staff members' capacity for emotional regulation.

7.3.3 Creating a culture of other-regulation

The concept of other-regulation is an integral part of TIP when it comes to meeting the needs of children or adolescents. Informants' experience points to the importance of making it central to organisational and cultural practices of collegial support as well. As outlined in Paper II, staff capacity for emotional regulation can be enhanced in five ways: 1) By examining automatic thoughts (critical self-reflection), 2) by examining one's own specific emotional issues (self-reflection and self-acceptance), 3) by allowing oneself to be vulnerable (self-acceptance), 4) by asking, and getting, help from a colleague (a regulating work environment), and 5) by learning about and leaning on a theoretical model that makes sense (having a trustworthy theoretical model to be guided by). These principles and procedures may encourage collegial other-regulation when applied in staff seminars or group supervision settings. Such a practice could include conversations about staff emotions or reactions that are triggered by adolescents, along with reflections on the sources and origins of these triggers.

Such practices are not new to those working in residential care. Larsen (2018) divided work in residential care into primary and secondary work processes. Primary work processes are direct work with children and youth, while secondary processes are supervision, training, and organisational routines, for example, time for reflection, planning, and evaluation. Larsen argues that these work processes are crucial for the experience of work satisfaction and feelings of competency. Furthermore, he states that '… supervision is mandatory. Supervision is crucial to uncover all the projections staff is subjected to; being unloved, being the hated one' (Stokvold, Landmark, & Lillevik, 2020, p. 156, my translation). In line with this thinking, other-regulation could be integrated as a mandatory part of the secondary work processes, operationalised as regular supervision sessions, training, and regular team meetings. Such practices could allow

for negotiation on preferred lines of action, disclosure of worries, and conversations concerning self- and other-regulation.

7.3.4 Establishing the 'why'

One of the important insights from the informants concerned the importance of being able to make sense of the complex and challenging situations that occurred on a regular basis. One informant described the intensity of such situations: '…I pass and go to the office to write up the report, she forces her way into the office, and then everything escalates and it all ends with a restraint situation. (…). It is so painful, it's … twisting my soul. I go to bed and hear her screaming outside… those situations, it just builds up…These situations are so hard, I feel…I keep thinking about the baby child inside her, how do you meet her in a good way? (…). Then she screams at me, she doesn't trust me anymore, everything is lost, I'm a fucking whore… And the next morning all is forgotten, I hug her, and all is fine, and we start all over this dance. It's tough, you know…' (Paper III). This situation illustrates both the emotional investment of staff, but also the intense need to feel that you are doing the right things and most importantly, the need to know *why* you do it.

The call for a 'why' seem also embedded in their emphasis on the importance of 'Having a trustworthy theoretical model to lean on' in order to be able to maintain an emotionally regulated state (Paper II). TIP served this purpose as long as it corresponded with their personal values and was perceived as beneficial for adolescents. Sundborg and Kendall-Tackett (2019) state that the effectiveness of a theoretical model depends on its perceived relevance and its ability to explain the phenomena that play out. Furthermore, the interventions derived from the model must be perceived as sensible and productive and not in collision with the staff's personal values.

Simon Sinek (2011), a renowned corporate leadership lecturer, advises starting any initiative, enterprise, or implementation effort with a 'why'. According to Sinek, commitment to the job and to the workplace depends on all staff having a clear

understanding of 'why' they do all the things they do related to their work. If you know the 'why', the 'how' becomes easier.

Implementation research considers several different factors as essential for successful change processes, including motivation and readiness for implementation. Scaccia and co-workers (2015) divide motivation factors into 1) Compatibility: is the intervention consistent with existing beliefs, values and experiences?, 2) Manageability: is the intervention easy to understand and considered 'doable'?, 3) Prioritisation, reflecting the degree to which both change and the intervention is regarded as important, 4) Relative advantage: is the intervention better than the existing models?, and 5) Visibility of outcomes, are positive outcomes visible at an early stage. Based on the informants' responses, the TIP implementation process in this project responded to these requests. A general implication is to ask those who are to perform a certain method whether or not they *believe* in the method and the interventions. The importance of investing in staff's understanding of and belief in the approach finds indirect support in psychotherapy research as well. Wampold and Imel (2015) argue that therapeutic change depends on the patient's belief in the therapist, and that the treatment plan makes sense to both the patient and therapist.

7.3.5 Clarifying what is TIP, and what is not

TIP has become popular and widespread in Norway. However, confusion about what it is and what it is not has arisen (Rosten, 2020). As we have seen, this confusion was also expressed by the informants of this project, especially regarding how to set adequate boundaries for youths' behaviours. Also, we identified a possible conflict between the roles of other-regulation and authenticity within TIP. This may, as described by Hanson and Lang (2016), be connected to the general lack of a common conceptualisation of TIP. Even if there are advantages to theoretical frameworks that caution against standardisation and encourage contextual operationalisation, people need to have a sense of direction and guidance.

Furthermore, I find that TIP scholars tend to have a 'matter of course' attitude towards boundary setting, like a self-evident routine that is not necessarily articulated. Among the various conceptualisations of TIP in the literature identified in this project, only one explicitly mentioned setting safe boundaries: Yatchmenoff and her colleagues (2017) listed 'clear and consistent boundaries' as part of the overarching principle 'Create safe context' (see Table 1). Setting boundaries in this context is described as a way of providing safety, consistency, trustworthiness, and predictability for the child, described in the same manner as in the developmentally informed Circle of Security intervention: caregivers should be 'bigger, stronger, wiser, and kind' (Powell, Cooper, Hoffman, & Marvin, 2014, p.31). Recently, a child residential care institution in Norway was shut down when it was found that adolescents were allegedly allowed to bring drugs onto institutional premises and to stay out all night. Some residents developed serious drug abuse problems. This institution claimed to be adhering to a TIP framework, and questions have been raised whether the TIP discourse at the institution contributed to misunderstandings about how and when to set boundaries (Hansen & Jarlsbo, 2020). The reasons for closing this institution were far more nuanced, as documented by the public audit (Helsetilsynet, 2020). Still, as observed by Rosten (2020), it appears to be a misunderstanding that TIP holds that the child or adolescent must be spared from all triggers and stress to avoid re-traumatisation, and that setting boundaries may cause harmful stress responses.

Waltz et al. 's (1993) taxonomy (see Paper I) suggests evaluating the distinctiveness of a certain model based on procedures and behaviours that are 1) both *unique and essential* to the model, 2) *essential but not unique*, 3) *compatible* but neither necessary nor unique, and 4) *proscribed* and not compatible. Using this model, in Paper I, we suggest that extinction and reinforcement procedures derived from a behavioural therapeutic tradition (Isaksen & Karlsen, 2018) may be incompatible with TIP and therefore proscribed. This suggestion is based on the 'trauma awareness' component described by Harris and Fallot (2001b). Here, the overt problem behaviour is not considered to be 'the problem' (Bath & Seita, 2018), but is seen as an expression of underlying emotional, cognitive, or relational dysregulation produced by adverse life events or previous detrimental care (van der Kolk, 2014). In the 'compatible' category, we suggest

including specialised trauma treatment, cognitive restructuring, and psychoeducation as *examples* of activities or methods that are compatible with but not essential to TIP. In the 'essential but not unique' category, we suggest placing all factors described by informants that are consistent with major TIP models (see Table 1, Section 3.4). As components 'unique and essential' to TIP, we suggest including trauma awareness, self-reflection, and other-regulation, based on the findings from the first study of the project presented in Paper I. This list is by no means exhaustive but may constitute a point of departure for further discussions on TIP conceptualisation.

Table 8. Suggested characteristics of TIP

Unique and essential	- Trauma awareness - Self-reflection (reflexivity) - Other-regulation
Essential, but not unique	- Safety (physical, emotional, relational, cultural) - Facilitating connections (relationships) - Empowerment, building strength - Collaboration (with youth and family) - Transparency - Authenticity - Staff self-regulation
Compatible, neither essential nor unique	- Cultural activities (music, sports, etc.) - Specialised trauma-treatment - Cognitive restructuring - Psychoeducation
Proscribed	- Punishment - Extinction and reinforcement procedures

7.3.6 Research questions to be addressed

Although the project has provided answers, it has brought in its strain questions to explore in further research as well. A first and natural path ahead to gain deeper insight into the research questions of the current project would be to explore them again in other contexts of residential care. As made clear throughout the thesis, TIP needs to be

contextualised in each concrete setting. The institution studied in this project represents a limited number of informants at a specific geographical location within a certain period of time. Since the data for the project were collected, TIP has become widespread, and it would be of great interest to explore how the framework is experienced and reflected upon by staff in other residential contexts today.

The project also identified some new topics that should be addressed in further research. A key finding of the project is that TIP relies on the person being the instrument of change rather than on standardised methods or protocols. Above, organisational practices that contribute to 'maintaining the instrument' were suggested: dealing with shame through self-compassion and self-disclosure. Although such measures have empirical evidence of reducing stress and promoting psychological wellbeing (Arch et al., 2014; Finlay-Jones, Rees, & Kane, 2015), few studies have examined how self-compassion and shame-resilience may relate to work performance in residential care. A valuable path ahead would be to implement the shame-resilience curriculum (Brown et al., 2011) and combine it with qualitative research on staff's perceptions and experiences of the value of such a practice.

Above, I suggested that self-disclosure of stressful childhood memories could be included as an organisational cultural measure, for instance during regular supervision sessions, to enable staff to maintain an emotionally regulated state faced with challenging interactions with residents. However, as discussed, such a practice may be seen as controversial and may even raise ethical concerns. Therefore, more qualitative knowledge is needed before routinely implementing it as a cultural and structural activity. Here, staff could be interviewed about anticipated challenges and benefits, and what organisational structures they would see as necessary for a perceived sufficient level of emotional and social safety.

Moreover, I would also recommend research specifically looking into the costs of working within a TIP framework revealed by this project. This cost may have been understated and handled too lightly by TIP stakeholders, along with the enthusiasm and

optimism that characterised TIP's progress and increased popularity in Norway. Not acknowledging the costs may, in a long-term perspective, lead to frustration and resistance to the framework. Research that addresses the added strain of TIP explicitly is therefore warranted, including quantitative measures that focus on how adherence to TIP may be correlated to burnout and sick leaves and qualitative measures focusing on staff's perceptions of personal and emotional costs.

Another key finding was the importance for staff to feel that the theoretical model they adhered to made sense, and that the model was experienced as able to explain the complexity they have to face in day-to-day work situations. Given the current variety of theoretical perspectives in residential care, it would be interesting to learn more about how staff in all kinds of residential care contexts value and reflect upon the theoretically based model they adhere to. Such research should, at least in a first round, preferably be qualitative, addressing questions about how staff would describe the model they follow, how they perceive it, and whether or not they 'believe' in its ability to guide their work. Such procedures could be followed up quantitatively, for example, by means of known quality parameters such as records of sick leave among staff and documents of critical incidents and restraint situations.

Lastly, the project also points in the direction of research clarifying the role of authenticity, other-regulation, and boundary setting within TIP. Above, we discussed a possible contradiction between other-regulation and authenticity, in the sense that being authentic might also involve expressions that can trigger affective responses and escalate conflicts between residents and staff. However, informants emphasised both themes as central ingredients of TIP, indicating that they themselves did not experience such a contradiction. Therefore, more in-depth knowledge of staff's ideas of how these concepts combine would be of value. Likewise, the role of boundary setting within TIP was described as a potential source of disagreement and frustration among staff, indicating a need for further exploration. Both these topics would be well suited to being addressed through focus group interviews, wherein staff in residential care units discuss and reflect upon how they understand the concepts and their role within TIP more in-depth than was done in this project.

7.3.7 Summing up the section

Findings from the project point to the importance of acknowledging the personal and emotional costs of working according to TIP principles and establishing cultural and organisational practices that enable staff to endure the strain they faced as the 'instruments of change'. Such internal practices should include a particular focus on the management of shame by working with self-compassion. Findings also highlight the need for more specific clarification of what TIP is and what it is not to prevent confusion. They also point to the importance of taking the time and effort needed to ensure that the model is seen as relevant and able to make sense of complex and ambiguous situations. Interesting pathways for future research could include studying how shame-resilience strategies, as well as self-disclosure practices, may contribute to staff's perceptions of the ability to self-regulate. Additionally, gaining more insight into staff's understanding of the potential emotional costs embedded in TIP was suggested, along with exploring staff's understanding and attitudes towards the theoretical model they adhere to. It would also be of interest to further explore the potential contradiction between authenticity and other-regulation, and how boundary setting can be understood within TIP.

