Understanding Foster Parents' Experiences of Secondary Traumatic Stress

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UNDERSTANDING FOSTER PARENTS’ EXPERIENCES OF SECONDARY TRAUMATIC STRESS

by

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Secondary traumatic stress, which has been studied across many helping professions, refers to symptoms similar to posttraumatic stress disorder which an individual may develop as a result of indirect exposure to another individual’s trauma (Sprang et al., 2019). Foster parents may be particularly susceptible to developing secondary traumatic stress due to their exposure to their foster child’s trauma history and trauma symptoms, which has been confirmed in recent studies (Bridger et al., 2020; Whitt-Woosley et al., 2020). Importantly, foster parents’ experiences of secondary traumatic stress may differ from those of other helping professionals given their unique role. The purpose of the present study was to develop an in-depth understanding of foster parents’ experiences of secondary traumatic stress through the use of qualitative interviews. The sample included fourteen foster parents who had fostered a child with trauma and experienced symptoms of secondary traumatic stress within the last year. Data from the semi-structured interviews were analyzed using Consensual Qualitative Research (CQR).

Findings suggest that participants were experiencing significant secondary traumatic stress symptoms in the domains of intrusion, avoidance, alterations in mood and cognition, and alterations in arousal and reactivity. Concerningly, negative impacts from secondary traumatic stress were identified by participants across different areas of their life, including work, self-care, and relationships. Participants’ parenting of their foster child was also negatively impacted, as participants described experiencing interpersonal difficulties with their foster child, wanting to stop trying to parent their child, and feeling like they were not being a good parent. While most participants planned to continue engaging as a foster parent after this experience, participants also shared that they stopped or reduced their fostering, were unsure about future fostering, or planned to be more selective about future placements. Factors that were helpful and challenging as they managed this experience were also discussed by participants. Unfortunately, most participants indicated that secondary traumatic stress was not adequately addressed by the child welfare system. Findings also include participants’ recommendations for ways that the child welfare system could better support foster parents experiencing secondary traumatic stress. Additionally, limitations, implications, and directions for future research are discussed.
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Sarah M. Boeding, M.S., M.Ed.

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Understanding Foster Parents’ Experiences of Secondary Traumatic Stress

Chapter 1: Introduction

Who can save a child from a burning house without taking the risk of being hurt by the flames? Who can listen to a story of loneliness and despair without taking the risk of experiencing similar pains in his own heart and even losing his precious peace of mind? In short: “Who can take away suffering without entering it?”

—Henri Nouwen, The Wounded Healer

The above quote captures the essence of this study: What happens to foster parents when they enter into the suffering and trauma of their foster children? Unknown to Nouwen at the time, he was describing a phenomenon now known as secondary traumatic stress, which was introduced by Figley in 1995. Broadly speaking, secondary traumatic stress refers to symptoms similar to PTSD that an individual may develop as a result of indirect exposure to another individual’s trauma (Sprang et al., 2019). Given the high rates of trauma and PTSD among children in foster care, foster parents may be particularly susceptible to developing secondary traumatic stress. While this phenomenon has been studied in other helping professionals such as social workers, mental health providers, and nurses, research on how foster parents experience secondary traumatic stress is lacking. Gaining a deeper understanding of foster parents’ experiences of secondary traumatic stress is important in order to better support them and the foster children in their care.

Background

Foster Care

Foster parents play a vital role in the lives of children in foster care. In 2021, foster parents provided care for 79% of the over 605,000 children served by the foster care system,
while the other 21% lived in settings such as group homes, institutions, and supervised
independent living situations (U.S. Department of Health and Human Services [HHS], 2022).
Unfortunately, experiencing time in foster care is not uncommon, as 5.3% of children in the
United States have spent time in foster care by the time they turn 18-years-old (Yi et al., 2020).
Foster children often enter the child welfare system due to abuse or neglect, frequently by their
primary caregivers (HHS, 2022). Numerous studies have found high rates of trauma within this
population (Greeson et al., 2011; Oswald et al., 2020; Salazar et al., 2013; Vasileva &
Petermann, 2017). In a large study conducted in the United States, researchers found that 11.7% of foster children had experienced all five types of complex trauma: physical abuse, sexual
abuse, emotional abuse, neglect, and domestic violence (Greeson et al, 2011). Not surprisingly,
foster care youth’s experiences of trauma can lead to posttraumatic stress disorder (PTSD),
which has been confirmed in many studies (Bronsard et al, 2016; Dubois-Comtois et al., 2021;
Keller et al., 2010; Kolko et al., 2010; McMillen et al., 2005; Vasileva & Petermann, 2017).
Studies of adolescents in foster care have found PTSD lifetime prevalence rates of 14% and
15.1%, which is much higher than the 5% prevalence rate found in a nationally representative
sample of adolescents (Keller et al., 2010; McMillen et al., 2005; Merikangas et al., 2010).

Unfortunately, children who spend time in foster care are at risk for a variety of negative
outcomes. In addition to their higher rates of PTSD, children in foster care often have high rates
of other mental health disorders (e.g., depression, anxiety, and attention-deficit/hyperactivity
disorder), including behavioral disorders (e.g., oppositional defiant disorder, conduct disorder)
(Bronsard et al., 2016; Clausen et al., 1998; Dubios-Comtois et al., 2012; Engler et al., 2022;
Lawrence et al., 2006; Oswald et al., 2010). Combined with foster children’s trauma history prior
to placement, the experience of being in foster care can also put youth further at risk for poorer
developmental outcomes, including poor physical health, poor mental health, attachment disorders, and difficulty with social skills (Harden, 2004). Outcome studies of former foster youth who have “aged out” of the child welfare system provide similarly concerning results. Compared to the general population, children who have spent time in foster care have difficulties across a variety of areas, including mental health, substance abuse, academic performance, employment, housing, and criminal involvement (Gypen et al., 2017).

A topic studied frequently in foster care is placement instability (i.e., frequent foster placement moves), which is a contributing factor to the negative outcomes experienced by foster children. Numerous studies show that placement instability is associated with poorer behavioral well-being in foster children (Konijn et al., 2019; Newton et al., 2000; Rubin et al., 2007; Villodas et al., 2016). While some argue that foster children’s behavior problems may cause placement moves, it is more likely a bidirectional relationship, with placement instability also contributing to behavior problems (Newton et al., 2000; Rubin et al., 2007). Placement instability has also been found to be associated with poorer physical health, increased mental health service utilization, academic difficulties, and risk of incarceration (Clemens et al., 2018; Jonson-Reid & Barth, 2000; Rubin et al., 2004; Villodas et al., 2016). Research has also shown that placement instability has longer-term negative consequences for foster children. Foster care alumni report a variety of negative impacts from placement instability that persist into adulthood, including difficulty trusting others, staying emotionally distant in their relationships, ongoing instability in their adult life, and increased use of substances (Chambers et al., 2018; Stott, 2012; Unrau, et al., 2008).

Related to placement instability, turnover of foster parents is unfortunately a major concern in the United States. In a study across three states, Gibbs and Wildfire (2007) found that
foster parents stayed in their role for a median length of time of 8 to 14 months. A surprising
number (13% to 21%) of foster parents stopped fostering by 90 days. After one year, 47% to
62% of foster parents had discontinued fostering. These results are concerning and are likely
contributing to the ongoing shortage of foster parents. Mainstream and local media coverage of
foster care often describe the current shortage of foster parents as a “crisis” (Adams, 2020;
Browder, 2022; Washington Post Editorial Board, 2020). These news articles showcase stories
about children spending the night in social workers’ offices or hotels when foster homes are
unable to be found, which unfortunately happens not infrequently (Browder, 2022; Wax-
Thibodeaux, 2019). Similarly, the lack of available foster homes can result in foster children
being placed in congregate care settings, such as group homes, juvenile detention centers,
residential treatment facilities, and shelters (Washington Post Editorial Board, 2020; Wax-
Thibodeaux, 2019). One can imagine how the already stressful and traumatic experience of being
removed from family and placed in foster care could be exacerbated by having to sleep in a
social workers’ office or being placed into a juvenile detention center. Clearly, the shortage of
foster parents and high turnover rate of current foster parents are issues that need attention within
the United States.

Secondary Traumatic Stress

Given the prevalence of trauma and subsequent PTSD within foster children, foster
parents understandably have a complex parenting role. In addition to providing daily care for
their foster child, foster parents may be exposed to details about their foster child’s trauma
history and may witness their child’s emotional and behavioral symptoms related to their trauma.
Unfortunately, research has found that working with populations who have experienced trauma
can put individuals at risk for developing secondary traumatic stress. This term, which was
originally introduced by Figley (1995a), refers to symptoms similar to PTSD that result from secondary exposure to another individual’s trauma. Figley described secondary traumatic stress as the distress, and resulting behaviors and emotions, that can occur when an individual attempts to help someone who is traumatized (Figley, 1995a). Figley (1995b) viewed secondary traumatic stress as a natural and predictable response to working with individuals who have experienced trauma.

Since Figley’s (1995a) original conceptualization of secondary traumatic stress, there has been a lack of consensus about its exact definition (Molnar et al., 2017; Sprang et al., 2019). This confusion is partially driven by several other terms that are often used in the field. First, compassion fatigue is a concept introduced by Figley (1995a) as a less stigmatizing term for secondary traumatic stress. Unfortunately, researchers often disagree on the exact operationalization of secondary traumatic stress (Branson, 2019; Elwood et al., 2011; Figley, 1995a; Sprang et al., 2019; Stamm, 2010). For example, Sprang et al. (2019) argued that it is not necessary for compassion to be experienced as a part of secondary traumatic stress, which highlights the importance of differentiating the terms. However, in this study, secondary traumatic stress and compassion fatigue will be used interchangeably, as is common in the literature.

Vicarious traumatization is another term that is sometimes used interchangeably with secondary traumatic stress. While vicarious traumatization does result from working with individuals who have experienced trauma, it refers more specifically to changes in an individual’s inner experience and cognitive beliefs about themselves, others, and the world instead of symptoms similar to PTSD (McCann & Pearlman, 1990; Pearlman & Saakvitne,
1995a; Pearlman & Saakvitne, 1995b). Importantly, it is possible for vicarious traumatization and secondary traumatic stress to co-occur (Newell & MacNeil, 2010).

Finally, burnout is another term sometimes used in the literature regarding the negative impacts of working with traumatized individuals. There are various conceptualizations of burnout, but they often focus on exhaustion that occurs in response to job stressors (Demerouti et al., 2001; Malsach et al., 2001; Stamm, 2010). It is important to note that burnout can happen in stressful work situations (e.g., feeling overwhelmed by job expectations or working in an unsupportive environment) without exposure to traumatic material (Elwood et al., 2011). The literature review below will explore these related concepts in more detail to clarify and differentiate them from secondary traumatic stress.

For this dissertation, secondary traumatic stress will be conceptualized using the definition outlined by Sprang et al. (2019). Developed during a scientific meeting of experts, this definition describes secondary traumatic stress as directly related to, or potentially mirroring, symptoms of PTSD, which includes intrusive reexperiencing, avoidance, alterations in mood and cognition, alterations in arousal and reactivity, and dissociation (Sprang et al., 2019). The experts noted that these symptoms develop “in reaction to empathically experiencing the psychobiological impact on clients of both their traumatic event(s) and their subsequent symptoms of PTSD” (Sprang et al., 2019, p. 76). They discussed the similar impact of directly witnessing another individual experience trauma and of hearing about a client’s trauma and witnessing their trauma symptoms. Importantly, they noted that those in helping roles may have an especially intense experience regarding secondary traumatic stress, given their emotional connection with the client and the responsibility they may feel toward them (Sprang et al., 2019). The experts also highlighted a noteworthy change in PTSD diagnostic criteria that occurred with
the publication of the 5th edition of *the Diagnostic and Statistical Manual of Mental Disorders* (*DSM-5*; APA, 2013). The diagnostic criterion of exposure to a trauma (Criterion A) was expanded to include indirect exposure to details of the traumatic event(s) that is repeated or extreme (APA, 2013). However, Sprang et al. (2019) pointed out that secondary traumatic stress can develop with indirect exposure to traumatic details that is not necessarily repeated or extreme. Given this distinction, the experts argued that, while secondary traumatic stress may mirror the symptoms of PTSD, it is not appropriate to simply reduce it to PTSD (Sprang et al., 2019).

Secondary traumatic stress has been researched across many different helping professions. There is evidence that secondary traumatic stress is prevalent among social workers, mental health providers, nurses, and other healthcare providers (Beck, 2011; Bride, 2007; Cieslak et al., 2013; Ivicic & Motta, 2017; Meadors et al., 2009). Of particular relevance to foster parents is the research on child welfare professionals, given that they also work closely with foster children. While foster parents and child welfare professionals have different roles in supporting foster children, both populations are exposed to the trauma, and subsequent symptoms of PTSD, of foster children. Concerningly, researchers have found that individuals working as child welfare professionals are significantly more likely to experience secondary traumatic stress compared to other behavioral health professionals (Sprang et al., 2011). In a study by Bride et al. (2007), 59% of child protective service (CPS) workers endorsed experiencing at least one symptom of secondary traumatic stress “often” in the last week. Shockingly, 34% of CPS workers in this study met criteria for a diagnosis of PTSD based on their secondary traumatic stress symptoms. In another study, Reinks (2020) found that 29.6% of their sample of child welfare workers had severe levels of secondary traumatic stress, while
another 27.3% had moderate to high levels of secondary traumatic stress. Other studies on child welfare professionals have produced similar results (Bride, 2007; Caringi & Hardiman, 2012; Salloum et al., 2015). Altogether, this body of research provides strong evidence for the prevalence of secondary traumatic stress among child welfare professionals who work with traumatized foster youth.

**Secondary Traumatic Stress in Foster Parents**

While researchers have studied secondary traumatic stress in child welfare professionals, there has been a surprising lack of focus on studying this concept in foster parents. Similar to child welfare professionals, it seems plausible that foster parents would be at risk for experiencing secondary traumatic stress as a result of their indirect exposure to their foster children’s trauma histories and their direct exposure to their foster children’s trauma symptoms. However, only nine published studies currently exist in the literature, with five of them being conducted in the United States. Interestingly, all nine of the published studies have been published since 2018, suggesting that the gap in the literature is starting to be recognized. Overall, these studies provide evidence that secondary traumatic stress is prevalent within foster parents.

