COMPLEX TRAUMA IN FOSTER YOUTH: HOW THE SYSTEM CAN BETTER SUPPORT FOSTER PARENTS AND THE CHILDREN IN THEIR CARE

by

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Foster youth endure disproportionate levels of trauma compared to the general population, often experiencing complex trauma before and during care. Complex trauma refers to repeated trauma events, usually faced during a youth's development, often within or associated with the caregiver context. While there is a recognition of the difficult experiences foster youth face, the current system fails to systematically promote trauma healing. By shifting towards a trauma-informed care system and representing the voices of foster parents and foster youth in research, foster youth and foster families could have better outcomes.

In this project, I present information on complex trauma and trauma diagnoses, the trauma experiences of foster youth, and how the foster system currently supports youth with trauma. In addition, I surveyed foster parents about their experiences serving youth with trauma by analyzing the relevant training they received, factors that helped them support youth, and the obstacles they faced. Finally, I integrate information from the literature and my survey data to make suggestions for improving how the foster care system serves youth with trauma.

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Chapter 1: Introduction

Nelson Mandela said, “There can be no keener revelation of a society’s soul than the way it treats its children.” On any given day in 2017, there were over 440,000 children in foster care in the U.S, and throughout the year over 690,000 youth were in the foster care system; this means more kids were in foster care in 2017 than there were people living in Portland, Oregon (Foster Care, 2018). This is an entire population of youth that the U.S. government has the potential to positively impact, and yet the current consensus among researchers, practitioners and foster parents is that our system is missing the mark (Leathers et al., 2009; Gypen et al., 2017).

It is well known both by social service experts and the general public that foster youth face a series of complicated and difficult experiences; this knowledge has sparked great outpours of support and programming aimed at helping foster youth through the means of donation drives, mentoring programs, and more. Yet beyond the need for new backpacks and school supplies, there lies a much more complicated interaction between repeated trauma and foster youth’s long-term health and happiness. One study indicated that 80% of foster youth had experienced at least one DSM (Diagnostic and Statistical Manual of Mental Disorders) qualified traumatic event, with over two-thirds experiencing two or more (Salazar et al., 2012). Foster youth face complex and compounded trauma that is associated with post-traumatic stress disorder, complex/developmental trauma disorder, and other harmful outcomes. “The traumatic experience of abuse, neglect, and separation as well as environmental factors can lead to a variety of emotional problems for children and a greater likelihood of poor child well-

being outcomes," (National Child Welfare Resource Center for Family-Centered Practice, 2003).

While some current and former foster youth receive post-traumatic stress disorder (PTSD) diagnoses, the overall rates of trauma disorders in the foster care system remain largely undocumented. However, the Northwest Foster Care Alumni Study, which surveyed youth from public and private care from the Pacific Northwest found that 1 in 4 former foster youth experienced PTSD (Pecora et al., 2005).

In June of 2018 the World Health Organization released their most recent edition of the International Classification of Diseases, which includes new and revised mental health disorders. In this edition, they created a new trauma disorder diagnosis, complex posttraumatic stress disorder. Complex trauma refers to repeated trauma events, usually faced during a youth's development, often within or associated with the caregiver context (Karatzias et al., 2017). This type of trauma is especially relevant for foster youth, who often have extensive trauma histories (Salazar et al., 2013). This ongoing pursuit to understand complex trauma is essential to the creation of effective interventions for foster children and the ability to inform social workers and foster parents of the symptoms youth may experience (Greeson et al., 2011). Real comprehension of complex trauma requires acknowledging not only the neglect and abuse by parents and caregivers, but also the shortcomings of our own child welfare system that is meant to protect foster children but often perpetuates trauma.

There is a serious lack of qualitative data from social service workers or foster parents who see the effects of severe trauma in context day in and day out. Through a search of psycnet with the phrases "trauma", "qualitative" and "foster care" I only

found about 7 articles providing qualitative data with a focus on trauma in U.S. foster care. This project will explore and document the opinion and experiences of relevant professionals and fosters parents about what strategies do or do not work when trying to intervene with foster youth with complex trauma, not in a highly regulated lab or clinic but in the wide range of places and with the diverse people that make up the child welfare system. This also meant analyzing the current barriers to supporting foster youth with trauma as well as the strengths of the current system and the training it provides. This project focuses on the following three questions that frame my survey and other contextual work:

1. What are the ways in which our child welfare system currently supports foster parents who serve children with trauma?
2. What supports/resources/policies do foster parents see as beneficial to their work in serving children with trauma?
3. What are obstacles that foster parents face when serving children with trauma?

While my survey focused specifically on foster parents, my thesis will synthesize the current research to be able to better understand the role of complex trauma in the foster care system overall. My project will explore the current supports that foster parents receive, their own opinions on the type of supports that are most beneficial, and the obstacles they face in serving youth with trauma. Further, this project will make recommendations for improving trauma-informed care in the child welfare system, providing more support and reducing obstacles for foster parents working with children with complex trauma histories, with the idea that parents being better supported will lead to better outcomes for foster youth as a whole.

Chapter 2: Literature Review

Foster Care System and Trauma

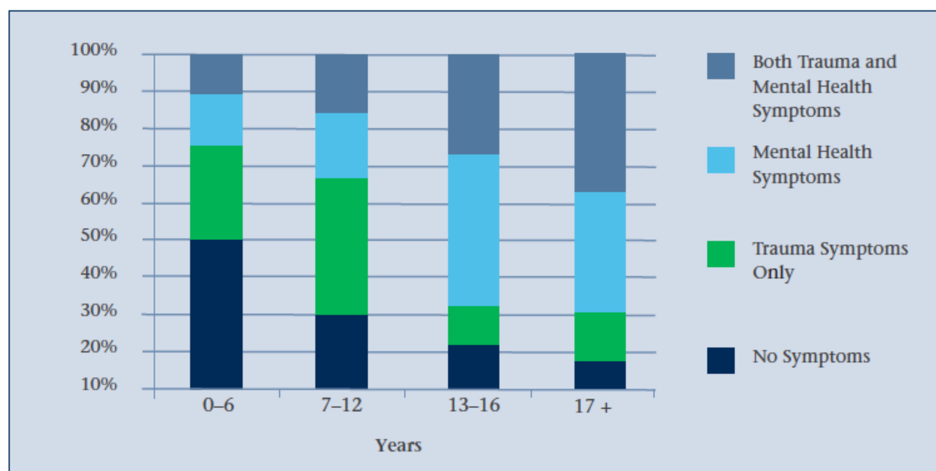


Figure 1: The Annie E. Casey Foundation, 2012. "Presence of Trauma and Mental Health Symptoms in Children and Adolescents in Foster Care by Age"

While the emerging diagnosis of complex trauma/developmental trauma disorder has received significant attention, with plenty of associated research and academic discussion, effective explorations of how to best treat foster youth's complex needs are still lacking (Greeson et. al, 2011; DeRosa et al., 2013). Much of the available research has focused on trauma in groups other than foster youth, such as youth in a certain neighborhood or therapeutic program. This research has explored the different types of traumas experienced by youth, and the prevalence of trauma occurrence. Although the results of these studies may be indicative of general trends in trauma types and rates, it is not directly applicable for foster youth (Milan et al., 2012).

While the child welfare system does not always have a fully accurate documentation of the trauma a youth has experienced before entering care, it is known

that foster youth tend to have a higher likelihood of having experienced multiple traumatic events, and that removal from a home and placement into foster care can in of itself be a traumatic experience for youth (American Academy of Pediatrics, 2015). Even though the majority of foster children are removed from their homes for neglect, according to the American Academy of Pediatrics neglect is often a source of chronic stress and therefore potentially a significant trauma (2015). Then, during and after the actual act of removal from a home there are a multitude of significant changes that can occur, "Entry into the child welfare system causes additional trauma due to separation from family, school, neighborhood, and community, as well as fear and uncertainty about the future" (Child Welfare Information Gateway, 2015).

The impacts of interpersonal trauma are far reaching, especially when trauma events occur repeatedly throughout development. Trauma related to a primary caregiver can cause long-term attachment issues, sometimes resulting in avoidant or indiscriminant attachment (Teague, 2013). In the context of foster care, this may affect the ability to trust and bond with future foster and/or adoptive parents, but it also can extend to friendships and romantic relationships later in life.

Another area developmental trauma can affect is cognition. "A child experiencing developmental trauma demonstrates delays in expressive and receptive language development and less flexibility and creativity in problem-solving tasks and shows deficits in attention and abstract reasoning" (Blaustein et al., 2007).

In addition, trauma can impact a child's ability to self soothe and control their emotions. Children who experience interpersonal traumas are more likely to struggle with controlling intense emotions, and therefore more likely to have aggressive and

self-destructive outbursts (Teague, 2013; Bartlett & Steber, 2019). This can make social and familial interactions more difficult, and contributes to a lack of self-compassion (Teague, 2013). Of course, this emotional dysregulation can also translate into behavioral issues, bridging the connection between trauma experiences and defiance and conduct disorders (Teague, 2013). In addition, previous stress and trauma can increase a child's response to future perceived threats, "Serious threats may not disturb one child, while minor ones may prove traumatic to another. It is the physiologic arousal that makes the difference, and this is determined by the child's perceptions" (American Academy of Pediatrics, 2015).

Another area that developmental trauma negatively impacts is self-concept, a construct that describes the way someone views their traits, competencies and values. Children's self-concept can be lowered by traumatic events, leading to a variety of diminished outcomes (Teague, 2013, Barlett & Steber, 2019). Children with extensive trauma histories are also more likely to experience bouts of dissociation- a feeling of disconnection from their body, experience, and/or environment. While disassociation is a natural response to protect the body and mind from trauma, it can also lead to disconnection from loved ones and positive experiences, impeding social connectedness and joy (Teague, 2013).

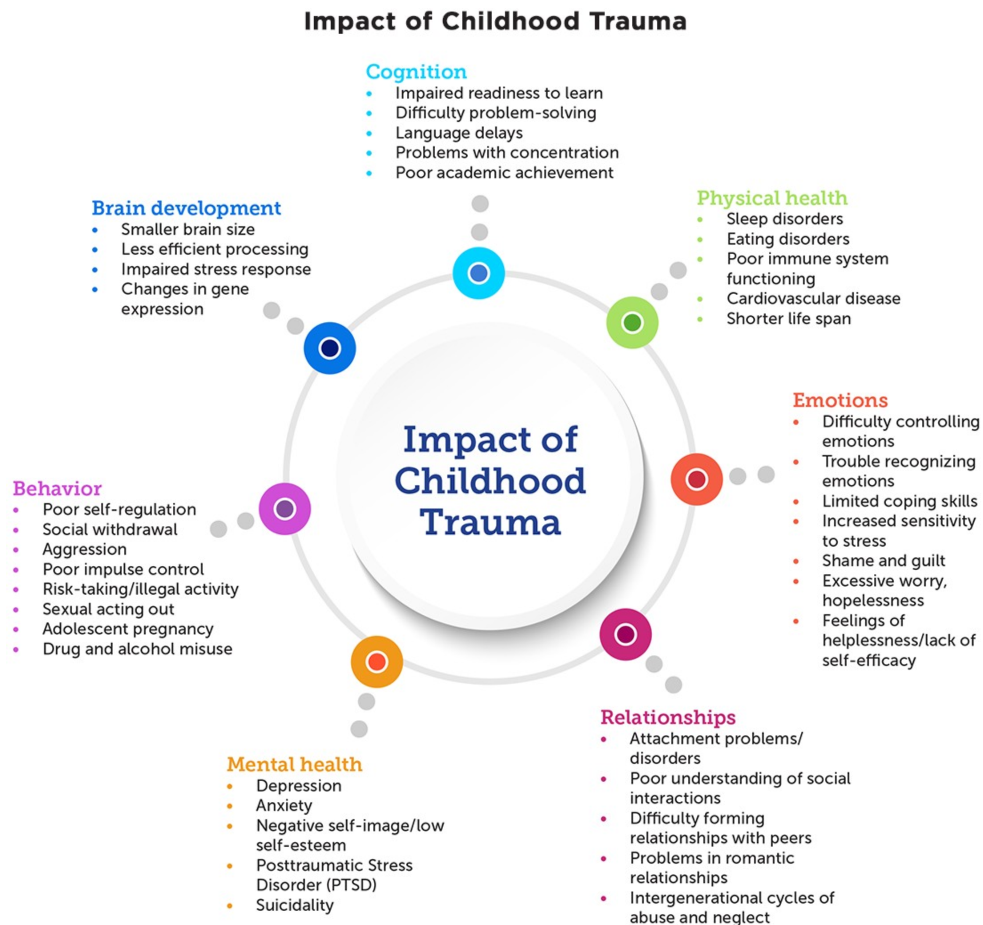


Figure 2: Bartlett & Steber, 2019. “Chart of Childhood Trauma Impacts”

Beyond the range of impacts trauma has on long-term mental, emotional, and physical health, suffering from trauma symptoms can translate to negative outcomes specific to the foster care context. Externalized symptoms related to trauma can increase the instability of a foster youth’s life while in care, “…the effects of trauma can be even reactions to trauma can serve as barriers to placement stability and permanency—two key predictors of well-being among children in out-of-home placements” (Murphy et al., 2017).

Further, being unaware of a child’s trauma does not only fail to improve mental health, it may actively worsen it. Being unaware of a child’s trauma history may cause

further trauma by accidentally triggering remembrance of the trauma and can actually increase symptoms (Murphy et al., 2017). In addition to the trauma an individual child has experienced, many of the families that become involved in the child welfare system have also experienced historical trauma (California Health and Human Services, 2018). Improving attention to the variety of trauma experiences youth and families involved in the foster care system have could not only improve the mental health and relationships of foster youth, but also decrease foster home placement changes that are hard on youth, foster families, and social workers (The Annie E. Casey Foundation, 2012).

The Northwest Foster Care Alumni Study's Findings on Mental Health

The Northwest Foster Care Alumni Study of 2005 is an in-depth, comprehensive study about a wide swath of foster youth outcomes. It delves deeply into the specific traumas faced by foster youth, both before entering the child welfare system and while in the child welfare system, and explores the rates of PTSD in foster youth (Pecora et al., 2005). It included information about foster youth alumnus from public and private foster care, both those served by DHS in Oregon and Washington, and by Casey Family Programs.

While their main focus was on outcomes, they also collected data on the maltreatment youth experienced before and in foster care. They found that over half of the alumni had experienced sexual abuse, and that 93% self reported as having experience some form of maltreatment (abuse, neglect, or both). Youth on average, spent 6.1 years in care, and had a mean number of 6.5 placements, meaning they had on average 1.4 placements per year (Pecora et al., 2005). Almost a third of youth had more than 8 placements during their time in care. Over a third of youth reported maltreatment

by a foster parent or another adult in their foster home during their time in foster care, with the highest percentage reporting physical neglect (Pecora et al., 2005).