7.4 Being the instrument of research

Before concluding and summing up the findings and lessons learned from the project, it is appropriate to revisit the possible threat to the trustworthiness of the findings.

I was involved in planning the implementation project and the training and supervision of staff throughout the project period. At the same time, I was responsible for the affiliated research. I became an instrument for the research process as a person. As discussed in Section 5.6, this dual role has both strengths and limitations. I learned to know many of the informants at the level of friendship. I supervised staff on issues related to both personal and professional domains and had regular talks with the management as part of the implementation procedure. In this way, I came close to the informants' perspectives and gained insight into day-to-day life at the institution. However, the same closeness could easily bias the results by making it harder for informants to share their honest opinions, including critical or negative thoughts of the TIP model (Hammersley & Atkinson, 2007). In addition, I could at every step in the

process, from planning to writing of papers be prone to influencing the findings due to my personal engagement and prior experiences in the field. My experience as a clinical psychologist may have been useful through insights gained from numerous encounters with children and adolescents in difficult life situations and by working closely with the child welfare system in many different contexts. On the other hand, being an experienced psychologist may also have led to biases that made me look for some aspects of the informants' descriptions and overlook others. However, these factors are known threats to the trustworthiness of findings from projects within a phenomenological-hermeneutic tradition (Alvesson & Sköldberg, 2017; Binder et al., 2012), and can only be countered employing the transparency and the thorough endeavours of reflexivity described in Section 5.6.

7.5 Conclusion

The main research question for the project was how staff in residential care transformed the Three Pillars TIP-framework into practice and how they experienced and reflected upon the practice. Concerning the first part of the question, the results revealed practices of *self-awareness,* in terms of self-reflection, authenticity, and other-regulation, *intended actions* of building the adolescents' strength, actively stimulating mentalisation, providing staff availability, setting safe limits, collaborating with adolescents, and *organisational and cultural practices* of having a shared mindset, ensuring stability and routines, and ensuring cultural safety. Described practices resonate with core TIP principles and informants' training in the Three Pillars Model. On one level, unique or specific features of TIP, compared to other general and relationally oriented approaches to residential care, seemed difficult to identify. On another level, it can be argued that self-reflection and other-regulation derived from trauma awareness represent something distinctive in TIP. TIP is typically implemented in the context of established practices inspired by other models. Results indicate that staffs' position at such a 'crossroads' between different discursive influences may induce confusion and a need for clarifying the roles of authenticity, other-regulation, and boundary setting within TIP.

An overarching interpretation is that informants, in their ways of practising TIP, experienced themselves as *instruments of change*. They took responsibility for distressing encounters with the residents and engaged in a reflexive endeavour where they constantly looked for reasons for the relational dynamics within themselves. Concerning the second part of the research question, experiences and reflections around TIP practices included both appreciation of engaging in TIP, but at the same time, experiences of being put in a vulnerable position producing personal and emotional costs. The work involved, sometimes on a daily basis, emotionally dysregulated situations. Situations identified as particularly emotionally demanding for staff were situations that were difficult to make sense of because of their complexity, situations in which memories of painful prior experiences were triggered, and situations of perceived lack of collegial support.

The findings imply that services applying or implementing TIP must acknowledge the strain staff members may endure being the 'instruments of change'. A specific focus should be placed on the staff's personal and emotional needs. I suggest establishing organisational and cultural practices and routines aimed at strengthening shame-resilience and self-compassion. To be able to face dysregulating situations on a day-to-day basis, the work environment must entail a culture of other-regulation, wherein cultural safety, transparency, and collegial support are emphasised. In addition, to be able to invest so much of themselves in work, personally and emotionally, staff members need an understanding of why they are doing it and confidence in the productivity of the approach. Services practising or implementing TIP must clarify as much as possible what TIP is and what it is not, including a clarification of what is unique or generic to the model. It is of particular importance to clarify the role of authenticity, other-regulation, and boundary setting within TIP. These topics need clarification at a conceptual and theoretical level as well and should be addressed in future TIP research.

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Paper III

CHILD & YOUTH SERVICES
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Experiences of Becoming Emotionally Dysregulated. A Qualitative Study of Staff in Youth Residential Care

Heine Steinkopf[a], Dag Nordanger[b,c], Brynjulf Stige[d], and Anne Marita Milde[e,f]

[a]Regional Trauma Center, RVTS-South, Kristiansand, Norway; [b]OsloMet, Oslo Metropolitan University, Oslo, Norway; [c]RVTS Vest, Helse Bergen HF, Bergen, Norway; [d]The Grieg Academy, University of Bergen, Bergen, Norway; [e]Regional Center for Child and Youth Mental Health and Child Welfare, NORCE AS, Bergen, Norway; [f]Department of Biological and Medical Psychology, University of Bergen, Bergen, Norway

ABSTRACT

Trauma informed care (TIC) emphasizes the importance of professionals maintaining an emotionally regulated state. We interviewed eight staff members in a residential care unit for children and adolescents where TIC had been implemented, about situations wherein they experienced difficulty regulating their own emotions. We identified three major narratives in informants' descriptions: (1) "Are we doing the right things?", (2) "My childhood issues surfaced", and (3) "Missing togetherness with trusted others." The narratives illustrate the emotional strain that can be evoked when working in residential child welfare settings, and within TIC frameworks, and point to potential challenges to resolve when implementing TIC in similar organizations.

KEYWORDS

Co-regulation; residential care; staff emotion dysregulation; trauma-informed care

Introduction

Toward the end of 2018, 1111 children and youth in Norway were living in residential child welfare units (Statistics Norway, 2019). Residential housing is considered the least preferable placement option and is typically selected after the foster parents are unable to fulfill the needs of the children or adolescents (Lehmann & Kayed, 2018). As a consequence, those entering residential programs often have a history of trauma and neglect (American Association Of Children's Residential Centers, 2014; Dovran et al., 2012; Jozefiak et al., 2016). Studies have shown that childhood trauma and neglect may interfere with normal childhood development and cause dysregulation and functional problems in terms of behaviors, emotions, and thoughts (Teicher et al., 2016; van der Kolk, 2014), thereby resulting in

CONTACT Heine Steinkopf heine.steinkopf@rvtssor.no Regional Trauma Center, RVTS-South, Universitetsveien 19, 4630, Kristiansand, Norway.

high-risk behaviors, such as aggression, delinquency, or substance abuse (Zelechoski et al., 2013).

To address these problems, stakeholders focus on the ability of staff members at child welfare residential care units to regulate the aforementioned effects by managing their emotions, avoiding feeling upset, and avoiding retaliation toward negative or provoking behaviors (Lillevik & Øien, 2012). Staff members are encouraged to use the relationship and their embodied actions and reactions as the modality of therapeutic change. This involves conscious use of their body posture, eye-contact, tone of voice, physical touch, and mindful presence (Blaustein & Kinniburgh, 2019; Smith & Spitzmueller, 2016).

On the other hand, emotional dysregulation implies stress-responses of the autonomic nervous system to the level wherein rational thinking is modulated and impaired (Porges, 2011). This may involve various emotions, such as frustration, anger, fear, shame, or sadness. The concept refers to normal experiences and reactions, instead of psychopathology or traumatic stress reactions (Pynoos et al., 1999). Staff in residential child welfare institutions are exposed to stressors with a dysregulating potential. They typically work long hours for a relatively low pay, and have been found to earn less appreciation, compared with other workers in the human service field (Seti, 2008). In addition, they are exposed to the stress related to facing children and adolescents' challenging behaviors, such as noncompliance, aggression, suicide attempts, self-harm, or attempts to run away (Bath & Seita, 2018; Hodgdon et al., 2013; Loughrey et al., 1997). Some staff members have also perceived that superiors do not listen to their input or value them as employees (Decker et al., 2002). Several studies have noted that the context of this type of work implies an elevated risk of burnout, secondary trauma, and compassion fatigue (Brend & Sprang, 2020; Kind et al., 2018; Lakin et al., 2008; Seti, 2008; Tullberg & Boothe, 2019).

Such stressful conditions may influence not only the well-being of staff members, but their work performance as well. Hodgdon et al. (2013) noted that reduced emotional self-regulation among staff may lead to less effective interventions. In a study examining ten residential care programs in Canada, Anglin (2002) found that staff reacted with insensitive and punishing responses when triggered by challenging behaviors from the youth in their care. In a study focused on secure units in Sweden, Andersson (2020) described that narratives of "the violent youth" persisted among the staff, thus potentially justifying coercive interventions. Bath and Seita (2018) further observed that traumatized children and adolescents tend to respond to emotional distress with screaming, threatening behaviors or other expressions that easily dysregulate caretakers and potentially lead to emotional outbursts or harsh reactions.

The importance of the self-regulation capacity of staff members has been particularly emphasized within trauma-informed models of residential care. In Norway, trauma-informed care (TIC) is primarily based on the works of Howard Bath (2008, 2015), who has endorsed the importance of co-regulation around an emphasis on *safety* (feeling safe, physically, emotionally, relationally, and culturally), *connections* (with caring adults, the normal community, and cultural roots), and *coping* (with inner stress and internal challenges) (Bath & Seita, 2018). Co-regulation involves a process wherein the adult caregiver recognizes the stress and inner turmoil of the child and provides a soothing and calming experience through presence and support. The child learns to regulate their own emotions by experiencing the responses of the adult. Over time, the child internalizes these experiences as their own self-regulation capacity (Bath & Seita, 2018; Blaustein & Kinniburgh, 2019).

Similar to other trauma-informed models, Bath's approach represents a mindset or a conceptual framework, instead of a method. The level of operationalization is intentionally low, because it is expected to be combined with more trauma-specific interventions (Bath & Seita, 2018).

The current study is part of a research process involving several stages. First, we designed a qualitative research project that was conducted alongside the implementation of a TIC program in a residential child welfare unit in Norway. The first author was involved throughout this process. The aim of the project was to derive insight regarding the experiences of staff working within a TIC framework and their interpretation of TIC in practice. Results related to the research project are published elsewhere (Steinkopf et al., 2020; Steinkopf et al., 2020). Through the process, we noted that the staff experiences in situations they encountered on a daily basis had the potential to be emotionally dysregulating and further the potential to disrupting their adherence to the TIC model. We administered a new wave of interviews, targeting specific narratives of situations or contexts that may threaten the self-regulation capacity of staff members. We address the following research question: "What factors characterise situations, contexts, and interactions that elicit, or threaten to elicit, emotional dysregulation among staff in this particular Norwegian residential child welfare unit?"

Method

Our qualitative approach is situated within a hermeneutic-phenomenological paradigm (Alvesson & Sköldberg, 2017). The phenomenological aspect is related to our interest in the subjective experiences of participants, and led to the use of individual semi-structured in-depth interviews as the data collection method (Kvale & Brinkmann, 2009). The hermeneutic aspect is

related to the method through which we, as researchers, engaged in the meaning-making process with participants. The final descriptions evolved through a back-and-forth process between the descriptions provided by participants and our interpretations. As recommended by Riessman (2008), to truthfully represent this process, we present the findings in the Results section as a combination of the participants' descriptions and our interpretative reflections (see also Binder et al., 2012).

The concepts of "co-regulation","emotion self-regulation", "and emotional dysregulation" are complex and comprise several layers. In this study, we describe and investigate these concepts through the use of a narrative lens. Bamberg (2012) noted that narratives are "portals into the realm of experience" (p.85). They provide meaning and coherence to life experiences, as well as an understanding of practices as consequences of discourses (Bruner, 1986; Ricoeur, 1992). The description of experiences may in turn lead to future actions and understandings (Riessman, 2008). Therefore, the use of a narrative lens enables the perception of staff being involved in constructing various representations and positions of themselves, their coworkers, the youth, and workplace, as part of their self-regulation project. Moreover, as noted by Kleres (2011), emotions are embedded in narratives—storytelling makes them visible and comprehensible.

