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Supporting Carers to Coregulate With Children in Care: Learnings From Action Research With Caseworkers

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ABSTRACT

Trauma negatively impacts on the ability of children in out-of-home care to experience safety in their relationships. Trauma rearousal can continue to occur even when children are living in a safe and stable setting due to environmental triggers. Carers who are emotionally regulated themselves can model and support emotional regulation (known as coregulation) when their child becomes dysregulated. To do this, carers need agencies to provide trauma-informed and therapeutic models of care, so they in turn can offer an emotionally secure experience for their child. This article reports on participatory action research with caseworkers from two nongovernment and one government organisation who supported foster and kinship carers to coregulate with children in long-term care. Reflective practice meetings were held over an eight-month period to capture the perspectives and experiences of 16 caseworkers who trialled practice changes for coregulation. An inductive analysis approach was used to elicit themes. Findings revealed a three-phase process took place for caseworkers and carers to (1) acknowledge the presence of trauma and stress, (2) become aware of their own emotional capacity and (3) apply coregulation strategies. This process was possible when organisations promoted trauma awareness and relational safety, thereby creating a 'holding environment' for their caseworkers and allowing coregulation to be experienced by carers and their children.

1 | Introduction

Children in out-of-home care (OOHC) often experience trauma from child maltreatment and being separated from their parents prior to entering care (Greeson et al. 2011; Bruskas and Tessin 2013; McCormack and Issaakidis 2018). Trauma is defined here as physical or emotional experiences perceived as harmful, with lasting adverse impacts on the individual's functioning and well-being (SAMHSA 2014). Prolonged exposure to traumatic events or experience of multiple simultaneous traumatic events in the context of interpersonal relationships has further extended the definition to encompass the concept of complex trauma (Cook et al. 2005; van der Kolk et al. 2005). Complex trauma encompasses collective traumas experienced by groups that occurs across generations (Blignault et al. 2014). In Australia, Aboriginal and Torres Strait Islander people have experienced trauma associated with the history of colonisation, including attempted genocide and policies that forcibly removed children from family, culture and community (Atkinson 2013). The repercussion of systemic abuse includes over-representation in the child protection system and high rates of intergenerational trauma among Aboriginal and Torres Strait Islander children (Australian Institute of Health and Welfare 2021; Atkinson 2013).

Trauma can have broad ranging impacts on physical and mental health through its impact on neurobiological mechanisms (De Bellis and Zisk 2014). Abuse and neglect experienced in early childhood can alter brain development of the limbic system, responsible for managing responses to stress (Frodl and O'Keane 2012; Giannopoulou 2012). Children who experience early life trauma have more difficulty managing behaviour (Bruce et al. 2013; Hart and Rubia 2012; Mueller et al. 2010), and trauma can reduce a child's ability to learn, self-regulate and build relationships (Laurens et al. 2020; Petruccelli, Davis, and Berman 2019; Rauter et al. 2018; Ziv et al. 2018). Given the impact of trauma on brain development, effective responses increasingly involve both biological and behavioural approaches. Coregulation is a multilevel approach in that it operates at both biological (hormonal and nervous system) and behavioural (affective and cognitive) levels (Bornstein and Esposito 2023).

Children in OOHC may continue to exhibit stress responses even when they live in safe settings where an overactive stress response is no longer adaptive (Streeck-Fischer and van der Kolk 2000). Environmental experiences that trigger somatic symptoms or traumatic memories are also associated with an increased likelihood of emotional dysregulation and behavioural difficulties. Harmful or disturbing behaviours may be externalised, such as physical violence toward other people or property, or internalised, which may include withdrawal and self-harming. Studies have identified that contact with birth family is one such environmental experience that has the potential to re-trigger traumatic memories (Boyle 2017; M. MacDonald 2021). Some studies have found an association between contact with birth family and increased externalising behaviours of children in OOHC (Poitras, Porlier, and Tarabulsy 2021; Poitras, Tarabulsy, and Pulido 2022). A recent study found more frequent contact and lower levels of foster carer sensitivity were associated with externalising behaviours in children (Poitras, Tarabulsy, and Pulido 2022). This research suggests that, when foster carers respond sensitively to a child's emotional distress, it can improve the child's ability to cope with stressful situations.

Enhancing coregulation between foster carers and children has the potential to improve children's biological and cognitive regulation. While there is an emerging set of evidence-based programmes that incorporate coregulation (Caron, Bernard, and Dozier 2018; Bernard et al. 2012; Bick and Dozier 2013), identifying explicit practices that build the capacity of caseworkers and their organisations to support coregulation between carers and children is underexplored. This paper reports on action research that trialled coregulation practices for caseworkers to use with long-term carers and their children.