In a study of foster parents from the United Kingdom, Hannah and Woolgar (2018) found that 25.5% of foster parents reported high levels of secondary traumatic stress. Similarly, high levels of secondary traumatic stress were also observed in Bridger et al.’s (2020) sample of British foster parents. In a study from the United States, Whitt-Woosley et al. (2020) found that their sample of foster parents was experiencing moderate secondary traumatic stress. Concerningly, their results also indicated that 15% of the foster parents demonstrated symptoms that were at or above the level associated with PTSD. A qualitative study by Riggs (2021)
highlighted themes regarding foster parents’ experiences of vicarious trauma, including the unpredictability of their foster child’s trauma behaviors, difficulty connecting with their foster child, social isolation due to caring for a child with trauma, and lack of support from the child welfare agency.

More recently, Teculeasa et al.’s (2022) study in Romania found that foster parents that had more sensitivity to their child’s posttraumatic stress symptoms had higher levels of secondary traumatic stress. They also found that increased secondary traumatic stress was associated with lower job satisfaction as a foster parent. In another study in the United States, Whitt-Woosley et al. (2022a) examined the impact of the COVID-19 pandemic on secondary traumatic stress within foster parents. Concerningly, 21% of their sample had levels of secondary traumatic stress at a level associated with PTSD. They also found that foster parents experienced an increase in intrusive symptoms and alterations in cognition and mood over the beginning of the pandemic. Whitt-Woosley et al.’s (2022b) follow-up qualitative study also provided helpful information about the impact that the COVID-19 pandemic had on foster parents. In another quantitative study, Steen and Bernhardt (2023) found that foster parents who engaged in religious/spiritual-help seeking behaviors had higher levels of secondary traumatic stress, though other help-seeking behaviors were not found to be associated with secondary traumatic stress.

Finally, results from Dowdy-Hazlett and Clark’s (2024) study provide evidence that there are three subpopulations of foster parents (Resourceful, Strained, and Disadvantaged). Interestingly, the researchers found that these three subpopulations had different levels of risk for both wanting to disrupt their placement and desiring to discontinue being a foster parent.

In addition to these published studies, one unpublished study from the United Kingdom, six dissertations, and one masters-level thesis have examined this topic, with the results from
these studies providing additional support to the argument that secondary traumatic stress is a concern within the foster parent population (Blanchette, 2011; Carew, 2016; Lively Cookson, 2022; McLain, 2008; Ottaway & Selwyn, 2016; Parker, 2009; Redfern, 2013; Reinhardt, 2016).

In addition to the overall lack of published studies on this topic, several gaps exist within the literature. There is an absence of longitudinal studies on secondary traumatic stress within foster parents, as well as a lack of studies examining the experience of foster parents who have discontinued fostering. While some of the studies have explored risk and protective factors for secondary traumatic stress in foster parents, only a few of the variables have been examined in more than one study, and conflicting results have been found between studies. An additional gap in the literature is the reliance on self-report measures for measuring secondary traumatic stress, as well as the lack of examination of how foster parents’ symptoms of secondary traumatic stress might impact their functioning. Finally, another important gap is the lack of qualitative studies focused on secondary traumatic stress within foster parents, specifically with samples of United States foster parents. One published qualitative study was conducted with Australian foster parents, and other qualitative studies (two dissertations and one unpublished study) were conducted in the United Kingdom and Ireland. The only published qualitative study conducted with foster parents in the United States was a follow-up to a quantitative study that examined secondary traumatic stress during the COVID-19 pandemic. The qualitative portion of the study was focused on how foster parents were impacted by COVID-19 and did not focus specifically on their experience of secondary traumatic stress. Examining foster parents’ experiences of secondary traumatic stress through qualitative methodology is especially important given that their experience of secondary traumatic stress may differ from other helping professionals, for
reasons described in detail below. Qualitative research could provide understanding of how foster parents uniquely experience secondary traumatic stress.

**Rationale for the Current Study**

Understanding foster parents’ experiences of secondary traumatic stress is important in order to better support them and improve their well-being as they care for a vulnerable group in society. As discussed above, children who spend time in foster care are at risk for a variety of negative outcomes, including PTSD, other mental health disorders, social difficulties, poorer physical health, and academic/employment difficulties. Importantly, there are a few ways that secondary traumatic stress in foster parents could contribute to these negative outcomes in foster children.

First, secondary traumatic stress could lead to reduced retention rates of foster parents. As discussed above, turnover of foster parents is a significant concern in the United States, and it is possible that secondary traumatic stress could be a contributing factor to this issue. Hannah and Woolgar’s (2018) study provided support for this argument, as they found that foster parents with higher levels of compassion fatigue had lower satisfaction with fostering and lower intent to continue fostering. Gaining a deeper understanding of foster parents’ experiences of secondary traumatic stress could help the child welfare system to better support them and hopefully improve retention rates. Therefore, understanding secondary traumatic stress in foster parents could be an important step to improving the current foster parent shortage and ensuring that there are enough foster parents to provide safe, secure homes for all foster children.

A second potential negative impact of secondary traumatic stress in foster parents is that it could lead to increased placement instability for foster children. If a foster parent is experiencing symptoms of secondary traumatic stress, they may request that their foster child is
moved to another placement. This possibility is supported by one study that found that foster parents with the highest levels of secondary traumatic stress were most likely to disrupt their placement (Dowdy-Hazlett & Clark, 2024). Additionally, Leathers et al. (2019) found that foster parents with higher levels of general stress reported more negative parenting experiences, and those negative parenting experiences were a strong predictor of future placement disruption. In addition to deciding to disrupt the placement, Hannah and Woolgar’s (2018) found that foster parents with higher levels of secondary traumatic stress have lower intent to remain as a foster parent suggests another avenue where secondary traumatic stress could lead to increased placement instability for foster children. Unfortunately, moving placements can be extremely disruptive for foster children, and placement instability during foster care has been found to be associated with a variety of negative outcomes discussed above. Clearly, ensuring stable placements for children in foster care is important. Developing a greater understanding of secondary traumatic stress in foster parents could be one important step in helping to reduce placement instability.

Finally, secondary traumatic stress may decrease foster parents’ ability to effectively parent foster children, especially those struggling with behavioral and emotional concerns. General parental stress in foster parents is associated with poorer parenting practices, including being less sensitive, committed, and engaged in parenting (Farmer et al., 2005; Leathers et al., 2019; Lipscombe et al., 2004; Vanschoonlandt et al., 2013). It is probable that secondary traumatic stress might be associated with similar parenting behaviors. One can imagine how experiencing secondary traumatic stress symptoms, such as negative emotions, intrusive thoughts, irritability, and difficulty sleeping, could decrease a foster parent’s ability to effectively parent their foster child. This is especially concerning given the research that shows that foster
parents’ parenting behaviors can negatively impact their foster children’s behavior problems, attachment security, and placement instability (Gabler et al., 2014; Konihn et al., 2019; Vanderfaeillie et al., 2013). Ideally, understanding secondary traumatic stress in foster parents could help to reduce the potential negative impact it might have on foster parents’ parenting abilities. Overall, future research to better understand foster parents’ experiences of secondary traumatic stress could help child welfare and mental health professionals to better support foster parents and hopefully decrease the potential negative outcomes on foster children discuss above (i.e., foster parent turnover, placement instability, and decreased parenting effectiveness).

**Purpose of the Current Study**

The purpose of this qualitative study was to understand foster parents’ experiences of secondary traumatic stress in order to better support them as they parent children with trauma. As described above, preliminary quantitative research suggests that secondary traumatic stress is prevalent within the foster parent population (Bridger et al., 2020; Hannah & Woolgar, 2018; Steen & Bernhardt, 2023; Whitt-Woosley et al., 2020; Whitt-Woosley et al., 2022a). However, qualitative studies are important in this area because the experience of secondary traumatic stress may be unique for foster parents compared to other helping professionals, such as child welfare workers. First, unlike helping professionals, foster parents are unable to separate their “work” and personal lives because they are caring for the foster child in their home environment. While child welfare professionals are able to set clearer boundaries between their work and personal life, foster parents’ roles likely prevent them from establishing such clear boundaries. Second, in addition to secondary traumatic stress, foster parents may also experience primary trauma from their foster child, such as physical harm (Bridger et al., 2020). The experience of primary trauma, which may occur in their own home, may further complicate the experience of secondary trauma.
for foster parents given the similarities between secondary traumatic stress and PTSD. Third, in addition to hearing about the child’s traumatic experiences, foster parents also often see the physical and psychological effects of the trauma in their day-to-day lives with the child. Foster parents may frequently witness the child’s trauma symptoms, such as being triggered by a reminder of their trauma, and be involved in reregulating the child. Fourth, while child welfare workers are exposed to the trauma histories of many different children, foster parents may only be exposed to the trauma of a few children. However, it is likely that foster parents may be more intimately exposed to the child’s trauma and trauma-related behaviors, given the substantial time spent with the child. Thus, while studies on child welfare professionals who work with foster children provide helpful information, it is concerning that there are few secondary traumatic stress studies specifically focused on foster parents. In particular, qualitative studies are needed to further understand foster parents’ unique experiences of secondary traumatic stress in order to better support them as they parent children with trauma.

**Research Questions**

This study aims to develop an in-depth understanding of foster parents’ lived experiences related to secondary traumatic stress. Three research questions guide this exploration. The first research question is “How do foster parents experience secondary traumatic stress when parenting their foster children?” As discussed above, the role of being foster parent is unique and may influence how secondary traumatic stress is experienced. It is important to gain an understanding of how foster parents’ experiences in this area may be both similar to and different from the experiences of other helping professionals.

The second research question is “What strategies do foster parents use to help manage their secondary traumatic stress?” Understanding how foster parents manage their secondary
trauma (e.g., through self-care or social support) could provide helpful information to guide future intervention in this area.

The final research question is “How could the child welfare system better support foster parents who are at risk for developing secondary traumatic stress?” While the child welfare system is primarily focused on supporting and providing adequate care for foster children, supporting foster parents is a crucial component of that care. It is important to understand whether there are specific strategies or policies that child welfare systems could implement to reduce the risk of secondary traumatic stress within foster parents, thereby reducing the potential impact on foster children.

Overview of Study Methods

Consensual Qualitative Research (CQR) methodology will be used in this study to examine foster parents’ experiences of secondary traumatic stress (Hill et al., 1997; Hill et al., 2005; Hill & Knox, 2021). CQR, which is grounded in both constructivist and postpositivist elements, is helpful for studying phenomena that are not easily observable, such as inner experiences and beliefs (Hill & Knox, 2021). Key elements of CQR include reliance on consensus among team members, use of a standardized interview protocol containing open-ended questions across participants, incorporation of multiple perspectives from the primary team and auditor, and use of a rigorous and systematic data analysis process (Hill et al., 1997; Hill & Knox, 2021). CQR was selected given its utility in gaining an in-depth understanding of participants’ experiences, which is the aim of this study (Hill & Knox, 2021). In addition, CQR can be particularly helpful when studying topics that do not have a lot of previous research, as is the case with secondary traumatic stress in foster parents.
Data collection for the current study involved semi-structured, individual interviews with foster parents, utilizing a consistent interview protocol across participants. The interviews, which occurred over video, were recorded and transcribed verbatim. Eligibility criteria for the study included having fostered a child with trauma within the last year, and experiencing self-identified symptoms of secondary traumatic stress within the last year. Recruitment was conducted through the use of social media and resulted in 14 participants. Data analysis followed the clearly outlined and structured process of CQR, which involved organizing interview data into domains (i.e., topics areas), developing core ideas (i.e., brief summaries of the participants’ words), and cross-analysis (i.e., creating categories that describe common themes across participants) (Hill et al., 1997; Hill & Knox, 2021). Chapter Three provides a detailed overview of the study methods.
Chapter 2: Literature Review

The focus of this literature review will be on examining research regarding both foster children and foster parents, as well as research on secondary traumatic stress. Given the limited research examining secondary traumatic stress within foster parents, this literature review will be expanded to include studies on child welfare professionals who work with children in foster care. While foster parents and child welfare professionals have different roles in supporting foster children, both populations are exposed to the trauma, and subsequent symptoms of PTSD, of foster children.

This literature review will begin with an overview of research on foster children, including studies on foster children’s exposure to trauma and the prevalence of mental health diagnoses within this population. Next, research on foster parents will be examined, focused on the training foster parents receive, their own trauma histories, and their experiences of general parental stress. The focus will then shift to secondary traumatic stress, where an overview of the concept, as well as several related terms, will be provided. Assessment instruments for secondary traumatic stress will also be reviewed in order to provide an understanding of how this concept is commonly measured in the literature. Next, both the prevalence and correlates of secondary traumatic stress within child welfare professionals will be examined. As noted above, while the experience of secondary traumatic stress may be different in foster parents and child welfare professionals, research on the later population provides a helpful start point for understanding this concept within foster parents. Finally, the currently available literature on foster parents’ experiences with secondary traumatic stress will be reviewed, including published studies as well as available dissertations.

Foster Care
Foster Care Overview

In 2021, there were 606,031 children served by the United States foster care system, with 391,098 children in care on the last day of the fiscal year (HHS, 2022). In total, 5.3% of children in the United States will have spent time in foster care between birth and age 18 (Yi et al., 2020). Of the children in foster care during 2021, 51% were male and 49% were female (HHS, 2022). Many of the children were White (43%), followed by Black/African American (22%) and Hispanic (22%). On average, children spent 21 months within the foster care system. The average age of children entering the foster care system in 2021 was eight years old. However, 37% of children entering the foster care system were four years old or younger, while 24% were 14 years old or older (HHS, 2022).