Participants

The study location is a public child welfare residential institution in southern Norway, wherein the residing adolescents were aged between 13 and 18 years. When interviews were conducted, the residents had documented histories of trauma and neglect, and the typical length of stay was approximately 12 months. The institution had four adolescent residents with a staff-adolescent ratio of 1:2.

The study participants were all staff who were available at the time scheduled for the interviews, and the total sample comprised of eight staff members—five women and three men. The age range of the participants was 24–65 (mean age 41 years). Six participants had ten years or more of social welfare experience, whereas two participants had less than two years of relevant experience. Seven participants were social workers by education, whereas one was educated as a police officer.

Ethics

The study was approved by the Norwegian Center for Research Data (NSD, ref. number 57112). All participants received written information about the aim of the study and signed a letter of consent. They were

informed about their right to withdraw from the study at any time and that they may not be guaranteed full anonymity, due to the small sample size.

Procedures

The interviews were conducted in-person in a quiet room at the institution. Each interview lasted between 28 and 41 min (mean = 39). Participants were asked to describe situations, events, or interactions that were likely to provoke emotional reactions and potentially produce emotional dysregulation. Furthermore, they were invited to describe the strategies they applied to avoid becoming emotionally dysregulated, and circumstances wherein they experienced inadequacies in these strategies. Following Riessman's (2008) principles of narrative inquiry, coherent stories were facilitated through active listening, vocal and non-verbal prompts (such as "Tell me some more" and "What was the reason?") or by simply repeating the last sentence stated by the participant. All interviews were digitally recorded and later transcribed into Word documents.

Data analysis

The narrative inquiry was based on the overall assumption that storytelling is the primary method of creating meaning and coherence in life (Bruner, 1986; Ricoeur, 1992), and that stories or narratives are a potent method of connecting events in a manner that is consequential for later actions (Riessman, 2008). Analyses were based on Riessman's approach to thematic narrative inquiry, which structures analysis around the content of the stories, instead of linguistic properties or sequential composition. We applied the categorical content mode of reading texts (Lieblich et al., 1998), guided by four analytic steps. The first step is selecting the subtext, which involved reading interviews to identify sections directly related to the research question. Through this step, we identified 29 narrative passages. The second step is determining content categories, wherein passages identified during the first step were categorized into seven categories related to the research question. The third step is sorting the categories into themes, wherein we allocated the seven categories into the following three broader themes: "Are we doing the right things?"; "My childhood issues surfaced"; and "Missing togetherness with trusted others." We selected excerpts for each theme that captured the essential content and meaning of the themes (Kvale & Brinkmann, 2009). The fourth step is drawing conclusions from the results, which involved elaborating on the content in each theme to understand

how staff narratively positioned themselves in relation to the question of emotional dysregulation.

In the current study with a phenomenological and hermeneutic entry, reflexivity is a crucial factor of the research methodology (Alvesson & Sköldberg, 2017). We aimed to derive a self-critical stance throughout the analytic process in which the entire research team took part, voicing critical opinions and questioning interpretations and methods of organizing data. The first author participated as a supervisor for the TIC implementation process at the examined unit and has extensive experience with similar work. Such experience may lead to numerous preconceptions and hypotheses about factors that one would expect to find. Through discussions regarding this issue, the research team identified expectations that participants would become more easily dysregulated by interactions that triggered challenging emotions, as well as interactions where they did not experience social support. Such preconceptions were scrutinized by the group to minimize their potential to affect the interview process and data interpretation.

Moreover, we used respondent validation (Torrance, 2012) as a form of triangulation, wherein preliminary findings and interpretations were regularly discussed individually with participants. During this process, our understandings of participants accounts were clarified, and they could add supplementary Information. Participants expressed confidence in the process through which the study findings were analyzed and interpreted.

Results and discussion

We will organize the results section based on the three overarching themes: (1) "Are we doing the right things?," wherein participants' narratives of emotionally dysregulating experiences were focused on doubt and emotional strain. (2) "My childhood issues surfaced," wherein informants linked emotionally dysregulating experiences to their prior life experiences. (3) "Missing togetherness with trusted others," wherein narratives focused on experiences relating to lack of support in challenging situations or interactions with adolescents. In the first theme, the experiences of all eight participants are represented, whereas the second and third themes represent descriptions from five participants. The narratives presented are excerpts from longer responses to the questions from the interview guide described above. Pseudonyms have been used to refer to participants for the sake of confidentiality.

Are we doing the right things?

In the following excerpt, "Heidi" reflected on her thoughts and feelings connected to a specific situation involving an adolescent with unpredictable

behavior. She highlighted her mental and emotional struggles as she experiences feelings of doubt and uncertainty (R = Researcher):

R: Well, this is interesting. Would this be an example of a situation that could lead to … failures?

Heidi: Yes. Yes.

R: So … then we're at the question (of dysregulation).

Heidi: Yes, this is very challenging. I'm looking for answers because I'm so afraid she'll feel rejected. We've built this base, you know, and she's so concerned that I notice everything she does, you know. If she refrains from making a mess at dinner time, and I don't notice, she makes a case of it: "Don't you see, I've stopped … " It's like walking on a tightrope. About this unhealthy intimacy that's an issue now, it centers around my worries that … this intimacy, this closeness, I feel it is a way of controlling me.

When asked about situations or contexts that may lead to dysregulation, Heidi was preoccupied with meaning-making. She wondered if she was using the right methods, or whether she would ruin the relational base that she perceives to have been built between herself and the adolescent. She aimed at being perceptive to determine and respond to the initiative made by the adolescent. If not, she feared that the adolescent would feel rejected and react with anger and aggression. She described the situation as "walking on a tightrope." In the meaning-making process, she also wondered if she is excessively yielding, and whether she is allowing the adolescent to control her in an unhealthy manner. This is further accentuated as the narrative goes on:

R: Mm. According to the model (TIC), you would think that meeting her needs was the right thing to do …

Heidi: Yes, but she doesn't let go of me.

R: What are your thoughts about this?

Heidi: I feel it's … you know, this is very emotional for me. Let me take an example. We've been sitting together, I've been caressing her, you know. She looks at her watch and realises it is close to bedtime (…). Then, even though watching TV is important to her, she starts to tie her hands to my shoelaces to prevent me from leaving her. Then I have to twist my shoes off and become strict, and tell her to let go that it is bedtime, and I will see her in the morning. Then she goes on saying she'll kill herself; I will not see her in the morning, she will overdose, and a whole lot of threats. I just have to repeat what I'm saying. See you tomorrow, I have to go to bed. She runs ahead, bars the door, won't let me pass. You know, we're able to joke about it in the middle of everything, I pass and go to the office to write up the report. She forces her way into the office, and then everything just escalates, and it all ends with a restraint situation. (…) It is so painful, it's … twisting my soul. I go to bed and hear her screaming outside … those situations, it

> just builds up. These situations are so hard, I feel. I keep thinking about the baby child inside her, how do you meet her in a good way? (…) Then she screams at me that she doesn't trust me anymore, everything is lost, I'm a fucking whore… The next morning all is forgotten; I hug her, and all is fine, and we start all over, this dance. It's tough, you know. I feel this is a critical thing about TIC. You have to make yourself so vulnerable, to allow all this to play out. How long can you take it? So many emotions inside me are activated.

The context for this narrative was an adolescent exhibiting behaviors that Anglin (2002) referred to as pain-based behaviors, involving self-harm, suicidality, and acting out in ways that elicited frequent restraint situations. She would quickly shift between mental states, from being calm to becoming agitated, and then back again. In one moment, she would behave in a manner akin to a child younger than her age, displaying apparent childish needs and behaviors, whereas in the next moment, she would act more in accordance with her age. Heidi described the emotional strain involved for staff when they are unaware about whether their actions, interventions, and choices will benefit the development of the adolescents. In such complex situations, staff will be "looking for answers," even though the "right" choice of intervention is not self-evident. Interventions may even be harmful to the youth or oneself.

The emotional strain involved for staff is evident through the following lines: "It is so painful, it's … twisting my soul. I go to bed and hear her screaming outside… those situations, it just builds up…." Heidi connected the experience of emotional dysregulation to fear or anxiety that follows from situations of doubt, unpredictability, and insecurity. She described a situation of being "in the dark," being in unknown terrain without a map to navigate with. Situations bearing such elements are well-known triggers of anxiety. Some scholars have even considered fear of the unknown as the primary essence of anxiety—"the one fear to rule them all" (Carleton, 2016).

The adolescent's sudden and unexpected shift of state and behavioral mode may lead to an enhanced sense of unpredictability and uncertainty. Heidi described how she and the adolescent would sit together, seemingly having a good time, and the adolescent would suddenly shift from being the "nice person" who appreciates being close, tender, and caressed, into a person who will overdose, kill herself, and scream obscenities at the top of her voice. The situation calls for a state of alertness, wherein staff need to be prepared for a sudden shift at any moment; staff cannot relax and enjoy the happy moments with the youth. Against the background of these experiences of doubt, uncertainty, fear of failure, and unpredictability—the complexity of "the unknown"—Heidís emotional dysregulation is not unusual.

Stress research may deepen our understanding of the dysregulating potential of such situations. Perry (2009) explained that a heightened state

of physiological arousal (e.g., related to situations of unpredictability and uncertainty), reduces connectivity in the prefrontal cortex structure that is crucial for regulating emotions, behaviors, thoughts, and social responses. His term "state-dependent functioning" refers to how the level of physiological arousal dictates the brain areas that are available, and the type of processing that may occur. In situations with high or moderate stress, the brain will be more preoccupied with self-preservation at the cost of reflective thinking and strategic planning (Perry, 1999). Therefore, although the primary task for Heidi is to provide co-regulation for the adolescent through her regulated state, her access to brain areas required for performing this task is at risk of being challenged by the unpredictability, ambiguity, and uncertainty of the situation.

My childhood issues surfaced

In the following two excerpts, narratives about how the staff's own vulnerabilities were triggered are conveyed by "Silje" and "Kari":

R: When it comes to adolescents, who gets you started most easily?

Silje: You mean what category of problems I struggle with?

R: Yes, when you start boiling over.

Silje: I think it must be those who are rude, those who are know-it-alls, better than others, world champions. I work myself up over those (…) I know a bit of what that's about … inside me, why I react so strongly to that category of youth. Those who are so extroverted and know everything, and kind of take control in the group in a way. I struggle with them.

R: You've been thinking about this, and you see why these kids get to you more than others?

Silje: I have. I come from a family where knowledge and mastery were cherished and I have always felt that I was less competent and had less knowledge than others. So, when I encounter these kids who are "know-it-alls," it is not a nice label, but they trigger something inside me, something from my own family.

R: What strategies are useful for you in such situations?

Silje: The most important for me is to express it, talk about it. Then I need not spend so much energy to hide that I … that I feel that way towards these adolescents.

Silje's narrative focused primarily on herself, not on the situation or the interaction with the youth. She attributed her problem of maintaining an emotionally regulated state to personal factors, rather than those within the youth. Kari conveyed a similar narrative:

Kari: Actually, I think it is this patronising attitude when someone looks down at you, commanding … it's degrading, in a way.

R: Yes.

Kari: That's the worst; that's a trigger for me.

R: Someone looking down at you …

Kari: That's a really heavy trigger.

R: (…) Lots of potential triggers, why this one?

Kari: It has something to do with my childhood; my father was very patronising. I guess it's still there.

R: Mm. Mm.

Kari: It's like … during my childhood, there were a lot of shouting, screaming, things breaking. So, such things don't make me feel unsafe, in a way. I've spent a lot of time thinking it over.

R: Yes.

Both narratives express the idea that challenging situations in the present, at the institution-level, are influenced by their own past experiences. Participants describe how memories of adversities serve as triggers for stressful emotions. The first excerpt (Silje) presents childhood experiences of feeling inferior. The narrative also indicates sensitivity to rudeness or disrespect, and promoting oneself at the cost of others; "better than others, world champions, (…) those who are so extrovert and kind of take control in the group." Silje has been reflecting on these issues and has noted an association between these past experiences and a feeling of being "less competent and having less knowledge than others." She described how such memories are evoked by youth with seemingly similar traits or behaviors. Likewise, Kari related a narrative of how memories of childhood familial unrest serve as a buffer against noise, screaming, violence, and threats in the present; "During my childhood, there was a lot of shouting, screaming, things breaking. So, such things don't make me feel unsafe, in a way." On the other hand, her reaction may also reflect a psychological defence mechanism—dissociation or avoidance (Silberg, 2013).