1.1 | Coregulation Between Carers and Children in OOHC

Caregiver ability to regulate their own emotions and teach self-regulation to the children in their care has been studied extensively. The term 'coregulation' broadly encompasses the process by which caregivers teach dependent children to develop regulatory strategies through role modelling and emotional support when they become dysregulated (Lobo and Lunkenheimer 2020). Research on coregulation between parents and children in the general population has identified that flexible and sensitive parenting styles are associated with higher levels of self-regulation in children (Lobo and Lunkenheimer 2020). Secure parent–child attachment has also been found to influence executive functioning and internalising behaviour patterns (Bernier et al. 2015; Guo, Spieker, and Borelli 2021). Secure caregiver attachment was found to be a predictor of positive coregulation and associated with lower rates of internalising behaviours in young children (Guo, Spieker, and Borelli 2021).

Research specifically examining coregulation for children in OOHC has identified that both circumstantial and relational factors influence the development of self-regulation skills. Children in OOHC often display lower levels of inhibitory control and higher rates of behavioural difficulties (Bruce et al. 2013; Goemans, van Geel, and Vedder 2015). A recent meta-analysis highlighted an association between parenting strategies used by foster carers and children's socio-emotional development (Chodura et al. 2021). Chodura et al. (2021) found that 'functional' parenting strategies, specifically those that promote secure attachment and adaptive functioning, were associated with increased self-regulation skills in children. Conversely, Lewis et al. (2007) found that children who had experienced placement instability and disruption of caregiver relationships had higher rates of oppositional behaviour than children in stable placements.

Recognising the centrality of the parent/carer and child relationship, interventions have been developed to increase caregiver sensitivity to a child's emotional needs in the context of child protection concerns. For example, the attachment and biobehavioural catch-up (ABC) intervention was developed to increase the sensitivity and coregulation skills of foster parents and has been widely evaluated across different contexts (Imrisek, Castaño, and Bernard 2018). The ABC model aims to teach three primary skills: nurturing children when they are distressed, following children's lead and helping children to remain calm when they are feeling dysregulated (Imrisek, Castaño, and Bernard 2018). The programme has been implemented with foster carers of infants and toddlers (Caron, Bernard, and Dozier 2018). The ABC intervention has undergone significant scientific scrutiny and received a 'high' evidence rating (California Evidence-Based Clearinghouse for Child Welfare 2021). Experimental evaluations of ABC suggest that supporting the skill development of foster carers can have a significant impact on child outcomes such as self-regulation skills and on the security of attachment between carers and children (Bernard et al. 2012; Bick and Dozier 2013). The evidence suggests that enhancing skills in coregulation between foster carers and children has the potential to improve children's emotional and cognitive regulation (Bernard et al. 2015; Korom et al. 2021; Lewis-Morrarty et al. 2012; Lind et al. 2014, 2017; Raby et al. 2019).

1.2 | Trauma-Informed Support for Carers

The ability of carers to regulate their own emotions, establish boundaries and provide consistency is essential to supporting children in OOHC to feel safe and secure. Recent research suggests that foster and kinship carers view themselves as playing

a role in assisting children to cope with, or recover from, their experiences of trauma through their day-to-day relationships (Cooper, Sadowski, and Townsend 2023). However, high rates of burnout and difficulties with retention of foster carers, often caused by vicarious trauma, can inadvertently re-traumatise children through reoccurring experiences of instability and separation from caregivers (Bailey et al. 2019). Foster carers often need significant support to establish and maintain an environment that provides stability for children who have experienced complex trauma, especially in the early stages of care (Gouveia, Magalhães, and Pinto 2021). The extent to which carers receive organisational support to provide ongoing care to children in OOHC has been linked to the retention and dropout rates of foster carers (Gouveia, Magalhães, and Pinto 2021; Randle et al. 2017). In response, there has been increasing priority placed on OOHC services to implement trauma-informed and therapeutic models of care (Bailey et al. 2019; Szilagyi 2018). These programmes are underpinned by a recognition that all individuals who care for children in OOHC are at risk of exposure to the effects of trauma (Wall, Higgins, and Hunter 2016). There has also been much discussion about the development of organisation and system-wide trauma-informed models in OOHC (Collings et al. 2022). However, little is known about the efficacy of organisational models that have been developed to address complex and vicarious trauma and related issues, such as high staff turnover, in the OOHC sector (Collings et al. 2022; Bailey et al. 2019). Parallel process is a useful concept for the OOHC sector to understand and incorporate into trauma-informed practice developments such as coregulation. It is similarly dyadic and relational in nature and may help build reciprocity and mutuality between caseworkers and carers to work together in supporting healthy development for children in OOHC.

The phenomenon of 'parallel process', first noted by Searles (1955) in clinical supervision between therapist and supervisor, holds that an unconscious process occurs between dyads whereby dynamics within the therapist–client relationship are replicated in the therapist–supervisor relationship, opening up a process of containment and solution (Szczygiel and Emery-Fertitta 2021; Williams. 1997). The theory of parallel process proposes that conflict occurring in the therapist–client relationship can be unconsciously replicated in the therapist-supervisor relationship (Szczygiel and Emery-Fertitta 2021; Williams. 1997). This concept may have broader utility and provide opportunities for learning and insight beyond the therapeutic setting (Szczygiel and Emery-Fertitta 2021). With its origins in psychotherapy, parallel process has been proposed as a helpful tool to enhance awareness of the unconscious patterns of transference and counter-transference that can be present between dyads in other caring profession settings (S. Miller 2004). In this paper, we apply it to understand how the unconscious patterns of conflict or tension between a caseworker (professional) and carer (client) may be replicated in the relationship between a carer (professional) and child (client).

