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Prerequisites for Maintaining Emotion Self-regulation in Social Work with Traumatized Adolescents: A Qualitative Study among Social Workers in A Norwegian Residential Care Unit

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**ABSTRACT**

Many adolescents in residential care have a history of traumatization, often with consequences on regulating emotions, thoughts, behaviors, as well as on establishing healthy relationships. Such evidence-based knowledge has paved the way for various trauma-informed models of care that emphasize the adolescents’ need to be other-regulated through caring adults. Being a “regulating other” requires the ability of self-regulation, which may be challenging for staff faced with intense emotional and behavioral expressions from the adolescents. In this qualitative study, fifteen social workers at a residential care unit for adolescents in Norway were individually interviewed on themes addressing what they perceived as necessary prerequisites for maintaining a regulated state in their context of work. Descriptions were analyzed in accordance with principles for thematic analysis. The informants regarded self-reflection and self-acceptance as essential prerequisites for self-regulation. Other salient themes were associated with having a regulating work environment and a trustworthy theoretical model to be guided by. These findings are important for institutions involved in offering competence building in residential care units and academic institutions that educate social workers, as to include systematic training in self-reflection and self-acceptance skills, to strengthen the ability to be a mature regulating other.

**KEYWORDS**

Other-regulation; residential care; emotion self-regulation; trauma-informed practice

**Introduction**

In 2018, 1111 children and adolescents were residing in Norwegian child welfare institutions (Statistics Norway, 2019). Residential care has typically been perceived as “the last resort,” reserved for youth who have failed to respond to other, less restrictive modalities of treatment, e.g., foster care, or community-based approaches (Hodgdon et al., 2013). The child protection service in Norway...
considers home-based interventions as the primary alternative. Consequently, most out-of-home placements take place late in childhood, where foster care is preferred above residential care (Lehmann & Kayed, 2018). The most common reasons for placement in institutions are due to conduct disorder and extensive substance abuse (Backe-Hansen et al., 2011).

According to Jozefiak et al. (2016), 76% of residents in Norwegian child welfare institutions fulfill the criteria for at least one mental health diagnosis. Briggs et al. (2012) found high rates of behavioral problems (80.3%), attachment problems (70%) substance use problems (41.5%), suicidal ideation (30%), criminal activity (30.3%) and self-injurious behaviors (28.4%) among youth residing in institutional care in the US. For many of these children, such difficulties may derive from a history of traumatization (Dovran et al., 2012). In Norwegian residential care institutions, 79% of adolescents have reported prior traumatic experiences (Kayed et al., 2015). Also in other contexts, an overrepresentation of trauma histories in this population has been reported (Baker & Purcell, 2005; Briggs et al., 2012). Several studies have found evidence for a dose-response relation between the number of trauma exposures and the levels of functional impairments across psychosocial parameters (Briggs et al., 2012; Finkelhor, 2008).

In trauma literature, it has become increasingly common to conceptualize the spectrum of consequences of early traumatization as different forms of dysregulation, or lack of self-regulation skills (Schore, 2003; Siegel, 2012; Teicher et al., 2016; Van der Kolk, 2014). A vital characteristic associated with affect dysregulation is limited ability to control or tolerate negative emotional states, often resulting in problems with regulating behavior, emotions, thoughts, and social interactions (Ford & Courtois, 2009; Siegel, 2012). Physiologically, these reaction patterns are related to sympathetic hyperarousal, characterized by hypervigilance, increased heart rate, respiration and muscle tone, or a state of hypoarousal characterized by decreased heart rate, respiration and muscle tone (Porges, 2007; Porges & Furman, 2011).