Both narratives can be perceived as reflecting the complexity of these contexts, where reminders of the workeŕs stressful memories from childhood may both provoke emotional dysregulation and simultaneously support mastery by providing familiarity with unpleasant situations. Kari proceeded with a narrative of emotional dysregulation related to encounters with youths who look down at the staff or display a patronizing attitude: "That's the worst; that's a trigger for me." Among numerous potential situations or contexts, a patronizing attitude seems to be the most challenging factor for her emotional regulation. Kari connected her sensitivity toward

this attitude to childhood memories of a patronizing father; youths who evoke this memory are the ones who most easily lead to her losing her temper.

Silje then related the strategy she used to avoid becoming dysregulated: "The most important for me is to express it, talk about it. Then I need not spend so much energy to hide that I … that I feel this way towards these adolescents." She was aware that holding back emotions and motivations consumed energy, because feelings of shame are activated, and that expressing difficult emotions through words can reduce their intensity (Lieberman et al., 2007).

Missing togetherness with trusted others

When "Jon" was asked about situations that could dysregulate him emotionally, he immediately started to discuss the team:

Jon: Well, you're not always sure. But what I would be most wary of would be to work together with someone who didn't know TIC well or … then I feel … eh, I think it may be hard.

R: Yes. Yes.

Jon: I've experienced some situations like that and what we did were not according to the model (TIC). It's got something to do with stability, both with those close in your team. I've seen many times that when colleagues are sick, and we get substitutes … and when they are unfamiliar with the model, then that's a challenge.

R: Yes. Yes.

Jon: Then you need to be more alert than in normal circumstances. You can't do it the way you would normally do.

Jon responded with a narrative of missing support from colleagues, attributing his emotional dysregulation to factors embedded in the team. He described that substitute staff may cause insecurity by being new, and staff members with diverging theoretical perspectives may destabilize the team. The context for the narrative is a situation with an adolescent with particularly challenging behavior. In this situation, less experienced staff may call for stricter boundaries and more restraints, whereas regular staff, who are more immersed in TIC, would argue against such measures. These discussions surfaced regularly during sick-leaves and periods of leadership instability.

Another aspect of "togetherness" is presented in the following story, forwarded by "Silje":

R: What would have made it worse? What would have made you lose it?

Silje: It would have been to be all alone. To have no backing. It's essential that I have someone close who understands me, or if I hadn't been working on my problems, if I didn't know of my challenges … then I guess the negative voices inside my head would have won and just continued to tell me what a

> failure I am and how bad I acted in this or that situation. Then I guess I would have lost it. But I feel I've improved since I've been working on it, and became more conscious about it. (…) You know, I have these reliable colleagues who support me when I've been uncertain. We've sat down and talked and discussed what can we do, what are the options …

As outlined above, when Silje was asked about emotionally dysregulating situations, her initial narrative focused on the childhood memories that were triggered. When asked about the factors that would escalate the situation—or cause her "boil over"—her response also turns to a narrative of togetherness, or lack thereof: "It would have been to be all alone." She continued referring to "negative voices" inside her head that would tell her "what a failure" she was and judge her performance. The "fear-of-failure" component can be noted in Silje's narrative. However, she also explained how she was able to cope due to co-regulation with a colleague: "I have these reliable colleagues who have supported me when I've been uncertain," thereby illustrating how co-regulation in staff–staff interactions serve to maintain an emotionally regulated state. She expressed the need for support from colleagues: "It's *essential* that I have someone close who understands me." Using the word "understand," she seemingly referred to something more tangible than professional support. She may have addressed more personal needs or challenges. However, her narrative reflects the fundamental human need to feel emotionally connected to others, and a key factor of this connection is the need to be understood (Porges, 2011). Social rejection, as the antagonist, is a widely acknowledged driving factor of anxiety (Buss, 1990). The emotional content of the narrative is prominent; fear of being a failure, fear of being alone or cut off from "the pack," and shame connected to the negative voices who will nail her to her failures.

Discussion

Residential care staff are subjected to various stressors that may challenge their capacity to maintain an emotionally regulated state. In this study, we addressed the phenomenological aspects of dysregulating situations, contexts, and interactions that were dysregulating. We identified the following narrative themes: "Are we doing the right things?"; "My childhood issues surfaced"; and "Missing togetherness with trusted others." These themes are focused on unpredictability, uncertainty, fear of failure, the effects of adverse childhood memories in daily practice, and the importance of social support

Studies regarding the emotional strain on staff at residential care units have focused on various external factors, such as pay, work hours (Seti, 2008), adolescents' challenging behaviors, noncompliance, suicide attempts, self-harm (Hodgdon et al., 2013), and secondary traumatization through the stories of these adolescents (Kind et al., 2018). Therefore, in the current study, the

participants' "self-scrutinising" focus was a notable factor. Narratives about emotionally dysregulating situations for staff may have been expected to be focused on the aggressive, violent, or suicidal behaviors of adolescents. However, the narratives presented in this study are focused on the staff's emotions that they perceived to be difficult to process and cope with. They described feelings of insecurity, helplessness, loneliness, failure, and shame. Moreover, participants did not externalize the causes of these emotions, but instead attributed them to factors within or among themselves. In the first theme ("Are we doing the right things?"), difficult emotions were primarily attributed to the continuous meaning-making processes in a complex work situation, such as that of a residential care unit. Without any clear answers, there is a situation-based negotiation of decisions regarding how can intervene. In the second theme ("My childhood issues surfaced"), staff blamed themselves and highlighted emotional vulnerabilities rooted in their childhood experiences. In the third theme ("Missing togetherness with trusted others"), they blamed their team members, and attributed experiences of becoming emotionally dysregulated to lack of support from other staff.

Participant narratives highlight the emotional strain that can be provoked when working within a TIC framework. Heidi stated that "you have to make yourself so vulnerable, to allow all this to play out." She implied that the trauma-informed mindset requires increased tolerance from staff and this method of working allows room for emotional and behavioral expressions to play out, compared with many other approaches. Because TIC is not a uniform method with operationalized interventions (Harris & Fallot, 2001; SAMHSA, 2014), staff are repeatedly subjected to interpretations and negotiations (Donisch et al., 2016; Hanson & Lang, 2016). The framework is based on the idea that the development of adolescents is facilitated through the ability of staff members to tolerate this complexity and deal with the often unexpected emotions and behaviors through their inner state. Therefore, one may note that TIC models welcome anxiety and emotional dysregulation, by challenging the deep-rooted human needs of predictability and control.

The narratives provided by informants highlight the emotional strain of being regularly exposed to these factors. As more services adapt trauma-informed practices to address the needs of traumatized adolescents (Tullberg et al., 2017; Yatchmenoff et al., 2017), it is increasingly crucial to acknowledge these emotional costs. If not, they may lead to frustration and demands for interventions that promise increased predictability and order (Van Beurden et al., 2013), beyond setting safe boundaries and having consistent routines. To avoid these processes, efforts must be focused toward ensuring that staff are in agreement about the theoretical model being used, and that all stakeholders, including the management and supervisors, commit to the same model (Sundborg, 2019).

Moreover, the participant narratives serve to highlight research that showed the effect of stressful childhood experiences on emotional functioning during later stages in life. Both Silje and Kari noted that emotional vulnerabilities originating from their past led them to become emotionally dysregulated. Many studies have demonstrated strong associations between stressful childhood experiences and a spectrum of social and emotional challenges in adulthood (Felitti & Anda, 2010), including the tendency to become more easily emotionally dysregulated (Cozolino & Siegel, 2010; van der Kolk, 2014). Awareness regarding such mechanisms may be particularly relevant in terms of working in a child welfare residential setting. First, as noted by the study participants, such work involves exposure to encounters that are likely to trigger challenging early-life experiences. Staff in residential care units run a high risk of being exposed to both physical and non-physical violence and aggression in the context of their work (Bath & Seita, 2018; Tullberg & Boothe, 2019; Wilson et al., 2017).

Second, some evidence suggest that residential care workers may have higher levels of adverse childhood experiences (ACEs) than the general population (Hiles Howard et al., 2015). Regardless, even if residential care staffs ACE levels are no lower than the prevalence in the community (Maunder et al., 2010)—given the need for residential care workers in TIC to leverage their emotional experience and expression in the service of the children in their care, and evidence suggesting an association between adverse childhood experiences and psychological distress (Maunder et al., 2010), this warrants more attention.

Against this background, despite being a delicate issue, the participant narratives may support the idea of making past stressful experiences of child welfare staff an explicit theme. Tullberg and Boothe (2019) discussed secondary trauma among child welfare staff, and argued that this must be addressed at an *organizational* level to avoid leaving it to staff as an individual responsibility. They noted that the use of self-care strategies alone are ineffective in terms of relieving secondary trauma symptoms (Bober & Regehr, 2006), and suggested that supervisors and managers must be trained to identify symptoms and address them effectively. The participant narratives are not focused on secondary traumatic stress, nor about how memories or experiences of a traumatic character were triggered. However, their descriptions highlight the importance of addressing different types of prior negative experiences in a coherent and agency-based manner, as part of the cultural practice of agencies.

One such cultural practice may include explicitly attending to the emotional experiences of residential care workers through strategies that promote the development of self-and co-regulation skills into the structural procedures in child welfare residential settings. Although the concept of co-regulation

originates from developmental psychology and primarily refers to the care methods used for infants (Tronick, 2007), the participants emphasized the importance of togetherness as a reminder of the more general relevance of the concept. Research has identified social support as the most central protective factor in times of stress and hardships (Seikkula et al., 2003), thereby indicating that our need for co-regulation continues throughout our life cycle. According to Porges (2011), engaging in relationships is our primary source of emotional regulation and stress management. When we feel upset or afraid, our primary line of defence is to reach out to other humans for self-regulation. If this strategy fails, our brain retreats to more basic defence mechanisms, such as fight, flight, freeze, or submission (ibid.). Moreover, because one cannot constructively regulate others while being dysregulated, such mechanisms reduce the ability of staff to handle the challenging behaviors and emotional expressions of adolescents. The concept of co-regulation is an integral part of the TIC perspective on fulfilling the needs of traumatized adolescents. As observed by Brend and Sprang (2020), the practices embedded in TIC may both address and reduce distress among staff. However, in their article, they referred to secondary traumatic stress, whereas our study focuses on emotional dysregulation in general, and ensuring that general TIC practices that are crucial for organizational and cultural systems of collegial support may serve to integrate the various aspects of TIC (see also Blaustein & Kinniburgh, 2019; Bloom, 2013; Brend & Sprang, 2020).

Strength and limitations

The contribution of the current study is limited due to its sample size and small-scale qualitative analysis. Moreover, interviewees were attuned to having a reflexive attitude toward their own practice due to their TIC training. This may account for their self-scrutinising focus and their awareness of potential influences from their own childhood experiences. However, their TIC training ensures that our study is increasingly relevant for other child welfare systems where such approaches are implemented or in the process of being implemented. The study provides situated, contextual descriptions of real-life challenges for residential care workers partaking in such processes. Along with reports from other contexts, our study results may provide a background for further advances in residential treatment and care.

Conclusions and implications for practice

In this study, situations and contexts resulting in the risk of staff becoming emotionally dysregulated were connected to emotions of insecurity, helplessness, loneliness, failure, and shame, elicited by complex situations and

contexts. Participants also reported emotion dysregulation connected to triggering distressing memories and the fear of being disconnected from others. These narratives suggest a need for cultural and organizational responses to address the prevailing stress involved in day-to-day decision making. Furthermore, although this is a sensitive issue, it may be useful to address the distressing childhood memories of staff members that are triggered by the youth, through organizational practices and routines. These structures may also serve to enhance feelings of connectedness within the organization. Finally, these findings suggest that adherence to TIP models may imply more emotional strain for staff, compared to other models, thus indicating a promising topic for future research efforts.