The process of removing children from their home due to abuse or neglect and placing them into foster care is monitored by the court system (HHS, n.d.). Before children are placed into foster care, child welfare professionals must attempt to keep them with their biological families by providing the family with services such as in-home support, mental health/substance use services, and parenting skill classes. Unfortunately, in situations where the child’s safety is still at risk, a court decision may be made to place the child into foster care (HHS, n.d.). Several options exist for placement within the foster care system (HHS, n.d.). First, children may be placed to live with a non-relative family, who is licensed by the state. Second, children may be placed to live with relatives, also known as kinship care. If possible, being placed in kinship care is preferred because it minimizes the trauma of a child being separated from their family and helps to maintain family connections and stability. Third, treatment foster care, also known as therapeutic foster care, is another option. In treatment foster care, foster parents have specialized training and are able to provide care for children that may have significant needs, including
emotional/behavioral issues and complex medical needs. Finally, children in foster care may also be placed in group homes, residential care facilities, or other institutions, as appropriate (HHS, n.d.). Of the children in foster care during 2021, 44% were placed in a non-relative foster home, while 35% were placed in a relative (or kinship) foster home (HHS, 2022). In addition, 4% were living in a group home and 5% were living in an institution (HHS, 2022).

**Trauma Prevalence in Foster Youth**

Many children in foster care enter the system due to maltreatment. According to the Adoption and Foster Care Analysis and Reporting System (AFCARS), children who entered the foster care system during 2021 were removed from their homes due to neglect (63%), physical abuse (12%), and sexual abuse (4%) (HHS, 2022). A recent literature review by Oswald et al. (2020) also found high rates of maltreatment exposure within this population. Across studies and similar to the AFCARS data, foster children had experienced neglect (18-78%), physical abuse (6-48%), emotional abuse (8-77%), and sexual abuse (4-35%). The authors noted that studies showed that children in foster care had often experienced multiple types of maltreatment.

Given the high rate of maltreatment, trauma is common across all ages of youth in foster care. In a study of 324 young German foster children (ages 3 to 7), 45.4% of the children had experienced at least one traumatic event in their lifetime (Vasileva & Petermann, 2017). The most common forms of trauma in this sample were physical abuse (22.2%), hospitalization or invasive medical procedure (22.2%), witnessing another person being hurt (15.7%), and sexual abuse (4.6%). The authors noted that the traumatic events were reported by foster parents, who often did not know the child’s entire history, so it is possible that the actual percentage of traumatic events may be higher. In a study of 732 older foster youth (ages 17 and 18) in three Midwestern states, researchers utilized structured interviews to gather information on exposure
to trauma (Salazar et al., 2013). Within this sample, 80.3% of foster youth had experienced at least one traumatic event in their lifetime, while 61.7% had experienced two or more traumatic events. The most common types of trauma were witnessing someone being injured or killed (40.4%), being physically attacked or assaulted (30.3%), being molested (27.2%), and being threatened with a weapon, kidnapped, or held captive (26.5%). It is not surprising that the trauma prevalence in this sample was higher than in Vasileva & Petermann’s (2017) study given that the adolescents may have presumably experienced more trauma as they aged. A strength of Salazar et al.’s (2013) study was that the foster care youth were interviewed, so the reports of trauma may have been more accurate compared to those obtained by caregivers. However, the authors noted that asking the youth to retrospectively remember their traumas could still be prone to memory errors. Additionally, youth in foster care who were residing in inpatient hospitals or correctional facilities were not included in the study, so the actual prevalence of trauma within the full foster care population may have been higher.

In a large study of 2,251 foster care youth (ages 0 to 21), researchers found that 70.4% of participants had experienced at least two types of trauma that represent complex trauma (i.e., interpersonal trauma done by caregivers), including physical abuse, sexual abuse, emotional abuse, neglect, and domestic violence (Greeson et al., 2011). Shockingly, 11.7% of the sample had experienced all five types of trauma. While the large sample in this study was nationally representative, a limitation is that the youth had all been referred for mental health treatment. Given this, the youth may have had higher rates of trauma compared to those not referred for treatment.

Research has also shown that adverse childhood experiences (ACEs) are common among foster youth. Turney & Wildeman (2017) utilized data from a large nationally representative
survey of children (ages 0 to 17) living in the United States. Within this sample, 1.4% of the children had experienced foster care. As reported by the children’s caregivers, 75.5% of children with current or previous foster care involvement had experienced at least one ACE, which included violence, household member mental illness or substance abuse, and parental death, incarceration, abuse, or divorce/separation. Furthermore, children who had been in foster care experienced each of the seven ACEs at a higher rate than children with no foster care experience. They also experienced the ACEs at a higher rate than children who were living below the poverty line and children living in different family structures, such as single-mother homes. A limitation of this study is that the ACEs were reported by the children’s foster parents, and it is possible that they were unaware of some of the ACEs experienced by the children. Taken together, these studies provide support for the high rate of maltreatment and trauma within the foster care population.

**Foster Youth Mental Health**

Given the trauma that many foster youth experience, it is not surprising that this population has high rates of mental health disorders. A meta-analysis by Bronsard et al. (2016) calculated the pooled-prevalence of mental health disorders across eight studies focused on youth in the child welfare system. They found that 49% of the youth met diagnostic criteria for a mental health disorder, which is almost four times greater than the rate of 13.4% found in the general youth population (Polanczyk et al., 2015). Pooled-prevalence rates were also calculated for specific disorders, including conduct disorder (20%), oppositional defiant disorder (12%), anxiety (18%), attention-deficit/hyperactivity disorder (ADHD) (11%), depressive disorders (11%), and PTSD (4%). Unfortunately, this meta-analysis only included 8 studies and most of the studies focused on specific geographic areas. The studies also included youth that were in
residential group homes, as well as foster care homes. Given that the needs of youth in residential group homes may be higher than those in foster care homes, it is possible that this meta-analysis overestimated the prevalence rates for youth within foster care homes.

A recent meta-analysis of 41 studies also found that youth in foster care had increased levels of psychopathology compared to youth living with their biological parents ($d = 0.19$) (Dubois-Comtois et al., 2021). The authors suggested that foster care youth remain vulnerable to developing mental health disorders due to the maltreatment they experienced before entering foster care. Relatedly, across the 25 articles included in their systematic review, Engler et al. (2022) found that youth in foster care had higher rates of mental health diagnoses compared to youth not in foster care. Oppositional defiant disorder, conduct disorder, major depressive disorder, PTSD, and reactive attachment disorder were the most common diagnoses within the foster care population.

The trauma that foster care youth experience can result in PTSD, which has been confirmed by a number of studies. In Vasileva and Petermann’s (2017) study on young German foster children (ages 3 to 7), they found that 15.4% of the children had clinically significant symptoms of posttraumatic stress, as reported by their foster parents. Additionally, 11.7% of the young children met criteria for a diagnosis of PTSD. In a study of 1,848 older children (ages 8 to 14) who had been referred to the child welfare system due to possible abuse or neglect, 11.7% of the children had symptoms of posttraumatic stress in the clinically significant range (Kolko et al., 2010). However, when separating out the children who were placed in foster care, the level of posttraumatic stress symptoms rose to 19.2%. While this sample was large and nationally representative, a potential limitation of the study is that the children reported on their own symptoms, which may have resulted in underreporting.
Studies have also examined the prevalence of PTSD in older adolescents in foster care. Using structured interviews with 373 17-year-old foster care adolescents, McMillen et al. (2005) found that 14% of the foster care youth had a lifetime prevalence of PTSD, while 8% of the youth met criteria for PTSD within the last year. Similarly, Keller et al. (2010) also used structured interviews with 732 foster care adolescents (ages 17 and 18). Within their sample, PTSD was the most common mental health diagnosis, with 15.1% of the foster youth meeting diagnostic criteria for PTSD across their lifetime. Both of these studies had samples that were limited geographically, as McMillen et al.’s (2005) sample only included one Southern state and Keller et al.’s (2010) sample only included three Midwestern states. Additionally, both of these studies used self-report from the youth, so it is possible that the studies underestimated the actual prevalence of PTSD within this population. However, it is important to note that the lifetime prevalence rates of PTSD found in these studies (14% and 15.1%) are much higher than the prevalence rate of 5% found in a nationally representative sample of adolescents (ages 13 to 18) (Merikangas et al., 2010).

Other mental health diagnoses besides PTSD are also common within the foster care population. In a meta-analysis examining the mental health of pre-school aged foster children, Vasileva and Petermann (2018) found that 39% of the children had mental health problems, including internalizing and externalizing diagnoses. Relatedly, examining foster youth (ages 0 to 21) who were receiving mental health treatment, Greeson et al. (2011) found that 49.1% of the youth had clinically significant externalizing behavior problems (e.g., aggressive behavior), while 36.7% of the youth had internalizing behavior problems (e.g., depression, anxiety). Using a nationally representative sample, Turney and Wildeman (2016) compared the mental health of foster care youth (ages 0 to 17) with those not in foster care. Children in foster care were more
likely to have diagnoses of ADHD, anxiety, depression, and behavioral problems compared to children not in foster care. In older adolescents in foster care, high rates of depression, ADHD, conduct disorder, oppositional defiant disorder, and substance use disorders have been found (Keller et al., 2010; McMillen et al., 2005).

Foster Parents

Foster parents, whether non-relative or kinship, play an important role in the child welfare system, as they care for 79% of children in foster care (HHS, 2022). Given the behavioral and emotional problems that foster children are at risk for, foster parents have a complex parenting role. In addition to having experienced trauma, foster children often face uncertainty about their future as well as potential loss in relation to their biological families (Sharda, 2022). Understanding the experience of foster parents is important in order to ensure their well-being and provide them with adequate supports, which will ultimately have positive impacts on foster children as well.

Foster Parent Training

In the United States, the licensing of foster parents is done at the state level (Child Welfare Information Gateway [CWIG], 2018). Given this, the laws surrounding foster care licensing, including training requirements, vary from state to state (CWIG, 2018). Completing orientation and training prior to becoming licensed (i.e., preservice training) is a requirement in 45 states (CWIG, 2018). While this training varies between states, common topics include foster parent roles and responsibilities, licensing requirements, agency policies, child development, attachment, behavior management, home and child safety, cultural sensitivity, and the potential impact of fostering on the foster family (CWIG, 2018). While preservice training aims to prepare foster parents by helping them to understand their role and gain knowledge and skills for
fostering, it also serves as a way to screen potential foster parents (Cooley et al., 2019). In addition to preservice training, 42 states require foster parents to complete ongoing training (i.e., in-service training) in order to keep their license, often on an annual basis (CWIG, 2018). It is important to note that kinship foster parents often have different requirements for licensure, although this varies between states (CWIG, 2018). Some states exempt kinship foster parents from certain licensing requirements or conduct expedited home studies, while other require kinship foster parents to meet the same licensing requirements as non-relative foster parents (CWIG, 2018).

Benesh and Cui (2017) conducted a review of the structure and content of 22 different foster parent training programs, the majority of which were in-service trainings. The researchers found that the training programs varied in the number of sessions used (1-18 sessions) and session length (1-8 hours). The majority of training programs (65%) used an in-person format that occurred over multiple sessions. Additionally, almost all of the training programs used a group format, although a few used individual training or web-based training. The content of the training programs varied between preservice and in-service training. The preservice training programs tended to focus on orientation to foster care and psychoeducation, without an emphasis on parenting skills. The authors noted that the lack of focus on parenting skills is a possible inadequacy of the preservice trainings, as foster parents may have children placed with them immediately following preservice training. The in-service training programs varied more in their content, tending to focus on three areas. Psychoeducation on specific topics, such as drug exposure or sexual trauma, as well as parent skill training were common in the in-service trainings. In addition, in-service trainings often included reflective training, which involved foster parents sharing their parenting experiences, processing their emotions, and gaining social
support. Benesh and Cui (2017) discussed the fact that foster parent training programs are rarely published in academic journals, as they are often developed within agencies. Given this, they suggested caution in generalizing the results of their study across all foster parent training programs. In addition, they argued that more work needs to be done to evaluate and disseminate information on foster parent training programs.

In contrast to Benesh and Cui’s (2017) study, a systematic review by Cooley et al. (2019) focused exclusively on the structure and content of preservice training programs for foster parents. Out of the 11 published studies that were reviewed, the researchers found that the studies focused on four different specific programs. However, the authors noted that there are many preservice training programs being used that have not been researched and/or published yet. The training programs reviewed by Cooley et al. (2019) were in-person and included 9-12 sessions which lasted 2.5-3 hours. The programs covered multiple competencies and topics, which varied across the programs. Similar to Benesh and Cui (2017), the researchers found that parenting skill training was not included in many of the preservice training programs. Many of the studies reviewed demonstrated positive results in terms of foster parent competency, including knowledge, skills and attitudes. However, the authors noted that there was a lack of consistency across the studies in the design and measures used, which made it difficult to draw conclusions on the effectiveness of the programs. In addition, many of the studies relied on self-report measures by the foster parents to assess effectiveness, instead of directly assessing their changes in behavior, which is concerning given the role that social desirability may play in this population. Additionally, many of the studies’ samples were primarily White, female, and non-relative foster parents, which may limit generalizability to other demographics. Overall, Cooley et al. (2019) highlighted the lack of rigorously designed research on foster parent preservice
training programs. They noted the need for research to establish the essential components of training programs, as well as the need for universal competencies for foster parents.

While researching the structure and content of foster parent training programs is important, it is also crucial to understand the impact of these programs. In 2011, Rork and McNeil (2011) conducted a critical analysis of studies examining the effectiveness of foster parent training programs. Overall, the researchers found that there was a lack of research in this area, as they identified only 17 studies to review. After reviewing the studies, the researchers concluded that the currently available literature contained a lot of methodological limitations, including small sample sizes, overreliance on foster parent self-report measures, use of measures with questionable psychometric properties, and lack of follow-up measurement. Rork and McNeil (2011) provided several suggestions for future research on foster parent training programs. First, using empirically validated measures, the authors highlighted the importance of using multiple modes of assessment instead of relying solely on foster parent self-report data. Second, they argued that future research should examine pre-existing variables that may impact the effectiveness of training, such as parental stress or baseline parenting skills. Third, they suggested that examining satisfaction with training, as well as trainings’ impact on foster parent retention, are important areas of future research.