As treatment- and care models for children and adolescents within recent years stem from different trauma theories, several trauma-informed practices (TIPs) have emerged in clinical practice and social work especially. A standard definition of TIP is given by the Substance Abuse and Mental Health Services Administration (SAMHSA, 2014): “... a program, organization or system that is trauma-informed realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and responds by fully integrating knowledge about trauma into politics, procedures, and practices, and seeks to actively resist re-traumatization” (p 9). In Norway, TIPs are mainly based on the “three-pillar model” of Howard Bath (2008, 2015), namely safety, connections, and coping (initially emotion-regulation). Even though trauma-informed practices have been conceptualized with some
variations by different scholars (Bath, 2008, 2015; Blaustein & Kinniburgh, 2010; Hanson & Lang, 2016; Harris & Fallot, 2001; Hodas, 2006), there is a consensus that affect-dysregulated children and adolescents need to be other-regulated through interactions with stable and caring adults in order to develop a self-regulation capacity of their own (Bath, 2008; Bath & Seita, 2018; Tronick, 2007). The other-regulation concept originates in child development studies and refers to how the infant, when distressed, is emotionally regulated by the caretaker’s tone of voice, warm physical contact and gentle rocking. The repeated cycle of becoming emotionally upset, followed by calming responses from the caretakers, provides a foundation for learning self-regulation (Tronick, 2007). When the child is distressed, both the response and the emotional state of the caretaker are adopted, thus enabling the child’s internalization of a more regulated version of its original emotion. Hence, within this context, other-regulation is vital for the development of mentalization (Fonagy, 2004).

Such specific perception of children and adolescents’ need for other-regulation is aimed toward the importance of interpersonal skills of the helper/caregiver. In enabling skills of other-regulation, the helper needs to maintain a state of self-regulation (Bath, 2015). Faced with aggressive behavior, outbursts, or other strong emotional expressions from adolescents, maintaining self-regulation may be difficult, and failing to do so in the worst-case, may cause the implementation of harmful punitive actions and restraints (Anglin, 2002). Also, research shows that handling adolescents with severe conduct disorder professionally may take its toll in terms of increased proneness to burnout and turnover among child and adolescent welfare workers (Kind et al., 2018; Seti, 2008; Steinlin et al., 2017).

Self-regulation, despite being identified as essential within TIP (Bath & Seita, 2018), few descriptions are to be found on how self-regulation among staff can be achieved in practice. Hence, this study aims at investigating how staff members themselves will explain what they believe is vital for remaining self-regulated faced with challenging situations at their workplace. The following research question is explored; What are social workers’ perceptions of what it takes to stay regulated in interactions with adolescents in their institution?

Method

This study is part of a more extensive qualitative investigation on trauma-informed residential care for children and adolescents in collaboration with the Governmental Child and Family department (BUFetat) and the Regional Trauma Center in Southern Norway (RVTS-south). The aim of the overarching project is to longitudinally monitor the implementation of TIP in one particular child and adolescent welfare institution in Norway. The present study was based on a phenomenological epistemology, where interview data
was analyzed in accordance with Braun and Clarke's (2006) principles for thematic analysis. This epistemology was chosen since we wanted a closeness to the day-to-day experiences of the informants. The study was also informed by a hermeneutic understanding as the researchers continuously interpreted informants’ descriptions and the understanding embedded in the descriptions. (Alvesson & Sköldberg, 2017). The Norwegian Center for Research Data (NSD) approved the study (reference number: 57112). Participants signed a written letter of consent and were informed of the possibility to withdraw the consent at any time during the process with no further consequence. Oral information about the project and issues of securing full anonymity due to a limited sample size was given to all participants.

**Study Site and Participants**

The institution of investigation was the first to implement TIP in Norway in accordance with the three pillars approach (Bath, 2008, 2015). It’s a state-owned institution for adolescents from 13 to 18 years of age. The total sample comprised of fifteen staff members, nine women with a mean age of 35, and six men with a mean age of 48.5. The mean age for the sample was 44.3 years (total range 35–65). Twelve participants had ten or more years of experience from relevant services, two had between 5 and 10 years experience, while the last had less than five years of relevant experience. Eight were social workers by education; three were teachers, one was a nurse, one an occupational therapist, one was an economist while the last informant was a corrections officer. This educational diversity illustrates that “social worker” in Norway is both a separate education, but also a job description that may apply to people with other educational backgrounds who work in social welfare. Most commonly, Norwegian residential care social workers have a bachelor’s degree in social sciences or health-related subjects, but due to sparsity of personnel, educational backgrounds typically vary more outside the larger cities.

In the Norwegian system, residential care is organized into four categories; 1) acute, short-term placements, 2) placements for adolescents with substance abuse problems, 3) placements for adolescents who have experienced general detrimental care with no other available options (e.g., foster care), and 4) placements for adolescents with predominantly behavior problems. The site for the study is an institution within the third category, with four adolescent residents and a staff-adolescent ratio of 1:2. The purpose of the stay is generally to provide a base of safety and positive growth while finding an appropriate foster home or to help the adolescents to establish an autonomous life beyond the age of 18. Length of stay is typically around one year but may vary.
**Procedures**

Data were collected on two different waves with a twelve-month interval. Totally, 19 interviews were conducted. On each occasion, all available staff at the institution were interviewed. Four staff-members were interviewed twice.