OOHC organisations have a critical role to play in managing patterns of transference and counter-transference between various dyads. OOHC is a trauma saturated space involving children with trauma experiences, and the carers and workers who are tasked with supporting them are also unconsciously impacted by their life experiences and are within a system that is under pressure (Collings et al. 2022). This results in difficult and complicated interactions between them, giving rise to parallel processes (Bloom 2011). OOHC organisations need to ensure that they establish a trauma-informed environment where workers and carers are supported to identify and process the inevitable stress that comes with their roles within a trauma-saturated environment and provide consistent and constructive responses for children impacted by complex trauma.

To address the impact of parallel process on children, carers and workers, it is important that all individuals within the OOHC organisation have appropriate spaces to process difficult experiences and emotions. British psychoanalyst D. W. Winnicott introduced the concept of a 'holding environment' to describe healthy caregiving relationships between mothers and infants (Kahn 2001). It represents the physical and mental space that a mother creates for her young child to promote wellbeing, development and emotional regulation (Borg 2013). Mothers, or another primary caregiver, provide a holding environment for their child when they provide appropriate boundaries that allow their child to feel loved and secure even when faced with obstacles or challenges (Kahn 2001).

The concept of a holding environment has mainly been used in the context of caregivers and infants but is applicable to other contexts, such as the relationship between a professional caregiver and client within social service settings (Borg 2013; Kahn 2005). In its broadest sense, the term 'professional caregivers' describes caseworkers and carers. Caseworkers hold paid professional roles while carers receive a paid allowance to compensate for the costs of providing care. Both groups are recruited and trained by OOHC organisations to provide services to clients - children in long-term care. However, we acknowledge that the role of carers is unique, involving 'complex hybridity' where they are both professional and personal caregivers and their caregiving takes place within a familial, not a workplace setting (Kirton 2022). So too, carers often play a critical function as an advocate for the child in their care with less resources and support than caseworkers. As such, we position carers as clients when referring to the caseworker-carer dyad. We position carers as professionals when referring to the carer-child dyad and do so with the belief that a carer's professionalism does not substitute or undermine their emotional connection with children they care for (Boddy 2011).

Research shows that professional caregivers can establish a safe and secure environment for a client by providing a space of undivided attention, assistance to deal with challenges and encouragement to develop new coping strategies for emotional growth (Borg 2013). However, in practice, they can struggle to maintain a reliable holding environment due to a multitude of factors including understaffing, staff isolation, lack of funding, high caseloads and pressure to produce fast results (Borg 2013). Therefore, organisations and systems can fail to provide a holding environment for professional caregivers to manage their roles and provide the best support for their clients. As a result, a parallel process can occur when an inefficient system leads to staff being overworked and clients being unsupported. According to Kahn (2005), having caregiving as the central task of the organisation is a prerequisite

for worker-client holding environments. This ensures professional caregivers are supported and able to maintain the emotional energy to continue their work. To be effective, it is crucial that a holding environment is provided within each layer of the system including in the relationships between the organisation and the worker, the worker and the carer and the carer and child. This theoretical perspective proposes that establishing a stable and safe environment is essential to creating systems that maintain competent workers, capable carers and healthy children. The action research reported on in this article explores trauma-informed casework support for carers with attention to parallel process and the role of organisations in providing a holding environment.

2 | Method

This paper reports on findings from a larger participatory action research (PAR) study, *Fostering Lifelong Connection for Children in Permanent Care*, conducted in New South Wales, Australia to develop, trial and evaluate small practice changes to improve relationship-based over a 2-year period (Ciftci, Collings, and Wright 2022; Collings et al. 2022). PAR is a qualitative methodology designed to promote, document and evaluate a change process (Chevalier and Buckles 2019; C. MacDonald 2012). Action, participation and research lay at the heart of PAR projects (Schubotz 2020). Importantly, PAR recognises participants as experts in the field with knowledge and experiences that are critical to developing solutions and driving social change (Chouinard and Milley 2016). PAR is achieved through collaborative, coresearcher relationships between academic researchers and research participants and follows a 'cyclical process of planning, acting, observing and reflecting' (Silver 2008, p. 104). Coghlan and Brannick (2014) suggest that it is the latter activity of reflecting that integrates action and research. The study used a specific PAR methodology called Breakthrough Series Collaborative, which was developed to improve health system outcomes and adapted to bridge the research-to-practice gap in child welfare systems (O. Miller and Ward 2008).