In a meta-analysis of 16 studies with a total sample size of 1,650 foster parents, Solomon et al. (2017) also examined studies focused on foster parent training outcomes. Eight of the studies in the meta-analysis explored the impact of training on foster child problem behaviors, and 13 of the studies explored the impact on foster parents’ skills and knowledge. Results indicated that foster parents who went through training reported lower levels of externalizing behavior in their foster children compared to those who did not attend training, with a small but
significant effect size (-0.20). However, the researchers noted that these results were strongly impacted by one large study. Additionally, foster parents who went through training were found to have higher levels of self-reported parenting skills and knowledge compared to those who did not have training, with a significant, moderate effect size (0.52). While the results of this meta-analysis are promising, there was an overall low number of studies included due to the need for studies to have a control group. Given this, the researchers cautioned that the trainings included in this meta-analysis may not reflect the majority of trainings being conducted with foster parents. This meta-analysis also only included studies with non-relative foster parent samples, which may limit the applicability to kinship foster parents. Additionally, the reliance on foster parent-reported measures of child behavior and parenting skills and knowledge is an additional limitation.

In addition to understanding the effectiveness of foster parent training programs, it is important to examine foster parents’ satisfaction with the training programs, including how well the training meets their needs. Kaasboll et al. (2019) conducted a systematic review of 13 studies, 10 of which were done in the United States. Results from the quantitative studies included in this review suggested that foster parents have overall high levels of satisfaction with foster parent training. However, results from the qualitative studies highlighted a need for more training focused on caring for foster children with special needs, including mental health issues and trauma. In addition, the results suggested that there is also an unmet training need regarding how to deal with real life situations, including more real life and flexible practice during training. Kaasboll et al. (2019) noted that there is an overall lack of research on foster parents’ needs and satisfaction with training programs, as these measures were often included as secondary outcomes in the reviewed studies. Additionally, the authors highlighted the importance of future
research examining longer-term satisfaction, as many of the studies assessed satisfaction immediately after training. Similar to Benesh and Cui (2017), Kaasboll et al. (2019) discussed the fact that foster parent training is often evaluated on a smaller scale and not published in academic journals, which makes it difficult to draw broad conclusions.

**Trauma Histories of Foster Parents**

Given that foster parents often care for children who have experienced significant trauma, it is important to examine foster parents’ own histories of trauma and how this might impact their care of foster children. Three recent studies examined adverse childhood experiences (ACEs) within the foster parent population. ACEs include abuse (emotional, physical, and sexual), neglect (emotional and physical), family member substance use or mental illness, domestic violence, family member incarceration, and parental separation or divorce (Centers for Disease Control and Prevention [CDC], 2021). Cooley et al. (2020) examined the prevalence of ACEs within a national sample of 150 foster parents. In this sample, 68% of the participants had experienced at least one ACE, which is similar to the rate of 64% found within a general sample in the United States (CDC, 2021; Cooley et al., 2020). Interestingly, using multiple linear regressions, the authors found no relationship between the number of ACEs that a foster parent had experienced and their levels of parental stress, satisfaction with fostering, and perceived challenges with fostering.

In a similar study, Adkins et al. (2020) measured ACEs within a sample of 89 foster parents from Texas. The researchers found that 66.3% of the participants had experienced at least one ACE, which is consistent with the results from Cooley et al. (2020). Additionally, 40.7% of the participants had experienced two or more ACES, while 19.8% had experienced four or more ACEs. The authors highlighted the large difference between individuals who had experienced
four or more ACEs in this study (19.8%) compared to a general sample in the United States (12.5%) (CDC, 2021). This result indicates that a substantial subset of this foster parent sample had experienced a large number of ACEs in their past. Additionally, the authors noted that this sample of foster parents experienced certain ACEs at a higher rate than the general sample, including emotional abuse, physical neglect, family member mental illness, and family member incarceration. They suggested that foster parents who have experienced these ACEs may feel a drive to support children who have experienced similar situations. Finally, through multiple linear regressions, the number of ACEs experienced by a foster parent was found to be significantly correlated with their foster child’s difficulties, including emotional problems, conduct problems, and hyperactivity-inattention. While this association does not prove causality, the authors suggested that there may be a link between foster parents’ past experiences and their parenting practices, which may influence foster children’s behavioral and emotional functioning.

More recently, Reisz et al. (2023) conducted a study examining ACEs, adult attachment style, and parenting stress within foster parents. Within their sample of 55 foster parents from Texas, 67% of participants had experienced at least one ACE, while 20% reported experiencing four or more ACEs. These prevalence rates are similar to those found in the studies by Cooley et al. (2020) and Adkins et al. (2020). The researchers also found that foster parents who had experienced a higher number of ACEs reported more overall parenting stress, as well as higher levels of attachment avoidance. In particular, foster parents who had a history of childhood sexual abuse were more likely to indicate higher levels of parental distress, which is a component of overall parenting stress and refers to parents’ feelings of competence in their role as a parent. The researchers also examined whether adult attachment style mediated the relationship between
foster parents’ ACEs and their current parenting stress, but they found no evidence for that mediated relationship.

These studies provide evidence that the majority of foster parents have experienced at least one ACE, while a subset have experienced multiple ACEs (Adkins et al., 2020; Cooley et al., 2020, Reisz et al., 2023). While the foster parents’ number of ACEs was not found to be associated with parental stress in Cooley et al.’s (2020) study, Reisz et al. (2023) found evidence of a relationship with a higher number of ACEs being associated with increased parental stress. Additionally, foster parents’ number of ACEs was found to be associated with their foster children’s emotional and behavioral difficulties. Unfortunately, the samples in these studies were fairly small and the majority of participants were female and White. These sample characteristics may limit the generalizability of these findings to the wider foster parent population. Additionally, the cross-sectional nature of these studies limits the ability to make casual inferences between foster parents’ number of ACEs and the studied variables.

**Foster Parent Stress**

Foster parent turnover is an ongoing concern in the United States. In a study across three states, the median length of time that foster parents served in their role was between 8 and 14 months (Gibbs & Wildfire, 2007). Shockingly, between 13% and 21% of foster parents provided foster care for only 90 days or less. After one year, between 38% and 53% remained in the foster care role. Given this high rate of turnover, examining factors related to foster parents’ well-being is important. One of the most studied factors in this area is the parental stress experienced by foster parents.

**Sources of Foster Parent Stress.** In an older study by Jones and Morrissette (1999), foster parents in Canada identified a variety of stressful experiences related to fostering that
negatively affected them. The participants identified several relationships as sources of stress, including their relationships with their foster child, the foster child’s biological family, and the child welfare worker. Additionally, the relationship between the foster child and their biological family was viewed as a source of stress, particularly when biological parents disappointed the foster child (e.g., by not attending scheduled visits). Foster children’s aggressive behaviors, emotional instability, and academic issues were additional sources of stress identified by the foster parents. Other sources of stress included difficulty maintaining their own well-being, administrative issues associated with foster care policies, and communication issues between the foster parent and child welfare agency. Finally, the foster parents identified clinical issues as a source of stress, including not being provided background information on their foster child and not being included in their child’s treatment plan.

Similarly, Heller et al. (2002) described their observations from working with foster parents as part of a treatment program in the United States for young foster children under the age of four. The authors identified four areas where foster parents in their program experienced challenges and conflict. First, the foster parents had difficulty navigating the medical, mental health, and educational systems for the foster child. Second, interacting with the legal and child welfare systems was a challenge, including the lack of information provided to the foster parents from these systems and foster parents feeling like these systems controlled the future of their foster child. Third, managing the foster child’s difficult behaviors was a challenge. Finally, managing the demands and unique parts of being a foster parent was challenging, such as foster parents’ fear of losing their child, feeling undervalued, and dealing with misconceptions in the community.
A study by Murray et al. (2011) identified similar areas of stress through semi-structured interviews with 11 foster parents from New Zealand. Foster parents in this study described difficulty with accessing medical, mental health, and education services, as well as a need for more support from child welfare workers. They identified difficulty with their foster children’s biological families as an additional source of stress, as well as a need for more support to manage their child’s difficult behaviors. Access to relevant trainings on children’s behaviors and trauma was another area of need. Finally, the foster parents described their difficulty managing their own well-being and their desire for more training and support in this area.

More recently, Findley and Praetorius (2023) conducted a qualitative interpretive meta-analysis on sources of stress that foster parents experience within the child welfare system. From the 21 published qualitative studies included in the meta-analysis, the researchers found four main themes. First, the foster parents felt like they had to fight for respect and inclusion as a parent, especially by professionals within the child welfare system. Second, feeling unsupported was a common theme. Participants felt unsupported by the lack of responsiveness of caseworkers, as well as caseworker turnover. Feeling unsupported also arose from difficulty accessing services for their foster children, as well as not feeling prepared for their role as a foster parent. Third, the foster parents indicated that they were missing important information about their foster children, which caused stress. Fourth, participants described parenting stress that they felt was unique to the role of being a foster parent. In particular, it was difficult for participants to balance the competing needs of both their foster children and their biological family at the same time.

The COVID-19 pandemic added an additional source of stress for most individuals, including foster parents. A qualitative study by Findley (2023) examined foster parents’ stress as
they navigated the COVID-19 pandemic. Using thematic analysis, five themes emerged from the interviews of 20 foster parents, which were conducted a year into the pandemic (April to July 2021). First, participants in this study described a variety of both positive and negative experiences regarding fostering during the pandemic. Second, the foster parents noted the difficulty of having nowhere to go when schools and businesses closed, which left them with fewer parenting resources and outlets. Third, participants described stress related to their fear of both giving or getting COVID-19, and the efforts they took to protect their families. Fourth, it was challenging for foster parents and their foster children to switch to virtual services during the pandemic, including virtual visits with biological parents, virtual therapy services, and virtual schooling. Finally, participants highlighted several ways that they engaged in stress relief during the pandemic, including finding ways to cope personally and as a family. They noted that peer and social support, as well as support from the child welfare system, was particularly helpful for stress relief.

**Prevalence of Foster Parent Stress.** In addition to identifying specific sources of stress for foster parents, studies have examined the prevalence of stress within this population. Along with the semi-structured interviews described above, Murray et al. (2011) used the Parenting Stress Index to measure parenting stress within their sample of 17 foster parents (Abidin, 1995). The Parenting Stress Index contains three subscales: Parent Domain Stress, Child Domain Stress, and Life Stress. Results indicated that the foster parents in this sample were experiencing high levels of parenting stress within the Child Domain, with their mean score at the 99th percentile. Their Life Stress mean score was slightly high at the 75th percentile, while their Parent Domain Stress mean score was near the normative mean. While Murray et al.’s (2011) study had a small sample size, other studies have confirmed high levels of parental stress within the foster parent
population. In a study of 158 foster care and kinship parents in Australia, Harding et al. (2018) assessed levels of parental stress using the Parenting Stress Index IV-Short Form (Abidin, 2012). The researchers found that 20% of the participants had clinically significant levels of parental stress. Interestingly, foster parent stress was associated with the length of the foster placement, with foster parents who had cared for their foster child for a longer period of time demonstrating higher levels of parental stress.

Foster parents have also been found to have higher levels of parental stress compared to biological parents. In a longitudinal study conducted in Norway, Bergsund et al. (2020) assessed parental stress in 60 foster parents and a control group of 42 biological parents using the Parenting Stress Index (Abidin, 1995). Parental stress was measured when the foster children were two, three, and eight years old. The results demonstrated that foster parents had significantly higher levels of parental stress on the Child Domain subscale compared to the biological parents across all three measurement points. Additionally, the levels of stress on all three domains (Child, Parent, and Life Stress) increased for the foster parent sample as their foster children got older. The longitudinal design and use of a control group are strengths of this study. Similar results regarding foster parents’ higher level of parental stress were found in an earlier study by Lohaus et al. (2017), which examined parental stress of parents caring for young children (ages 2 to 7) in Germany. The study included non-relative foster parents of 79 children, as well as biological parents of 140 children as a control group. Using the Parental Stress Questionnaire (Domsch & Lohaus, 2010), the researchers found that foster mothers reported significantly higher levels of parental stress compared to biological mothers. However, this result was not found with the father sample. Using hierarchical regression analysis, the researchers found that maternal and paternal stress levels in both samples were strongly predicted by the
children’s externalizing behavior problems, as measured by the Child Behavior Checklist (Achenbach, 1991; Achenbach & Rescorla, 2000). Internalizing behavior problems of the foster children were not found to predict parental stress levels. Interestingly, the difference in stress levels between foster and biological mothers was no longer significant when the foster child’s behavior problems were added as covariates, indicating that the children’s mental health concerns were contributing to the development of parental stress.