We used individual semi-structured in-depth interviews as the source of information (Kvale & Brinkmann, 2009). The interview guide focused on staff’s perceptions of the adolescents’ needs, their thoughts of how troubled children and adolescents can achieve positive change, their understanding of TIP, and staff qualifications deriving from TIP, with particular emphasis on how they were able to self-regulate. The guide also focused on their attitudes and personal values, and their understanding of what was needed for the TIP model to work in organizational culture and structures.

All interviews except one were conducted by the first author face-to-face. One interview was carried out by using Skype. Each interview lasted between 25 and 56 minutes (Mean = 42.5). Interviews were digitally recorded and transcribed verbatim into Word documents by the first author.

**Data Analysis**

As the study addressed staff members’ subjective understanding and experiences, we applied an explorative thematic analysis (Braun & Clarke, 2006). The first author read through the transcriptions thoroughly several times to get an overall impression. Next, the initial coding of possible meaningful units in correspondence with the research question was constructed. The codes were then subjected to further discussions with the coauthors and elaborated into themes in consensus among all authors. We reviewed the themes thoroughly before ultimately categorizing them into the final organizing themes. We also performed respondent validation (Torrance, 2012) by discussing preliminary interpretations with the informants. All analyses were done in Norwegian, and only the selected quotes for the results section were translated into English by the first author. Translations were controlled and verified by all authors. In the quotes, the interviewer’s questions, interjections and fill words were omitted, in order to obtain closeness to the meaning embedded in the quotes and improve readability.

We used the computer program NVIVO (QRS-International, 2018) to facilitate the process.

**Results**

Through the analytic steps outlined above, we found that informants’ reflections on prerequisites for being able to maintain emotion self-regulation could be organized into four main themes; 1) critical self-reflection, 2) self-
acceptance, 3) a regulating work environment, and 4) having a trustworthy theoretical model to be guided by. The first two themes refer to processes aiming at understanding oneself and tolerating their own shortcomings. The theme “A regulating work environment” refers to factors connected to organizational culture, routines, resources, and management. The theme “Having a trustworthy theoretical model to be guided by” refers to informants’ reflections on the need for an overarching model that provides meaning and purpose to their work, thus inspiring a sense of safety. In the following presentation, “some” refers to 2 to 5 informants, “many” and “commonly” refer to 6 to 9 informants, and “most” refers to 10 or more informants.

Critical Self-reflection

As a prerequisite for staying emotionally regulated, faced with strong emotions and challenging behavior, most informants emphasized different aspects of what we have labeled a critical self-reflection. One aspect described by several informants was a need for self-awareness or knowing oneself well, i.e., “You need to know yourself quite well to deal with all the challenges here. It is not just about education and experience, but your ability to be stable or regulated”. Some informants described the importance of self-reflection in terms of the importance of continuously observing yourself when it comes to own vulnerabilities, the origins, and triggers of emotions, and the motives behind responses. As a central aspect of such self-reflection, one informant emphasized the ability to distinguish between own emotions and reactions, and those of the youth;

TIP is about receiving emotions, to experience the emotions of others. On every shift, I contain a lot of emotions … anxiety, powerlessness, grief, or anger. When you’re in the middle of it, you get automatic thoughts about giving up, resigning, going home, or get sick leave. To distinguish between my anxiety and that of the youth is very important.

When further elaborated, the informant explained the critical reflection needed as a form of self-centrism;

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 your vulnerabilities. And you need to be willing to share it with your colleagues.

Some informants explained the importance of self-reflection by pointing at the destructive processes one may fall into if such reflection fails, like if one fails to distinguish between own emotional states, reactions, and needs and those of the youth. One informant described how such a lack of self-reflection might result in blaming the adolescents for their problems;

I feel it is too easy to hide behind the chaotic youth. That way, we don’t have to face our own chaos. We need to look at our own inner processes, our own vulnerabilities, what
affects us, and acts as triggers. That goes for what comes from the youth, but also what comes from other staff. We must dare to address that also.