They also found significantly higher rates of mental health issues than present in the general population, one especially shocking finding was that one in four alumni had experienced PTSD within the last year. They found that PTSD and major depression were the most significant mental health issues for alumni, and that PTSD was a major barrier to alumni in other areas of life like employment. While depression as found to have relatively high rates of recovery, the recovery rate for PTSD in alumni was only 15%, recovery being defined as having previously experienced symptoms but not experiencing symptoms in the past year. This is in high contrast with the general population who experiences PTSD, which based on one study experienced a recovery rate of 41% (Pecora et al., 2005.

In order to translate their findings into actionable steps, the authors worked with foster care alumni, foster parents, caseworkers, agency executives and other specialists in the field to create policy and program recommendations to improve outcomes. The Northwest Alumni Study identified their number one goal for future research was to learn more about PTSD and mental health in foster youth. Specifically, they suggested further research on current rates of PTSD in foster youth, on what within the system perpetuates trauma and therefore trauma diagnoses, and what supports and interventions would lessen rates of trauma diagnoses.

Trauma Types and Diagnoses

When examining trauma and complex trauma in foster youth, it is essential to know that there are many different commonly used terms in the social work field for

experiencing multiple traumatic events. One of these terms, complex trauma, was initially coined to describe a complicated trauma history within the caregiver context. While I have overall chosen to not focus on the more psychology-based specifics of the debate about creating new diagnoses and corresponding evidenced-based interventions, understanding the basics of the diagnosis is crucial to understand the way complex trauma impacts foster youth.

As previously mentioned the term complex trauma also refers to a resulting diagnosis, also known as Complex PTSD (as created in the ICD-11) or in the U.S., the proposed Developmental Trauma Disorder (Karatzias et al., 2017; Teague et al., 2013). Greeson et al. (2011) examined this ambiguity, "Complex trauma, for example, is a term used to describe both a constellation of causal risk factors involving repeated interpersonal trauma by caregivers early in life; and the resulting dysregulation that occurs across a range of areas including emotional, behavioral, interpersonal, physiological, and cognitive functioning" (Cook et al., 2005). In Cook et al.'s study, they defined complex trauma as the exposure to two of the five types of interpersonal traumas: emotional abuse, sexual abuse, physical abuse, domestic violence, or neglect. Based on this definition, 70% of their sample of foster youth had experienced complex trauma, and over 11% had experienced all five types of interpersonal traumas. Experiencing complex trauma during childhood is associated with a wide range of negative outcomes, including poor work and academic progress, issues in relationships, substance use, suicidality and even poor physical health (Cook et al., 2005).

The complex trauma diagnosis originated in the 1990s because of the evidence that a PTSD diagnosis often fails to capture the repeated and complicated nature of

complex trauma experiences (Ai et al., 2013). The symptoms of the complex trauma diagnosis "includes the core PTSD symptoms plus three additional symptoms that identify 'disturbances in self-organization' (DSO): (1) affective dysregulation (AD), (2) negative self-concept (NSC), and (3) disturbances in relationships (DR)" (Karatzias et al., 2017).

The current CPTSD profile was proposed by the 11th edition of the WHO International Classification of Diseases, which was adopted in 2018 but will not go into place until 2022, meaning there will not be reported data using the new CPTSD diagnosis until then (World Health Organization, 2019). However, the ICD-11 proposals were publically unveiled in 2011, giving time for the research community to investigate the changes.

In 2017, Karatzias et al. conducted a study on the proposed ICD-11 trauma questionnaire used to differentiate between PTSD and CPTSD to see if they would be able to successfully differentiate between the trauma diagnoses in their sample, and to find differences in trauma exposure types between the two diagnoses. They were successful in differentiating between the different trauma diagnoses, and found those with CPTSD were more likely to have "more frequent and a greater accumulation of different types of childhood traumatic experiences and poorer functional impairment" (Karatzias et al., 2017). They determined complex PTSD was "highly prevalent" in populations seeking services who have had multiple traumatic events and highlighted the importance of developing interventions and treatments specific to CPTSD (Karatzias et al., 2017).

Finally, they found that in comparison to those who received the standard PTSD diagnosis, clients who were diagnosed with CPTSD had poorer outcomes in many areas, especially with family connections and other interpersonal relationships. They also were less likely to be employed, married or living with a partner, and were more likely to be on psychotropic medication (Karatzias et al., 2017).

Whether treated as a separate diagnosis or a subset of PTSD, it can be difficult to treat the variety of symptoms of complex trauma in youth due to the multitude of ways complex trauma impacts a child's development and ongoing behavioral and emotional wellbeing (Dauber et al., 2015). Without a diagnosis or subcategory that honors the differences of complex trauma, these symptoms are often misattributed to other disorders or interpreted as purely behavioral issues. Speaking to these other diagnoses often made for traumatized children, Blaustein et al. wrote,

> Each of these diagnoses captures an aspect of the traumatized child's experience, but frequently does not represent the whole picture. As a result, treatment often focuses on the particular behavior identified, rather than on the core deficits that underlie the presentation of complexly traumatized children. (2007).

Regardless of how it is classified in diagnostic manuals, it is essential that clinicians have a guide for recognizing the impacts of complex/developmental trauma (Teague, 2013).

While this specific project focuses more on the supports and obstacles to serving youth with trauma in our current foster care system, it is essential to understand the impacts of trauma, and the importance of the recognition of complex trauma. While the exact percentages vary from study to study, it is clear foster youth have experienced high levels of trauma both before and during involvement in the foster care system.

Many foster youths are especially impacted by interpersonal and complex trauma. The core symptoms of PTSD fail to address the many impacts complex trauma has on cognition, socioemotional development, and long-term outcomes. Chapter 3 of this paper will more directly examine the current approaches to addressing trauma in the foster care system, and analyze the trauma-informed care movement.

Chapter 3: Current Approaches in Foster Care

Issues with Current System in Regard to Trauma

Social service workers and foster parents need additional support in order to be able to serve youth with intense trauma histories that can result in comorbid mental health issues, attachment disorders, and more (National Child Welfare Center, 2003; Child Welfare Information Gateway, 2015).

While there is plentiful information available about general trauma effects on youth, there is a lack of formalized knowledge about the prevalence of trauma in foster children (Springer, 2000; Milan et al., 2013; The Annie E. Casey Foundation, 2012). Part of this is linked to the current system of analyzing mental health issues and trauma in foster youth. The current norm in the U.S. foster care system includes an initial entry assessment of the youth's mental health and trauma history, but does not typically require follow up assessments (Greeson et al., 2011). This is despite the evidence that regular screening, and early intervention thereafter, is essential to alleviate mental health issues and their associated outcomes. Further, parents and practitioners are often operating without a full or accurate history of the youth (Ai et al., 2013). In addition, while youth's formal diagnoses are tracked in the foster care system, significant but subdiagnostic levels of emotional issues are less likely to receive attention and follow-up which could help prevent manifestation into more serious mental health and behavioral problems (Ai et al., 2013).

A sentiment repeated in many studies about the foster care system is a need for a full paradigm shift (Greeson et al., 2011). It is not just the implementation of different

services, or small changes in policy, but a realignment of goals and mindsets so that all essential people are looking at the system and children in the system through a trauma-informed lens. Pecora et al. emphasized that while some data from foster care alumnus found the positive impacts of helpful staff members and foster parents, the current system approach is not addressing the mental health issues of many foster youth and "it is unlikely that improvements in children's mental health services will have much effect unless foster care systems become more therapeutic" (2009). Greeson et al. described how the child welfare system tends to place a focus on the easier to detect behavioral issues of a child, without getting to the context behind the symptoms like trauma histories and trauma triggered reactions (2011).

One of the results of the lack of adequate support for foster parents and foster youth's unsolved trauma is high rates of placement change for youth. Foster children can live and move between a variety of placement settings: a non-relative foster family, relative foster family (also known as kinship care), in a group home, institution, pre-adoptive home, or supervised independent living (Children's Bureau, 2019). Unfortunately, runaway is also listed under a placement category, and while at the time of the 2019 study that was only 1% of foster youth, that accounted for 4,247 youth (Children's Bureau, 2019).

The number of placements a youth experiences while in care is one of the biggest indicators for long term outcomes of foster youth. The more placements a youth experiences, the lower change they have of having positive educational, mental health, and relational outcomes. In the Northwest Foster Care Alumni Study they found, "Optimizing Placement History and Experience (e.g., few placement changes, no

reunification failures, and no runaway incidents) resulted in a 22.0% decrease in negative mental health outcomes" (Pecora et al., 2005). However, they also found that the average number of placements was 6.5, with one third of youth experiencing 8 or more placements (Pecora et al., 2005). There is a cyclical relationship between trauma, behavior issues, and instable placements that is traumatizing for youth. Of course, even with adequate trauma-informed mental health services for youth, there will be some mismatches and necessary placement changes, but simultaneous increased support and training for foster parents could greatly decrease the instability of placement changes the system sees now. However, the risk of misunderstanding trauma has reach even beyond the foster care system,

> The lack of understanding of trauma and development can lead to overuse of psychotropic medications, inaccurate labeling in schools, placement disruptions, poor legal representation, and ineffective child welfare services that further traumatize young people (The Annie E. Casey Foundation, 2012).

Another issue is inconsistency in the full inclusion of the child's care team in treatments or updates. "For example, foster or biological parents rarely participate in treatment (Leathers, Testa, & Falconnier, 1998), despite evidence that parental involvement is essential for many of the most commonly diagnosed childhood disorders, such as externalizing behavior disorders (Farmer, Crompton, Burns, & Robertson, 2002)" (Leathers et al., 2009).

Promising Approaches

Movement Away from Congregate Care: Role of Therapeutic Foster Homes

In 2019, the Children's Bureau reported that 10% of foster youth lived in a group home or institution. While there may be a place for occasional institutionalization in the spectrum of services for foster youth, it is no longer seen as a positive long term option for foster youth. Residential options like group homes tend to cost more to run, and decrease the chance for foster youth to have positive familial experiences, including the chance of being adopted (Barth, 2002). Youth who lived in congregate care were found to be more likely to experience abuse in care, to be involved in crime later in life, and had worse educational outcomes than youth placed in family homes (Casey Family Programs, 2018).

As many states have moved away from congregate care models in the past decade, they are finding new ways to replace the services institutions provided. For youth with higher needs than can be provided in a typical setting, there has been a growth of therapeutic foster homes, a certification for foster parents who have the specialized training, time and resources to support youth with more severe mental and physical health needs (Boyd, 2013). This is a significant movement in the acknowledgement of the retraumatization of youth in the foster care system, and a move towards better mental health services and trauma-informed care. Therapeutic foster homes are a significant piece of a greater paradigm shift towards organizing a trauma-informed foster care system.

A Response to Common Issues: The Trauma-Informed Care Movement

As previously mentioned, there has been a movement in social services in general and specifically in the child welfare system, to move towards trauma-informed care. A trauma-informed child welfare system means a standardized focus on recognizing and effectively responding to trauma and trauma symptoms, system-wide assessment of children for trauma histories and trauma diagnoses, system-wide training, and the implementation of evidenced-based treatments. Another concise definition describes a trauma-informed system as "one in which all parties involved recognize and respond to the varying impact of traumatic stress on children, caregivers, families, and those who have contact with the system" (California Health and Human Services, 2018).

While work should be coordinated, there is also an understanding that it is crucial that services are tailored on an individual basis (Murphy et al., 2017). As mentioned in the previous section, intensive therapeutic services were once mostly offered within the context of residential group care, but evidence has suggested a movement towards therapeutic services offered within the family context holds the potential for better outcomes for foster youth (Barth, 2002). While being labeled a therapeutic foster home requires a specific set of guidelines, the entire system being trauma-informed means that every foster home would operate under the assumption that their youth may have trauma that may need to be addressed, regardless of whether they qualify for the services of a therapeutic foster home or not. It is essential in a trauma-informed system that the entire family is part of identifying and screening for trauma, and is kept involved in treatment plans (California Health and Human Services, 2018).

Further, services and support should be available for the entire family, not just the youth, with the knowledge that foster families dealing with trauma regularly are vulnerable to Secondary Traumatic Stress or vicarious trauma (Child Welfare Information Gateway, 2015).

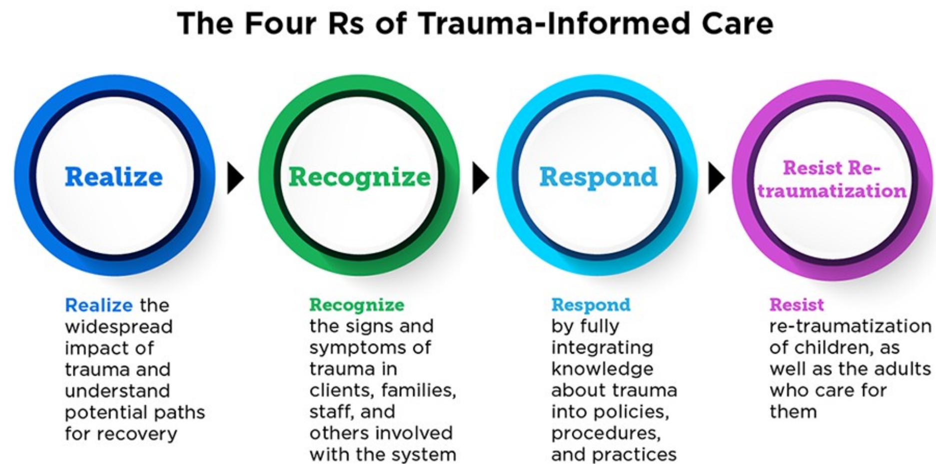


Figure 3: Bartlett & Steber, 2019. “Child Trends’ adapted Trauma-Informed Care Model”

Implementation of Trauma-Informed Systems in Foster Care

One such effort of a trauma-informed foster system was the Trauma Systems Therapy (TST) model, which was implemented in the entirety of a private foster care agency (Murphy et al., 2017). The basic tenets of TST were to repeatedly assess the child and their environment, and to train all of a child’s care team on the impacts of trauma and ways to respond to trauma.

Another significant example was the 2018 California approval of a bill to amend the existing work of the Continuum of Care Reform, a project implementing reforms in California’s Child Welfare System. This adopted bill worked to add to the current

model by “developing a coordinated, timely, and trauma-informed system-of-care approach for children and youth in foster care who have experienced severe trauma” (AB-2803, 2018). The implementation of the Continuum of Care Reform (CCR) in 2015 and the amending bills brought new focus to the trauma needs of California foster youth. One Sacramento county CCR implementation analysis document found that they were having significant issues meeting the mental health needs of their foster youth, and that “while not all children placed in care are in need of mental health services, a majority do qualify for services based on the trauma they have experienced” (Sacramento County Children’s Coalition, 2017). This was before the amendment with AB-2803 that increased the specific implementation of trauma-informed care, but supported the need for more specific focus on trauma.