A recent study by Miller et al. (2022) examined how foster parents’ parenting stress was impacted during the COVID-19 pandemic. Using the Parenting Stress Scale (Berry & Jones, 1995), 990 foster parents reported on their stress levels during spring of 2020. Additionally, participants were asked to retrospectively report on their stress levels prior to the pandemic. The researchers found that foster parents’ parental stress levels had increased between the two ratings, indicating that foster parents were experiencing heightened parenting stress during the pandemic. Additionally, several variables increased participants’ risk for experiencing increased stress levels during the pandemic, including not being married, having worse mental health, and having financial difficulties. While this data sheds light on foster parents’ experiences during the pandemic, this study has several significant limitations. First, data collection occurred in April 2020, which was the height of the COVID-19 pandemic. This data was from a snapshot in time, and it is unclear whether these heightened stress levels continued throughout the pandemic. Additionally, this study relied on participants’ retrospective ratings of their stress prior to the pandemic, which may not have been reliable. While it seems plausible that foster parents (and potentially all parents) experienced heightened stress during the COVID-19 pandemic, it would be beneficial to understand how their stress level may have changed as the pandemic progressed.
**Foster Parent Stress and Foster Children Mental Health.** Similar to Lohaus et al. (2017), a number of studies have consistently found an association between foster parents’ parental stress and foster children’s challenging behaviors. In a study of 58 foster parents from the United Kingdom, Morgan and Baron (2011) examined the relationship between parental stress and foster children’s behavior. Parental stress was measured using the Parental Stress Index – Short Form (Abidin, 1995). Overall, they found that 54% of foster parents scored within the borderline or clinical ranges on the Parental Stress Index. The foster children’s behavior was measured using the Strengths and Difficulties Questionnaire, as reported by the foster parents (Goodman, 1997). Using hierarchical regression analysis, the researchers found that increased challenging behavior in the foster children was significantly associated with increased parental stress in the foster parents. Additionally, positive relationships were also found between the foster children’s challenging behaviors and levels of both depression and anxiety within the foster parents. Another study, conducted by Goemans et al. (2020) in the Netherlands, examined parental stress in a sample of 432 foster parents of children ages four to 17. This longitudinal study measured parental stress using the Nijmeegse Ouderlijke Stress Index, which is based on the Parenting Stress Index (De Brock et al., 1992). Additionally, the Strengths and Difficulties Questionnaire (Goodman, 1997) was used to measure foster children’s behavior. These measures were completed by the foster parents at three time points (baseline, six months, and one year) and were analyzed using multilevel modeling. Results indicated that the level of parental stress experienced by the foster parents significantly predicted the foster children’s mental health, as measured by the Strengths and Difficulties Questionnaire. More specifically, increased internalizing and externalizing behavior problems in the foster children, as well as decreased prosocial behavior, were found to be associated with increased parental stress. Importantly, a
large amount of attrition occurred between the three waves of data collection in this study, which may have impacted the results. Other studies, conducted in Australia and Belgium, have similarly found an association between foster parents’ levels of parental stress and challenging behaviors displayed by foster children (Harding et al., 2018; McKeough et al., 2017; Vanderfaeillie et al., 2013; Vanschoonlandt et al., 2013). It is important to note that all of these studies on parental stress and child behavior used parent-report measures for both constructs. This is a potential limitation, given that foster parents who are highly stressed may simply perceive more challenging behavior in their foster child, which may or may not be a reflection of their actual behavior. Including observational data or reports from other caregivers (such as teachers) would strengthen these studies.

The studies reviewed above provide evidence for the relationship between foster parents’ parental stress and foster children’s challenging behaviors. However, these studies do not provide information on the direction of this relationship. Goemans et al. (2018) attempted to fill this gap through their longitudinal study of 237 foster children (ages 4 to 17) from the Netherlands. Similar to Goemans et al.’s (2020) study, the Nijmeegse Ouderlijke Stress Index (De Brock et al., 1992) and the Strengths and Difficulties Questionnaire (Goodman, 1997) were completed by the children’s foster parents at three time points: baseline, six months, and one year. Using cross-lagged structural equation modeling, the researchers found that there was a unidirectional prospective relationship from foster children’s behavior problems (both internalizing and externalizing) to foster parents’ reported parental stress levels. However, a pathway from parental stress to behavior problems was not found. This result was surprising, as the researchers expected to find a bidirectional pathway. As a possible explanation for this finding, the researchers suggested that foster parents’ expression of their stress may be done in a
manner that does not impact their foster child. Alternatively, they suggested that foster children may be resilient to minor stress experienced by their foster parents, given their more extreme trauma history. Unfortunately, more than half of the sample dropped out of the study between the baseline and one-year measurement, which is a significant limitation of this study.

Concerningly, foster parent stress has also been linked to foster children’s symptoms of posttraumatic stress. In Vasileva and Petermann’s (2017) study, German foster parents of children ages 3 to 7 years old completed the Parental Stress Questionnaire (Domsch & Lohaus, 2010), as well as a measure of their child’s posttraumatic stress symptoms. Using multiple regression analysis, the researchers found that foster parents’ levels of parental stress significantly predicted their foster children’s symptoms of posttraumatic stress. Unfortunately, the cross-sectional design of this study does not allow determination of causality between the two variables. It is possible that foster parents experiencing high parental stress may be less sensitive and available towards their foster child, which could lead them to develop increased symptoms from their trauma exposure. Alternatively, it is possible that foster children’s symptoms of posttraumatic stress could lead to increased levels of parental stress within their foster parents. Regardless of the direction of the association, this is an important finding because it highlights a relationship between foster children’s mental health and foster parents’ functioning.

**Impact of Foster Parent Stress.** The negative impact of foster parents’ parental stress has also been examined in terms of foster parents’ well-being, as well as its relation to parenting experiences. In a recent study conducted in the United States, Sharda (2022) surveyed 139 foster parents using the Parenting Stress Scale (Berry & Jones, 1995). Foster parents also completed the Mental Health Continuum (Lamers et al., 2011) as a measure of well-being, as well as the Social
Provisions Scale (Cutrona & Russell, 1987) as a measure of social support. Using multiple linear regression analysis, foster parents’ parental stress was found to be a significant negative predictor of their overall well-being. Interestingly, foster parents’ perceived social support was found to moderate the relationship, in that the well-being of those who reported high social support was less impacted by stress from parenting. This result highlights the important role that social support may play in the lives of foster parents.

In another study done in the United States, Leathers et al. (2019) assessed general stress in 139 foster parents using the question “How much stress or pressure is in your life right now?” In this sample, foster parents who indicated higher levels of stress reported more negative parenting experiences. Unfortunately, having negative parenting experiences was found to be a strong predictor of future placement disruption, which highlights the potential impact of parental stress on foster children’s placement stability. Another study by Lopez et al. (2023) examined the relationship between parental stress and parenting behaviors, including both adaptive and maladaptive behaviors. The researchers found that parental stress levels were negatively associated with parental involvement, such that foster parents who had increased parental stress were less involved with their foster children. They also found that parental stress levels were positively correlated with the use of inconsistent discipline practices, as well as corporal punishment. While the cross-sectional design of this study limits the ability to draw inferences about the direction of these relationships, it is still noteworthy that increased parental stress in foster parents is associated with decreased use of adaptive parenting behaviors and increased use of maladaptive parenting behaviors.

**Summary.** The studies reviewed above provide valuable information on foster parents’ experiences of parental stress. However, many of the studies share similar limitations. First, most
of the studies were completed in countries other than the United States. While there are likely similarities in the foster parenting experience across countries, there may be important cultural and systemic differences which could limit the generalizability of the findings to foster parents in the United States. Second, many of the samples consisted primarily of White females. Foster fathers play an important role in the lives of many foster children, so their exclusion from the research is concerning. In addition, foster parents from diverse racial and ethnic backgrounds may have different experiences related to parental stress. Third, the studies reviewed above used several different measures of parental stress, which makes it difficult to compare between studies. However, it is notable that similar results were found across many of the studies, regardless of the instrument used. Finally, all of the studies reviewed relied on parent-report data. This is concerning given the possibility of social desirability bias, as foster parents may be reluctant to disclose the difficulties that they or their foster children are experiencing.

Secondary Traumatic Stress

In addition to general parental stress, foster parents may be at risk for experiencing secondary traumatic stress as a result of their exposure to details about their foster child’s trauma history, as well as their child’s trauma symptoms. Substantial research has been conducted on the concept of secondary traumatic stress, as will be reviewed below. Given the similarities in working with foster children, research on secondary traumatic stress within child welfare professionals will also be reviewed.

Original Definition of Secondary Traumatic Stress

As Figley (1995a) noted, there is often a “cost to caring” for working with populations who have experienced trauma (p. 18). Figley (1995a) conceptualized this cost as secondary traumatic stress, which he defined as “the natural consequent behaviors and emotions resulting
from knowing about a traumatizing event experienced by a significant other – the stress resulting from helping or wanting to help a traumatized or suffering person” (p. 21). More specifically, secondary traumatic stress has been conceptualized to include the same symptoms as post-traumatic stress disorder (PTSD), although the symptoms develop from secondary exposure to another person’s trauma instead of from directly experiencing a trauma (Figley, 1995a). An empathic relationship with an individual and exposure to details about their trauma are necessary requirements for the development of secondary trauma symptoms, which can come about quickly with little warning (Figley, 1995a). Figley (1995b) proposed that developing secondary traumatic stress is a natural and predictable response to working with individuals who have experienced trauma. He believed that therapists who work with trauma victims are especially vulnerable to developing secondary traumatic stress given their exposure to details about their clients’ trauma. In addition, he noted that individuals working with traumatized children are particularly at risk, given the provocative nature of childhood trauma (Figley, 1995a).

**Secondary Traumatic Stress vs. Posttraumatic Stress Disorder**

To fully understand secondary traumatic stress, it is important to review the symptoms of posttraumatic stress disorder (PTSD). PTSD was first recognized as an official disorder in the 1980 publication of the *Diagnostic and Statistical Manual of Mental Disorders* (3rd ed; *DSM-III*; American Psychiatric Association [APA], 1980). At that time, PTSD was conceptualized to contain three clusters of symptoms: reexperiencing, avoidance, and increased arousal. In addition, in order to qualify for a PTSD diagnosis, an individual had to have directly experienced a traumatic event. Significant changes were made to the diagnostic criteria for PTSD with the publication of the 5th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed; *DSM-5*; APA, 2013). One of the main changes in the *DSM-5* was that PTSD was now
conceptualized to contain four clusters of symptoms: intrusive symptoms, avoidance of stimuli, negative alterations in cognitions and mood, and marked alterations in arousal and reactivity (APA, 2013). In order to meet diagnostic criteria for PTSD, it is outlined that an individual must have been exposed to a trauma, including actual or threatened death, serious injury, or sexual violence. However, an important change is that exposure can now be indirect through “learning that the traumatic event(s) occurred to a close family member or friend” or “experiencing repeated or extreme exposure to aversive details of the traumatic event(s)” (APA, 2013, p. 271). This is an important change related to the concept of secondary traumatic stress, as it indicates that PTSD can be diagnosed through secondary exposure, either through friends and family or through one’s work environment. In theory, this change means that a foster parent could be diagnosed with PTSD based on their exposure to their foster child’s trauma. The diagnostic criteria for PTSD remained the same in the 2022 publication of the Diagnostic and Statistical Manual of Mental Disorders (5th ed, text revision; DSM-5-TR; APA, 2013).

Several groups have highlighted the fact that it is important to distinguish how secondary traumatic stress differs from, and is similar to, PTSD (Elwood et al., 2011; Molnar et al., 2017; Walsh et al., 2017). Given that the symptoms overlap, being able to distinguish between these two syndromes is crucial in terms of research and treatment. Elwood et al. (2011) proposed two ways that the conceptualization of secondary traumatic stress has differed from PTSD in the literature. While functional impairment is a requirement for a PTSD diagnosis, this is often overlooked when examining secondary traumatic stress (APA, 2013). Research often assesses the presence of secondary traumatic stress symptoms without also examining the impact of the symptoms on the individual. In addition, research on secondary traumatic stress also often overlooks assessing for the chronicity of symptoms. In contrast, symptoms must be present for at
least one month in order for PTSD to be diagnosed (APA, 2013). Elwood et al. (2011) explained that the expected course or duration of secondary traumatic stress symptoms is unclear. Clarifying the chronicity of symptoms is important given that some individuals may experience normal, short-term symptoms which may resolve naturally, similar to what happens to many individuals who experience direct trauma (Elwood et al., 2011).

**Multifactorial Models of Secondary Traumatic Stress**

Figley (2002) originally outlined a multifactorial model of secondary traumatic stress, which included 10 variables that were proposed to predict the development of secondary traumatic stress. First, an individual’s empathic ability, empathic concern (i.e., motivation to help people in need), and exposure to clients who are suffering are three variables that contribute to a fourth variable, their empathic response (i.e., the extent to which the individual tries to reduce the suffering of another through empathic understanding). Next, the variable of compassion stress refers to the stress resulting from the emotional energy required by the empathic response. Two variables were thought to prevent compassion stress: a sense of achievement and disengagement (i.e., the individual’s ability to distance themselves from their clients). Finally, prolonged exposure to being responsible for caring for individuals with trauma, previous traumatic memories that trigger symptoms of PTSD, and life disruptions were all thought to contribute to secondary traumatic stress (Figley, 2002).

More recently, Ludick & Figley (2017) proposed an updated multidimensional model for the mechanism by which secondary traumatic stress develops. Similar to Figley’s (2002) original model, exposure to suffering, empathic ability, and empathic concern were all proposed to contribute to an individual’s empathic response. Engaging in contact and empathic responses with traumatized people over time can result in emotional numbing and eventual development of
secondary traumatic stress. In addition, their model highlights the important role of traumatic memories and other life demands. Trauma memories, from their own trauma history and from experiences shared by clients, as well as stressful life situations, are proposed to increase an individual’s risk for developing secondary traumatic stress. Finally, their model highlights several positive pathways that help individuals maintain resilience against secondary traumatic stress. Similar to Figley’s (2002) model, a sense of satisfaction and detachment are proposed to build an individual’s resilience. In addition, self-care practices and social support are suggested to be additional positive factors that can increase an individual’s ability to deal with trauma exposure and thus decrease their risk of secondary traumatic stress. Both Figley’s (2002) model, as well as the updated model provided by Ludick and Figley (2017), help to explain why some individuals may experience secondary traumatic stress as a result of their work with traumatized individuals, while other individuals may demonstrate resilience against developing these symptoms. For example, individuals who engage in self-care, seek out social support, and are able to detach from their work, may be more protected against developing secondary traumatic stress. Empirical research related to the potential risk and protective factors for secondary traumatic stress will be reviewed in more detail below.

Recent Conceptualizations of Secondary Traumatic Stress

Since the initial conceptualization of secondary traumatic stress by Figley (1995a), there has been a lack of consensus across the field about its exact definition, which has led to inconsistencies in how it is operationalized and measured (Molnar et al., 2017; Sprang et al., 2019). In 2015, a group of experts met as part of the Secondary Traumatic Stress San Diego Think Tank (Walsh et al., 2017). This group discussed the difficulty of having different terms and definitions for secondary traumatic stress used within the literature. They highlighted several
areas that needed further clarification, including whether or not secondary traumatic stress only relates to professionals who are indirectly exposed to trauma through their work, or whether it also includes those who are exposed through their caregiving with family and friends. They also discussed the importance of clarifying the impact that secondary traumatic stress may have on individuals, including the PTSD-like symptoms, impacts on functioning in work and personal life, and changes in an individual’s worldview.