One informant described a situation where own vulnerabilities were triggered by rejection and negative responses from an adolescent, and how in this particular situation self-reflection was used actively to maintain a regulated state;

Rejection is tough. (…). Then I feel I’m not coping with the situation, and I feel shame. And then you must try to understand; why are they rejecting you, what lies behind the rejection … what are my signals, what am I doing to make the youth reject me? (…). And then, I made it. And it was so good. I humiliated myself and said, I’m sorry, I have met you in a way that is not good for you. Because I felt insecure, and when I feel insecure, I armor up, because I am afraid. I feel bad when you call me a whore, and I put on my armor, I get strict and authoritarian. And I don’t think you need that. And then I was accepted.

The same informant went on to describe how feedback from a colleague, though hard to accept at first, facilitated a self-reflective process:

(…). I got some help from a colleague. 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 realized I felt shame that I had not handled the situation well. So, I started to think about what I could do, and I discussed it with my colleague.

The last excerpt may also illustrate that responses that originate in their own vulnerabilities may not always be triggered by the adolescents alone but also by other factors, such as comments or actions of other staff members.

**Self-Acceptance**

As another prerequisite for maintaining an emotionally regulated state in their work, some of the informants described what we have named an ability of self-acceptance. Though closely related to self-reflection, we found it reasonable to see them as separate themes or phenomena. As we interpreted the informants’ descriptions, they typically termed self-acceptance as an outcome of a critical self-reflection, where they, through perceiving and acknowledging own weaknesses and vulnerabilities, came to the point of accepting them. The following excerpts may illustrate such a process;

I can only speak for myself; I have been through a lot of things in my private life to the extent that I see myself as just who I am. You have to let go. I have experienced anxiety with difficulties breathing and accelerated heartbeat and felt outside of my own body. I think such experiences do things with you, make you accept yourself as who you are. Acknowledge that you’re in a process, and that is demanding. Some are reluctant to share personal issues and have to be competent at all times, not showing weaknesses or vulnerabilities. I guess that’s what it’s all about.
Some of us, including myself, had to go through a process. We had to face a crisis. I had to accept that I was ill (burnout) and that I could not blame it on the system. I had to accept it to be able to look at factors in myself to enable me to handle things differently (...). I have made an agreement with myself that I have reached the other side a stronger person, someone who can recognize own feelings and thoughts in stressful situations.

Some informants described how they achieved self-acceptance through a painful process of self-reflection, where they had to face that the responsibility of their situation was their own. To some informants, self-acceptance seemed to serve the purpose of self-regulation in the following way: Accepting and acknowledging one’s vulnerabilities on a personal level makes it easier to contain and empathize with the pain and vulnerability of the youth. Parts of that perspective may be illustrated by the following quote;

Concerning my personal development, I feel safer, more confident about who I am and what I do. It doesn’t matter so much if I make mistakes. If I do, I can make up to them, make it right. I can be frank. I can convey painful messages without being offensive, and I care about the dignity of the receiver. It is easier to be with adolescents and their families in their moments of crisis without becoming part of the crisis. I am more stable inside my own window of tolerance. I am more regulated, which makes it easier to be supportive.

A Regulating Work Environment

In addition to the more individual qualities and processes outlined above, informants commonly reported that their ability to be emotionally regulated in their work with the adolescents would depend on the presence of certain kinds of support in their work environment. We named this theme “A regulating work environment.” In particular, some informants stressed the need for an organizational culture characterized by openness, i.e.;

To be a community at the institution, where (sensitive issues) are discussed and worked through. We all have our vulnerabilities, and we need a common arena to talk about it, but also do something about it.

Some informants emphasized that the TIP model, as it in itself invites a level of openness, may influence the organizational culture in a positive direction in this regard, i.e., “Especially since we need to have this openness (with this model), you need openness among your colleagues (...) to be able to express all issues, weaknesses, and strengths (...).”

Frequently stressed was also the importance of trust, where all relevant issues could be disclosed and discussed. One informant appreciated the work environment at the care institution for just those reasons, saying that the institution “is a great place to work. We are openhanded and generous, we can disagree about matters, but we discuss it openly, and settle things right”.

Some of the informants drew into attention that for them to maintain an emotionally regulated state in challenging interactions with adolescents, specific system structures had to be in place. Among these were having enough human resources, i.e., “... I’ve seen that when we are enough personnel, situations don’t usually escalate. When staffing is sparse, we have more unrest”.