While trauma-informed care is being implemented more and more, on a national level the concept is still relatively new, “The field is still in the beginning stages of gathering evidence about what is required to implement a trauma-informed approach to child welfare, and what the outcomes of such an approach may be” (Child Welfare Information Gateway, 2015). In order for a trauma-informed lens to work in the child welfare system there must be a mindset shift for everyone in a foster youth’s care team-foster parents, social workers, mental health specialists, etc. “Developing a trauma lens includes reinterpreting behaviors that were previously seen as being caused by a mental illness or behaviors exhibited by a ‘bad kid’ as the potentially reversible consequences of trauma” (Child Welfare Information Gateway, 2015). This momentous shift requires policy change, and significant training for everyone involved. Trauma training cannot

be a one-time thing, but must instead be an ongoing learning process that provides guidance for individualization to the needs of different youth.

The implementation of a trauma-informed care system could also help to solve some of the issues stopping systems from being able to best serve youth now, specifically the lack of data about trauma in the child welfare system. A trauma-informed system would not only regularly screen for trauma, but keep an ongoing record of a child's trauma and mental health experiences and symptoms (Child Welfare Information Gateway, 2015).

While we are a long way from trauma-informed child welfare systems on a national level, California's and some other states' moves to recognize and shift the system to better treat trauma signifies a substantial change towards better serving foster youth. It is by no means a small adjustment, and requires a significant mindset shift for everyone involved in the child welfare system, with readjusted goals and standardization to ensure even outcomes. While the initial shift may be complex and laborious, the potential outcomes of both preventing retraumatization and intervening in trauma before it causes long-term harm will change the lives of foster youth. The next chapter will more directly analyze research on the needs of foster parents, especially in regard to serving youth with trauma.

Chapter 4: Ecological Framework for Trauma-Informed Care

This section will organize recommendations for trauma-informed care through the lens of the ecological framework. This also serves as the literature review of the research base which informed the development of my survey.

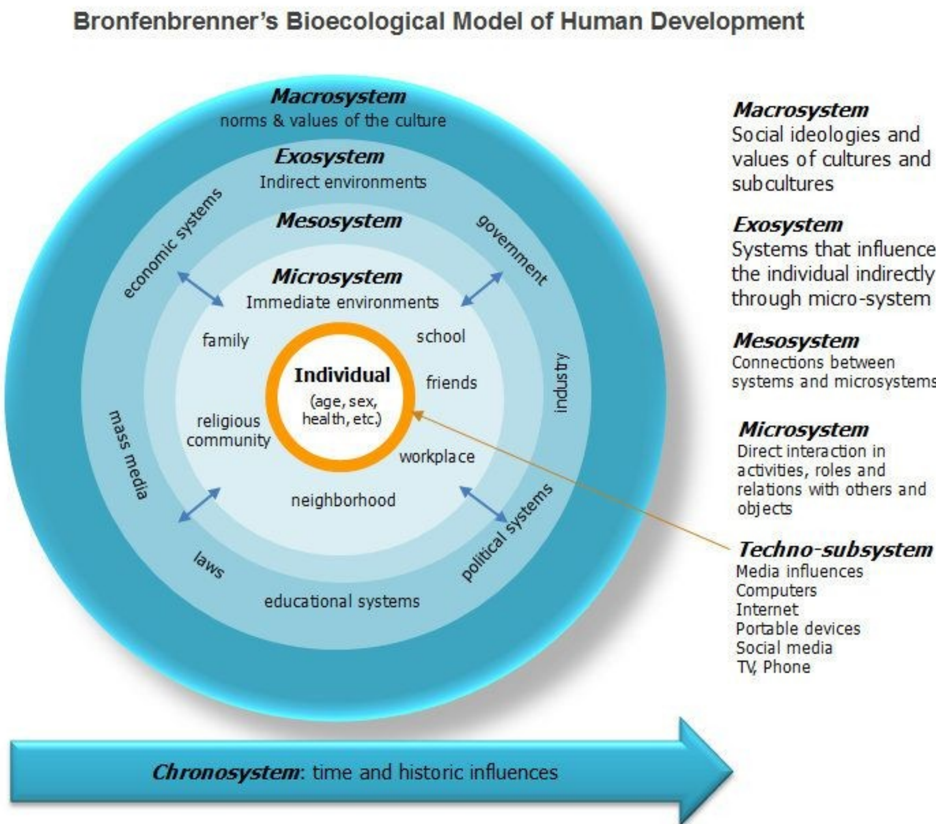


Figure 4: Gudjohnsen, 2016. Bronfenbrenners's Bioecological Model of Human Development

Microsystem

One study focusing on the opinions and needs of foster parents interviewed 30 foster families and used that data to create concept maps of the themes that came up. They ended up with five concept clusters, one of which solely focused on the self-identified personality trails and individual skills foster parents perceived to be important

to being a good foster parent (Brown & Calder, 2002). These characteristics fit well into the microsystemic level because they largely pertain to individual relationships, such as the relationship between a foster youth and foster parent. These identified traits included patience, love, calmness, emotional stability, commitment and more (Brown & Calder, 2002). Some of them were more related to acquired skills like parenting skills, stress coping skills and parenting experience.

Another important aspect of the microsystem that influences working with a foster youth with trauma and is key to the trauma-informed care model is the ability to look at behaviors through a trauma-informed lens. Like many attributes, this also depends on the exosystemic emphasis on training, although it can be supplemented by individual research. Not only is this an important skill for foster parents, but for anyone who is part of the youth's care team: social workers, pediatricians, educators, etc. (Child Welfare Information Gateway, 2015; California Health and Human Services, 2018). As mentioned above in the section on the trauma-informed care movement, a trauma lens can help foster parents and other care team members reframe "bad" behaviors as the externalization of trauma, leading to better understanding and more appropriate reactions to a child's behavior (Child Welfare Information Gateway, 2015; Greeson et al., 2011; Bunting et al., 2019).

I posit that the relationship between using a trauma lens and positive relationships may be a positive feedback loop, in which correctly understanding a youth's behavior can improve the relationship, and the ability for the care team to identify trauma-influenced behaviors may also be improved by having close relationships with foster youth. When members of a care team are informed of potential

trauma histories they can respond in ways that encourage healing, “Responses that are consistent and which respect the child’s prior adaptation facilitate learning, and may eventually permit re-adaptation” (American Academy of Pediatrics, 2015). This also emphasizes the importance of the issue of attachment. “The ability to trust and form relationships will affect the emotional health, security, and safety of the child, as well as the child’s development and future relationships.” (National Child Welfare Resource Center for Family-Centered Practice, 2003). Trauma interferes with some foster youth’s ability to develop a healthy attachment to foster parents, therefore creating further risk factors for future mental health issues (National Child Welfare Resource Center for Family-Centered, 2003; California Health and Human Services, 2018; Dauber et al., 2015).

Mesosystem

Mesosystemic influences in this context speak to the interaction between the people and systems that are part of a youth’s life. One study that spoke to the importance of these interactions conducted four focus groups with caseworkers, therapists, and foster parents to gather information on a proposed new system of care for foster youth based in the ecological model. They found that a need for more training and support from agencies and caseworkers was crucial for foster parents to be able to help foster youth with their mental health issues (Leathers et al., 2009). In addition, they found that current mental health services tend to be child-focused, but often fail to include foster parents and other relevant adults like teachers, mentors, etc. in treatment. This is also echoed by the Children’s Bureau’s suggestions on addressing mental health services in the child welfare system; it reemphasizes the importance of including the

entire care team as part of treatment and mental health services (2019). This can improve relationships between foster parents and social workers, between foster parents and therapists, and can better prepare foster parents for spotting and intervening with mental health issues when they show up at home (National Child Welfare Resource Center for Family-Centered Practice, 2003). If reunification with a youth's biological family is the goal, them being part of treatment is important to strengthening positive attachment (Teague, 2013; Dauber et al., 2015). Even if immediate reunification is not the goal, the attitudes of foster parents towards youth's biological families can impact youth mental health. It has been observed that consistent constructive contact with biological families has positive effects on foster youth's mental health. Further, social workers and foster parents having positive attitudes towards a youth's biological family is associated with higher biological parent involvement (McWey et al., 2010).

In regard to the interactions in foster parents lives, foster parents voiced directly their need for more training, both with behavior and crisis issues, but also with their own organizational and time management skills. "If we are trained well enough to deal with certain issues, certain problems that arise, and I think a lot of times a lot of us are not equipped and this is why we get bogged down with our own situations of how to deal with it" (Leathers et al., 2009). Some of this speaks to the individual fine-tuning of skills, although the largest underlying message was a challenge in balancing the variety of relationships and commitments each foster parent balances.

In addition, foster parents highlighted the importance of having networks of support with other foster parents, and even suggested trainings be done by other foster parents instead of social workers. This showcased a need for support networks and

alternative looks at training for foster parents to feel prepared and adequately supported (MacGregor et al., 2006).

As written by the National Child Welfare Resource Center for Family-Centered Practice, “Foster families are frontline therapists” and need to be able to identify the mental health needs of youth, as well as to be apart of treatment later on (2003). This reemphasized how important foster families are in the mental health of foster youth, and supported my survey’s focus on foster parents. “The most important message of this lesson is that foster families need as much support in the community and home as do birth families. To ignore or minimize the pressures of foster parenting puts the placement and the foster child with emotional problems at great risk” (National Child Welfare Resource Center for Family-Centered Practice, 2003).

Exosystem

The exosystemic aspect of a trauma-informed system focuses on policy that influences youth; the policy of a youth’s foster care agency is especially relevant. One article mentioned above that is also relevant for the exosystem was a qualitative focus group study of foster parents which identified trends as well as giving specific quotes from focus group participants (MacGregor et al., 2006). They found the training foster parents received, or did not receive, was crucial to their feelings of safety and effectiveness in their role, and that it correlated with retention rates as well. They also found that foster parents’ satisfaction and intent to continue fostering was correlated to their perceptions about the effectiveness of training, which can help them feel more prepared and supported in dealing with difficult children (MacGregor et al., 2006). Specifically, foster parents in this study spoke to a need for more “realistic and

specialized training that was geared to the specific needs of children" (MacGregor et al., 2006).

Another study that highlighted specific obstacles foster parents faced that asked 30 families of foster parents what they needed to be successful, then arranged themes that emerged out of responses in a concept map (Brown & Calder, 2000). They found some systemic factors that foster parents reported as important to success included access to the child's system records, access to abundant resources, and help for children with special needs (Brown & Calder, 2000).

Another important aspect of the exosystemic approach to trauma-informed systems was analyzed in a brief titled *Mental Health Issues in the Child Welfare System*, which spoke to current barriers to better mental health services for foster youth and made corresponding recommendations. They identified the need for more mental health specific training for foster families (National Child Welfare Resource Center for Family-Centered Practice, 2003). Holistic support for foster families is necessary for family and youth success, "Thus, foster parents need positive agency relationships, emotional support, and a variety of concrete supports to be motivated and satisfied with fostering and to increase the likelihood of retention" (MacGregor et al., 2006). These concrete supports also include respite care, financial support, help with school interactions, etc. (National Child Welfare Resource Center for Family-Centered Practice, 2003; MacGregor et al., 2006; Brown & Calder, 2000).

Macrosystem

The macrosystemic view addresses the beliefs and values of a culture and the way those values influence policies, individual choices, and more within a society. In

the literature, macrosystemic values came up most in the concept mapping study within the realm of family values and beliefs. One reoccuring concept that foster parents identified as important to success was cultural sensitivity: a broad term that denoted an ability to create an individualized connection with the foster child based on openness to their culture, personality, experiences, and any traditions important to them (Brown & Calder, 2000). Foster parents mentioned this in regard to working with youth from different ethnic and cultural backgrounds, and in the context of working with biological families with different value sets and/or parenting styles. Foster parents spoke to the importance of considering and valuing youth's cultural backgrounds, and understanding that youth might come into the home having different ideas of what a family looks like and how family members contribute (Brown & Calder, 2000). In fact, family cohesion was another concept cluster; foster parents emphasized the importance of all of their family members getting along well. These findings expressed the ways in which family's and youth's values and beliefs interact with the ability to adequately serve youth with trauma and function as a family (Brown & Calder, 2000).

Chapter 5: Methods

Considerations

When doing my initial research for my project I identified early on that there was a large gap of information from the perspective of foster youth and foster parents available within the context of academic sources and information about trauma in foster youth. The more informal information like briefs and resources sometimes considered information that considered foster parents' perspectives, although it often came from the perspectives of workers and agencies instead of directly from foster parents and youth. For this reason, I decided a crucial part of my thesis would be to highlight the experiences and opinions of foster parents. While I would have liked to focus a survey on foster youth, issues of consent and confidentiality meant that it was much more feasible for my undergraduate project to focus on foster parents. Foster parents, as the caregivers for youth with trauma, are a close look into the lives of foster youth, and a way to investigate the training and support that foster families receive in regard to serving youth with trauma. Due to the nature of collecting information from human subjects, it was necessary to complete a human subjects research compliance review. However, after an initial review it was approved as being exempt due to the low-risk nature of the study (see Appendix C).

Recruitment

Through connections at the College of Education I was connected to Dr. Jeffrey Todahl, the associate professor in the Couples and Family Therapy Program and the Co-Director and Director of Research of the Center for the Prevention of Abuse and

Neglect. He also is the co-director of Lane County's 90by30, a program working to reduce child abuse in Oregon. Dr. Todahl connected me to various professionals who currently work or previously worked with foster parents. I sent out an email to these contacts with information about who I am and why the survey is important to my thesis. I included the link to the survey in the email and encouraged them to reach out with any questions they had about the survey or thesis overall. Although I have no way to confirm this information because it was anonymous, it is likely that the majority of my participants came through a contact from a local DHS department in Lane County, Oregon.

Participant Privacy

As mentioned above, the survey was anonymous to protect participant privacy, so the questions did not request any information that could be considered identifying-such as their name, workplace, or demographics. However, participants were made aware through the consent form that privacy and confidentiality could not be fully guaranteed. The only real chance of collecting private information was if the participant included private or identifying information in the comment section of the survey questions. My advisor and I planned ahead of time that if this did occur, we would delete anything confidential before including those results in analyses to be used as part of the thesis data. Survey results were collected on a private platform that only I had access to, and were only shared with my primary advisor. I also turned off any functions on the survey platform that would give me information about the participants' IP addresses.

Consent Procedures

The informed consent was imbedded as a necessary component to move forward to the questions in the bulk of the survey (see Appendix B for the informed consent document at the start of the survey). Participants had to answer yes to “Do you agree to the terms above? By clicking yes, you consent that you are willing to answer the questions in this survey.” A no response disqualified participants from completing any further questions, and would take them to the end page of the survey instead.