In 2017, another group of experts gathered in an attempt to define secondary traumatic stress and review related interventions (Sprang et al., 2019). These experts defined secondary traumatic stress as directly related to, or potentially mirroring, the DSM-5 symptoms of PTSD, including intrusive reexperiencing, avoidance, alterations in mood and cognition, alterations in arousal and reactivity, and dissociation. However, there was also discussion that secondary traumatic stress may involve additional responses beyond those in PTSD, such as decreased empathy, moral distress, decreased self-efficacy, and feeling stigmatized. Unfortunately, the authors did not provide a definition for their conceptualization of moral distress. In secondary traumatic stress, the experts explained that these symptoms develop “in reaction to empathically experiencing the psychobiological impact on clients of both their traumatic event(s) and their subsequent symptoms of PTSD” (Sprang et al., 2019, p. 76). The experts noted that hearing about a client’s trauma and witnessing the impact it has had on them can be comparable to directly witnessing another’s actual exposure to trauma. However, they also noted that, when in a helping role, the emotional connectedness and responsibility that one may feel towards their client may add more intensity to this experience. In addition, Sprang et al. (2019) discussed the changes in the DSM-5 to include secondary exposure as a potential avenue to experiencing a PTSD-qualifying traumatic event. However, they noted that this definition may be too limited for
secondary traumatic stress, as it can develop with indirect exposure to traumatic details which is not necessarily repeated or extreme (Sprang et al., 2019). In fact, they argued that symptoms of secondary traumatic stress could be clinically significant and lead to substantial functional impairment, even without the exposure being repeated or extreme, as would be needed for a PTSD diagnosis. Thus, while the symptoms of secondary traumatic stress may mirror PTSD, the experts concluded that secondary traumatic stress cannot always be reduced to PTSD (Sprang et al., 2019).

Clarification of Related Terms

The lack of consensus on the definition of secondary traumatic stress is partially driven by several other terms that are often used in the field, including compassion fatigue, vicarious traumatization, and burnout. As Stamm (1997) stated, “The great controversy about helping-induced trauma is not ‘Can it happen?’ but ‘What shall we call it?’” (p. 1). Secondary traumatic stress and these related terms are often used interchangeably in the literature, despite their differences (Branson, 2019; Elwood et al., 2011; Molnar et al., 2017; Newell & MacNeil, 2010). Branson (2019) conducted a review of the literature, which identified a substantial issue with how these terms are used and operationalized in research. Branson (2019) found several issues including the incorrect use of terms, ambiguous use of terms, and similar terms being combined into one study variable. The lack of clarity around how these terms should be used and conceptualized presents a significant barrier to conducting and understanding research in this area (Branson, 2019; Elwood et al., 2011). These related terms will be reviewed below in an attempt to distinguish them from the concept of secondary traumatic stress.

Compassion Fatigue
Compassion fatigue is often used interchangeably with secondary traumatic stress, especially in the literature (Sprang et al., 2019). Figley (1995a) originally suggested that compassion fatigue may be a less stigmatizing and more friendly term for secondary traumatic stress. Figley (1995a) explained that helping professionals often preferred the word compassion fatigue and argued that it could be used as a substitute for secondary traumatic stress for those who felt uncomfortable with that term. However, Sprang et al. (2019) noted that experiencing compassion is not necessarily a requirement of secondary traumatic stress, so using the terms interchangeably may not be appropriate. Stamm (2010) outlined a slightly different conceptualization for compassion fatigue, describing it as the negative aspects of professional quality of life. In Stamm’s (2010) conceptualization, compassion fatigue is viewed as a combination of secondary traumatic stress and burnout symptoms. Others have described compassion fatigue as more general emotional and physical fatigue that helping professionals experience as a result of their prolonged use of empathy in their work with clients (Newell et al., 2016; Newell & MacNeil, 2010; Turgoose & Maddox, 2017). In terms of other differences, some have argued that secondary traumatic stress can be utilized across a variety of populations, while compassion fatigue should only be used for those in helping professions (Elwood et al., 2011). In contrast, Branson (2019) stated that compassion fatigue should be used with helping professionals, as well as loved ones and lay-persons, who become overwhelmed as a result of their secondary exposure to trauma. A review of the literature suggested that there is disagreement across the field in the operationalization of compassion fatigue and whether it differs from secondary traumatic stress. However, for the purposes of this review, secondary traumatic stress and compassion fatigue will be used interchangeably, as they frequently are in the literature.
Vicarious Traumatization

Vicarious traumatization, a term developed by McCann and Pearlman (1990), is another term commonly used to describe the impact of indirect exposure to trauma. Vicarious traumatization is defined as “transformation in the inner experience of the therapist that comes about as a result of empathic engagement with clients’ trauma material” (Pearlman & Saakvitne, 1995a, p. 31). The concept of vicarious traumatization was developed from Constructivist Self-Development Theory, as it emphasizes how individuals will react uniquely to their clients’ trauma material as a result of their own personality and psychological needs, as well as the social and cultural variables of the situation (McCann & Pearlman, 1990; Pearlman and Mac Ian, 1995). Vicarious traumatization results in disruptions of cognitive schemas related to self, other, and the world in five areas of psychological need: safety, trust, control, esteem, and intimacy (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995b). It may also disrupt an individual’s identity, worldview, spirituality, ability to tolerate strong affect, ability to maintain a positive sense of self, and ability to sustain connection to others (Pearlman & Saakvitne, 1995a).

Additionally, vicarious traumatization may result in intrusive imagery related to a client’s trauma, which may manifest as intrusive thoughts, dreams, or flashbacks and may result in difficult emotions (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995b). The development of vicarious traumatization is thought to be a cumulative process, in that it develops over time as a result of exposure to multiple client’s stories (McCann & Pearlmann, 1990; Pearlman & Saakvitne, 1995a). The effects of vicarious traumatization are believed to be permanent and pervasive, as they impact all areas of a therapist’s life, both personally and professionally (McCann & Pearlmann, 1990; Pearlman & Saakvitne, 1995a; Pearlman & Saakvitne, 1995b). In addition, it is believed that the development of vicarious traumatization is
inevitable, as it will occur in all therapists who work with clients who have experienced trauma (McCann & Pearlmann, 1990; Pearlman & Saakvitne, 1995a).

While vicarious traumatization and secondary traumatic stress can both occur through contact with individuals who have experienced trauma, there are several important differences between the two constructs. First, the two constructs differ in their focus on symptoms versus theory (Jenkins & Baird, 2002). Secondary traumatic stress is conceptualized based on an observable group of symptoms similar to PTSD (Pearlman & Saakvitne, 1995a). In contrast, vicarious traumatization was developed from Constructivist Self-Development Theory and thus has a focus on how an individual adapts and makes meaning of their experiences (Pearlman & Saakvitne, 1995a; Pearlman & Saakvitne, 1995b). Second, the nature of the symptoms experienced differs between the two constructs (Jenkins & Baird, 2002). In secondary traumatic stress, the main focus is on experiencing outward, observable symptoms similar to PTSD. In contrast, while symptoms similar to PTSD may be seen in vicarious traumatization, the focus is more on covert changes that occur in an individual’s thinking and belief system. Third, vicarious traumatization is specific to mental health professions who are doing trauma work with clients, while secondary traumatic stress can occur in professionals providing a variety of services to trauma survivors, as well as the friends and family of trauma survivors (Jenkins & Baird, 2002; Pearlman & Saakvitne, 1995b). Finally, the two constructs also develop differently. Vicarious traumatization develops as a result of cumulative exposure to clients with trauma, while secondary traumatic stress can develop after a single exposure to a traumatized client (Branson, 2019; Jenkins & Baird, 2002). Given this, vicarious traumatization tends to develop gradually, while symptoms of secondary traumatic stress can develop rapidly (Jenkins & Baird, 2002). It is important to recognize that vicarious traumatization and secondary traumatic stress are two
separate constructs, which may co-occur or happen independently of each other (Newell & MacNeil, 2010). In a recent study, Gusler et al. (2023) confirmed that secondary traumatic stress and vicarious traumatization are unique and distinct constructs, despite having some overlap.

**Burnout**

Burnout is another term that is often used when discussing the negative impacts that working with traumatized clients can have on helping professionals. It is important to note that burnout is not necessarily related to exposure to client’s trauma, but instead can happen in any profession (Elwood et al., 2011). Maslach et al. (2001) viewed burnout as a prolonged response to work-related interpersonal stressors and proposed a conceptualization of burnout that contains three domains. First, burnout involves exhaustion, where individuals feel like their emotional and physical resources have been drained by their work. Maslach et al. (2001) noted that the exhaustion dimension is the central component of burnout. Second, feelings of cynicism and depersonalization occur within burnout. Individuals develop a negative and detached response to their work, and oftentimes attempt to put distance between themselves and their job. Third, feelings of inefficacy and reduced accomplishment are common in burnout. Individuals may feel incompetent at their job and struggle to see their accomplishments. In contrast to Maslach et al.’s (2001) conceptualization, Demerouti et al. (2001) viewed burnout as being a result of two processes: exhaustion and disengagement. They proposed that exhaustion comes about from job demands which require significant physical or mental effort, while disengagement is a result of a lack of job resources to meet the job demands. In other words, burnout occurs when the demands of a job are high, while the resources provided by a job are low. Finally, Stamm (2010) described burnout as involving feelings of exhaustion, hopelessness, frustration, disconnectedness, unhappiness, depression, and anger, which may be connected to a high workload or an
unsupportive work environment and may lead to ineffective job performance or difficulty managing the demands of work.

Regardless of the exact conceptualization of burnout, there are several ways that burnout and secondary traumatic stress differ. Burnout is thought to develop gradually and become worse over time, whereas secondary traumatic stress can develop rapidly (Figley, 1995a; Stamm, 2010). Burnout also focuses on the effects of dealing with stressors at the environmental and organizational level in an individual’s work situation, compared to the focus with secondary traumatic stress on psychological processes that may occur when an individual interacts with a traumatized client (Turgoose & Maddox, 2017). Additionally, as mentioned above, secondary traumatic stress is specific to working with traumatized clients, whereas burnout is broader and may occur in any profession.

Despite these differences, there is evidence that burnout and secondary traumatic stress may share significant overlap. In a meta-analysis by Cieslak et al. (2014), 41 studies were used to examine the relationship between burnout and secondary traumatic stress among individuals who worked with trauma survivors. The researchers hypothesized that burnout and secondary traumatic stress would have a moderate association, given their different theoretical underpinnings. However, they found a strong correlation between job burnout and secondary traumatic stress (weighted $r = 0.69$), with the two constructs sharing 48% of the variance. Given this, the researchers concluded that it is likely that individuals exposed to trauma within their jobs would have similar levels of burnout and secondary traumatic stress. A limitation of this meta-analysis is that the researchers did not control for other confounding variables, which may have served as either risk or protective factors for the two constructs. An additional limitation is that most of the studies included in the meta-analysis were cross-sectional, which does not allow
determination of whether one construct might cause the other or whether the relationship is bidirectional.

Shoji et al. (2015) aimed to clarify the direction of the relationship between the two constructs by conducting two longitudinal studies. The first study included 135 mental health providers who worked with United States military personnel, while the second study included 194 Polish healthcare providers, social workers, and human service professionals working with civilians who had experienced trauma. Participants in both studies completed the Secondary Traumatic Stress Scale, which is described in detail below (Bride et al., 2004). They also completed the Oldenberg Burnout Inventory, which is based on the two-factor conceptualization of burnout and demonstrated adequate Cronbach alpha coefficients in these samples (Halbesleben & Demerouti, 2005). The researchers used a cross-lagged panel design with structural equation modeling to analyze the results. Consistent results were found between the two samples. Higher levels of job burnout measured at baseline predicted high levels of secondary traumatic stress measured at the six-month follow-up. However, levels of secondary traumatic stress at baseline did not predict levels of burnout at the six-month follow-up. Thus, results from this study suggested that the relationship between burnout and secondary traumatic stress is unidirectional, as experiencing burnout may increase the risk of later developing symptoms of secondary traumatic stress. A strength of this research is that the two samples differed in terms of culture, type of profession, and type of client population (military vs. civilian), yet similar results were obtained. However, a limitation is that the samples in both studies decreased between the baseline and six-month measurements, with only 46% of participants retained in the first study and 64% retained in the second study. Additionally, the researchers noted that, while the results suggest a casual pathway from burnout to secondary
traumatic stress, the data is still correlational in nature and thus does not imply causation. Taken together, these studies suggest an overlapping relationship between burnout and secondary traumatic stress.

**Compassion Satisfaction**

Finally, compassion satisfaction is another term that is often discussed alongside secondary traumatic stress and compassion fatigue. In contrast to the terms discussed above, which are focused on the negative aspects of working with those who have experienced trauma, compassion satisfaction is related to the positive side of working as a helping professional (Turgoose & Maddox, 2017). Stamm (2002) described compassion satisfaction as the satisfaction that helping professionals gain from their work of helping others. Additionally, compassion satisfaction is related to the pleasure and sense of reward that individuals feel when they are able to do their jobs well (Stamm, 2010). When individuals experience compassion satisfaction, they feel invigorated, successful, and happy with their work, and they believe they can make a difference in the lives of others (Stamm, 2010). As will be discussed below, compassion satisfaction is one of the scales of the Professional Quality of Life scale (ProQOL), so it is often studied alongside secondary traumatic stress and burnout (Stamm, 2010).

Interestingly, in a recent systematic literature review, Sprang et al. (2023) found that secondary traumatic stress and compassion satisfaction can coexist together, suggesting that individuals can experience symptoms of secondary trauma while also finding satisfaction in their work as a helping professional.

**Assessment of Secondary Traumatic Stress**

As secondary traumatic stress has become more widely recognized, several instruments have been created to measure the construct. The two most commonly used measures are the
Secondary Traumatic Stress Scale (Bride et al., 2004) and the Professional Quality of Life scale (Stamm, 2010), which will be reviewed in detail. Both of these studies have been used in studies on secondary traumatic stress in foster parents. In addition, a newer measure, as well as several older measures, will be briefly reviewed.