The study reports findings from one of four action research cycles which was used to trial, reflect on and embed strategies for supporting carers to coregulate with their children. The action research team, which included caseworkers and academics (Authors 1, 2 and 4) worked with a qualified trauma therapist from the Australian Childhood Foundation (Author 3) to support caseworkers to bring an intentional focus to the area of coregulation. The Australian Childhood Foundation developed the Trauma Expression and Connection Assessment (TECA), which was trialled during the action research. The TECA is a purpose-designed tool that helps adults understand how trauma impacts children's behavioural and relational presentations and recommends regulating activities that are matched to children's needs.[1] Ethical approval for the study was obtained from the University of Sydney Human Research Ethics Committee.

2.1 | Sample, Participants and Data Collection

A purposive sampling method was used to recruit caseworkers and managers from organisations participating in the broader study. A total of 16 caseworkers participated in the coregulation practice trial (Table 1).

Data collection took place between October 2020 and June 2021 at monthly reflective practice meetings. Schon's (1983) formulation of reflective practice describes how professionals engage in 'reflection *in* action' by thinking consciously about what they are doing while they are doing it and later using 'reflection *on* action' to integrate theory and knowledge into their practice (Ferguson 2018; Fisher and Somerton 2010). All four authors took part in reflective practice meetings, which were facilitated by the first author. Author 3 provided expert guidance to the action research team. During the meetings, caseworkers were invited to reflect on what worked well and not so well over the last month, sharing how they overcame challenges, new learnings and their impacts on children's birth family and carer relationships. Due to ongoing COVID-19 restrictions, most meetings were convened on MS Teams and audio recorded with the permission of attendees. The recordings were saved locally then transferred to a secure data storage and permanently deleted from the local drive to protect the privacy of participants. A transcript was made for data analysis.

2.2 | Data Analysis

At the end of the PAR cycle in June 2021, the first author worked with the action research teams to prepare a written summary of their key learnings and these were presented to the group. At the same time, the authors commenced thematic analysis using the six-phase process outlined by Braun

TABLE 1 | Participant details.

Participant details	No. of participants (%)
Gender	
Female	16 (100)
Male	0 (0)
Total	16 (100)
Role	
Caseworker	11 (69)
Casework manager	5 (31)
Total	16 (100)
Organisation type	
Government	4 (25)
Nongovernment	12 (75)
Total	16 (100)
Location	
Urban	9 (56)
Regional	7 (44)
Total	16 (100)

and Clarke (2012). Transcripts were uploaded to Dedoose, a secure cloud-based programme designed for team-based research. A deductive approach was used to create a coding framework based on the key learnings identified by the action researchers. The first author then completed inductive open coding of all data and the authors met to refine the coding framework and create preliminary categories. When all data had been coded and duplicates removed, the authors met to confirm categories and discern key themes. The themes were presented back to the action researchers for validation and consensus.

3 | Findings

Three interrelated themes were identified: (1) acknowledging trauma and stress, (2) awareness of own emotional capacity and (3) applying strategies of coregulation. These themes described a parallel process wherein patterns of transference and countertransference between caseworkers, carers and children were uncovered (Table 2).

3.1 | Acknowledging Trauma and Stress

This theme explores the role of workplace pressures and stressors as a barrier to caseworkers supporting carers to coregulate and the flow-on impact on carers, in turn, supporting children to coregulate. Alongside this, caseworkers acknowledged the unique challenges of the carer role, particularly for carers with their own trauma histories. They validated these experiences as a first step in supporting carers to be able to coregulate with the children in their care.

3.1.1 | Caseworker Internal Process: *Reflecting on Workplace Stress*

Caseworkers reflected on the difficulties they faced when they attempted to introduce a practice focus to coregulation with carers and children while working in a crisis-driven and resource-constrained work environment. Despite willingness to support coregulation in principle, caseworkers described how common organisational factors in the OOHC sector, such as policy reforms and organisational change processes, high caseloads and inadequate resources, adversely impacted their capacity to implement new practices, leaving them vulnerable to burnout. This is summed up by one caseworker:

> To give some organisational context … we're going through a restructure … finding the time to do structured and meaningful work has kind of not been on our hands … we're kind of in a bit of a fight or flight…There's just not enough time, resources and energy for constructive change, because caseworkers just don't have the capacity …. And whilst caseworkers are very eager and willing to give it a go, you can only give so much, before you burn out, because you're just like, 'I just don't have the time', and I guess that's a question for the sector.

It was a challenge for caseworkers to reorient their practice from crisis mode to a more proactive focus on strengthening carer capacity to offer an emotionally attuned response to the trauma expressions their child/ren displayed. Caseworkers reflected that the reactive nature of their work made it hard for them to even broach the subject of coregulatory strategies with carers. As one caseworker put it, 'it's very difficult having these sorts of discussions about [co-regulation] when you're in the middle of crisis.'