Research Base

To build the questions in the survey, I utilized a variety of sources, some specific to dealing with mental health issues and trauma, and some generally examining obstacles that foster parents and foster youth face. It is notable that I built the survey after doing a significant amount of research for this thesis, so many of the references for this project influenced the survey design, but I will note a few here that were especially influential and focused on the views of foster parents.

Overall, foster parents agreed that more specialized training and support networks would increase retention and increase their capacity for serving foster youth (MacGregor et al., 2006). This supported not only my emphasis on training overall in my survey, but also the importance of my specific questions about if various areas of specialization were present in the training they had received. Further, it reinforced the importance of addressing the role of other support systems and resources foster parents had accessed.

I also reflected themes from the concept mapping study that I analyzed in Chapter 4. While many of the needs and corresponding obstacles that foster parents

brought up confirmed the viability of obstacles I had, the personality trait cluster added new information about obstacles to foster parents supporting youth with trauma. Specifically, this study is why I added work-life balance and stress coping skills to my obstacles. This particular study was especially important to consider because it represented the voices of foster parents and what they felt was important, which is what I also want reflected in my survey results (Brown & Calder, 2002).

Another study that interviewed caseworkers, therapists, and foster parents about a proposed new model of child welfare found a large degree of variation between the opinions of different members of care teams, and especially differing opinions towards the capability of the other groups. This emphasized the importance of including questions about support from DHS, relationships and communication with teachers, therapists, and caseworkers (Leathers et al., 2009).

These studies along with the general information from my literature review reinforced the important of the training and supports foster parents receive, as well as the interaction between different members of the care team. In the next sections I will more clearly detail the purpose behind specific questions.

Questions and Purpose

This section serves as an explanation for the specific sections and questions I included, for the exact order and wording of the survey see Appendix B. The focus of the survey was on what practices foster parents have perceived as effective when working with youth with trauma, how thoroughly they are being supported by the system's resources and training regarding trauma-informed care, and what obstacles make it difficult to serve youth with trauma. Many questions included an ability to

select an answer from a drop down list and a comment box to give room for further elaboration. My goal by including comment boxes was to give as much room as possible for elaboration, with my goal of ending up with quantitative and qualitative data.

Background Information and Analyzing Trauma Prevalence

For basic background information, I first asked how long the participants had been a foster parent, and second if they worked with DHS or a private foster agency. I wanted to get an idea of the level of experience my participants had, and it was also important to address that government and private foster care agencies can vary widely in their training and approaches.

One of my goals with this survey was to get a rough outline of the impact of trauma in youth's lives of this particular sample, and to gather information about foster parents' perceptions of the ways youth's behaviors were impacted by trauma. Further, to get a sense of how many youths might be experiencing the symptoms of complex trauma (currently not diagnosed under the DSM-V) I listed the ICD-11 symptoms to see if parents felt these symptoms were relevant in foster youth they had worked with. While of course it is not intended to mimic making an actual diagnosis, it served as a preliminary gauge for the relevance of the complex trauma diagnosis among the foster youth population based on the perception of foster parents.

Analyzing Current Training and Supports

I started by asking if they had received training on trauma in the last 3 years, if they had not, the survey advanced them forward past the group of questions specific to

trauma training. Some examples of those questions include: “How many hours of training did you receive on trauma from DHS/your agency in the last 3 years?”. This was measured on a sliding scale from 0-20 hours. This was followed up by questions for parents to rate how much the trainings emphasized real-world skills, highlighted the specific needs of youth of color and lgbtqia+ youth, etc.

Other questions aim at understanding what they have perceived to be positive intervention strategies, so asking participants to describe day-to-day skills that have been helpful fro their work with youth with trauma, and a question about utilizing resources from other organizations or communities that helped them work with youth with trauma.

Obstacles

Another main goal of the survey was to understand the current obstacles that make it more difficult for foster parents to serve foster youth with trauma. These questions followed an ecological format model, although I named the categories in a way that was more accessible for those unfamiliar with that specific model. I asked about external obstacles (exosystem) intrapersonal obstacles (microsystem), interpersonal obstacles (mesosystem), and societal obstacles (macrosystem). For this block of questions, they rated the obstacle under each category as something they experienced never, seldom, sometimes, often, or always.

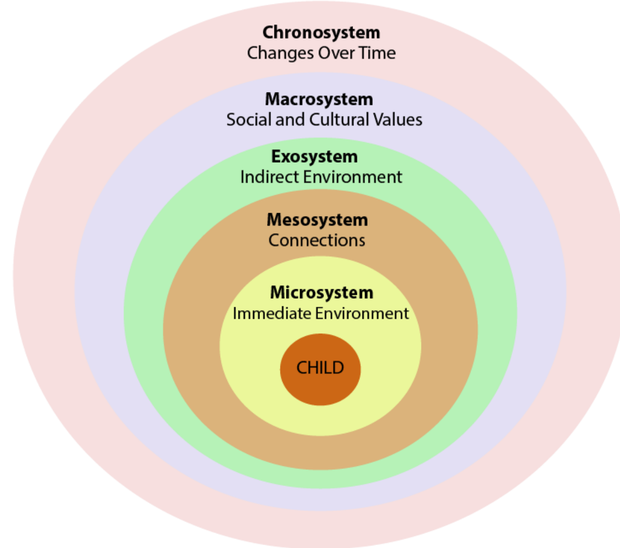


Figure 5: The Psychology Notes Headquarter, 2019. "Bronfenbrenner's Ecological Systems Theory"

Skills and Missing Information

Finally, I ended with a question about day-to-day skills they identified as helpful for their work as foster parents, and a final comment box for them to write about anything else important to their experience working with foster youth with trauma that I did not address in my survey. I wanted to end with an acknowledgement of the skills and resources they already have, a question that focuses on their strengths instead of ending the survey discussing obstacles. Further, with the very last question I wanted to acknowledge in a tangible way that although my survey was carefully planned, focused in research, and received feedback from other academics and foster parents, foster parents will always know best what is important to their work and it is possible I may not have addressed aspects key in their personal experiences and lives. And of course, in addition to those survey design reasons, I wanted to gather data on helpful and practical skills foster parents commonly use in their work with youth with trauma.

Overall, my goal with this survey was to get an idea of this sample’s experiences working with youth with trauma, how they were currently being supported, and how they could be better supported. In addition to the supports offered by DHS, I also wanted to analyze any common themes in helpful skills and external resources that foster parents in this sample applied. Finally, I wanted there to be a lot of room for individualized feedback and comments to represent the complex experiences and varying opinions of foster parents working with youth with trauma.

Chapter 6: Survey Results

When I closed my survey, about 49 people had opened the survey and 28 foster parents had completed it. The survey was open from April 4th-April 24th, and I received the large majority of my responses on April 12th and 13th. It is worth noting that during this time Oregon was in mandated shelter-in-place due to covid-19, and that it comes up in some of the responses. I will organize the results under the same categories as I divided the questions above, so the questions are not necessarily represented in the order it was presented in the survey.

Background Information and Analyzing Trauma Prevalence

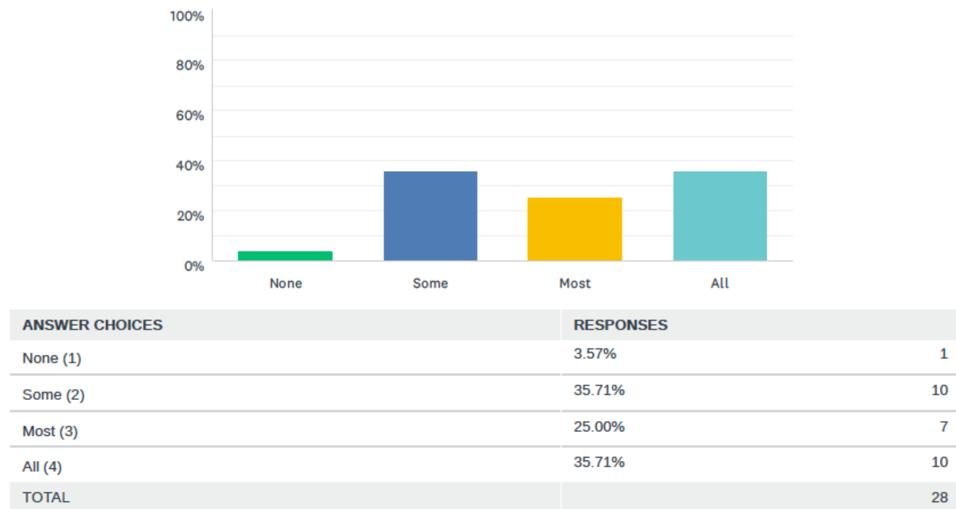
All of the participants provided foster care through DHS, as opposed to a private agency. On average, respondents had been foster parents for 7 years, although they ranged from 1-25 years of experience.

After question 17, the survey shifts to focus more specifically on trauma diagnoses and symptoms, as well as relevant obstacles parents have faced in regard to helping youth with trauma. Question 18 asks foster parents if any youth they have had in their care were diagnosed with PTSD, and found in this sample about 71% of parents had worked with youth with PTSD. I also provided a space here for foster parents to leave comments about the most significant symptoms they saw in the youth who had PTSD. While they of course varied here are some symptoms parents cited in order of most to least common: emotional dysregulation, sleep issues and nightmares, anger and violent outbursts, increased fear reactions, disassociation, and food issues. One foster parent provided a summary explaining how some of these behaviors manifest that was

echoed by other parents' comments, "I find that children with PTSD live in a constant state of fight or flight. The behaviors associated with this change from moment to moment and from kid to kid. Often they appear as unable to focus, easy to cry, easy to anger or spaced out." Other comments spoke to youth with PTSD who were commonly defiant, engaged in self harm behaviors, and struggled with suicidal ideation. Another parent spoke to their perception of the underlying feelings of youth with PTSD and how this drives their behavior,

> Perhaps most significant is the lack of feeling safe. There is a difference between BEING safe and FEELING safe. Their behaviors stem from not feeling safe…Not feeling safe affects every moment of every day for our kids. It is the root of all behaviors.

After the question about PTSD, I asked foster parents how many of the youth with intense trauma histories they had worked with displayed all three symptoms of complex trauma and listed the name and description of each symptom. This question is in no means intended to serve as an approximation of what rates of diagnoses would be, but to provide a gauge to see if these symptoms are relevant in the lives of foster youth through the perception of foster parents. Similar to question 17, there was again comment space provided for foster parents to elaborate on how those symptoms manifested in behaviors, in relationships with others, and/or in their homes.



ANSWER CHOICES	RESPONSES	
None (1)	3.57%	1
Some (2)	35.71%	10
Most (3)	25.00%	7
All (4)	35.71%	10
TOTAL		28

Figure 6: Graphed results for how many youths with significant trauma histories exhibited all three complex trauma symptoms

You can see in the results above, that almost all foster parents felt it was relevant for some of their youth, with one quarter of my sample reporting that all of their foster youth with significant trauma histories exhibited all three of the symptoms of complex trauma. In the comments, a majority of respondents detailed varying kinds of emotional disturbances, followed by relationship issues and diminished self. One parent described inconsistent expressions of attachment that multiple other parents also described, “On one hand, these kiddos will demonstrate constant demands for attention either through outright clinginess or through challenging behaviors and then then next moment they'll demonstrate outright rejection of attachment or forms of bonding.” Emotional disturbances described included aggression and outbursts, and diminished self attributes like low self esteem, disproportionate feelings of guilt, etc.

Analyzing Current Training and Supports

About 75% of respondents had received training on trauma from DHS in the past 3 years, and the 25% who had not were redirected past the questions that were specific to trauma training to question 17. This means for questions 9-16, my number of responses dropped to 21. On average, respondents who had received training had done about 10 hours in the past 3 years. However, the responses ranged widely from 2-20 hours with a standard deviation of 7.42, with a median amount that was only 6 hours.

Most of the foster parents in my sample, 75%, had sought out their own information on serving youth with trauma, and commented on a variety of reasons why and resources they found helpful. Some themes were finding helpful books, connecting with support groups both virtually and in-person, and online resources and videos. A couple participants spoke to the importance of doing research to cater to the individual needs of youth, “The DHS original training is a good start, but each child has specific issues and it helps to seek methods and tools that can help each child.” A few foster parents referenced their own careers as helpful, working in education or related fields. Other notable comments marked the support of pediatricians and mental health specialists.

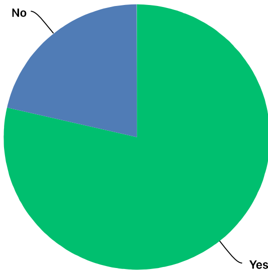
> A couple hours of training here and there throughout the year can't really cover the reality of what works best for traumatized children. I want to be the best parent I can be to all my children, birth, adopted and foster... that means I read articles when I can, go to extra trainings, join Facebook groups and seek out others who have been through similar experiences so I can provide for my children in the best way possible.

Throughout the comments was a theme of foster parents’ desires to continue learning and be able to improve their parenting skills and relationship with youth.

In the next question, the survey asked specifically if they had used resources or supports from other communities, to get an idea of other organizations that might be relevant or especially helpful for this sample of foster parents. Again, the results reflected that virtual and online foster parent support groups were a major theme, as well as counselors and a variety of local nonprofits and government agencies with supports for youth and families.

Q7 Have you utilized resources or support from other communities or organizations (besides DHS/foster agency) in regard to working with youth with trauma?

Answered: 28 Skipped: 1



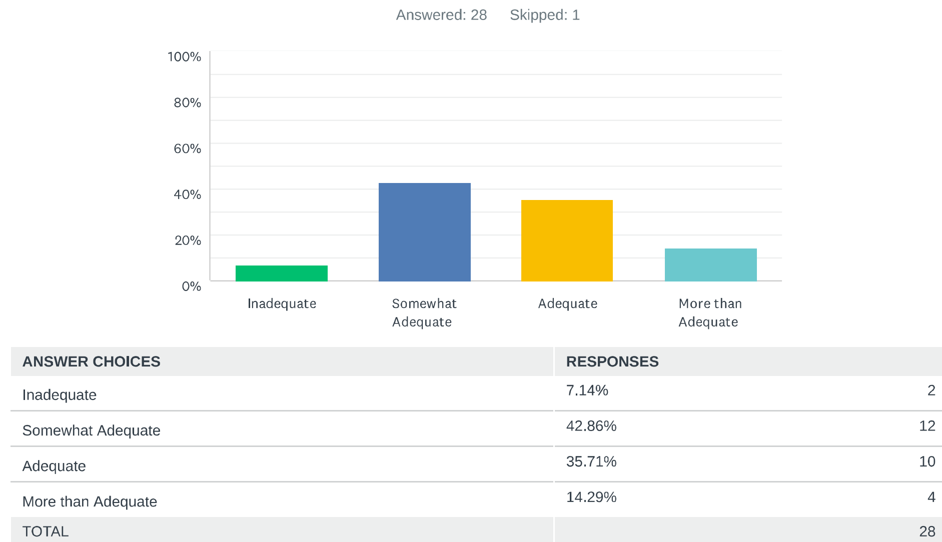
ANSWER CHOICES	RESPONSES	
Yes	78.57%	22
No	21.43%	6
TOTAL		28

Figure 7: Breakdown of how many foster parents have accessed resources from external communities or organizations

These results mimic the outcome of question 5 in which participants ranked the things they found most helpful for working with you with trauma, with one being the most helpful and three the least helpful. On this question, about 62% of foster parents ranked support systems (other foster parents, friends, family, community groups, etc.) as the most helpful, followed by trainings and education as the most common second choice, and policies as the least helpful.