Another destabilizing factor commonly mentioned was leadership instability. One informant described how such a factor affected him emotionally as follows; “The head of the department was at sick leave, and I felt that the other executives were absent. I was frustrated and angry with the system”. Some related similar concerns to staff-turnover and the use of temporary staff, i.e., “For a period of time, the unit was run by temporary staff. They should be credited for their efforts, but most of them lacked the knowledge and experience of the regular staff”. As yet another structural factor crucial to their ability to be regulating others for the youth, some informants emphasized the importance of standard debriefings;

It is crucial to have debriefing as a standard, mandatory procedure to ensure we focus on the right things. You know, we have chosen this line of work, we work with challenging kids, it is challenging in its own right. But we need a daily debrief, how did you affect your surroundings today, are you content, did I do well?

Having a Trustworthy Theoretical Model to Be Guided By

In various ways, most informants expressed that to be emotionally regulated in their work, and to feel that they were doing a good job, they needed a theoretical model to lean on – a model that they perceived as meaningful to the work with these adolescents. This theme may relate to the general need for a coherent theoretical rationale independently of TIP, but also to the perceived meaningfulness embedded in the TIP model. Having trust in the model and stay committed to it was commonly reported as an essential factor, as stated by one informant: “Staff needs to understand TIP and believe in it (...) They need to feel that ‘this is right’ (...). This must be embedded in the group and in the organizational culture”.

Correspondingly, many informants reported a lack of a meaningful theoretical understanding as a significant source of dysregulation, especially related to the sense-making of adolescent’s symptoms and behaviors. One informant described it as follows;

I do a lot of thinking about (the young person). I cannot calm myself; there is something I can’t control; it makes me uneasy, and makes me look desperately for answers. What is happening? (...). This youth is sending out signals that make me worried; she seems detached but has rapid behavioral changes.

Another informant expressed the need for a theoretical rationale to overrule own primitive emotional reactions:
Rejection is very concrete, and you will naturally feel it unpleasant, and withdrawal is the natural response. Then you have to be aware that your urge to withdraw is not beneficial. So, to have a rationale that can take precedence over your emotional impulses is important.

Informants also commonly described situations where they managed to maintain calm due to their ability to refer their understanding and actions as relevant and purposeful, as exemplified in the following quote:

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.

This informant was unfolding how the theory (trauma-theory) gave substance and meaning to the work they do. It was also emphasized that personal values and values embedded in the model need to fit together; “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 behaviorally oriented facilities”.

**Discussion**

Overall, we found that most participant’s descriptions of prerequisites for emotion self-regulation circled the importance of a critical self-reflection and, subsequently, a state of self-acceptance, supported by a regulating work environment. In addition, the informants described a need for a trustworthy theoretical model to lean on. Descriptions correspond with the general theoretical outline of major TIP models, with emphasis on personal qualities of staff as essential requirements (Bath, 2008, 2015; Blaustein & Kinniburgh, 2010; Harris & Fallot, 2001; Hodas, 2006). Self-reflection was the most salient characteristic of informants’ descriptions, pointing toward an almost radical self-scrutiny and self-disclosure as prerequisites for emotional self-regulation. The direction and intensity of these descriptions may appear unfamiliar to those accustomed to more manualized interventions or models with a more methodological focus. On the other hand, most generic models of residential treatment and care emphasize relationships as an essential agent for change, which directs attention toward reflections on own contribution in relational interactions with youth (Lillevik & Øien, 2015).

Based on these findings, staff emotion regulation is 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).
Self-acceptance is rarely mentioned in TIP literature. The concept may have commonalities with the concepts of self-compassion (Neff, 2003b) and shame resilience (Brown, 2006). Both of these concepts are related to the acceptance of own shortcomings and failures. Self-compassion contains three components; 1) self-kindness, that involves being supportive and understanding toward oneself, 2) a sense of belonging to humanity which entails that all humans make mistakes, and 3) mindfulness, that involves being aware of negative self-talk and confronting it with compassion for oneself (Neff, 2016). Self-compassion strategies seem to contribute to the reduction of stress, depression, and anxiety (MacBeth & Gumley, 2012). Similarly, shame resilience, which involves becoming aware of and accepting feelings of shame and unworthiness, seems to be correlated with general psychological wellbeing, including stress reduction (Brown, 2015). Against this background, self-compassion and shame-resilience measures, like the self-compassion scale (Neff, 2003a) and the shame resilience curriculum (Brown et al., 2011) could prove useful for service providers within residential child welfare seeking to improve their self-regulation skills. The shame resilience curriculum (also known as the connections curriculum) is a twelve session program consisting of theoretical input and experiential exercises. The self-compassion scale is included in the curriculum, in one of the sessions that deal with practicing empathy (Brown et al., 2011).