ORCID


Heine Steinkopf http://orcid.org/0000-0002-3329-3204

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Appendix

Appendix 1:

Emne: Sv: Traumebevisst institusjonsbehandling av barn og ungdom med komplekse traumer;
Fra: post@helseforskning.etikkom.no
Dato: 04.12.2014 15:57
Til: heine.steinkopf@bufetat.no
Kopi:

Vi viser til innsendt skjema for fremleggingsvurdering for ovennevnte prosjekt *Traumebevisst institusjonsbehandling av barn og ungdom med komplekse traumer*, mottatt *10.11.2014*. Leder av REK sør-øst C har nå vurdert henvendelsen, med tilhørende dokumentasjon.

Det fremgår av søknaden at man skal måle effekten av implementert modell (NMT) på de ansattes språkliggjøring av fenomener de observerer, samt undersøke om organisasjonskulturen endrer seg i "traumebevisst" retning. Det skal forskes på ansatte, og metoden som skal innføres ser ut til å være etablert som en anerkjent behandlingsmetode.

Komiteen mener, basert på den dokumentasjonen som er fremlagt, at studien således ikke har til formål å skaffe til veie ny kunnskap om sykdom og helse, slik dette forstås i helseforskningslovens § 4.

Prosjektet er derfor ikke fremleggelsespliktig, jf. helseforskningslovens §§ 2 og 4. Studien kan gjennomføres uten REK-godkjenning.

REK antar for øvrig at prosjektet kommer inn under de interne regler for behandling av opplysninger som gjelder ved ansvarlig virksomhet. Søker bør derfor ta kontakt med enten forskerstøtteavdeling eller personvernombud for å avklare hvilke retningslinjer som er gjeldende.

Vi gjør oppmerksom på at avgjørelsen av spørsmålet om fremlegging er å anse som veiledende jfr. forvaltningsloven § 11.

Med vennlig hilsen

Claus H. Thorsen
Rådgiver
Sekretariatet
REK sør-øst

NSD

Heine Steinkopf
Institutt for biologisk og medisinsk psykologi Universitetet i Bergen
Jonas Lies vei 91
5009 BERGEN

Vår dato: 11.12.2017 *Vår ref: 57112/3/OOSRH* *Deres dato:* *Deres ref:*

TILBAKEMELDING PÅ MELDING OM BEHANDLING AV PERSONOPPLYSNINGER

Vi viser til melding om behandling av personopplysninger, mottatt 10.11.2017 og e-post med oppfølgende informasjon mottatt 04.12.2017. Meldingen gjelder prosjektet:

57112	*Trauma-informed residential care for children and adolescents with complex trauma. The neuro-sequential model of therapeutics and its effect on organisational culture*
Daglig ansvarlig	*Heine Steinkopf*

For sen melding av meldepliktig prosjekt
Det fremgår av meldeskjema at første fase av prosjektet allerede er påbegynt ved at informasjon er gitt til utvalget og datainnsamling er påbegynt. Manglende melding er av daglig ansvarlig begrunnet med usikkerhet om prosjektet var meldepliktig eller ikke. Personvernombudet finner dette beklagelig, og minner om at prosjekter som omfattes av meldeplikten skal meldes senest 30 dager før oppstart.

De registrerte lydopptakene av intervjuene inkluderer rolle ved arbeidsstedet (som for eksempel leder), gjør at datamaterialet fremstår som indirekte identifiserbart. Personvernombudet har vurdert prosjektet og finner at behandlingen av personopplysninger omfattes av meldeplikten iht. personopplysningsloven § 31.

Personvernombudet kan foreta en vurdering av om prosjekter er i henhold til de rammene som er gitt av personopplysningsloven. I avsnittet som følger har vi ført opp de merknadene vi har til prosjektet slik det er utført og bør utføres ved videre oppbevaring av datamaterialet.

Informasjonsskrivet
Utvalget informeres skriftlig om prosjektet og samtykker til deltakelse. Informasjonsskrivet er godt utformet, og personvernombudet har ingen innvendinger til den informasjonen som har blitt gitt.

Datasikkerhet
Personvernombudet legger til grunn at forsker etterfølger Universitetet i Bergen sine interne rutiner for datasikkerhet. Dersom personopplysninger skal lagres på privat pc /mobile enheter, bør opplysningene krypteres tilstrekkelig.

Prosjektslutt
Forventet prosjektslutt er 18.06.2019. Ifølge prosjektmeldingen skal innsamlede opplysninger da anonymiseres. Personvernombudet gjør oppmerksom på at anonymisering innebærer å bearbeide datamaterialet slik at ingen enkeltpersoner kan gjenkjennes. Det gjøres ved å:
- slette/omskrive indirekte personopplysninger (identifiserende sammenstilling av bakgrunnsopplysninger som f.eks. arbeidssted og arbeidstittel)
- slette digitale lydopptak

Avslutning

Personvernombudets vurdering forutsetter at prosjektet gjennomføres i tråd med opplysningene gitt i meldeskjemaet, korrespondanse med personvernombudet, samt personopplysningsloven med forskrifter.

Det gjøres oppmerksom på at det skal gis ny melding dersom behandlingen endres i forhold til de opplysninger som ligger til grunn for personvernombudets vurdering. Endringsmeldinger gis via et eget skjema, http://www.nsd.uib.no/personvernombud/meld_prosjekt/meld_endringer.html. Det skal også gis melding etter tre år dersom prosjektet fortsatt pågår. Meldinger skal skje skriftlig til ombudet.

Personvernombudet har lagt ut opplysninger om prosjektet i en offentlig database, http://pvo.nsd.no/prosjekt.

Personvernombudet vil ved prosjektets avslutning, 18.06.2019, rette en henvendelse angående status for behandlingen av personopplysninger.

Ta gjerne kontakt dersom noe er uklart.

Vennlig hilsen

Marianne Høgetveit Myhren

Øyvind Straume

Appendix 2:

Forespørsel om deltakelse i forskningsprosjektet

«Traumainformed residential care for children and adolescents with complex trauma; the Neurosequential Model of Therapeutics and its effect on organizational culture».

Bakgrunn og hensikt

Dette er et spørsmål til det om å delta i en forskningsstudie som har som målsetting å øke forståelsen for barn og unge med omfattende traumeerfaringer, og spesielt barn som utsettes for svært tidlige belastninger.

I deler av hjelpetjenestene er det et behov for ny kunnskap, og kanskje også holdningsendringer for å kunne hjelpe disse barna på en hensiktsmessig måte.

I denne forbindelsen ønsker vi å prøve ut «the Neurosequential Model of Therapeutics» (NMT) sammen med Traumebevisst omsorg (TBO) på en strukturert måte i en barnevernsinstitusjon, og se om denne nye forståelsen også faktisk bidrar til endringer i holdning og forståelse hos de ansatte.

Studien er en del av et PhD program ved Universitetet i Bergen, og driftes av RVTS-sør. Veiledere for prosjektet er dr.Psychol Dag Nordanger ved RKBU, dr. Psychol Anne Marita Milde ved UIB, og dr. Polit Anne Halvorsen ved UIA.

Miljøterapeuter ved institusjonen Orion (Buskerud Ungdomssenter) deltar som informanter i prosjektet.

Hva innebærer studien?

Det gjennomføres et semi-strukturert intervju med miljøterapeutene på to tidspunkt; tidlig i implementeringen av NMT, og etter ca 2 år.

Intervjuet kan bidra til kunnskapsutviklingen om best mulig omsorg for barn og ungdom i barnevernsinstitusjoner i Norge.

Hva skjer med informasjonen du gir?

Lydopptaket gjøres på båndopptaker. Opptaket overføres til en ekstern datalagringsdisk hvor lydfilene passordbeskyttes. Den eksterne datalagrinsdisken oppbevares nedlåst. Opptaket på båndspilleren slettes umiddelbart. Lydfilen transkriberes, og det transkriberte materialet oppbevares nedlåst. Lydfiler og transkribert materiale oppbevares til PhD´en er godkjent, og slettes deretter.

Frivillig deltakelse

Deltakelse i studien er frivillig, og du kan når som helst trekke ditt samtykke, og kreve at intervju som er gjort av deg, både lydopptak og de transkriberte intervjuene slettes, og ikke blir en del av datamaterialet for studien.

Personvern

All informasjon om deg blir anonymisert, og filene (lyd og tekst) lagres med koder og ikke med navn. Samtidig er dette en studie med relativt få informanter, og det vil være mulig å identifisere hvem som hadde jobb på Orion på den tiden intervjuene ble gjort, selv om ditt navn ikke blir brukt.

Samtykke til deltakelse i studien

Jeg er villig til å delta i studien.

Dato: _____Navn:_____

Appendix 3:

Intervjuguide: første intervjurunde, 2015

Alder:

Kjønn:

Utdanning:

Erfaring:

Hva er din personlig filosofi omkring det å arbeid med barn og unge?

Fortell meg litt generelt om barn og ungdom du jobber med, hvordan forstår du årsakene til deres vansker?

Ungdommene som bor her, hva trenger de først og fremst?

Hva trenger de for å utvikle seg bra? Hva er din Endringsteori?

Hvilke kvalifikasjoner, egenskaper trenger hjelpere? Hva kreves for å være en regulerende voksen?

Hva med ungdommer som utfordrer, tøyer grenser?

Hvis du var leder, ville du gjort endringer, hva ville du gjort annerledes i tilfelle?

Hvilke råd vil du gi til andre i tilsvarende jobb

Er det noe du savner i den tilnærmingen dere har nå?

Fortell om en episode som illustrerer godt/dårlig arbeid, evt gav arbeidsglede

Kan du peke på noe i ditt eget liv som forklarer yrkesvalg? Hvorfor er du i denne jobben?

Intervjuguide, 2. Intervjurunde, 2016

Alder:

Kjønn:

Utdanning:

Erfaring:

Etter 2 år med Traumebevisst praksis; kan du si litt om modellen, om innholdet slik du ser det, hva er annerledes enn andre modeller?

Hvordan har prosessen vært, både personlig og arbeidsmessig?

Har noe endret seg?

- Har noe endret seg som angår din faglige forståelse?
- Har du endret deg som menneske på noen måte?
- Har det skjedd noen endringer i praksis? Endringer i måten du jobber på?
- Hvis du har endret noe, hvordan har du opplevd det?
- Endring i forholdet til kolleger?
- Endret din forståelse av hva ungdommene strever med?

Hvordan er forholdet mellom dine personlige verdier, og verdiene i TBO?

Ser du eventuelt noen ulemper med modellen?

Hvis vi hadde spurt ungdommene, hva ville de sagt om TBO?

Kan du se noen kostnader ved modellen? For deg personlig?

Noen har opplevd sykemeldinger.. Hvis noe av det er jobbrelatert, hva kan det være?

Hvilke egenskaper trenges for å jobbe etter en slik modell?

Hva skal til for å være en regulerende voksen?

Hvordan klarer du selv å være regulert?

Hva tenker du om selve implementeringsprosessen, hva kunne vært annerledes?

Hvilke tanker har du om det nevrobiologiske perspektivet? Hvordan har du opplevd de kartleggingene som er gjort?

Hvis du skulle tenke organisasjonskultur, hva kreves for å drive en traumebevisst praksis?

Hva tenker du om ditt forhold til å vise egne følelser og egen sårbarhet?

Intervjuguide 3. intervju, 2018:

Alder:
Kjønn:
Utdanning:
Erfaring:

Hva gjør du for å regulere en ungdom?

Hva gjør dere for å regulere ungdom?

Hva er din typiske strategi når du skal regulere en ungdom?

Kan du beskrive en situasjon hvor du ikke klarte å etterleve modellen, målsettingen (i TBO?)

Når har du mislykkes med dine typiske strategier?

TBO som modell har føringer for hvordan en andre-regulerer; har du opplevd at du ikke klarer å etterleve disse føringene? (innenfor eller utenfor TBO-modellen)

Hva var det ved situasjonene, ungdommene, deg, som gjorde det vanskelig?

Hva tenker du om grensesetting i TBO?

Hva opplever du er institusjonens strategier for reguleringsarbeid?