Participants in my sample ranked the overall support provided by DHS relatively neutrally, with only about 7% rating the support as inadequate, and the majority of respondents rating it as somewhat adequate.

Q4 Rate the overall support provided by DHS/your foster agency in regards to serving youth with trauma



ANSWER CHOICES	RESPONSES	
Inadequate	7.14%	2
Somewhat Adequate	42.86%	12
Adequate	35.71%	10
More than Adequate	14.29%	4
TOTAL		28

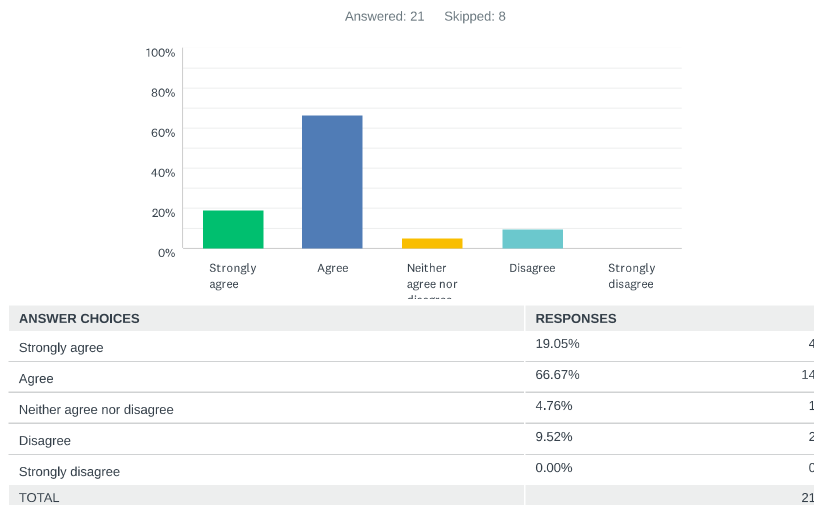
Figure 8: Ratings of overall support from DHS/foster agency in serving youth with trauma

More specifically, the majority of participants (~57%) agreed that the training they received emphasized real-world skills for working with kids with trauma, although about 24% neither agreed nor disagreed with the statement. About half of the participants who answered this question commented, many speaking to the difficulty of applying training to individualized cases and just the reality of training differing from the real world experience, “You can have all the training in the world but sometimes it doesn’t prepare you enough when you are in that moment and situation. You have to have compassion and [a] gentle heart.” One issue a participant brought up in this section was the repetitive nature of the training, which meant experienced foster parents

participate in the same training every two years and do not tend to learn new or advanced techniques, "It offers no advanced techniques for foster parents with more experience. The initial year was very helpful, follow up years become less and less helpful and more and more annoying and feel like a greater waste of time for all involved." There was a sense through comments in response to questions that even when training was adequate, it could not always translate to the lived experience.

Generally positive attitudes were reported about the extent to which the training offered specific information about how to understand behaviors through a trauma-informed lens, with ~67% of participants agreeing and ~19% strongly agreeing with the statement.

Q11 To what extent to do you agree that the training you received offered specific information about how to understand behaviors through a trauma-informed lens?



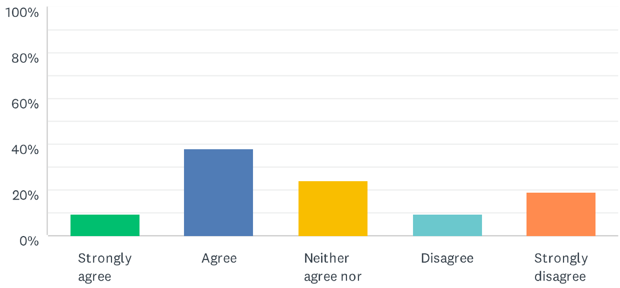
ANSWER CHOICES	RESPONSES	
Strongly agree	19.05%	4
Agree	66.67%	14
Neither agree nor disagree	4.76%	1
Disagree	9.52%	2
Strongly disagree	0.00%	0
TOTAL		21

Figure 9: Perceptions of how training provided understanding of behavior through a trauma-informed lens

One foster parent noted an experience with an especially effective trainer, "The initial training and instructor worked diligently to tell the stories and create a trauma-informed lens--- from the perspective of the child/children." Another parent commented noting the focus in the training on the science of how trauma changes brain functioning and impacts emotional function. Of all the subcategories and focuses of the training that the survey asked about, understanding behaviors through a trauma-informed lens received the highest percentage of respondents agreeing and strongly agreeing.

Q13 To what extent to do you agree that the training you received highlighted the specific needs of youth of color who have experienced trauma?

Answered: 21 Skipped: 8



ANSWER CHOICES	RESPONSES	
Strongly agree (1)	9.52%	2
Agree (2)	38.10%	8
Neither agree nor disagree (3)	23.81%	5
Disagree (4)	9.52%	2
Strongly disagree (5)	19.05%	4
TOTAL		21

Figure 10: Perceptions of how training highlighted needs of youth of color with trauma histories

In contrast, there was more deviation on the responses to question thirteen about how the training highlighted the needs of youth of color who have experienced trauma. The largest percentage, about 38% agreed, although we also see a significant proportion who chose the neutral option, and ~10% who strongly agreed, contrasted by the ~19%

who strongly disagreed with the statement. In the comments, two participants spoke to the need for much more coverage specific to youth of color, while another participant wrote that color is irrelevant to the topic of how people are affected by trauma.

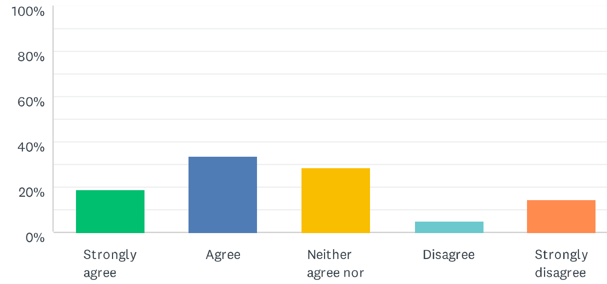
In response to “To what extent to do you agree that the training you received highlighted the specific needs of lgbtqia+ youth who have experienced trauma?” the sentiments in comments also varied widely. Some felt it was an afterthought and that information was lacking, another participant agreed writing,

> There isn’t hardly anything for LGBTQ+ and people the work with DHS don’t know the information so they can’t teach it. Also, policy and protocols for working with LGBTQ+ children are not in place, so it is up to the caseworker and office you are working with and their own bias

However, a third foster parent wrote that there was way too much about LGBTQ youth, “I feel this is a primary focus although this group is a minority”. These comments reflected a range of feelings from foster parents about how much training specific to youth’s identities was helpful.

Q14 To what extent to do you agree that the training you received highlighted the specific needs of lgbtqia+ youth who have experienced trauma?

Answered: 21 Skipped: 8



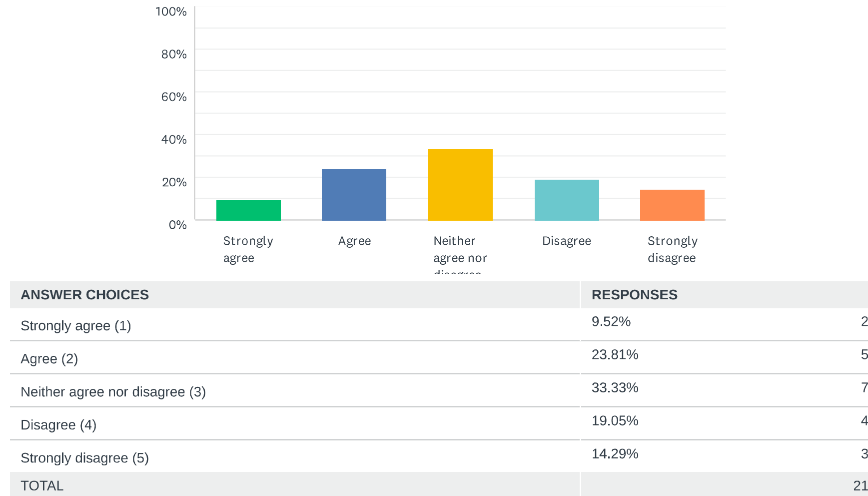
ANSWER CHOICES	RESPONSES	
Strongly agree (1)	19.05%	4
Agree (2)	33.33%	7
Neither agree nor disagree (3)	28.57%	6
Disagree (4)	4.76%	1
Strongly disagree (5)	14.29%	3
TOTAL		21

Figure 11: Perceptions of how training highlighted needs of LGBTQIA+ youth with trauma histories

In response to question 15 about the training's incorporation of different cultural and religious beliefs, the majority of respondents, about 48%, rated it as adequate and about 29% rated it as somewhat adequate although approximately 19% of respondents marked it as inadequate. There were no comments to elaborate on the responses to this question, so it is unknown what parents' perspectives were about what may have improved the training.

Q16 To what extent to do you agree that the training you received offered skills in self-care and coping for you as a foster parent?

Answered: 21 Skipped: 8



ANSWER CHOICES	RESPONSES	
Strongly agree (1)	9.52%	2
Agree (2)	23.81%	5
Neither agree nor disagree (3)	33.33%	7
Disagree (4)	19.05%	4
Strongly disagree (5)	14.29%	3
TOTAL		21

Figure 12: Responses about how training offered skills in self-care

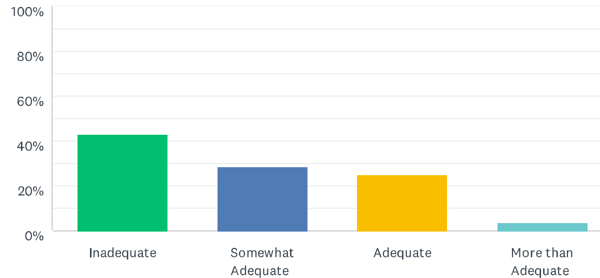
Foster parents, while marking many types of trainings as largely accurate, did not necessarily agree that the training emphasized skills on their own coping and dealing with secondhand trauma. In response to the question, “To what extent to do you agree that the training you received offered skills in self-care and coping for you as a foster parent?” one participant wrote,

> While I have been able to find resources to inform my parenting skills, it has been harder to find resources to help foster parents cope with the added stress of working with and caring for kids, who by definition, have experienced trauma. After all, even being removed from their family is traumatic, if nothing else.

This comment was especially interesting in the way it noted the participant’s desire to seek out extra information to help support youth, but not necessarily feeling they had as much information or support for their own coping with the effects of secondhand trauma.

Q17 Rate the quality of information you receive from DHS/your agency about the trauma history of children placed with you before their placement

Answered: 28 Skipped: 1



ANSWER CHOICES	RESPONSES	
Inadequate (1)	42.86%	12
Somewhat Adequate (2)	28.57%	8
Adequate (3)	25.00%	7
More than Adequate (4)	3.57%	1
TOTAL		28

Figure 13: Ratings of information about trauma history of foster youth prior to placement

Question 17 about the quality of information parents receive from DHS about the trauma history of foster youth before their placement received by far the lowest scores of this block of questions, with about 43% of participants rating it as inadequate. This echoes sentiments found in other comments about the struggle of attempting to patch together youth's full histories.

Obstacles

Questions 20-23 asked about various potential obstacles to helping youth with trauma, which foster parents ranked as something they faced never, seldom, sometimes, often, or always. Based on the assigned associated values with each answer, the higher the weighted average signaled an obstacle that was experienced more often. For my first question regarding external obstacles, lack of background information on youth was

rated as the most frequently occurring obstacle, with about 37% of the sample saying it occurred often, and more than one fifth of the sample reporting it was always an obstacle.

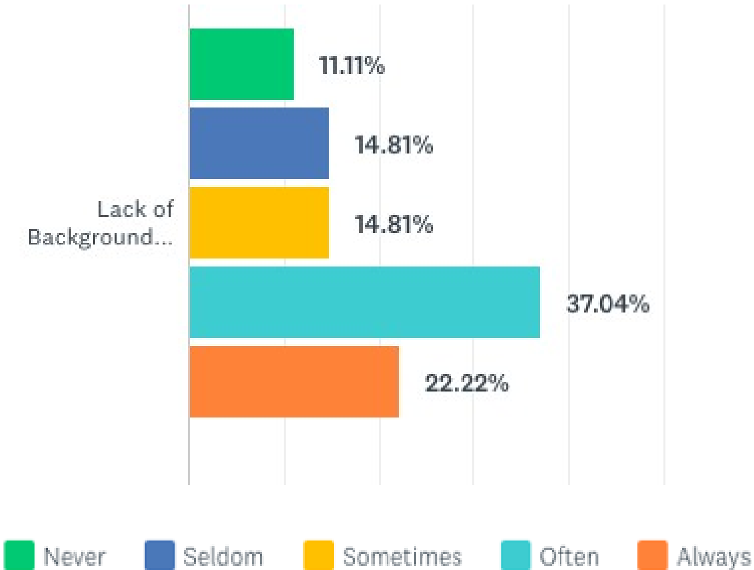


Figure 14: Perceptions of lack of background information on youth as an obstacle

Following after that in descending order was lack of resources, difficulty accessing mental health services, and lack of training. However, it is worth noting that ratings for difficulty accessing mental health services had the most variation in responses, with about ~18% reporting it was always an obstacle, but also about 21% reporting it was never an obstacle they faced.

One comment detailed the issues related to a lack of trauma-informed care that came up both in mental health services, in DHS, and at school-

> Mental health services for children are severely lacking. Many trauma behaviors are viewed as a child being spoiled, trying to get attention, or "all in their heads". We've had DHS caseworkers who were trauma informed and very supportive, but we've also had them blow off issues as non-existent. Even finding therapists who are trauma-informed can be

> difficult, as the general population doesn't have the issues that many MANY foster children have. Just by being in care, they have trauma, and a lot of people who work with our kids don't fully understand this. Teachers and school administrators have very little knowledge of trauma, although this is beginning to slowly change.

Another parent described a very similar sentiment about youth with trauma in school, "The whole educational system is set up to cater to one normalized child type. Few programs are designed with the forethought necessary to accommodate the behaviors that come with traumatized you." Another felt the same way and remarked, "Teachers and staff at school don't know how to spot or help kids who have experienced trauma." Despite this themes in the comment, school policy and school personnel were not rated as a particularly prevalent obstacle.