**Secondary Traumatic Stress Scale (STSS)**

The Secondary Traumatic Stress Scale (STSS) was developed in 2004 by Bride et al. to assess symptoms of secondary traumatic stress in helping professionals. Bride et al. (2004) conceptualized secondary traumatic stress as “intrusion, avoidance, and arousal symptoms resulting from indirect exposure to traumatic events by means of a professional helping relationship with a person or persons who have directly experienced traumatic events” (p. 28). The measure was developed in response to a gap in the literature related to the assessment of secondary traumatic stress. At the time of development, there was an overall lack of empirical research on the construct due the absence of a validated measure, and much of the literature was conceptual or related to anecdotal evidence (Bride et al., 2004). The STSS is a 17-item self-report measure which is administered by paper-and-pencil. The items on the STSS correspond to specific symptoms of PTSD, as outlined in the *DSM-IV* (APA, 1994). Some items are specific to stressors associated with being exposed to client’s trauma (e.g., “I had disturbing dreams about my work with clients”). Other items are more general and related to negative emotions and effects of secondary traumatic stress (e.g., “I felt numb”). Participants are asked to indicate how frequently the statements have been true for them over the past seven days. Items are on a Likert-type scale ranging from 1 (never) to 5 (very often). Scoring of the STSS involves summing scores assigned to each of the three subscales: Intrusion, Avoidance, and Arousal. In addition, a Total score is obtained by summing all three of the subscales.
In an effort to examine the reliability and validity of the STSS, Bride et al. (2004) conducted a study with 287 licensed social workers in a southeastern state. First, Cronbach’s alpha was used to estimate internal consistency reliability. The researchers found evidence of reliability for the STSS total score, as well as its subscales. Alpha values were as follows: Total STSS (α = 0.93), Intrusion subscale (α = 0.80), Avoidance subscale (α = 0.87), and Arousal subscale (α = 0.83). Second, the researchers examined convergent validity of the STSS by assessing correlations between the STSS total and subtest scores and several variables that were thought to be associated with increased secondary traumatic stress. They found evidence of convergent validity for the STSS and its subscales as the scores correlated significantly with the following: extent to which the participant’s client population was traumatized (r = 0.211 – 0.269), frequency of work with clients that addressed trauma (r = 0.200 – 0.232), symptoms of depression (r = 0.391 – 0.516), and symptoms of anxiety (r = 0.461 – 0.563). Third, as evidence for discriminant validity, they found that STSS scores were uncorrelated with age, ethnicity, and income, which was expected. Finally, internal structure validity for the STSS was examined through confirmatory factor analysis using structural equation modeling techniques. They found support for a three-factor model, corresponding to the three subscales of Intrusion, Avoidance, and Arousal. The model had good fit and the factor loadings were significant, ranging from 0.58 to 0.78. The authors noted that the three factors had high intercorrelations (r = 0.737 – 0.831), but they argued that these correlations were consistent with the idea that secondary traumatic stress consists of three related domains of symptoms.

In a study using the STSS with social workers, Bride (2007) proposed several ways to interpret scores from the STSS. First, the algorithm approach involves looking at each of the three subscales of the STSS to determine if an individual meets diagnostic criteria for PTSD
based on their secondary trauma. In order to meet diagnostic criteria, Bride (2007) explained that an individual must endorse items at a level of three or higher (i.e., occasionally, often, or very often) based on the following: one item on the intrusion subscale, three items on the avoidance subscale, and two items on the arousal subscale. Second, Bride (2007) recommended several categories of severity based on the normative scores gathered from his sample of social workers. The categories are as follows: little to no STS (scores less than 28; less than 50th percentile), mild STS (scores 28 to 37; 51st to 75th percentile), moderate STS (scores 38 to 43; 76th to 90th percentile), high STS (scores 44 to 48; 91st to 95th percentile), and severe STS (scores 49 and above; 96th and above percentile). Third, Bride (2007) recommended using a cut-off score of 38 to determine if an individual has PTSD due to their secondary trauma. A score of 38 is based on the lower end of the moderate range discussed above. The author compared the algorithm approach with the cutoff score approach. He found that using the cutoff score of 38 resulted in sensitivity of 0.93 and specificity of 0.91, which indicates good diagnostic performance.

In addition to Bride et al.’s (2004) original study, several other studies have examined the psychometric properties of the STSS. First, Ting et al. (2005) conducted a confirmatory factor analysis, as well as an examination of internal consistency reliability, of the STSS. Their sample included 275 master’s-level mental health social workers from across the United States. Using Cronbach’s alpha, the total score of the STSS demonstrated very high internal consistency reliability (α = .94). Similarly, the subscales demonstrated moderately high internal consistency reliability as follows: Intrusion (α = .79), Avoidance (α = .85), and Arousal (α = .87). Additionally, the authors conducted a confirmatory factor analysis to examine the three-factor structure of the STSS. They found that the factor loadings were significant for all items, ranging from 0.46 to 0.82. Additionally, the model fit indices suggested acceptable fit of the three-factor
model. However, there were high correlations found between all three of the factors, ranging from 0.96 to 1.0, which suggested the possibility that the STSS may be unidimensional. Given this, the researchers conducted another confirmatory factor analysis with only one factor, which resulted in adequate fit indices and no improvement of fit compared to the three-factor model. The authors concluded that it is unclear whether the STSS is unidimensional or measuring three different constructs. However, they noted that the principle of parsimony would indicate that the one-factor model would have the best fit, as it has the least free parameters.

A recent study by Benuto et al. (2021) found similar results to Ting et al. (2005). In their study, the STSS was administered to 135 victim advocates who work with victims of crime and interpersonal violence. Internal consistency reliability was found to be high within this sample’s data: Total score (α = 0.93), Intrusion (α = 0.80), Avoidance (α = 0.85), and Arousal (α = 0.79). The researchers also conducted two confirmatory factor analyses, one with a single-factor model and another with a three-factor model. Similar to Ting et al. (2005), they found that both models had equivalent fit, suggesting again that the STSS may be unidimensional.

Interestingly, a study conducted by Kellogg et al. (2018) with 350 pediatric nurses found slightly different results. Consistent with the previously reviewed studies, the STSS total score and subscales demonstrated high internal consistency reliability in this study (Total score α = 0.92, Intrusion α = 0.84, Avoidance α = 0.81, and Arousal α = 0.81). The researchers first used an exploratory factor analysis to determine the factor structure arising from the data. This analysis indicated that the STSS had two latent factors. Next, the researchers conducted three confirmatory factor analyses for a three-factor model (in alignment with the original 3 subscales), two-factor model (as derived from the exploratory factor analysis), and one-factor
model. The results of the analyses suggested that the two-factor and three-factor models had similar fits, while the one-factor model performed more poorly.

In summary, the STSS has several strengths. First, Bride (2007) provided several ways to interpret STSS scores, which allows for flexibility in research studies. Second, all four studies reviewed above demonstrate strong evidence for internal consistency reliability of STSS total score and subscales (Benuto et al., 2021; Bride et al., 2004; Kellogg et al., 2018; Ting et al., 2005). Third, the psychometric quality of the STSS has been examined with different populations of helping professionals, including social workers, pediatric nurses, and victim advocates. Additionally, most of these samples have recruited participants from across the United States. In contrast, the STSS and its psychometric studies also have several weaknesses. First, the samples from the psychometric studies have been primarily White and female, which may limit the generalizability of the results. Second, the samples have all been voluntary, which makes it possible that there was a selection bias in the sample, where those who participated in the studies may have been either more or less likely to be impacted by secondary traumatic stress. Third, additional research is needed to ensure that the STSS can differentiate between secondary traumatic stress and other symptoms, such as depression, burnout, and PTSD from direct trauma exposure (Bride et al., 2004). As Bride et al. (2004) noted, it is possible that some items on the measure may be assessing symptoms that could also arise from primary trauma. Fourth, the scope of symptoms on the STSS is narrow, as it takes a somewhat limited view of secondary traumatic stress as only paralleling PTSD (Sprang et al., 2019). Finally, a significant weakness of the STSS is that the results from the confirmatory factor analysis studies are not consistent, as there is evidence for one-, two-, and three-factor models. While it is possible that
the differing results were an artifact of the different helping professional samples used, more research is needed to determine the best factor structure of the STSS.

An additional limitation of the STSS, as noted above, is that it was developed in accordance with PTSD criteria from the *DSM-IV* (APA, 1994). While the instrument developer has not published an updated version of the STSS to fit with the changes in PTSD diagnostic criteria in the *DSM-5* or *DSM-5-TR*, an updated version has been used in several studies (Carew, 2016; Whitt-Woosley, 2020; Whitt-Woosley et al., 2022a). In the updated version, several changes were made to the measure to align with *DSM-5* criteria. First, four additional questions were added to the measure to capture updated criteria (Item 18: “I experienced intense negative emotions,” Item 19: “I engaged in reckless self-destructive behavior,” Item 20: “I unrealistically blamed others for the cause or consequences of the traumas experienced by my client(s),” and Item 21: “I had negative expectations about myself, others, or the world”). Second, Item 5 (“I felt discouraged about the future”) was deleted from the scoring of the measure, although it was retained as an item in the measure to allow comparison with previous studies that used the original version of the STSS. Finally, the subscales were revised to reflect the following: Intrusion subscale (Items 2, 3, 6, 10, and 13), Avoidance subscale (Items 12 and 14), Negative Alterations in Cognitions and Mood subscale (Items 1, 7, 9, 17, 18, 20, and 21), and Alterations in Arousal and Reactivity subscale (Items 4, 8, 11, 15, 16, and 19). While this version was used in their dissertation, Carew (2016) noted that there was a lack of published studies examining the psychometrics of the updated measure. More recently, Whitt-Woosley (2020) also used the updated version of the STSS in their study on secondary traumatic stress in foster parents. In this study, Cronbach’s alpha demonstrated good internal consistency on the total scale (α = 0.913), as well as the Negative Alterations in Cognitions and Mood (α = 0.83) and Arousal (α = 0.819)
subscales. However, Cronbach’s alpha was lower on the Intrusion (α = 0.66) and Avoidance (α = 0.57) subscales. More research is needed to establish the psychometric quality of the updated measure, as having an updated version to reflect *DSM-5-TR* PTSD criteria would be beneficial.

**Professional Quality of Life Scale (ProQOL)**

An additional instrument that is frequently used to measure secondary traumatic stress is the Professional Quality of Life scale (ProQOL) (Stamm, 2010). The most recent version of the ProQOL was published in 2010, although several versions existed previously. The first version of the instrument was named the Compassion Fatigue Self Test (CFST), which was originally published by Figley (1995a). The CFST was a 40-item measure with two scales: Compassion Fatigue and Burnout. The name was later changed to the Compassion Satisfaction and Fatigue Test (CSFT), which included the addition of compassion satisfaction into the measure (Stamm, 2002). This version contained 66 items and added positively oriented items to reflect compassion satisfaction. In the late 1990s, the instrument was renamed the Professional Quality of Life scale and Stamm took ownership of the measure (Stamm, 2010). Stamm (2010) noted that the current version of the ProQOL is more psychometrically sound than the CFST or CSFT, although they were both frequently used in older studies on compassion fatigue/secondary traumatic stress, burnout, and compassion satisfaction.

The ProQOL is a 30-item self-report instrument which measures professional quality of life, which Stamm (2010) defined as the “quality one feels in relation to their work as a helper” (p. 8). It contains three scales: Compassion Satisfaction, Burnout, and Secondary Traumatic Stress. Stamm (2010) conceptualized the constructs of burnout and secondary traumatic stress as combining into the construct of compassion fatigue. The Compassion Satisfaction scale measures pleasure and satisfaction gained from doing your job well. The Burnout scale measures
symptoms of burnout such as unhappiness, exhaustion, feeling overwhelmed, frustration, anger, and depression. The Secondary Traumatic Stress scale measures symptoms of secondary traumatic stress, which Stamm (2010) described as fear, difficulty sleeping, avoiding reminders of trauma, and intrusive/upsetting images. When completing the measure, respondents are asked to focus on their current work situation and consider how frequently they experienced the items within the last 30 days. Items are on a Likert-type scale ranging from 1 (never) to 5 (very often). Items from each scale are summed to obtain the scale scores, although five items on the Burnout scale must be reverse scored. Interestingly, no composite score is able to be obtained on the ProQOL. Stamm (2010) noted that the relationship between the scales is still unknown and previous versions of the measure demonstrated collinearity between the scales. Items were updated in the current version in an attempt to minimize collinearity, but Stamm (2010) noted that updated data needs to be collected to further understand the relationship between the scales. The ProQOL manual provides cutoff scores for the three scales based on the 25th and 75th percentile: 22 or less (low), 23 – 41 (moderate), and 42 or more (high). Interestingly, the cutoff scores are the same for all three scales. Stamm (2010) noted that the cutoff scores may be over inclusive (i.e., leading to a higher false positive rate), although Stamm argued that this is acceptable given that the ProQOL is a screening tool and not intended to be used as a diagnostic tool. In terms of psychometrics, Stamm (2010) reported on the reliability of the three scales as follows: Compassion Satisfaction ($\alpha = 0.88$), Burnout ($\alpha = 0.75$), and Secondary Traumatic Stress ($\alpha = 0.81$). They noted that reliability was calculated from their databank of 1,187 participants, although they provided little information on the sample. Additionally, Stamm (2010) reported that the ProQOL has demonstrated good construct validity, as it has been used in
over 200 published studies. However, Stamm did not expand upon this or provide additional information.

In 2018, De La Rosa et al. conducted a study to provide updated norms for the ProQOL. While Stamm’s (2010) ProQOL manual provided normative data, as well as interpretation guidelines, De La Rosa et al. (2018) noted that the cutoff scores in the manual may not be accurate. In this study, the researchers reviewed 30 studies that provided ProQOL raw scores with a total sample size of 5,612 participants. As discussed above, Stamm’s (2010) manual provides the following cutoff scores for all three scales, based on the 25th and 75th percentiles: 42 (high), 23 to 41 (middle), and 22 (low). In contrast, De La Rosa et al. (2018) found different cutoff scores for each of the three scales. For the Compassion Satisfaction scale, cutoffs were 42 (high), 38 (median), and 33 (low). For the Secondary Traumatic Stress scale, cutoffs were 21 (high), 17 (median), and 13 (low). For the Burnout scale, cutoffs were 27 (high), 23 (median), and 19 (low). The researchers did not provide much explanation for the differences in results between their study and the manual, although they noted that it is unlikely to be a result of different types of professionals in the samples as both samples used professional caregivers. Given these results, the authors cautioned against using the cutoff scores contained in Stamm’s (2010) manual, as those cutoffs may lead to inaccurate interpretation of scores.