Persistent exposure to high-volume workloads left caseworkers overwhelmed and less able to balance competing demands of the children and young people on their caseloads with urgent and complex needs such as mental health issues and trying to prevent placement breakdown. According to one caseworker, this had reached the stage, where 'I don't even get to do my normal, just basic casework with the other kids [on my caseload], let alone anything about co-regulation' and as such, bringing a practice focus to coregulation 'probably hasn't been my top priority with some of the chaos'. Although caseworkers agreed in principle that supporting carers to coregulate with children was worthwhile, they also saw it as time-intensive and difficult to implement.

3.1.2 | Caseworker Support for Carer: *Recognising Stress and Trauma/Validating Challenges*

Caseworkers used the practice trial to reflect and acknowledge that carers were under significant stress and to recognise that they may also have other trauma experiences that reduced their capacity to coregulate. While awareness of the trauma histories of the children and young people they work with is familiar territory for OOHC caseworkers, bringing intentional focus to coregulation practices increased their awareness of trauma

TABLE 2 | Themes.

Theme	Caseworker internal process	Caseworker support for carer
Acknowledging trauma and stress	Reflecting on workplace stress	Recognising stress and trauma/validating challenges
Awareness of own emotional capacity	Reflecting on emotional capacity	Encouraging carer self-awareness/impact of carer emotions on child
Applying coregulation strategies	Offering strategies to coregulate rather than co-escalate Sustaining coregulation through positive reinforcement	

symptoms expressed by carers, too. Caseworkers reflected that their agencies were likely to be oblivious to the trauma histories of carers. Reflective practice allowed them to see that aspects of the caregiver role itself could reactivate difficult emotions for carers and result in them being 'genuinely triggered in ways they've never been triggered before'. For example, one caseworker reflected that

> I think there is definitely fear of failure for some carers, some of the pain, and some of it truly triggers, especially for some of our carers, the female carers, the IVF journey and infertility, grief and loss, it all comes back. I couldn't do that. Now I can't do this.

In bearing witness to the interactions between carers and children, caseworkers considered the role that historical trauma could play in carer responsiveness, further directing their attention to the importance of offering carers practical and safe strategies to coregulate. This is illustrated by the following example:

> Maybe it's their own trauma as well ... the carer's becoming heightened ... Sometimes we see carers are actually more heightened than children and we start to reflect on what they've done. Like, the other day we had a carer act just so inappropriately and then when we pinned back to what had actually happened, she was the reason why the child was so heightened because she's thrown water on him and just completely lost it and it makes you think like, I'm doing this work with the carers, you know? Like more than anyone.

Caseworkers acknowledged that the legacy of trauma can manifest around events such as birth family contact and responding to children's emotional and behavioural states before, during and after contact visits adds to carer stress. Taking time to reflect on what carers go through witnessing their child's distress made caseworkers realise just how they need to be a non-judgemental and empathic presence for carers. One caseworker reflected: 'The crying, the soiling, potentially, all those things is different when you're the one caring .... we can't judge because, as a carer they're living that situation.'

Caseworkers recognised that carers are 'parenting under the microscope' of scrutiny by workers and OOHC agencies, which could leave many carers with 'a lot of anxieties and fears of losing the kids'. This prompted caseworkers to practice intentional efforts to normalise and validate these challenges, which built trust and laid a foundation for them to come up with coregulation strategies together. For example, showing that they understood how emotionally charged birth family contact was and reassuring carers that they were not being judged for their response. As one caseworker shared:

> I've just tried to reframe everything, 'cause, if she senses that she's being accused of doing something wrong, she' shut down and she'll be more resistant, whereas if you reframe it ... coming from a place of the importance of family and trying to support her as well ... that this is a reality that's gonna happen for him and also normalising that children in care will often have complicated feelings towards the birth family and that she's not doing anything wrong, but this is about being a team and getting through it together.

3.2 | Awareness of Own Emotional Capacity

This theme explores how caseworkers practiced bringing awareness to their own emotional states and those of the children and carers as a critical step toward supporting coregulation.

3.2.1 | Caseworker Internal Process: *Reflecting on Own Emotional Capacity*

Caseworkers identified that it was difficult to offer a self-regulated response to children and carers during highly stressful interactions, such as when there was a risk of placement breakdown. At these times, caseworkers own emotional capacities were depleted and they struggled to maintain the composure needed to model coregulation for carers and offer them skills and strategies to equip coregulate with children. One caseworker posed the question, 'how can you help someone else regulate when you're not in the state yourself?' As this caseworker explains, exhaustion reduces the ability to self-regulate and coregulate:

> I started at 7:30 in the morning and [the young person] had come back to the hotel where we were staying and then, next minute he's like, 'I'm out of here, I'm going' and I was just like, 'Its 9 o'clock at night, I've been at work all day, I don't even have the energy to talk to you.' One of my colleagues was with me, I said, 'It is so hard to just consistently have that expectation that you can be rational and, like, regulated in your response when you've been at work since 7:30am that day, you've been on an emotional rollercoaster with them and then, he's about to abscond' and I'm like, 'I've got nothing left. I don't know how else to help you' ... I'm so drained.