Informants described that their self-regulation capacity also depended on contextual factors such as organizational culture, openness, mutual trust, leadership stability, debrief routines, and a shared meaningful theoretical understanding. Even if the importance of such factors may seem obvious, they may not be enough emphasized by service providers. According to Strand et al. (2015), services have a general tendency to focus on evidence-based methodologies rather than on organizational and structural factors that are needed to execute programs and methods successfully. These structural regulatory mechanisms may parallel what Susan Hart has labeled macro-regulation (as opposed to micro-regulation); which refers to rules, routines, rituals, and limits that parents and carers apply every day with children and adolescents in order to make them feel safe and cared for (Bentzen & Hart, 2015). Within this conceptualization, one could argue that staff in residential settings need macro-regulation by organizational culture and structures in order to provide adolescents with micro-regulation (relational regulation) (Bentzen & Hart, 2015).

**Limitations**

The first author played a role in the implementation of the TIP model at the institution, with a potential risk of inviting certain responses from informants (Stige et al., 2009). For example, informants’ emphasis on the importance of having a trustworthy theoretical model to be guided by, could reflect that they were drawn toward confirming the usefulness of the researcher’s investment in
the organization. Therefore, following the analytic principles described by Janesick (2000), this particular risk was carefully addressed in the process of triangulating information between various sources, including colleagues, the research team, and the informants themselves. Still, as such biases may be hard to eliminate, findings must be interpreted with caution.

The present study was conducted while TIP was being implemented in the institution. This may have contributed further to informants' emphasis on a trustworthy model to lean on as a prerequisite for emotional self-regulation. Being in the middle of an implementation process of a model that is not manualized but still needs to be operationalized and contextualized, may add a level of confusion (Donisch et al., 2016; Yatchmenoff et al., 2017). On the other hand, the importance of maintaining emotional self-regulation is likely to remain an essential issue for residential staff regardless of changing methodological approaches.

The interviews, transcriptions, and analyses were all done in Norwegian. Translation into English was done only for the selected quotes used in the results section. There is a possibility that some information may have been lost or altered during the translation process. However, all authors were involved in the translation process to secure accuracy, and we reached a consensus on the translations through dialogue.

**Conclusions and Implications for Practice**

Findings from this study illustrate the complexity of social work in residential care settings. Staff need to maintain a self-regulated state, all the while being confronted with highly challenging work conditions. As TIPs continue to gain a foothold in social work, milieu therapy may receive more attention and credit as therapeutic work (Skårderud & Sommerfeldt, 2013). As we see it, our findings point in the direction of keeping in focus staff’s self-regulation abilities rather than adolescents’ perceived problematic behaviors. Derived from our informants’ descriptions, we allow ourselves to suggest five self-regulation practices to be maintained within residential care settings: 1) examining automatic thoughts, 2) examining one’s own specific emotional issues, 3) allowing oneself to be vulnerable, 4) asking for help from a colleague, and 5) learning about and leaning on a theoretical model that makes sense.

Findings may also provide some suggestions for both TIP stakeholders as well as for the residential care system in general:

For residential care institutions, it would seem of interest to focus both on each staff member’s ability to self-reflect, and on how an organized shared reflective culture can be facilitated within the agency. The focus should be on system attributes that sustain and support critical self-reflection on personal and system levels.
Results from this study suggest that self-acceptance is an essential prerequisite for staying regulated in a residential care context. Consequently, agencies should aim at establishing system structures that facilitate self-acceptance among staff-members. Examples of procedures with potential beneficial impact are the self-compassion scale (Neff, 2003a) and the psychoeducational shame-resilience curriculum (Brown et al., 2011).

Moreover, these findings might have implications for general training for both social workers and other professions within treatment- and care units. Mirabito (2012) describes how schools of social work try to adjust professional training to the shifting contemporary context. She outlines several skills that social workers need to acquire; clinical skills, knowledge of practical intervention strategies, communication skills, among others. There is, however, no reference to the need for self-reflection and self-acceptance skills. We suggest that academic institutions that educate social workers and mental health professionals develop training programs to ensure that students acquire self-reflective and self-acceptance skills.

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