	NEVER (1)	SELDOM (2)	SOMETIMES (3)	OFTEN (4)	ALWAYS (5)	TOTAL	WEIGHTED AVERAGE
School Policy	25.00% 7	17.86% 5	35.71% 10	17.86% 5	3.57% 1	28	2.57
School Personnel	32.14% 9	14.29% 4	35.71% 10	10.71% 3	7.14% 2	28	2.46
Lack of Resources	3.57% 1	17.86% 5	53.57% 15	14.29% 4	10.71% 3	28	3.11
Lack of Training	14.29% 4	10.71% 3	39.29% 11	28.57% 8	7.14% 2	28	3.04
Lack of Background Information on Youth	11.11% 3	14.81% 4	14.81% 4	37.04% 10	22.22% 6	27	3.44
DHS/Agency Policy	10.71% 3	21.43% 6	46.43% 13	7.14% 2	14.29% 4	28	2.93
DHS/Agency Personnel	21.43% 6	28.57% 8	35.71% 10	10.71% 3	3.57% 1	28	2.46
Difficulty accessing mental health services (due to long wait lists, lack of specialists available under medicaid, etc.)	21.43% 6	10.71% 3	25.00% 7	25.00% 7	17.86% 5	28	3.07
Personal Finances	28.57% 8	14.29% 4	32.14% 9	17.86% 5	7.14% 2	28	2.61

Table 1: Table of external obstacle results

Question 21 focused on intrapersonal obstacles, with difficulty with own self care/coping from stress ranked the highest, although the overall values for intrapersonal obstacles deviated less than external obstacles. That being said, many of them were ranked on average around a 3, meaning each one was perceived to on average sometimes be an obstacle.

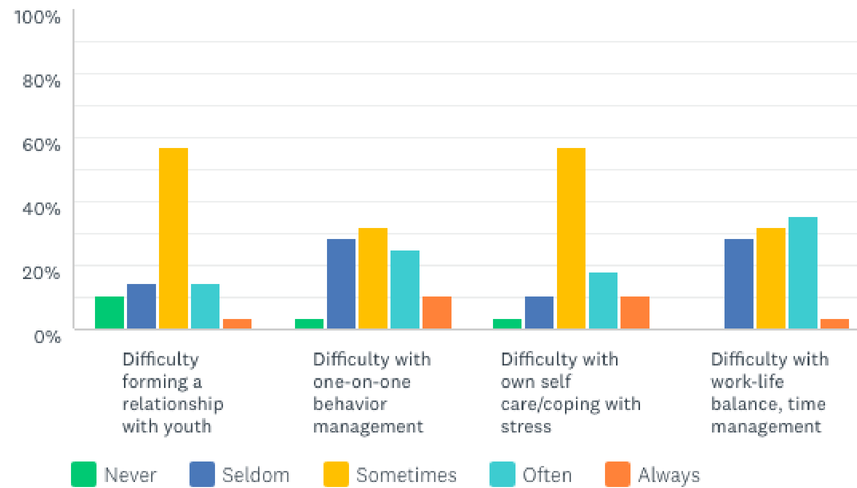


Figure 15: Intrapersonal obstacle bar graph

About 36% of parents rated time management and life work balance as an obstacle that came up often, “It can be very challenging balancing visits, medical appointments, transporting to out of district schools, working, and taking care of the kids already in the home. There is not much support for foster parents, if any, to help with this.” The comments spoke to an interaction between the obstacles, such as difficulty managing behavior and developing a positive relationship contributing to the difficulty balancing time and dealing with stress. Speaking specifically on behavior management one parent wrote, “Behavior management is always an issue within foster care because we don't always have a good feel for WHAT causes behaviors, and so it's trial and error to figure out what triggers a child and how we can best help them.” This spoke to the complicated nature of behavior management with a desire to have a deeper understanding of the underlying issues in order to best support youth.

	NEVER (1)	SELDOM (2)	SOMETIMES (3)	OFTEN (4)	ALWAYS (5)	TOTAL	WEIGHTED AVERAGE
Difficulty forming a relationship with youth	10.71% 3	14.29% 4	57.14% 16	14.29% 4	3.57% 1	28	2.86
Difficulty with one-on-one behavior management	3.57% 1	28.57% 8	32.14% 9	25.00% 7	10.71% 3	28	3.11
Difficulty with own self care/coping with stress	3.57% 1	10.71% 3	57.14% 16	17.86% 5	10.71% 3	28	3.21
Difficulty with work-life balance, time management	0.00% 0	28.57% 8	32.14% 9	35.71% 10	3.57% 1	28	3.14

Table 2: Full results for intrapersonal obstacles

The next question on obstacles focused on interpersonal obstacles, focusing on the role and difficulties of interpersonal relationships for the family and youth. Difficulty working with youth's biological family was ranked as the most commonly occurring obstacle for foster parents, with ~41% say it was often an issue, and about 37% rating it as an obstacle that came up sometimes. In contrast, communication problems with youth's teachers and communication problem with youth's mental health workers were ranked the lowest, although they also had the highest standard deviations. The comments on interactions with biological families represented a variety of kinds of interactions, "Bio family is challenging, but not ordered. I keep the communication so youth can learn healthy relationships with them. There is active drug use in family which can make things challenging." This quote elaborated on the conflict between the desire to keep a youth connected with their biological family and ongoing issues that make that difficult.

	NEVER (1)	SELDOM (2)	SOMETIMES (3)	OFTEN (4)	ALWAYS (5)	TOTAL	WEIGHTED AVERAGE
Lack of understanding from your friends and/or family	7.14% 2	32.14% 9	35.71% 10	21.43% 6	3.57% 1	28	2.82
Difficulty working with youth's biological family	7.41% 2	11.11% 3	37.04% 10	40.74% 11	3.70% 1	27	3.22
Youth conflict with peers	10.71% 3	17.86% 5	28.57% 8	39.29% 11	3.57% 1	28	3.07
Difficulty with your home's family dynamics	7.14% 2	32.14% 9	46.43% 13	14.29% 4	0.00% 0	28	2.68
Communication problems and/or lack of understanding with youth's teachers	32.14% 9	17.86% 5	35.71% 10	7.14% 2	7.14% 2	28	2.39
Communication problems with youth's therapist/mental health specialists	25.00% 7	39.29% 11	14.29% 4	14.29% 4	7.14% 2	28	2.39

Table 3: Full results for interpersonal obstacles

The final question analyzing different obstacles foster parents faced to helping youth with trauma focused on societal obstacles. Of the four potential obstacles, misconceptions about foster youth and beliefs about trauma and kids with trauma had the same mean ranking, followed by societal beliefs about parenting and cultural conflict related to parenting and trauma. Like many of the other lower average scoring obstacles, cultural conflict related to parenting and trauma had the highest standard deviation of any of the societal obstacles.

Most of the comments from foster parents elaborating on societal obstacles spoke to a lack of understanding from other people especially related to raising foster children and the behavioral issues that can result from extensive trauma.

> We face judgment and criticism from strangers often when our daughter, who has brain damage due to her mother's drug use while pregnant, throws tantrums due to a physiological inability to regulate her emotions. We have had her taken away from us on a plane by a flight attendant because she was "disturbing" the woman behind us. It is hard because

> she looks typical, so people assume we are just terrible parents. We want to tell them her history so they aren't so judgmental but it is none of their business and we are protective of her privacy.

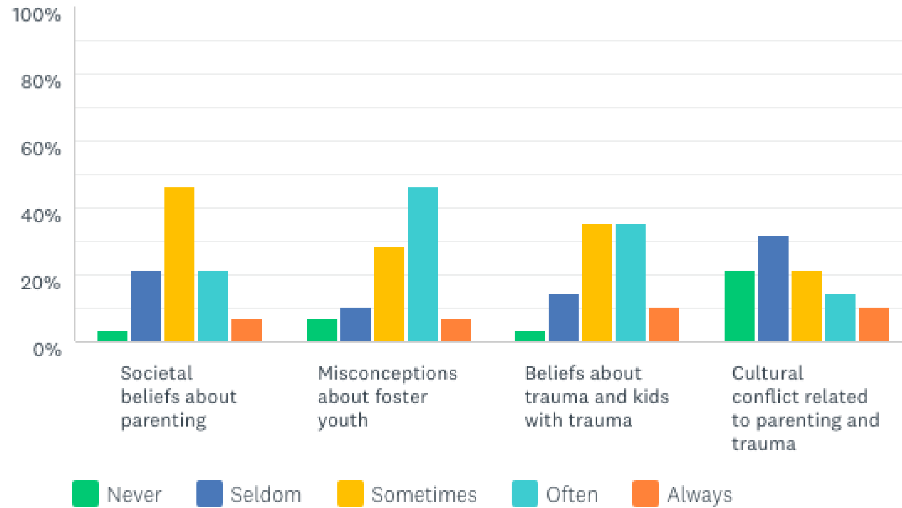


Figure 16: Bar graph for societal obstacles

This was a shared experience, with another parent describing the judgment from strangers when their foster child had behavioral outbursts in public, and feeling others assumed something about what kind of parents they were based on that. To summarize the overall sentiment from foster parents on societal obstacles to helping youth with trauma, I will let this quote from a foster parent say it best, “Unless you've lived it, you don't understand it.

	NEVER (1)	SELDOM (2)	SOMETIMES (3)	OFTEN (4)	ALWAYS (5)	TOTAL	WEIGHTED AVERAGE
Societal beliefs about parenting	3.57% 1	21.43% 6	46.43% 13	21.43% 6	7.14% 2	28	3.07
Misconceptions about foster youth	7.14% 2	10.71% 3	28.57% 8	46.43% 13	7.14% 2	28	3.36
Beliefs about trauma and kids with trauma	3.57% 1	14.29% 4	35.71% 10	35.71% 10	10.71% 3	28	3.36
Cultural conflict related to parenting and trauma	21.43% 6	32.14% 9	21.43% 6	14.29% 4	10.71% 3	28	2.61

Table 4: Full results for societal obstacles

Skills and Missing Information

My final two questions were an open format for longer writing to capture anything the rest of my survey had not and to end the survey focusing on skills and strengths of the foster parent participants. Question 24 asked for parents to describe any helpful day-to-day skills for working with youth with trauma, and I created the word cloud below with relevant words from the responses that occurred most frequently.

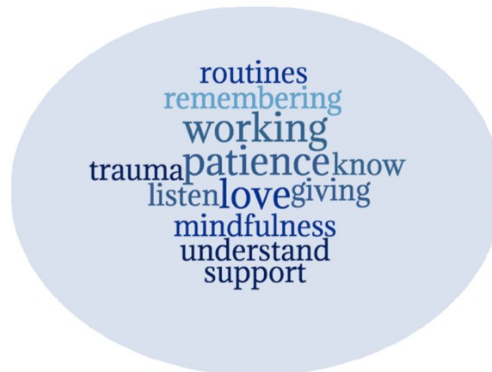


Figure 17: Word cloud with key words describing day-to-day skills for working with youth with trauma

The comments themselves varied widely in content, some focusing on parenting skills, many on coping skills for parents, and some focusing on creating connection with the youth. Some themes that reoccurred included an emphasis on adaptability and honoring

the individual needs of each youth. Others emphasized empathy, especially adopting the child’s point of view and remembering their history and how that affects current behaviors. As reflected in the world cloud, being loving came up over and over, as well as mindfulness skills, patience, drawing on positive strengths based approaches, maintaining structure, and more.

Here are a couple samples that give a better idea on the depth and variety of the comments on day-to-day skills:

> **ADVOCATE for your child, even when it is hard**. Sometimes schools don’t understand that a child cannot focus when they are in a triggered state. That said, do not baby, encourage the child to identify healthy ways to cope that do not turn the focus to them (as this is often a trigger in and of itself) this can include a pencil fidget/bracelet, tapping, drawing an ugly picture on the back of the worksheet...the teacher should be taught that this is a coping skill, and the child should be taught this is not a “get out of an assignment free” tool**. I think that people oftentimes forget that the goal is to get functional adults out of the children as they grow, so teaching life coping skills should be the focus once beyond the initial trauma.**

> **Love. Patience. Compassion. Empathy**. Focus on successes, massive praise to the kiddo. De-escalation techniques. Consistency. Giving ourselves personal time-outs. Passing the baton (child hand-off to our partner.) Structured daily routines. Tenacity. Dedication. Mindfulness techniques--- 'The Power of Now' (Eckhart Tolle) Commitment. Sharing conversation with partner at the end of the day. Zoning out on TV at night. Neck massage any and all the time. Did I mention compassion, de-escalation and hand-offs?

> Breathe! Breathe!! Breathe!!! Count to 10 before speaking or acting! Listen, look, ask before speaking. **Remember who is in crisis, & who is the crisis interventionist**. Step back far enough to see the child in a much bigger picture, from a distance far enough to remove you from the target spot on the dartboard of their acting out darts.

> Spend **unwavering love** on them.

> Being one family unit. **Treating them as if we have always been together**.

The final question asked if there was anything else important to foster parents' experiences working with youth with trauma that had not been addressed in previous questions. As might be expected there were not any clear themes that came out of this question, but some reemphasis on themes that were present in other questions, such as the importance of patience when working with youth with trauma and looking at each child individually.

One foster parent reemphasized the importance of self care for parents, especially when working with youth with trauma on a regular basis.

> When you begin to feel like you have experienced as much trauma as the child/ren, it's time to find a way to learn from that - how to respond more gently, how to protect yourself from their trauma so transference is limited, how to help the child identify what's behind their acting out, find more acceptable and satisfying ways to express their emotional, physical, spiritual, intellectual pain, confusion, hurt, fear, etc. Then get a counselor for yourself!

Another foster parent detailed their experience with frustrations with failed reunifications with biological families, and feeling disheartened at the subpar outcomes a lot of foster youth face, "It's also disheartening to really not have a voice in the ultimate end of the story for the kiddos." They felt these rough realities were not often addressed by DHS and higher policies.

In contrast, one foster parent took the opportunity to emphasize that they had had very positive experiences with DHS and the staff, "I have noticed that a lot of the

foster parents who I have connected with on Facebook are pretty negative about DHS and agencies who contract to do foster care. My experience was very much the opposite - my caseworkers were very supportive and responsive to any needs or questions I had."

Finally, I will end the survey results with a fitting quote from a foster parent that wraps up obstacles, the struggles, and what really matters when working with foster youth.

> There is a lot. I really think we should be given more tools and support to do this. I have been to trainings and can't understand how some people I meet are allowed to take care of youths. It would be great to get background information on the child to know what had happened. And I can't stress it enough that youths need to be placed in accepting homes. We are not here to change their beliefs, culture, color, gender, and sexual orientation. Most youths in the system have already gone through so much, then to be placed in a non accepting home and to work with non accepting people is even more trauma. This will only make things worse. **We need to honor who they are at their core and welcome them with support.**

Chapter 7: Discussion

This survey focused on foster parents serving youth with trauma by analyzing current ways the system trains and supports foster parents, other supports and resources foster parents access, and obstacles foster parents face to working with youth with trauma.