Reflecting on how the demands of their role impacted their own emotional state prompted caseworkers to empathise with the persistent stress that many carers live with and to reset their expectations for carers to offer attuned responses to their child under these circumstances. As one caseworker remarked:

> It helps [caseworkers] to understand that actually we're not always as reflective. We do have

> expectations on our carers to be reflective about how they can be better, or their relationships to the kids [can be better]. But we ourselves, realise that when we're in a fight or flight, we act differently as well.

Recognition that they were only capable of modelling coregulation to carers when they were in a regulated state themselves helped caseworkers value reflecting on their own emotional states. This led to identifying taking 'time out' of the routine casework activities to reflect as a crucial casework practice. One caseworker summed this up by describing how she takes a moment before a home visit to reflect on how she feels and how this might affect her behaviour:

> I think that has been the biggest learning curve for me as a 'newbie' caseworker. It's emotionally draining, it's very, very difficult. And it does impact on my own self-regulation and my own awareness of how my emotions are playing up in the situation. So, I always tried to reflect before meeting with the family. How was the last meeting? And how do I expect this meeting to go? And what parts of my own behaviour I need to watch in order to keep that meeting as a positive one, so I don't dysregulate the carer and therefore the child as well.

3.2.2 | Caseworker Support for Carer: *Encouraging Self-Awareness and Impact of Emotions on Child*

Caseworkers used these insights to bring carers' attention to their own emotional states and to the potential impact they may have on their capacity to coregulate with a child. They initiated sensitive and honest conversations which encouraged carers to take time to reflect on their feelings about their child's trauma-related behaviours. One caseworker who noticed that carers and children became heightened in tandem after family contact encouraged carers to reflect on how their emotions when their children returned from visits and then observe how able they were to model a calm state for the child in that moment. The caseworker explained:

> I have new carers, they're first-time carers ... they're really chewed off by the boys' needs, especially after visits with parents ... but I find that the carers can get quite heightened about certain things ... And they get so focused on what the children are doing and they want to know what's happened in the past ... And I'm trying to kind of pull it back with them [so they are] aware of how they're feeling on it, because I was like, 'If you are heightened, the boys are really going to [get] heightened'.

In some cases, encouraging carers to reflect on their own emotions allowed carers and caseworkers to reach a mutual understanding of barriers to addressing children's trauma symptoms that would otherwise have remained hidden. For example, one caseworker explained that sensitive conversations with a carer had allowed them both 'to identify that [the children's] anxiety of going to school is not only a feeling that the kids are having, but also foster mum ... it's a two-way avenue'. Keeping children at the centre of discussions about carer self-regulation allowed carers to gain understanding of why managing their own emotions was a crucial precondition for coregulation. Caseworkers encouraged carers to reflect on how their child might feel when their carer was dysregulated. For example, one casework manager stated:

> Reminding the carers – how is the child feeling when you do this and that? I know you are probably not regulating properly yourself ... ... what do you think is going through the child's mind when you're not regulating? So, we are constantly having those conversations with our carers, and the caseworkers as well.

Coregulation occurs when safe adults use their calm state to initiate strategies that help to bring a child back into a state of regulation. As such, caseworkers frequently drew carers' attention to the need to model a calm state for children as a precondition to coaching children on activities that can help them achieve emotional regulation. As one caseworker recounted:

> I said to the carer, 'if you're able to manage your emotions, so that you're calm, [then] you can talk to your family in a calm manner'. I said, 'that is going to make them calm, that's going to that's going to give them a sense that you've got everything under control and that you're together, you can support [young person]'.

3.3 | Applying Coregulation Strategies

This theme describes how building emotional self-awareness in caseworkers and carers facilitated a spirit of mutuality between them which allowed caseworkers to shift into an intentional focus on strategies for coregulation between carers and children.

3.3.1 | Applying Coregulation Strategies: *Offering Strategies to Coregulate Rather Than Co-Escalate*

Recognising and validating carer stress and encouraging carer awareness of their own emotional states and the impact these have on children enabled caseworkers to create a supportive environment in which coregulatory strategies could be suggested. As such, caseworkers began to equip carers with appropriate therapeutic responses that were attuned to their child's needs. They emphasised the importance of 'empower[ing] [carers] on how to manage each situation as it's happening ... trying to upskill them ... so that they can respond to the kids immediately and make them feel safe'. Caseworkers advised carers to focus

on the best ways to respond safely when their child's behaviour was escalating rather than to focus on the behaviour they displayed. As one caseworker reflected:

> What I said was, the thing with [child] is try not to focus so much on the behaviour and more on staying present. He would always go to the floor and get quite escalated. So, I [said], 'maybe sit on the floor with him, face to face'. It works really really well with him because of his need for that kind of sense of security. That's what he really thrives on.

Taking part in the practice trial gave caseworkers a reason to look for changes carers were making in real time and monthly action research meetings gave them a space to reflect on the tangible benefits of offering carers scaffolded support which, in turn, resulted in them offering more attuned responses to the child in their care. One caseworker, for example, noticed a significant improvement in the way a carer responded to a young person who was prone to rapid behavioural escalation by learning about the importance of maintaining a calm state.