Doctoral Theses at The Faculty of Psychology, University of Bergen

1980	Allen, Hugh M., Dr. philos.	Parent-offspring interactions in willow grouse (Lagopus L. Lagopus).
1981	Myhrer, Trond, Dr. philos.	Behavioral Studies after selective disruption of hippocampal inputs in albino rats.
1982	Svebak, Sven, Dr. philos.	The significance of motivation for task-induced tonic physiological changes.
1983	Myhre, Grete, Dr. philos.	The Biopsychology of behavior in captive Willow ptarmigan.
	Eide, Rolf, Dr. philos.	PSYCHOSOCIAL FACTORS AND INDICES OF HEALTH RISKS. The relationship of psychosocial conditions to subjective complaints, arterial blood pressure, serum cholesterol, serum triglycerides and urinary catecholamines in middle aged populations in Western Norway.
	Værnes, Ragnar J., Dr. philos.	Neuropsychological effects of diving.
1984	Kolstad, Arnulf, Dr. philos.	Til diskusjonen om sammenhengen mellom sosiale forhold og psykiske strukturer. En epidemiologisk undersøkelse blant barn og unge.
	Løberg, Tor, Dr. philos.	Neuropsychological assessment in alcohol dependence.
1985	Hellesnes, Tore, Dr. philos.	Læring og problemløsning. En studie av den perseptuelle analysens betydning for verbal læring.
	Håland, Wenche, Dr. philos.	Psykoterapi: relasjon, utviklingsprosess og effekt.
1986	Hagtvet, Knut A., Dr. philos.	The construct of test anxiety: Conceptual and methodological issues.
	Jellestad, Finn K., Dr. philos.	Effects of neuron specific amygdala lesions on fear-motivated behavior in rats.
1987	Aarø, Leif E., Dr. philos.	Health behaviour and sosioeconomic Status. A survey among the adult population in Norway.
	Underlid, Kjell, Dr. philos.	Arbeidsløyse i psykososialt perspektiv.
	Laberg, Jon C., Dr. philos.	Expectancy and classical conditioning in alcoholics' craving.
	Vollmer, Fred, Dr. philos.	Essays on explanation in psychology.
	Ellertsen, Bjørn, Dr. philos.	Migraine and tension headache: Psychophysiology, personality and therapy.
1988	Kaufmann, Astrid, Dr. philos.	Antisosial atferd hos ungdom. En studie av psykologiske determinanter.

	Mykletun, Reidar J., Dr. philos.	Teacher stress: personality, work-load and health.
	Havik, Odd E., Dr. philos.	After the myocardial infarction: A medical and psychological study with special emphasis on perceived illness.
1989	Bråten, Stein, Dr. philos.	Menneskedyaden. En teoretisk tese om sinnets dialogiske natur med informasjons- og utviklingspsykologiske implikasjoner sammenholdt med utvalgte spedbarnsstudier.
	Wold, Bente, Dr. psychol.	Lifestyles and physical activity. A theoretical and empirical analysis of socialization among children and adolescents.
1990	Flaten, Magne A., Dr. psychol.	The role of habituation and learning in reflex modification.
1991	Alsaker, Françoise D., Dr. philos.	Global negative self-evaluations in early adolescence.
	Kraft, Pål, Dr. philos.	AIDS prevention in Norway. Empirical studies on diffusion of knowledge, public opinion, and sexual behaviour.
	Endresen, Inger M., Dr. philos.	Psychoimmuniological stress markers in working life.
	Faleide, Asbjørn O., Dr. philos.	Asthma and allergy in childhood. Psychosocial and psychotherapeutic problems.
1992	Dalen, Knut, Dr. philos.	Hemispheric asymmetry and the Dual-Task Paradigm: An experimental approach.
	Bø, Inge B., Dr. philos.	Ungdoms sosiale økologi. En undersøkelse av 14-16 åringers sosiale nettverk.
	Nivison, Mary E., Dr. philos.	The relationship between noise as an experimental and environmental stressor, physiological changes and psychological factors.
	Torgersen, Anne M., Dr. philos.	Genetic and environmental influence on temperamental behaviour. A longitudinal study of twins from infancy to adolescence.
1993	Larsen, Svein, Dr. philos.	Cultural background and problem drinking.
	Nordhus, Inger Hilde, Dr. philos.	Family caregiving. A community psychological study with special emphasis on clinical interventions.
	Thuen, Frode, Dr. psychol.	Accident-related behaviour among children and young adolescents: Prediction and prevention.
	Solheim, Ragnar, Dr. philos.	Spesifikke lærevansker. Diskrepanskriteriet anvendt i seleksjonsmetodikk.
	Johnsen, Bjørn Helge, Dr. psychol.	Brain assymetry and facial emotional expressions: Conditioning experiments.
1994	Tønnessen, Finn E., Dr. philos.	The etiology of Dyslexia.
	Kvale, Gerd, Dr. psychol.	Psychological factors in anticipatory nausea and vomiting in cancer chemotherapy.

	Asbjørnsen, Arve E., Dr. psychol.	Structural and dynamic factors in dichotic listening: An interactional model.
	Bru, Edvin, Dr. philos.	The role of psychological factors in neck, shoulder and low back pain among female hospitale staff.
	Braathen, Eli T., Dr. psychol.	Prediction of exellence and discontinuation in different types of sport: The significance of motivation and EMG.
	Johannessen, Birte F., Dr. philos.	Det flytende kjønnet. Om lederskap, politikk og identitet.
1995	Sam, David L., Dr. psychol.	Acculturation of young immigrants in Norway: A psychological and socio-cultural adaptation.
	Bjaalid, Inger-Kristin, Dr. philos.	Component processes in word recognition.
	Martinsen, Øyvind, Dr. philos.	Cognitive style and insight.
	Nordby, Helge, Dr. philos.	Processing of auditory deviant events: Mismatch negativity of event-related brain potentials.
	Raaheim, Arild, Dr. philos.	Health perception and health behaviour, theoretical considerations, empirical studies, and practical implications.
	Seltzer, Wencke J., Dr. philos.	Studies of Psychocultural Approach to Families in Therapy.
	Brun, Wibecke, Dr. philos.	Subjective conceptions of uncertainty and risk.
	Aas, Henrik N., Dr. psychol.	Alcohol expectancies and socialization: Adolescents learning to drink.
	Bjørkly, Stål, Dr. psychol.	Diagnosis and prediction of intra-institutional aggressive behaviour in psychotic patients
1996	Anderssen, Norman, Dr. psychol.	Physical activity of young people in a health perspective: Stability, change and social influences.
	Sandal, Gro Mjeldheim, Dr. psychol.	Coping in extreme environments: The role of personality.
	Strumse, Einar, Dr. philos.	The psychology of aesthetics: explaining visual preferences for agrarian landscapes in Western Norway.
	Hestad, Knut, Dr. philos.	Neuropsychological deficits in HIV-1 infection.
	Lugoe, L.Wycliffe, Dr. philos.	Prediction of Tanzanian students' HIV risk and preventive behaviours
	Sandvik, B. Gunnhild, Dr. philos.	Fra distriktsjordmor til institusjonsjordmor. Fremveksten av en profesjon og en profesjonsutdanning
	Lie, Gro Therese, Dr. psychol.	The disease that dares not speak its name: Studies on factors of importance for coping with HIV/AIDS in Northern Tanzania
	Øygard, Lisbet, Dr. philos.	Health behaviors among young adults. A psychological and sociological approach
	Stormark, Kjell Morten, Dr. psychol.	Emotional modulation of selective attention: Experimental and clinical evidence.

	Einarsen, Ståle, Dr. psychol.	Bullying and harassment at work: epidemiological and psychosocial aspects.
1997	Knivsberg, Ann-Mari, Dr. philos.	Behavioural abnormalities and childhood psychopathology: Urinary peptide patterns as a potential tool in diagnosis and remediation.
	Eide, Arne H., Dr. philos.	Adolescent drug use in Zimbabwe. Cultural orientation in a global-local perspective and use of psychoactive substances among secondary school students.
	Sørensen, Marit, Dr. philos.	The psychology of initiating and maintaining exercise and diet behaviour.
	Skjæveland, Oddvar, Dr. psychol.	Relationships between spatial-physical neighborhood attributes and social relations among neighbors.
	Zewdie, Teka, Dr. philos.	Mother-child relational patterns in Ethiopia. Issues of developmental theories and intervention programs.
	Wilhelmsen, Britt Unni, Dr. philos.	Development and evaluation of two educational programmes designed to prevent alcohol use among adolescents.
	Manger, Terje, Dr. philos.	Gender differences in mathematical achievement among Norwegian elementary school students.
1998 V	Lindstrøm, Torill Christine, Dr. philos.	«Good Grief»: Adapting to Bereavement.
	Skogstad, Anders, Dr. philos.	Effects of leadership behaviour on job satisfaction, health and efficiency.
	Haldorsen, Ellen M. Håland, Dr. psychol.	Return to work in low back pain patients.
	Besemer, Susan P., Dr. philos.	Creative Product Analysis: The Search for a Valid Model for Understanding Creativity in Products.
H	Winje, Dagfinn, Dr. psychol.	Psychological adjustment after severe trauma. A longitudinal study of adults' and children's posttraumatic reactions and coping after the bus accident in Måbødalen, Norway 1988.
	Vosburg, Suzanne K., Dr. philos.	The effects of mood on creative problem solving.
	Eriksen, Hege R., Dr. philos.	Stress and coping: Does it really matter for subjective health complaints?
	Jakobsen, Reidar, Dr. psychol.	Empiriske studier av kunnskap og holdninger om hiv/aids og den normative seksuelle utvikling i ungdomsårene.
1999 V	Mikkelsen, Aslaug, Dr. philos.	Effects of learning opportunities and learning climate on occupational health.
	Samdal, Oddrun, Dr. philos.	The school environment as a risk or resource for students' health-related behaviours and subjective well-being.
	Friestad, Christine, Dr. philos.	Social psychological approaches to smoking.
	Ekeland, Tor-Johan, Dr. philos.	Meining som medisin. Ein analyse av placebofenomenet og implikasjoner for terapi og terapeutiske teoriar.

H	Saban, Sara, Dr. psychol.	Brain Asymmetry and Attention: Classical Conditioning Experiments.
	Carlsten, Carl Thomas, Dr. philos.	God lesing – God læring. En aksjonsrettet studie av undervisning i fagtekstlesing.
	Dundas, Ingrid, Dr. psychol.	Functional and dysfunctional closeness. Family interaction and children's adjustment.
	Engen, Liv, Dr. philos.	Kartlegging av leseferdighet på småskoletrinnet og vurdering av faktorer som kan være av betydning for optimal leseutvikling.
2000 V	Hovland, Ole Johan, Dr. philos.	Transforming a self-preserving "alarm" reaction into a self-defeating emotional response: Toward an integrative approach to anxiety as a human phenomenon.
	Lillejord, Sølvi, Dr. philos.	Handlingsrasjonalitet og spesialundervisning. En analyse av aktørperspektiver.
	Sandell, Ove, Dr. philos.	Den varme kunnskapen.
	Oftedal, Marit Petersen, Dr. philos.	Diagnostisering av ordavkodingsvansker: En prosessanalytisk tilnærmingsmåte.
H	Sandbak, Tone, Dr. psychol.	Alcohol consumption and preference in the rat: The significance of individual differences and relationships to stress pathology
	Eid, Jarle, Dr. psychol.	Early predictors of PTSD symptom reporting; The significance of contextual and individual factors.
2001 V	Skinstad, Anne Helene, Dr. philos.	Substance dependence and borderline personality disorders.
	Binder, Per-Einar, Dr. psychol.	Individet og den meningsbærende andre. En teoretisk undersøkelse av de mellommenneskelige forutsetningene for psykisk liv og utvikling med utgangspunkt i Donald Winnicotts teori.
	Roald, Ingvild K., Dr. philos.	Building of concepts. A study of Physics concepts of Norwegian deaf students.
H	Fekadu, Zelalem W., Dr. philos.	Predicting contraceptive use and intention among a sample of adolescent girls. An application of the theory of planned behaviour in Ethiopian context.
	Melesse, Fantu, Dr. philos.	The more intelligent and sensitive child (MISC) mediational intervention in an Ethiopian context: An evaluation study.
	Råheim, Målfrid, Dr. philos.	Kvinners kroppserfaring og livssammenheng. En fenomenologisk – hermeneutisk studie av friske kvinner og kvinner med kroniske muskelsmerter.
	Engelsen, Birthe Kari, Dr. psychol.	Measurement of the eating problem construct.
	Lau, Bjørn, Dr. philos.	Weight and eating concerns in adolescence.
2002 V	Ihlebæk, Camilla, Dr. philos.	Epidemiological studies of subjective health complaints.