Background Information and Analyzing Trauma Prevalence

The large majority of parents in my sample, 71%, had worked with youth with PTSD diagnoses. This on its own speaks to the importance of being able to work with youth with trauma, and is intensified by the fact that research suggests large amount of foster youth are also dealing with subdiagnostic levels of trauma symptoms (Ai et al., 2013).

While youth all have varied symptoms and displays of symptoms, there was a lot of overlap in the symptoms parents perceived to be most significant, especially outbursts of violence and anger, general emotional dysregulation, and increased fear reactions. These may just stand out to parents the most when reflecting back due to their nature as emotionally charged and intense events that effect family members. In regard to the question about complex trauma, the responses pointed to a high relevance that I did not expect, even with my prediction that complex trauma would be significant in foster care populations. In response, 36% of foster parents said all of their youth with significant trauma histories had all three symptoms and 25% said most did. This could be related to being primed by the question about PTSD diagnoses, and of course perceptions of symptoms would not translate to diagnostic levels. However, I believe it

is significant if nothing else for pointing to that learning more about complex trauma effects and treatments could feel very relevant to foster parents' work with youth.

Analyzing Current Training and Supports

Overall, foster parents' ratings of the adequacy of training and support was fairly neutral, and sometimes leaned rather positive. Based on the responses, it appears the training these foster parents received especially succeeded in helping foster parents use a trauma-informed lens to view youth's behaviors. However, there was a theme throughout the comments on a variety of aspects of training that training could never full prepare you for the real world application and the individual needs of foster youth. Some of the opinions on various aspects of the training, especially those tied to identity, received a wide variety of feedback. Specifically, the questions on if the training catered specifically to serving LGBTQIA+ youth and youth of color received vastly different responses in the comments. This could reflect the variety of values and identities foster parents hold, or could have more to do with the extent to which they see those identities influencing or not influencing a youth's trauma experiences.

As far as supports, connections with other foster parents in local or virtual support groups seemed to be one of the most commonly noted forms. In general, social connections and supports were ranked and commented on as being especially important, whether that took the form of especially good connections with social workers, support of a partner, or other foster parents.

The large majority of foster parents in this sample did their own research and accessed support from organizations other than DHS in order to further their knowledge on serving youth with trauma. Most foster parents described accessing multiple

different forms of extra resources, in combination with things like support groups or virtual groups. This supports the need for external resources and especially resources or supports that can help cater to the individual needs of youth.

The low ratings on whether the training incorporated information about foster parents coping suggests discussions of self-care and secondhand trauma may be lacking for foster parents. It is also important to note this difficulty with self-care and work-life balance when suggesting any changes to the system that require more of foster parents.

Obstacles

Many of the lowest rated obstacles based on their mean scores, such as difficulty accessing to mental health services, cultural conflict, and communication issues with educators, also tended to have the most deviation. This suggests that lower scores do not point to being completely irrelevant obstacles, but just that they are significant for some parents, and insignificant for others. This could be expected given the natural variation of foster parents' lives outside of parenting. In fact, there were no obstacles that seemed to be largely insignificant based on this sample.

In regard to interactions with social workers and educators, the experiences seemed to vary widely, from person to person and within the experience of the same person. It seems that case workers, therapists and educators who were trauma-informed and went above and beyond made lasting impacts on the experiences of foster parents and the youth they care for. However, there were also a variety of negative experiences with individuals that were marked as active barriers to getting help.

One sentiment that I found reflected in the survey was that while many foster parents had a variety of sources of support, training and tools to care for their foster

youth, there was a sense they did not have the tools, support, or training to take care of themselves. This came up in questions about the training, about coping and time management. Many foster parents described trying to balance an impossible mix of their own personal and professional lives while trying to balance supporting their families.

It is also interesting to note that behind the logistical issue of not receiving enough information about youth prior to placement, it was two societal/macrosystemic obstacles that had the mean highest rating as significant obstacles. These two obstacles, misconceptions about foster youth and beliefs about trauma and kids with trauma, suggest the beliefs of our greater society influence in foster parents' ability to smoothly work with youth with trauma.

Skills

In the last two open-ended questions, I came away with the summary that while parents varied in their specific approaches on working with youth, many foster parents who took this survey shared similar core values about being caring and empathetic towards their foster children. This sample had significant interest in mindfulness, and many spoke to techniques they used to center themselves especially in times of crisis.

Limitations

There are a variety of limitations to this survey. As I mentioned previously, this survey is in no means meant to stand as the opinions of foster parents across the country, but just to reflect the opinions and experiences of a small sample of foster parents, likely predominantly from the same area and district in Oregon. While one of

the major goals of this project was to represent the voices of foster parents, there is an inherent limitation of me, an undergraduate student unassociated with the foster care system, representing the voices of foster parents. This is why I did my best to include direct quotes whenever relevant, although of course I still chose the quotes and themes to pull out of the research.

In a longer project, a project like this would ideally be a collaboration with a foster parent as a coauthor, or just completely run by a foster parent, because as one participant put best "Unless you've lived it, you don't understand it." I also would have liked to survey foster youth on their experiences with trauma and the supports and obstacles they faced, although it was not logistically feasible for this project due to high level of protections in place for foster youth and a limited timeline.

For the sample that I ended up with, most of my participants likely accessed this though a voluntary link sent out by DHS and so my sample may be the most highly involved parents who took the time to do the survey, or who were especially interested in the topic.

Summary of Main Findings

The results from this sample suggested a very high prevalence of trauma symptoms and trauma disorders among foster youth. The majority of foster parents accessed resources and research outside of DHS, and usually multiple different sources. Connection with other foster parents in the form of in-person and virtual support groups surfaced as particularly important. The trauma training parents received was overall rated relatively neutrally; parents most strongly agreed that training offered a trauma lens to understand behaviors. However, parents were very mixed on if the training

offered self-care skills and on rating the training’s focus on youth of color and LGBTQIA+ youth. Not receiving enough information about youth’s trauma histories prior to placement emerged as a significant obstacle, as well as societal beliefs about foster youth and youth with trauma. Parents emphasized the importance of being able to individualize knowledge to best serve different youth, using parenting skills, empathy, and patience.

Chapter 8: Suggestions for Supporting Youth with Complex Trauma

This section integrates the findings from the literature review of relevant research and the findings of this project's survey to make suggestions for supporting youth with complex trauma.

Foster Parent Training

In regard to improving trauma trainings for foster parents, my first suggestion is to work on making trainings more interactive and involving practice applications to help bridge the gap between the training and real life application. While training and the real world application will always have differences, the research and survey highly supported the importance of foster parents feeling well-trained to deal with real world issues. Based on themes in the research and survey, one way that training may be made to feel more relevant is by including experienced foster parents in delivering the training.

Based on survey feedback, I also suggest some sort of progressive trauma training system, where foster parents who have completed the base level training and can prove proficiency can then opt into moving onto gaining novel, more advanced information. This would not only keep them engaged in training that feels relevant, but would also end up with the outcome of a larger breadth of knowledge for foster parents.

The survey data also suggested that there is room for improvement in the delivery of information about the ways various identities can influence trauma experiences. The lack of consensus from the survey makes it difficult to suggest if there was a lack of information or not, but does suggest that foster parents did not walk away

with a feeling of why understanding the way identities and trauma can intersect is important.

Finally, and perhaps most importantly, the research and the specifics of my survey supported a need for more acknowledgement and training on secondhand trauma and coping skills. Foster parents expressed their dedication to gathering additional resources on their own about serving youth with trauma, but did not overall report feeling that their own self care was marked as important in trainings.

Supports for Foster Parents

My largest suggestion for facilitating extra supports for foster parents is agencies not only encouraging but taking part in organizing social opportunities and support networks for foster parents to come together. Both in the literature and the results of my survey foster parents reflected on the immense support they gained from being able to commune with other foster parents.

In addition, to supplement the fact that training is only a base and that real application often requires more individualized knowledge, agencies should ensure they have on call support options for foster parents, so there are always reliable supports in the case something comes up a foster parent does not feel prepared for. Further, a centralized way to access a variety of resources specific to common needs of foster youth could supplement training and based on the sample in my survey, would certainly be utilized.

Mental Health Services

While changes within DHS and local agencies are impactful, a coordination of trauma-informed efforts within the mental health services foster youth access is also important. While this project only lightly touches on it, there is a crucial need for more evidenced-based prevention and intervention programs to serve foster youth (Pecora et al., 2005). Evidenced-based practice is a great place to start, but the ability to adapt it to the foster care context is crucial. Further, The Northwest Foster Care Alumni Study asserted that in addition to eliminating barriers with receiving adequate mental health due to insurance and access, it is necessary that therapists working with foster youth receive more training specific to trauma (Pecora et al., 2005). This was also reflected by my survey results where parents wrote about inconsistencies with therapists' capability to serve their youth with trauma, sometimes result in the discontinuation of therapy.

In addition, I think the implementation of some form of a complex trauma or developmental trauma diagnosis in the DSM and corresponding treatment recommendations will lead to more accurate diagnoses and therefore better holistic treatment not only for foster youth, but all youth who have experienced complex trauma throughout development.

Foster Care System Goals

While the details of recommended foster care system goals are complicated, in summation I recommend the widespread implementation of the trauma-informed care model, following the basic four r's of trauma-informed care. This means realizing the widespread impact of trauma, recognizing symptoms of trauma (both in youth and symptoms of secondhand trauma in adults), responding to the impacts of trauma

through policy, procedure, and practice, and resisting retraumatization (Bartlett & Steber, 2019). Some first steps towards implementing a fully trauma-informed model are increasing trauma screenings, and emphasizing trauma in trainings to staff and foster parents.

Macrosystemic Changes

Finally, there are a series of macrosystemic changes that would ultimately be necessary for the success of the broad implementation of trauma-informed symptoms. The first is the acknowledgement of the large variety of valid trauma experiences, which I think is occurring as an ongoing relearning process in the psychology and social work fields, shifting away from a view of trauma as just the experience of war or a natural disaster, to include a large variety of interpersonal traumas and other experiences. It also requires an adjustment of the ways we as a society look at behaviors and mental illness, to increase our ability to understand the context of behaviors instead of automatically pathologizing. Further, by valuing and prioritizing accessible mental health care on a national level, foster youth could access a wider variety of specialists and services with their provided insurance. Finally, as results from my survey pointed to, a shift in the ways we as a society judge and comment on other people's parenting could improve foster parents' ability to care for and involve their children with trauma in various aspects of life without facing uninformed judgment.

Future Research

While there are many areas left to explore in regard to foster youth with trauma, I think research that represents more directly the experiences and views of foster parents

and foster youth is crucial to being able to use research to inform policy and decision making. There is immense knowledge from lived experiences and acquired knowledge that is currently largely inaccessible in available formalized research on the foster care system.

Further, while researching complex trauma in any format is valuable, researching complex trauma and how to effectively prevent it and provide interventions in the context of the foster care system is crucial. Finally, larger scale collection of data about trauma prevalence and trauma diagnoses in foster youth could bring more substantial attention and resources to promoting trauma healing.

Chapter 9: Conclusion

The foster care system should not only protect foster youth from retraumatization, but also work to actively promote healing from past traumatic experiences. The trauma-informed care movement details ways systems can implement change by realizing the widespread prevalence and impacts of trauma, recognizing symptoms, responding to trauma, and resisting retraumatization (Bartlett & Steber, 2019).

The high prevalence of foster youth who experience complex trauma calls for a trauma diagnosis that accurately describes the traumas and related outcomes youth experience. While recognition of complex trauma has risen in the international conversation about mental health over the last decade, the U.S. still lacks a DSM diagnosis and treatment plan.

Discovering that research on the foster care system often left out the voices of the very people who are part of it day to day, I sought to bring together information on trauma and represent the experiences and opinions of foster parents in this thesis. I analyzed the ways our child welfare system currently supports foster parents, what supports are helpful to parents, and what obstacles continue to make serving foster youth with trauma more difficult. While I believe there is significant work to be done and considerable shifts that need to be made, I think the emerging focus on providing trauma-informed services throughout the entirety of the foster care system will lead to better outcomes for everyone involved.

Appendix A

Further Readings and Resources

These readings may be interesting for anyone wanting to learn more about complex trauma, trauma in the foster care system, or the intersection of both. The websites and briefs are the most accessible sources and provide a great density of information aimed at different audiences, which I have tried to indicate in my headings. I am repeating some sources I used in the paper to gather the most helpful briefs and resources in a way that is easier to sort out than the reference list.

Websites

Child Welfare Information Gateway-
https://www.childwelfare.gov/pubs/factsheets/child-trauma/

Child Trend's on Trauma-Informed Care-
https://www.childtrends.org/publications/how-to-implement-trauma-informed-care-to-build-resilience-to-childhood-trauma

The National Child Traumatic Stress Network-
https://www.nctsn.org/

The Annie E. Casey Foundation on Foster Care-
https://www.aecf.org/topics/foster-care?start=160

Foster Care Newsletter about PTSD-
http://foster-care-newsletter.com/haunted-by-the-past-foster-children-with-ptsd/#.W-uraXpKiRs

Briefs

Brief explaining biological impacts of toxic stress and trauma-
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Overview of trauma-informed services-

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Extensive guide for caregivers and social workers on how to seek help for youth with trauma and deciding on treatments-

Children's Bureau et al. (2015). Supporting youth in foster care in making healthy choices: A guide for caregivers and caseworkers on trauma, treatment, and psychotropic medications. Washington, DC: *Children's Bureau.*

Prevention and Intervention Studies

Johnson, S. B. and Pryce, J. M. (2013). Therapeutic mentoring: Reducing the impact of trauma for foster youth. *Child Welfare, 92*(3), 9-25.

Lawson, D. M., and Quinn, J. (2013). Complex trauma in children and adolescents: evidence-based practice in clinical settings. *Journal of Clinical Psychology*, *69*(5), 497-509. DOI: 10.1002/jclp.21990

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Appendix B

Survey Document

Trauma in Foster Youth- Foster Parents

Informed Consent

Thank you for participating in our survey. Before you proceed to questions, please read through the informed consent information below.

Consent for Research Participation

Title:	Complex Trauma in Foster Youth
Researcher(s):	Rebecca Foley, University of Oregon
	Karrie Walters, University of Oregon
Researcher Contact Info:	916-599-6727
	rfoley2@uoregon.edu

You are being asked to participate in a research study. The box below highlights key information about this research for you to consider when making a decision whether or not to participate. Carefully consider this information and the more detailed information provided below the box. Please ask questions about any of the information you do not understand before you decide whether to participate.

Key Information for You to Consider

- **Voluntary Consent**. You are being asked to volunteer for a research study. It is up to you whether you choose to participate or not. There will be no penalty or loss of benefits to which you are otherwise entitled if you choose not to participate or discontinue participation.