> When I first started working with them, they were very reactive, but now I've really just been trying to get them to understand she's connection-seeking when she's having these heightened behaviours and trying to get them to think about what's going on for her at the moment and they've just really started understanding. Now that they understand they're able to react better ... At first, he was just biting back and would keep arguing with her about something and that just heightened her even more. Whereas now, he'll just leave it, stay calm and just say, 'Oh, maybe we can talk about this later'. And then she comes back down, and then they address it another time. And that has just worked so well.

Caseworkers reported that carers were surprised how effective coregulation strategies could be. For example, one caseworker recounted how she suggested a carer blow bubbles with children to promote a return to calm states.

> Something I said to them a while ago was, 'Get some bubbles' and now they just blow bubbles after a visit and they've really seen a difference. Yeah, it's just that release. And they're like, 'That was so simple!' ... because they're in the back of the car, they're heightened after seeing their mum and dad for two hours, they're exhausted after they've been running around the playground and then, that's why I was like, 'Well you just need that calmness.'

Another caseworker described how a carer had gained confidence due to her newfound skills to coregulate and was able to reinitiate contact with her child's birth family after several years.

> I've been working with the carer in terms of the importance of staying in touch with family members and how she can regulate her own emotions to help [child] in meeting [family members] again and staying calm in those meetings. I think she felt more prepared now to give it a go. The visitation didn't go all rosy. But at least they gave it a chance, and afterwards they did a bunch of debriefing and breathing, and it was really nice that it happened.

3.3.2 | Applying Coregulation Strategies: *Sustaining Coregulation Through Positive Reinforcement*

Caseworkers praised carers for using their coregulation strategies to bring children back into a calm state, irrespective of their success. Positive reinforcement was viewed as critical to the success of the coregulation practice. Caseworkers discussed how they moved to a phase where their practice was 'more about reinforcing what's working well for them' and 'providing them with that support [to know] that what they're actually doing is right for him'. Caseworkers described how providing carers with positive reinforcement strengthened carer motivation to sustain their newfound coregulatory practices with children in the long term.

> Some of our carers just want to know that they're doing a good job and it reinforces them to keep going 'cause often they are doing a lot of the right things ... And then you tell them, and it kind of reinforces them to do more of that stuff.

4 | Discussion

Trauma is a common thread linking the lives of children in OOHC and their birth families, carers and caseworkers. Children experience trauma both before entry to care and as a result of being removed from their families (McCormack and Issaakidis 2018). Their birth families experience the trauma of child removal and many also carry their own trauma histories (Collings et al. 2022). Carers live with the realities of their child's trauma history, expressed in distressing and sometimes challenging behaviours, and can become affected by secondary trauma (Riggs 2021). Caseworkers can also experience transference of trauma symptoms, impacting on themselves, the children and families with whom they work and the organisation they work for (Rienks. 2020).

Children's contact visits with their families can be particularly re-triggering of trauma, for the children themselves, their family members and carers. Carers are best placed to implement the key tenets of trauma-informed care, promoting a sense of safety and stability, through their ability to remain consistent and connected (Hoffnung-Assouline and Knei-Paz 2024). Carers have reported valuing the support from caseworkers who listen and try to understand them, within a non-judgemental relationship where it is safe for them to disclose challenges (Cooper, Sadowski, and Townsend 2023). For caseworkers to build

relationships with carers based in trust, respect and acceptance, in line with trauma-informed care (Levenson 2017), our findings emphasise that they need to experience this within their own organisations.

Organisations, like individuals, can be traumatised and under pressure, and this can result in poor service delivery to children and families for whom the organisation aims to support while also harming the organisation's workforce (Collings et al. 2022; Bloom and Farragher 2010; Bloom 2011). The consequence of these complex and trauma-saturated interactions between children, families, workers and organisations often perpetuates cycles of trauma rather than offering an opportunity for healing, as intended. Trauma-informed practices that are implemented within trauma-informed organisations are needed to disrupt these cycles of trauma (Collings et al. 2022).

In this PAR study, caseworkers chose to bring an intentional practice focus to supporting carers to coregulate with a child in their care. The aim was to equip carers with the skills they needed to promote healing and connection as a response to children's trauma symptoms, including those arising around contact visits with birth family members. The reflective process employed in the study brought intentional focus to internal emotional states and revealed a parallel process at play, pointing to the role of both individuals—caseworkers and carers—and organisations within this dynamic.