	Rosén, Gunnar O. R., Dr. philos.	The phantom limb experience. Models for understanding and treatment of pain with hypnosis.
	Høines, Marit Johnsen, Dr. philos.	Fleksible språkrom. Matematikklæring som tekstutvikling.
	Anthun, Roald Andor, Dr. philos.	School psychology service quality. Consumer appraisal, quality dimensions, and collaborative improvement potential
	Pallesen, Ståle, Dr. psychol.	Insomnia in the elderly. Epidemiology, psychological characteristics and treatment.
	Midthassel, Unni Vere, Dr. philos.	Teacher involvement in school development activity. A study of teachers in Norwegian compulsory schools
	Kallestad, Jan Helge, Dr. philos.	Teachers, schools and implementation of the Olweus Bullying Prevention Program.
H	Ofte, Sonja Helgesen, Dr. psychol.	Right-left discrimination in adults and children.
	Netland, Marit, Dr. psychol.	Exposure to political violence. The need to estimate our estimations.
	Diseth, Åge, Dr. psychol.	Approaches to learning: Validity and prediction of academic performance.
	Bjuland, Raymond, Dr. philos.	Problem solving in geometry. Reasoning processes of student teachers working in small groups: A dialogical approach.
2003 V	Arefjord, Kjersti, Dr. psychol.	After the myocardial infarction – the wives' view. Short- and long-term adjustment in wives of myocardial infarction patients.
	Ingjaldsson, Jón Þorvaldur, Dr. psychol.	Unconscious Processes and Vagal Activity in Alcohol Dependency.
	Holden, Børge, Dr. philos.	Følger av atferdsanalytiske forklaringer for atferdsanalysens tilnærming til utforming av behandling.
	Holsen, Ingrid, Dr. philos.	Depressed mood from adolescence to 'emerging adulthood'. Course and longitudinal influences of body image and parent-adolescent relationship.
	Hammar, Åsa Karin, Dr. psychol.	Major depression and cognitive dysfunction- An experimental study of the cognitive effort hypothesis.
	Sprugevica, Ieva, Dr. philos.	The impact of enabling skills on early reading acquisition.
	Gabrielsen, Egil, Dr. philos.	LESE FOR LIVET. Lesekompetansen i den norske voksenbefolkningen sett i lys av visjonen om en enhetsskole.
H	Hansen, Anita Lill, Dr. psychol.	The influence of heart rate variability in the regulation of attentional and memory processes.
	Dyregrov, Kari, Dr. philos.	The loss of child by suicide, SIDS, and accidents: Consequences, needs and provisions of help.
2004 V	Torsheim, Torbjørn, Dr. psychol.	Student role strain and subjective health complaints: Individual, contextual, and longitudinal perspectives.

	Haugland, Bente Storm Mowatt Dr. psychol.	Parental alcohol abuse. Family functioning and child adjustment.
	Milde, Anne Marita, Dr. psychol.	Ulcerative colitis and the role of stress. Animal studies of psychobiological factors in relationship to experimentally induced colitis.
	Stornes, Tor, Dr. philos.	Socio-moral behaviour in sport. An investigation of perceptions of sportspersonship in handball related to important factors of socio-moral influence.
	Mæhle, Magne, Dr. philos.	Re-inventing the child in family therapy: An investigation of the relevance and applicability of theory and research in child development for family therapy involving children.
	Kobbeltvedt, Therese, Dr. psychol.	Risk and feelings: A field approach.
2004 H	Thomsen, Tormod, Dr. psychol.	Localization of attention in the brain.
	Løberg, Else-Marie, Dr. psychol.	Functional laterality and attention modulation in schizophrenia: Effects of clinical variables.
	Kyrkjebø, Jane Mikkelsen, Dr. philos.	Learning to improve: Integrating continuous quality improvement learning into nursing education.
	Laumann, Karin, Dr. psychol.	Restorative and stress-reducing effects of natural environments: Experiencal, behavioural and cardiovascular indices.
	Holgersen, Helge, PhD	Mellom oss - Essay i relasjonell psykoanalyse.
2005 V	Hetland, Hilde, Dr. psychol.	Leading to the extraordinary? Antecedents and outcomes of transformational leadership.
	Iversen, Anette Christine, Dr. philos.	Social differences in health behaviour: the motivational role of perceived control and coping.
2005 H	Mathisen, Gro Ellen, PhD	Climates for creativity and innovation: Definitions, measurement, predictors and consequences.
	Sævi, Tone, Dr. philos.	Seeing disability pedagogically – The lived experience of disability in the pedagogical encounter.
	Wiium, Nora, PhD	Intrapersonal factors, family and school norms: combined and interactive influence on adolescent smoking behaviour.
	Kanagaratnam, Pushpa, PhD	Subjective and objective correlates of Posttraumatic Stress in immigrants/refugees exposed to political violence.
	Larsen, Torill M. B. , PhD	Evaluating principals` and teachers` implementation of Second Step. A case study of four Norwegian primary schools.
	Bancila, Delia, PhD	Psychosocial stress and distress among Romanian adolescents and adults.
2006 V	Hillestad, Torgeir Martin, Dr. philos.	Normalitet og avvik. Forutsetninger for et objektivt psykopatologisk avviksbegrep. En psykologisk, sosial, erkjennelsesteoretisk og teorihistorisk framstilling.

	Nordanger, Dag Øystein, Dr. psychol.	Psychosocial discourses and responses to political violence in post-war Tigray, Ethiopia.
	Rimol, Lars Morten, PhD	Behavioral and fMRI studies of auditory laterality and speech sound processing.
	Krumsvik, Rune Johan, Dr. philos.	ICT in the school. ICT-initiated school development in lower secondary school.
	Norman, Elisabeth, Dr. psychol.	Gut feelings and unconscious thought: An exploration of fringe consiousness in implicit cognition.
	Israel, K Pravin, Dr. psychol.	Parent involvement in the mental health care of children and adolescents. Emperical studies from clinical care setting.
	Glasø, Lars, PhD	Affects and emotional regulation in leader-subordinate relationships.
	Knutsen, Ketil, Dr. philos.	HISTORIER UNGDOM LEVER – En studie av hvordan ungdommer bruker historie for å gjøre livet meningsfullt.
	Matthiesen, Stig Berge, PhD	Bullying at work. Antecedents and outcomes.
2006 H	Gramstad, Arne, PhD	Neuropsychological assessment of cognitive and emotional functioning in patients with epilepsy.
	Bendixen, Mons, PhD	Antisocial behaviour in early adolescence: Methodological and substantive issues.
	Mrumbi, Khalifa Maulid, PhD	Parental illness and loss to HIV/AIDS as experienced by AIDS orphans aged between 12-17 years from Temeke District, Dar es Salaam, Tanzania: A study of the children's psychosocial health and coping responses.
	Hetland, Jørn, Dr. psychol.	The nature of subjective health complaints in adolescence: Dimensionality, stability, and psychosocial predictors
	Kakoko, Deodatus Conatus Vitalis, PhD	Voluntary HIV counselling and testing service uptake among primary school teachers in Mwanza, Tanzania: assessment of socio-demographic, psychosocial and socio-cognitive aspects
	Mykletun, Arnstein, Dr. psychol.	Mortality and work-related disability as long-term consequences of anxiety and depression: Historical cohort designs based on the HUNT-2 study
	Sivertsen, Børge, PhD	Insomnia in older adults. Consequences, assessment and treatment.
2007 V	Singhammer, John, Dr. philos.	Social conditions from before birth to early adulthood – the influence on health and health behaviour
	Janvin, Carmen Ani Cristea, PhD	Cognitive impairment in patients with Parkinson's disease: profiles and implications for prognosis
	Braarud, Hanne Cecilie, Dr.psychol.	Infant regulation of distress: A longitudinal study of transactions between mothers and infants
	Tveito, Torill Helene, PhD	Sick Leave and Subjective Health Complaints

	Magnussen, Liv Heide, PhD	Returning disability pensioners with back pain to work
	Thuen, Elin Marie, Dr.philos.	Learning environment, students' coping styles and emotional and behavioural problems. A study of Norwegian secondary school students.
	Solberg, Ole Asbjørn, PhD	Peacekeeping warriors – A longitudinal study of Norwegian peacekeepers in Kosovo
2007 H	Søreide, Gunn Elisabeth, Dr.philos.	Narrative construction of teacher identity
	Svensen, Erling, PhD	WORK & HEALTH. Cognitive Activation Theory of Stress applied in an organisational setting.
	Øverland, Simon Nygaard, PhD	Mental health and impairment in disability benefits. Studies applying linkages between health surveys and administrative registries.
	Eichele, Tom, PhD	Electrophysiological and Hemodynamic Correlates of Expectancy in Target Processing
	Børhaug, Kjetil, Dr.philos.	Oppseding til demokrati. Ein studie av politisk oppseding i norsk skule.
	Eikeland, Thorleif, Dr.philos.	Om å vokse opp på barnehjem og på sykehus. En undersøkelse av barnehjemsbarns opplevelser på barnehjem sammenholdt med sanatoriebarns beskrivelse av langvarige sykehusopphold – og et forsøk på forklaring.
	Wadel, Carl Cato, Dr.philos.	Medarbeidersamhandling og medarbeiderledelse i en lagbasert organisasjon
	Vinje, Hege Forbech, PhD	Thriving despite adversity: Job engagement and self-care among community nurses
	Noort, Maurits van den, PhD	Working memory capacity and foreign language acquisition
2008 V	Breivik, Kyrre, Dr.psychol.	The Adjustment of Children and Adolescents in Different Post-Divorce Family Structures. A Norwegian Study of Risks and Mechanisms.
	Johnsen, Grethe E., PhD	Memory impairment in patients with posttraumatic stress disorder
	Sætrevik, Bjørn, PhD	Cognitive Control in Auditory Processing
	Carvalhosa, Susana Fonseca, PhD	Prevention of bullying in schools: an ecological model
2008 H	Brønnick, Kolbjørn Selvåg	Attentional dysfunction in dementia associated with Parkinson's disease.
	Posserud, Maj-Britt Rocio	Epidemiology of autism spectrum disorders
	Haug, Ellen	Multilevel correlates of physical activity in the school setting
	Skjerve, Arvid	Assessing mild dementia – a study of brief cognitive tests.

	Kjønniksen, Lise	The association between adolescent experiences in physical activity and leisure time physical activity in adulthood: a ten year longitudinal study
	Gundersen, Hilde	The effects of alcohol and expectancy on brain function
	Omvik, Siri	Insomnia – a night and day problem
2009 V	Molde, Helge	Pathological gambling: prevalence, mechanisms and treatment outcome.
	Foss, Else	Den omsorgsfulle væremåte. En studie av voksnes væremåte i forhold til barn i barnehagen.
	Westrheim, Kariane	Education in a Political Context: A study of Konwledge Processes and Learning Sites in the PKK.
	Wehling, Eike	Cognitive and olfactory changes in aging
	Wangberg, Silje C.	Internet based interventions to support health behaviours: The role of self-efficacy.
	Nielsen, Morten B.	Methodological issues in research on workplace bullying. Operationalisations, measurements and samples.
	Sandu, Anca Larisa	MRI measures of brain volume and cortical complexity in clinical groups and during development.
	Guribye, Eugene	Refugees and mental health interventions
	Sørensen, Lin	Emotional problems in inattentive children – effects on cognitive control functions.
	Tjomsland, Hege E.	Health promotion with teachers. Evaluation of the Norwegian Network of Health Promoting Schools: Quantitative and qualitative analyses of predisposing, reinforcing and enabling conditions related to teacher participation and program sustainability.
	Helleve, Ingrid	Productive interactions in ICT supported communities of learners
2009 H	Skorpen, Aina Øye, Christine	Dagliglivet i en psykiatrisk institusjon: En analyse av miljøterapeutiske praksiser
	Andreassen, Cecilie Schou	WORKAHOLISM – Antecedents and Outcomes
	Stang, Ingun	Being in the same boat: An empowerment intervention in breast cancer self-help groups
	Sequeira, Sarah Dorothee Dos Santos	The effects of background noise on asymmetrical speech perception
	Kleiven, Jo, dr.philos.	The Lillehammer scales: Measuring common motives for vacation and leisure behavior
	Jónsdóttir, Guðrún	Dubito ergo sum? Ni jenter møter naturfaglig kunnskap.
	Hove, Oddbjørn	Mental health disorders in adults with intellectual disabilities - Methods of assessment and prevalence of mental health disorders and problem behaviour
	Wageningen, Heidi Karin van	The role of glutamate on brain function