- **Purpose**. The purpose of this research is to collect quantitative and qualitative research from foster parents on their experiences working with children with trauma. Further, this project will look at factors that foster parents report are beneficial in their work with foster youth, as well as obstacles they face. Using this information, this project will provide recommendations for how the child welfare system can better support foster parents who are caring for foster youth with complex trauma.

  Duration. It is expected that your participation will last 20 to 40 minutes, depending on the amount of write-in information you choose to share.

- **Procedures and Activities.** You will be asked to answer survey questions related to your work with foster youth, perception of ways the system could better support you, and perceptions of youths' experiences of trauma.

- **Risks.** Some of the foreseeable risks or discomforts of your participation include difficulty discussing sensitive topics and hardships.

- **Benefits**. Some of the benefits that may be expected include contributing to knowledge in the field so that youth and families may be better served.

- **Alternatives.** Participation is voluntary and the only alternative is to not participate.

What happens if I agree to participate in this research?

If you agree to be in this research, your participation will include filling out a survey about your experiences and perspectives related to complex trauma in foster youth.

You may skip any question that makes you uncomfortable and you can stop at any time.

Sample questions include:

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Have any youth you have worked with in foster care been diagnosed with post-traumatic stress disorder (PTSD)?

Select any intrapersonal obstacles you have experienced to helping a child with trauma and trauma symptoms.

We will tell you about any new information that may affect your willingness to continue participation in this research.

What happens to the information collected for this research?
We hope this information will contribute to helping better serve foster youth and foster parents in the future. We may publish/present the results of this research. However, we will not have any identifying information like your name attached to the results. In the event that you include any identifying information in the responses, this information will be immediately removed and deleted from any data analysis.

How will my privacy and data confidentiality be protected?

We will not be collecting any identifying information, such as your name. We will take measures to protect your privacy including conducting the surveys on a private account that only the researcher has access to. Despite taking steps to protect your privacy, we can never fully guarantee your privacy will be protected.

We will take measures to protect the security of any personal information including that only the researchers will have access to the data and it will not be stored in any shared or public accounts. Despite these precautions to protect the confidentiality of your information, we can never fully guarantee confidentiality of all study information.

Individuals and organizations that conduct or monitor this research may be permitted access to and inspect the research records. This may include access to your private information and survey responses. These individuals and organizations include:

- The Institutional Review Board (IRB) that reviewed this research

The research team includes individuals who are mandatory reporters. If the research team has reasonable cause to suspect abuse or neglect of a child or adult, a report may be required under Oregon State Law. In such a case, the research team may be obligated to breach confidentiality and may be required to disclose personal information.

What if I want to stop participating in this research?

Taking part in this research study is your decision. Your participation in this study is voluntary. You do not have to take part in this study, but if you do, you can stop at any time. You have the right to choose not to participate in any study activity or completely withdraw from continued participation at any point in this study without penalty or loss of benefits to which you are otherwise entitled. Your decision whether or not to participate will not affect your relationship with the researchers or the University of Oregon.

If you decide to withdraw once the study has already begun, you can request your survey information not be used in our study.

Will I be paid for participating in this research?

You will not be paid for taking part in this research.

Who can answer my questions about this research?

If you have questions, concerns, or have experienced a research related injury, contact the research team at:

Rebecca Foley
916-599-6727
rfoley2@uoregon.edu

An Institutional Review Board ("IRB") is overseeing this research. An IRB is a group of people who perform independent review of research studies to ensure the rights and welfare of participants are protected. UO Research Compliance Services

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is the office that supports the IRB. If you have questions about your rights or wish to speak with someone other than the research team, you may contact:

Research Compliance Services
5237 University of Oregon
Eugene, OR 97403-5237
(541) 346-2510

* 1. Do you agree to the above terms? By clicking Yes, you consent that you are willing to answer the questions in this survey.

◯ Yes

◯ No

Trauma in Foster Youth- Foster Parents

2. How many years have you worked with foster youth?

0 15 30

3. Do you provide foster care through DHS or a private agency?

◯ DHS

◯ private foster care agency

4. Rate the overall support provided by DHS/your foster agency in regards to serving youth with trauma

◯ Inadequate

◯ Somewhat Adequate

◯ Adequate

◯ More than Adequate

5. What have you found most helpful for working with foster youth with trauma? Rank them from 1- most helpful to 3- least helpful

Support Systems- other foster parents, friends, family, community groups, etc.

Policies- DHS, state, and/or federal policy

Trainings/Education- provided by DHS or other groups

6. Have you sought out information on your own on how to serve youth with trauma?

◯ Yes

◯ No

If yes, what prompted you to do your own research? What resources did you find?

12. To what extent to do you agree that the training you received offered specific skills about *forming relationships with children* who experienced trauma with prior caregivers?

- Strongly agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly disagree

Add any relevant comments here in regards to received trauma training

7. Have you utilized resources or support from other communities or organizations (besides DHS/foster agency) in regard to working with youth with trauma?

- Yes
- No

If yes, give any helpful details about these other supports or resources.

8. Have you received training on trauma from DHS/your agency in the past 3 years?

- Yes
- No

Trauma in Foster Youth- Foster Parents

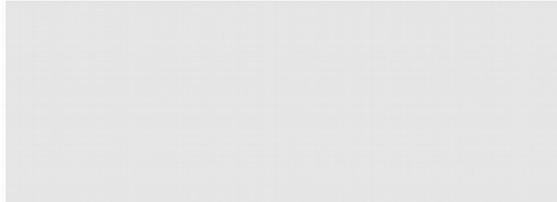
9. How many hours of training did you receive on trauma from DHS/your agency in the last 3 years?

0 10 20

10. To what extent to do you agree that the training you received *emphasized real-world skills* for working with kids with trauma?

- Strongly agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly disagree

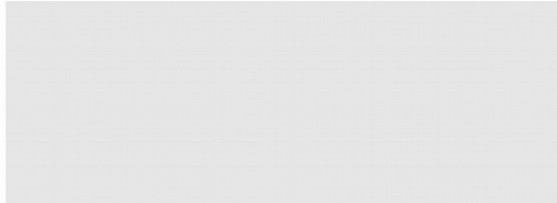
Add any relevant comments here in regards to received trauma training



11. To what extent to do you agree that the training you received offered specific information about *how to understand behaviors* through a trauma-informed lens?

- Strongly agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly disagree

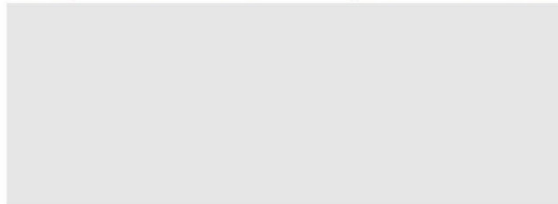
Add any relevant comments here in regards to received trauma training



12. To what extent to do you agree that the training you received offered specific skills about *forming relationships with children* who experienced trauma with prior caregivers?

- ○ Strongly agree
- ○ Agree
- ○ Neither agree nor disagree
- ○ Disagree
- ○ Strongly disagree

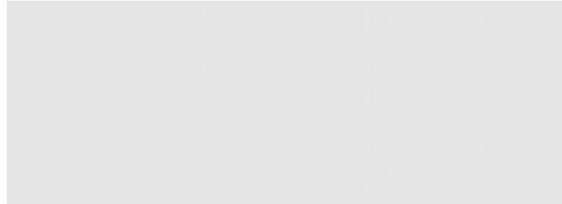
Add any relevant comments here in regards to received trauma training



13. To what extent to do you agree that the training you received *highlighted the specific needs of youth of color* who have experienced trauma?

- ◯ Strongly agree
- ◯ Agree
- ◯ Neither agree nor disagree
- ◯ Disagree
- ◯ Strongly disagree

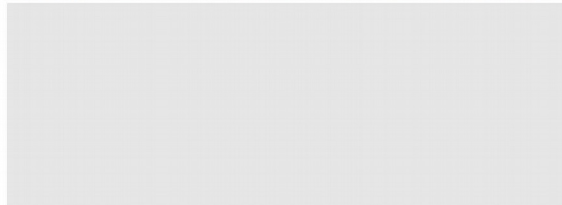
Add any relevant comments here in regards to received trauma training



14. To what extent to do you agree that the training you received *highlighted the specific needs of lgbtqia+ youth* who have experienced trauma?

- ◯ Strongly agree
- ◯ Agree
- ◯ Neither agree nor disagree
- ◯ Disagree
- ◯ Strongly disagree

Add any relevant comments here in regards to received trauma training



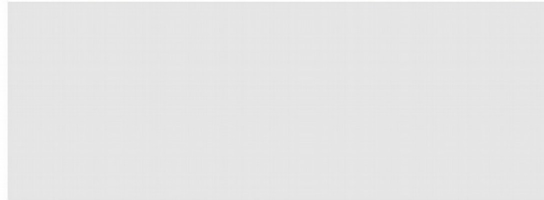
15. Rate the training's acknowledgement and incorporation of different cultural backgrounds and religious beliefs

- Inadequate
- Somewhat Adequate
- Adequate
- More than Adequate

16. To what extent to do you agree that the training you received *offered skills in self-care and coping for you* as a foster parent?

- Strongly agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly disagree

Add any relevant comments here in regards to received trauma training



17. Rate the quality of information you receive from DHS/your agency about the trauma history of children placed with you before their placement

◯ Inadequate

◯ Somewhat Adequate

◯ Adequate

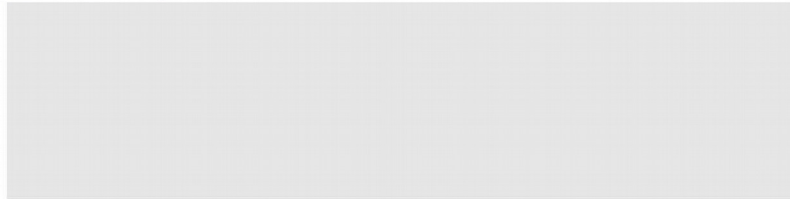
◯ More than Adequate

18. Have any youth you have worked with in foster care been diagnosed with post-traumatic stress disorder (PTSD)?

◯ Yes

◯ No

If yes, what did you perceive to be their most significant symptoms and/or behaviors related to their PTSD diagnosis?



19. How many of the foster youth you worked with, who had significant trauma histories, exhibit all three of the following symptoms?

Emotional Disturbances- heightened emotional reactivity, violent outbursts, impulsive or reckless behaviors and dissociation

Defeated/Diminished Self -marked by feeling diminished, defeated and worthless, feelings of shame, guilt, or despair

Disturbances in Relationships- marked by difficulties in feeling close to others, having little interest in relationships or social engagement more generally. There may be occasional relationships but the person has difficulty sustaining them.

- None
- Some
- Most
- All

If present, comment on how these symptoms manifested in behavior, in relationships with others, or at home.

20. Rate how often you experience the following external obstacles in regards to helping a child with trauma.

	Never	Seldom	Sometimes	Often	Always
School Policy	○	○	○	○	○
School Personnel	○	○	○	○	○
Lack of Resources	○	○	○	○	○
Lack of Training	○	○	○	○	○
Lack of Background Information on Youth	○	○	○	○	○
DHS/Agency Policy	○	○	○	○	○
DHS/Agency Personnel	○	○	○	○	○
Difficulty accessing mental health services (due to long wait lists, lack of specialists available under medicaid, etc.)	○	○	○	○	○
Personal Finances	○	○	○	○	○

Please elaborate on any obstacles you have experienced if relevant.

21. Rate how often you experience the following intrapersonal obstacles when helping a child with trauma.

	Never	Seldom	Sometimes	Often	Always
Difficulty forming a relationship with youth	○	○	○	○	○
Difficulty with one-on-one behavior management	○	○	○	○	○
Difficulty with own self care/coping with stress	○	○	○	○	○
Difficulty with work-life balance, time management	○	○	○	○	○

Please elaborate on any obstacles you have experienced if relevant

22. Rate how often you experience the following interpersonal obstacles when helping a child with trauma.

	Never	Seldom	Sometimes	Often	Always
Lack of understanding from your friends and/or family	○	○	○	○	○
Difficulty working with youth's biological family	○	○	○	○	○
Youth conflict with peers	○	○	○	○	○
Difficulty with your home's family dynamics	○	○	○	○	○
Communication problems and/or lack of understanding with youth's teachers	○	○	○	○	○
Communication problems with youth's therapist/mental health specialists	○	○	○	○	○

Please elaborate on any obstacles you have experienced if relevant

23. Rate how often you experience the following societal obstacles when helping a child with trauma.

	Never	Seldom	Sometimes	Often	Always
Societal beliefs about parenting	○	○	○	○	○
Misconceptions about foster youth	○	○	○	○	○
Beliefs about trauma and kids with trauma	○	○	○	○	○
Cultural conflict related to parenting and trauma	○	○	○	○	○

Please elaborate on any obstacles you have experienced if relevant

24. Describe any day to day skills that are helpful for your work as a foster parent with kids with trauma.

25. If there is anything else important to your experience working with foster youth with trauma that was not covered in the questions, please elaborate here.

Appendix C

IRB Approval

UNIVERSITY OF OREGON

DATE: March 04, 2020 **IRB Protocol Number: 01292020.050**

TO: Rebecca Foley, Principal Investigator
Erb Memorial Union

RE: Protocol entitled, "Complex Trauma in Foster Youth"

Notice of Review and Exempt Determination

The above protocol has been reviewed and determined to qualify for exemption. The research is approved to be conducted as described in the attached materials. Any change to this research will need to be assessed to ensure the study continues to qualify for exemption, therefore an amendment will need to be submitted for verification prior to initiating proposed changes.

For this research, the following determinations have been made:

- This study has been reviewed under the **2018 Common Rule** and determined to qualify for exemption under **Title 45 CFR 46.104(d)(2).**

Approval period: March 04, 2020 - March 31, 2021

If you anticipate the research will continue beyond the approval period, you must submit a Progress Report at least 45-days in advance of the study expiration. **Without continued approval, the protocol will expire on March 31, 2021 and human subject research activities must cease.** A closure report must be submitted once human subject research activities are complete. Failure to maintain current approval or properly close the protocol constitutes non-compliance.

You are responsible for the conduct of this research and adhering to the Investigator Agreement as reiterated below. You must maintain oversight of all research personnel to ensure compliance with the approved protocol.

The University of Oregon and Research Compliance Services appreciate your commitment to the ethical and responsible conduct of research with human subjects.

Sincerely,

Chris Duy
Research Compliance Administrator
Research Compliance Services

CC: Karrie Walters

COMMITTEE FOR THE PROTECTION OF HUMAN SUBJECTS • RESEARCH COMPLIANCE SERVICES
677 E. 12th Ave., Suite 500, 5237 University of Oregon, Eugene OR 97401-5237
T 541-346-2510 F 541-346-5138 http://rcs.uoregon.edu

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