On an individual level, study findings indicate patterns of transference and counter-transference between caseworkers, carers and children. Simultaneous occurrences of emotional difficulties and emotional regulation were described, which involved the repetition of relational dynamics travelling 'up the line' from child to carer to caseworker and 'down the line' from caseworker to carer to child (Crowe et al. 2011). Role modelling a calm state lay at the heart of practicing coregulation, and through reflective practice, caseworkers brought an awareness of the impact of trauma and stress on their own emotional capacity to model a calm state for carers so they could replicate this state with the child. These insights enabled caseworkers to see the value in creating a reflective space for sensitive conversations with carers so they, too, could examine their emotions and how these internal states impact on their own behaviour and capacity to coregulate with the child. The findings highlight that taking time out for reflection is a prerequisite to successfully applying strategies of coregulation because it means difficult feelings that are transferred and/or counter-transferred can be acknowledged. Participating in this PAR study afforded caseworkers the time and space for this reflection to take place. OOHC organisations can likewise create reflective spaces aimed at uncovering parallel process and supporting coregulation between caseworker-carer and carer-child dyads. Previous work has similarly shown the value of reflection for surfacing parallel process and creating a learning environment in which unconscious dynamics can be subverted (Ganzer and Ornstein 1999; S. Miller 2004).

The concept of parallel process becomes useful at an organisational-level too, given it is an illustration of isomorphism—the tendency for patterns to repeat at all levels of the system (Kadushin 1985). When applied to organisations, the concept of parallel process offers a useful framework for organisational leaders to understand how trauma and chronic adversity affect functioning (Bloom 2011). Findings of this study, which reflect the perspective of caseworkers and their managers, highlight the critical role that organisations can play in creating and sustaining environments in which coregulation can occur. Caseworkers often identified chronic workplace stress and crisis-driven organisational environments as barriers to supporting carers to coregulate with children. At the same time, they acknowledged the unique challenges carers face responding to the impacts of trauma on the children in their care. Caseworkers in this study recognised the need to validate the challenges carers faced in order to establish a trusting and non-judgemental holding environment, conducive to reflecting upon emotional states and capacities and a precursor to supporting carers to coregulate with children. Caseworkers, however, felt less able to do this work when they were experiencing burnout. *There were clear parallels in the overwhelm of worker burnout and carer stress described in the study. Under these conditions, children risk losing both their carer and caseworker through placement breakdown and worker turnover.* As such, organisations that work within a trauma saturated context must be able to operationalise trauma-informed approaches with their clients and staff alike to provide a reliable holding environment and an experience of downstream coregulation. This is experienced as an anchoring in relational safety with peers, processes and management structures that allow for self-reflection and meaning making in times of chronic stress.

This study has suggested that trauma-informed practices such as coregulation would be best implemented and sustained in a trauma-informed organisation. In the OOHC context, there have been increasing calls for whole-of-organisation changes that could enable systemic trauma-informed care, but the implementation of such models remains in its infancy (Wall, Higgins, and Hunter 2016), and systemic barriers to implementing organisation-wide trauma-informed models exist. OOHC is a highly regulated environment and macro-level constraints can make it difficult for organisations to enact trauma-informed care in practice (Collings et al. 2022). Substantive changes to macro factors such as legislative and policy frameworks, institutional and policy requirements and political decisions about resource allocation are required to develop and sustain trauma-informed OOHC organisations where trauma-informed practice, like coregulation, can flourish (Collings et al. 2022).

5 | Limitations

The study relied solely on caseworker accounts of supporting carers and children to coregulate. Consistent with an action research approach, the academic researchers made no attempt to verify the accuracy of these accounts or to challenge observations and interpretations made by individuals. Feedback was not sought from children or carers about caseworker attempts to support coregulation, and such data triangulation would have strengthened the reported results. However, data collection at regular intervals with the same caseworkers over an 8-month period provided the researchers an opportunity to follow up on previously noted observations and clarify inconsistencies, thereby enhancing reliability. Notwithstanding this,

caseworkers may have overstated the gains made and the extent to which any gains were sustained over time is unknown.

6 | Conclusion

To support a parallel process of coregulation rather than co-escalation, caseworkers in the OOHC sector must have appropriate spaces to process and reflect on difficult experiences and emotions, to create a safe and secure holding environment for carers who can, in turn, hold that space for children. This study shows that organisations can apply supports for trauma-informed practice alongside insights about parallel processes to improve their own internal processes and work toward reducing the secondary trauma for caseworkers and carers that leads to burnout and relinquishment. Caseworkers who can recognise their own emotional states are able to model a calm state with carers, which enhances stability and safety for children in care.

Author Contributions

Dr Sarah Ciftci, Dr Susan Collings and Professor Amy Conley Wright contributed to the study design. Data collection and analysis were performed by all authors. Dr Sarah Ciftci prepared the first draft of the manuscript, and all authors provided feedback and contributed to subsequent versions. All authors read and approved the final manuscript.

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Ethics Statement

Ethical approval for the study was obtained from the University of Sydney Human Research Ethics Committee (2019/1032). All participants in the study gave informed consent prior to data collection.

Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

The data that support the findings of this study are available from the corresponding author upon reasonable request.

Endnote

[1]The Trauma Expression and Connection Assessment tool is freely available for use at https://professionals.childhood.org.au/prosody/2022/03/trauma-expression-and-connection-assessment/.

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