	Bjørkvik, Jofrid	God nok? Selvaktelse og interpersonlig fungering hos pasienter innen psykisk helsevern: Forholdet til diagnoser, symptomer og behandlingsutbytte
	Andersson, Martin	A study of attention control in children and elderly using a forced-attention dichotic listening paradigm
	Almås, Aslaug Grov	Teachers in the Digital Network Society: Visions and Realities. A study of teachers' experiences with the use of ICT in teaching and learning.
	Ulvik, Marit	Lærerutdanning som danning? Tre stemmer i diskusjonen
2010 V	Skår, Randi	Læringsprosesser i sykepleieres profesjonsutøvelse. En studie av sykepleieres læringserfaringer.
	Roald, Knut	Kvalitetsvurdering som organisasjonslæring mellom skole og skoleeigar
	Lunde, Linn-Heidi	Chronic pain in older adults. Consequences, assessment and treatment.
	Danielsen, Anne Grete	Perceived psychosocial support, students' self-reported academic initiative and perceived life satisfaction
	Hysing, Mari	Mental health in children with chronic illness
	Olsen, Olav Kjellevold	Are good leaders moral leaders? The relationship between effective military operational leadership and morals
	Riese, Hanne	Friendship and learning. Entrepreneurship education through mini-enterprises.
	Holthe, Asle	Evaluating the implementation of the Norwegian guidelines for healthy school meals: A case study involving three secondary schools
H	Hauge, Lars Johan	Environmental antecedents of workplace bullying: A multi-design approach
	Bjørkelo, Brita	Whistleblowing at work: Antecedents and consequences
	Reme, Silje Endresen	Common Complaints – Common Cure? Psychiatric comorbidity and predictors of treatment outcome in low back pain and irritable bowel syndrome
	Helland, Wenche Andersen	Communication difficulties in children identified with psychiatric problems
	Beneventi, Harald	Neuronal correlates of working memory in dyslexia
	Thygesen, Elin	Subjective health and coping in care-dependent old persons living at home
	Aanes, Mette Marthinussen	Poor social relationships as a threat to belongingness needs. Interpersonal stress and subjective health complaints: Mediating and moderating factors.
	Anker, Morten Gustav	Client directed outcome informed couple therapy

	Bull, Torill	Combining employment and child care: The subjective well-being of single women in Scandinavia and in Southern Europe
	Viig, Nina Grieg	Tilrettelegging for læreres deltakelse i helsefremmende arbeid. En kvalitativ og kvantitativ analyse av sammenhengen mellom organisatoriske forhold og læreres deltakelse i utvikling og implementering av Europeisk Nettverk av Helsefremmende Skoler i Norge
	Wolff, Katharina	To know or not to know? Attitudes towards receiving genetic information among patients and the general public.
	Ogden, Terje, dr.philos.	Familiebasert behandling av alvorlige atferdsproblemer blant barn og ungdom. Evaluering og implementering av evidensbaserte behandlingsprogrammer i Norge.
	Solberg, Mona Elin	Self-reported bullying and victimisation at school: Prevalence, overlap and psychosocial adjustment.
2011 V	Bye, Hege Høivik	Self-presentation in job interviews. Individual and cultural differences in applicant self-presentation during job interviews and hiring managers' evaluation
	Notelaers, Guy	Workplace bullying. A risk control perspective.
	Moltu, Christian	Being a therapist in difficult therapeutic impasses. A hermeneutic phenomenological analysis of skilled psychotherapists' experiences, needs, and strategies in difficult therapies ending well.
	Myrseth, Helga	Pathological Gambling - Treatment and Personality Factors
	Schanche, Elisabeth	From self-criticism to self-compassion. An empirical investigation of hypothesized change prosesses in the Affect Phobia Treatment Model of short-term dynamic psychotherapy for patients with Cluster C personality disorders.
	Våpenstad, Eystein Victor, dr.philos.	Det tempererte nærvær. En teoretisk undersøkelse av psykoterapautens subjektivitet i psykoanalyse og psykoanalytisk psykoterapi.
	Haukebø, Kristin	Cognitive, behavioral and neural correlates of dental and intra-oral injection phobia. Results from one treatment and one fMRI study of randomized, controlled design.
	Harris, Anette	Adaptation and health in extreme and isolated environments. From 78°N to 75°S.
	Bjørknes, Ragnhild	Parent Management Training-Oregon Model: intervention effects on maternal practice and child behavior in ethnic minority families
	Mamen, Asgeir	Aspects of using physical training in patients with substance dependence and additional mental distress
	Espevik, Roar	Expert teams: Do shared mental models of team members make a difference
	Haara, Frode Olav	Unveiling teachers' reasons for choosing practical activities in mathematics teaching

2011 H	Hauge, Hans Abraham	How can employee empowerment be made conducive to both employee health and organisation performance? An empirical investigation of a tailor-made approach to organisation learning in a municipal public service organisation.
	Melkevik, Ole Rogstad	Screen-based sedentary behaviours: pastimes for the poor, inactive and overweight? A cross-national survey of children and adolescents in 39 countries.
	Vøllestad, Jon	Mindfulness-based treatment for anxiety disorders. A quantitative review of the evidence, results from a randomized controlled trial, and a qualitative exploration of patient experiences.
	Tolo, Astrid	Hvordan blir lærerkompetanse konstruert? En kvalitativ studie av PPU-studenters kunnskapsutvikling.
	Saus, Evelyn-Rose	Training effectiveness: Situation awareness training in simulators
	Nordgreen, Tine	Internet-based self-help for social anxiety disorder and panic disorder. Factors associated with effect and use of self-help.
	Munkvold, Linda Helen	Oppositional Defiant Disorder: Informant discrepancies, gender differences, co-occuring mental health problems and neurocognitive function.
	Christiansen, Øivin	Når barn plasseres utenfor hjemmet: beslutninger, forløp og relasjoner. Under barnevernets (ved)tak.
	Brunborg, Geir Scott	Conditionability and Reinforcement Sensitivity in Gambling Behaviour
	Hystad, Sigurd William	Measuring Psychological Resiliency: Validation of an Adapted Norwegian Hardiness Scale
2012 V	Roness, Dag	Hvorfor bli lærer? Motivasjon for utdanning og utøving.
	Fjermestad, Krister Westlye	The therapeutic alliance in cognitive behavioural therapy for youth anxiety disorders
	Jenssen, Eirik Sørnes	Tilpasset opplæring i norsk skole: politikeres, skoleledereres og læreres handlingsvalg
	Saksvik-Lehouillier, Ingvild	Shift work tolerance and adaptation to shift work among offshore workers and nurses
	Johansen, Venke Frederike	Når det intime blir offentlig. Om kvinners åpenhet om brystkreft og om markedsføring av brystkreftsaken.
	Herheim, Rune	Pupils collaborating in pairs at a computer in mathematics learning: investigating verbal communication patterns and qualities
	Vie, Tina Løkke	Cognitive appraisal, emotions and subjective health complaints among victims of workplace bullying: A stress-theoretical approach
	Jones, Lise Øen	Effects of reading skills, spelling skills and accompanying efficacy beliefs on participation in education. A study in Norwegian prisons.

2012 H	Danielsen, Yngvild Sørebø	Childhood obesity – characteristics and treatment. Psychological perspectives.
	Horverak, Jøri Gytre	Sense or sensibility in hiring processes. Interviewee and interviewer characteristics as antecedents of immigrant applicants' employment probabilities. An experimental approach.
	Jøsendal, Ola	Development and evaluation of BE smokeFREE, a school-based smoking prevention program
	Osnes, Berge	Temporal and Posterior Frontal Involvement in Auditory Speech Perception
	Drageset, Sigrunn	Psychological distress, coping and social support in the diagnostic and preoperative phase of breast cancer
	Aasland, Merethe Schanke	Destructive leadership: Conceptualization, measurement, prevalence and outcomes
	Bakibinga, Pauline	The experience of job engagement and self-care among Ugandan nurses and midwives
	Skogen, Jens Christoffer	Foetal and early origins of old age health. Linkage between birth records and the old age cohort of the Hordaland Health Study (HUSK)
	Leversen, Ingrid	Adolescents' leisure activity participation and their life satisfaction: The role of demographic characteristics and psychological processes
	Hanss, Daniel	Explaining sustainable consumption: Findings from cross-sectional and intervention approaches
	Rød, Per Arne	Barn i klem mellom foreldrekonflikter og samfunnsmessig beskyttelse
2013 V	Mentzoni, Rune Aune	Structural Characteristics in Gambling
	Knudsen, Ann Kristin	Long-term sickness absence and disability pension award as consequences of common mental disorders. Epidemiological studies using a population-based health survey and official ill health benefit registries.
	Strand, Mari	Emotional information processing in recurrent MDD
	Veseth, Marius	Recovery in bipolar disorder. A reflexive-collaborative exploration of the lived experiences of healing and growth when battling a severe mental illness
	Mæland, Silje	Sick leave for patients with severe subjective health complaints. Challenges in general practice.
	Mjaaland, Thera	At the frontiers of change? Women and girls' pursuit of education in north-western Tigray, Ethiopia
	Odéen, Magnus	Coping at work. The role of knowledge and coping expectancies in health and sick leave.
	Hynninen, Kia Minna Johanna	Anxiety, depression and sleep disturbance in chronic obstructive pulmonary disease (COPD). Associations, prevalence and effect of psychological treatment.

	Flo, Elisabeth	Sleep and health in shift working nurses
	Aasen, Elin Margrethe	From paternalism to patient participation? The older patients undergoing hemodialysis, their next of kin and the nurses: a discursive perspective on perception of patient participation in dialysis units
	Ekornås, Belinda	Emotional and Behavioural Problems in Children: Self-perception, peer relationships, and motor abilities
	Corbin, J. Hope	North-South Partnerships for Health: Key Factors for Partnership Success from the Perspective of the KIWAKKUKI
	Birkeland, Marianne Skogbrott	Development of global self-esteem: The transition from adolescence to adulthood
2013 H	Gianella-Malca, Camila	Challenges in Implementing the Colombian Constitutional Court's Health-Care System Ruling of 2008
	Hovland, Anders	Panic disorder – Treatment outcomes and psychophysiological concomitants
	Mortensen, Øystein	The transition to parenthood – Couple relationships put to the test
	Årdal, Guro	Major Depressive Disorder – a Ten Year Follow-up Study. Inhibition, Information Processing and Health Related Quality of Life
	Johansen, Rino Bandlitz	The impact of military identity on performance in the Norwegian armed forces
	Bøe, Tormod	Socioeconomic Status and Mental Health in Children and Adolescents
2014 V	Nordmo, Ivar	Gjennom nåløyet – studenters læringserfaringer i psykologutdanningen
	Dovran, Anders	Childhood Trauma and Mental Health Problems in Adult Life
	Hegelstad, Wenche ten Velden	Early Detection and Intervention in Psychosis: A Long-Term Perspective
	Urheim, Ragnar	Forståelse av pasientaggresjon og forklaringer på nedgang i voldsrate ved Regional sikkerhetsavdeling, Sandviken sykehus
	Kinn, Liv Grethe	Round-Trips to Work. Qualitative studies of how persons with severe mental illness experience work integration.
	Rød, Anne Marie Kinn	Consequences of social defeat stress for behaviour and sleep. Short-term and long-term assessments in rats.
	Nygård, Merethe	Schizophrenia – Cognitive Function, Brain Abnormalities, and Cannabis Use
	Tjora, Tore	Smoking from adolescence through adulthood: the role of family, friends, depression and socioeconomic status. Predictors of smoking from age 13 to 30 in the "The Norwegian Longitudinal Health Behaviour Study" (NLHB)
	Vangsnes, Vigdis	The Dramaturgy and Didactics of Computer Gaming. A Study of a Medium in the Educational Context of Kindergartens.

	Nordahl, Kristin Berg	Early Father-Child Interaction in a Father-Friendly Context: Gender Differences, Child Outcomes, and Protective Factors related to Fathers' Parenting Behaviors with One-year-olds
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