As Hemsworth et al. (2018) pointed out, a critical analysis of the psychometric properties of the ProQOL has been needed. Thankfully, several recent studies have focused on this. In Hemsworth et al.’s (2018) study, the researchers examined the psychometric properties of the ProQOL using three datasets of nurses and palliative caseworkers in Canada and Australia. The large combined dataset of 1,079 participants was a strength of this study. Across all three datasets, the three scales of the ProQOL demonstrated adequate reliability ($\alpha > 0.70$). Construct
validity was assessed through computing correlations between the ProQOL subscales and a measure of depression. As expected, the Compassion Satisfaction scale was found to have a significant negative correlation with depression, while the Burnout and Secondary Traumatic Stress scales had significant positive correlations with depression. The authors also conducted two tests to establish discriminant validity, including a chi-square difference test and a heterotrait-monotrait ratio test. Based on these tests, they found that all three scales demonstrated discriminant validity. In a test of convergent validity, the Compassion Satisfaction scale was found to have satisfactory validity, while the Burnout and Secondary Traumatic Stress scales did not meet criteria. The researchers then conducted three confirmatory factor analyses (one on each of the scales). The model fit well for the Compassion Satisfaction scale across all three datasets. The factor analysis of the Burnout scale had lower fit indices. Additionally, the reverse coded items (1, 4, 15, 17, and 29) on the Burnout scale had lower factor loadings compared to the other items. Given this, the researchers recommended rewriting these items. The factor analysis of the Secondary Traumatic Stress scale had reasonable model fit, although the results indicated that items 2 and 5 had very low factor loadings. Given this, the researchers recommended removing or replacing those items.

An additional study by Heritage et al. (2018) examined the ProQOL’s psychometric properties using a Rasch analysis procedure with 1,615 nurses from Australia. They found evidence for reliability of the three subscales: Compassion Satisfaction ($\alpha = 0.90$), Burnout ($\alpha = 0.80$), and Secondary Traumatic Stress ($\alpha = 0.84$). Additionally, the results indicated that the Compassion Satisfaction scale demonstrated adequate construct validity. However, both the Burnout and Secondary Traumatic Stress scales had inadequate evidence of construct validity. The researchers proposed an alternative Compassion Fatigue scale which combined 11 items
from the Burnout and Secondary Traumatic Stress scales. The reverse scored items from the
Burnout scale (items 1, 4, 15, 17, and 19) and four items from the Secondary Traumatic Stress
scale (items 2, 5, 7, and 28) were removed in the creation of this new scale due to inadequate fit.
The new Compassion Satisfaction scale demonstrated adequate reliability and construct validity.
Given their findings, the researchers in this study expressed concern about using the Burnout and
Secondary Traumatic Stress scales as they are currently presented in the ProQOL manual.

Geoffrion et al. (2019) also examined the psychometric properties of the ProQOL in a
study with 310 child protection workers in Canada. The researchers first conducted six different
confirmatory factor analyses. Inadequate fit indices for the following four factor analyses were
found: one-factor, two-factor, three-factor, and second-order factor models. Notably, this
includes the three-factor model originally outlined by Stamm (2010). The two bifactor solutions,
one with two group factors and one with three group factors, both fit the data well. Given this,
the researchers proposed using a bifactor model with a general factor, as well as three group
factors corresponding to the three scales. They noted that this model indicates unidimensionality
of the measure, while also allowing measurement of the individual constructs of compassion
satisfaction, burnout, and secondary traumatic stress. Using this model, the researchers
performed additional analysis. The model demonstrated adequate internal consistency reliability,
as the general and group factors all had high omega values. Convergent validity was
demonstrated through significant negative correlations of the general factor with measures of
PTSD and psychological distress at work, and significant positive correlation with a measure of
well-being at work. Discriminant validity was demonstrated through a lack of significant
correlations between the general factor and three subscales with a measure of lifetime exposure
to trauma. The authors highlighted the fact that the bifactor model suggested that the ProQOL is
measuring a unidimensional construct, and thus compassion satisfaction and compassion fatigue (i.e., burnout and secondary traumatic stress) can be thought of as two ends of the spectrum for the same construct.

Finally, a study by Keesler and Fukui (2020) examined the factor structure of the ProQOL. The researchers conducted a confirmatory factor analysis with data from a sample of 495 direct support professionals who work with individuals with intellectual and developmental disabilities. Results indicated that the three-factor model using the existing ProQOL did not have adequate fit. However, the results also suggested several adjustments to the measure. First, items 2, 5, 15, and 29 had low factor loadings, so they were removed from the measure. Second, several items were moved between scales. Item 8 was originally on the Burnout scale, but it fit better on the Secondary Traumatic Stress scale. Item 10 was left on the Burnout scale, but also added to the Secondary Traumatic Stress scale. Likewise, Item 11 was left on the Secondary Traumatic Stress scale, but was also added to the Burnout scale. After making these adjustments, the three-factor model was found to have acceptable fit with the updated measure. Reliability of the scales also improved after these adjustments. Cronbach’s alpha for the Burnout scale increased from 0.78 to 0.82, and from 0.82 to 0.85 for the Secondary Traumatic Stress scale. No changes were made to the Compassion Satisfaction scale, so alpha remained at 0.92. Given the significant adjustments that were recommended based on the confirmatory factor analysis, the authors highlighted the need for item revisions of the ProQOL, as well as caution when using the Burnout and Secondary Traumatic Stress scales as they are currently written, similar to concerns raised by Heritage et al. (2018).

In summary, while the ProQOL aims to provide information about several areas of professional quality of life, including secondary traumatic stress, there are significant concerns
about its psychometric properties. Stamm’s (2010) manual provides alpha coefficients for the scales, as well as a vague claim of construct validity. However, there is little information provided on how these were assessed. Thankfully, recent studies have examined the psychometric properties of the ProQOL in more detail, although these studies mainly raise concerns instead of providing evidence for the psychometric quality. These studies have spanned across several types of helping professionals, including nurses, palliative care workers, child protection workers, and direct support professionals. Results from De La Rosa et al.’s (2018) study suggested that the norms and interpretation guidelines provided in the ProQOL manual may not be accurate. While several studies found evidence of adequate reliability of the scales, validity evidence was not as strong. Several studies provided contradictory results regarding the best factor structure of the items (Geoffrion et al., 2019; Hemsworth et al., 2018; Heritage et al., 2018; Keesler & Fukui, 2020). Overall, the studies suggest that there are issues with both the Burnout and Secondary Traumatic Stress scales. Interestingly, despite different methods, populations, and overall factor structure results, a few studies found consistent issues with certain items. Both Hemsworth et al. (2018) and Heritage et al. (2018) found issues with the reverse coded items on the Burnout scale. Those studies, along with Keesler and Fukui’s (2020) study, also found issues with items 2 and 5 on the Secondary Traumatic Stress scale. Overall, these results suggest that caution should be used when interpreting results from scales.

**Concurrent Validity of STSS and ProQOL**

Given that the STSS and ProQOL’s Secondary Traumatic Stress subscale are the most widely used instruments to measure secondary traumatic stress, Cummings et al. (2021) conducted a study to examine concurrent validity between the two measures. Both instruments were administered to a sample of 132 victim advocates. While the sample was primarily female
(94%) and Caucasian (78%), the sample was obtained by outreach to agencies across the United States. The researchers found that scores on the STSS and STS subscale of the ProQOL had a large, positive correlation ($r = .83, p < .001$), which demonstrated concurrent validity. The researchers recommended using the ProQOL when measuring secondary traumatic stress, given that the instrument also measures burnout and compassion satisfaction. However, given the concerns identified in the psychometric research for the ProQOL discussed above, this recommendation is questionable.

**STS Clinical Algorithm (STS-CA)**

Recently, Sprang et al. (2021) proposed the use of the STS Clinical Algorithm (STS-CA) to assist with the assessment of secondary traumatic stress. The authors argued that the current self-report measures of secondary traumatic stress are inadequate because they do not assess functional impairment, determine whether the symptoms are related to secondary trauma (vs. primary trauma), or assess the duration of symptoms. The STS-CA, which is a stepwise, decision-making tool, was developed to help classify secondary traumatic stress into different types. Use of the tool results in four possible outcomes: no symptoms of secondary traumatic stress, symptoms without functional impairment, symptoms with functional impairment but does not meet diagnostic criteria for PTSD, and symptoms that meet diagnostic criteria for PTSD. To arrive at these classifications, an interviewer assesses the secondary trauma exposure, the onset, duration, and severity of symptoms, and the functional impairment.

Sprang et al. (2021) studied the STS-CA with a group of 181 helping professionals. Interviewers used an existing structured interview, the Clinician-Administered PTSD Scale for DSM-5 (CAPS-5), to assess for PTSD symptoms, distress, and functional impairment (Weathers et al., 2013). Not surprisingly, the researchers found 100% agreement between cases identified as
having PTSD with the CAPS-5 and the STS-CA. Participants were also administered a version of the STSS that was updated for the DSM-5. The researchers found fair agreement between cases identified using the STSS cutoff score and cases identified with PTSD from the STS-CA ($k = 0.426, p = 0.000$). After analyzing cases that had discrepancies between the STSS and STS-CA, the researchers determined that the STS-CA demonstrated more sensitivity and specificity than the STSS. They noted that relying only on secondary traumatic stress symptom levels, as is done with self-report measures, does not capture the full phenomenon of secondary traumatic stress, as functional impairment, symptom expression, and link to indirect trauma exposure are not able to be determined.

**Older Measures**

In addition to the STSS and ProQOL measures, there are several other measures that have been used in research on secondary traumatic stress. Given that these measures are older and not frequently used, only a brief overview will be provided. First, the World Assumptions Scale is a 23-item self-report instrument which measures changes in worldview and cognitive schema as a result of trauma (Janoff-Bulman, 1989). It contains three subscales measuring different worldview domains: Benevolence of the World, Meaningfulness of the World, and Self as Worthy. This measure was not designed specifically for secondary trauma, although it has been used for that purpose in studies (Sprang et al., 2018). Second, the Impact of Events Scale-Revised is a 22-item measure of PTSD symptomatology that has been used in studies on secondary traumatic stress (Weiss & Marmar, 1997). It contains three subscales (Intrusion, Avoidance, and Hyperarousal), which correspond to the three domains of criteria for PTSD in the DSM-IV-TR (APA, 2000). Finally, the Trauma and Attachment Belief Scale is an 84-item measure which assesses how trauma impacts beliefs about control, safety, self-esteem, intimacy,
and trust (Pearlman, 2003). The measure, which was based on Constructivist Self-Development Theory, was originally designed to be used with those who had experienced primary trauma, but it has been used in older studies on secondary trauma (Molnar et al., 2017). Given that all of these measures were developed to assess for primary trauma, there are limitations in their use for secondary trauma. These measures have received limited attention in the recent research on secondary traumatic stress, although they were utilized in some studies before the development of the STSS and ProQOL.

**Summary**

A substantial amount of research has been conducted on instruments to measure secondary traumatic stress. A benefit of the ProQOL is that it measures burnout and compassion fatigue, in addition to secondary traumatic stress (Stamm, 2010). However, the measurement development process for the ProQOL was not clearly outlined in its manual (Stamm, 2010). In addition, several studies have raised concerns about its psychometric properties, to the point where researchers have cautioned using the measure as it is currently written (Heritage et al., 2018; Keesler & Fukui, 2020). In contrast, the measurement development process of the STSS was described in detail by Bride et al. (2004). The psychometric quality of the STSS has been supported through several studies, although results from confirmatory factor analysis studies are inconsistent. Additionally, while an updated version of the STSS to reflect DSM-5 criteria has been used in some recent studies, it has not yet been published or thoroughly examined in terms of its psychometric properties. However, the review of current research indicates that the STSS is a stronger instrument compared to the ProQOL. Unfortunately, the self-report format of both of these measures may miss important information that might be gathered through behavioral observations or diagnostic interviews. Additionally, as Sprang et al. (2021) highlighted, these
measures do not assess functional impairment or the duration of symptoms. While the STS-CA addresses these issues, the utility of using the STS-CA in a research or clinical setting is questionable given the time requirement to administer the measure. Clearly, more research is needed in this area to develop a measure of secondary traumatic stress that gets at the full range of symptoms, as well as the impact on functioning (Molnar et al., 2017).

**Prevalence of Secondary Traumatic Stress**

Child welfare professionals work closely with children in the foster care system. They are responsible for investigating reports of child abuse and/or neglect, removing children from their homes when necessary, and continuing to provide services while the children are in foster care (Cornille & Meyers, 1999). Their job responsibilities include interviewing child abuse victims and reading case files that include graphic details of children’s abuse and neglect (Cornille & Meyers, 1999; Sprang et al. 2011). Given this, child welfare workers are frequently exposed to the traumatic events that foster children have experienced. Not surprisingly, a large amount of research has demonstrated that individuals working in the child welfare profession are at risk for developing symptoms of secondary traumatic stress. Molnar et al. (2020) conducted a systematic review of studies focused on vicarious traumatization within child welfare and child protection professionals. In this review, the authors noted that they used the term vicarious traumatization interchangeably with secondary traumatic stress, despite the conceptual differences outlined above. A portion of their review focused on studies examining the prevalence of vicarious traumatization/secondary traumatic stress within this population, with the authors highlighting 15 studies in this area. Relevant studies from this review, as well as additional studies found through a literature search, will be covered below.

**Early Prevalence Studies**
Cornille and Meyers (1999) conducted one of the first studies on secondary traumatic stress in child protective service (CPS) workers. Their sample consisted of 183 CPS workers in a southern state who had worked in the child welfare field for at least one year. Given that no measures to assess specifically for secondary traumatic stress were available at the time of the study, the researchers used the Brief Symptom Inventory (BSI) to assess for general psychological symptoms as a measure of emotional distress (Derogatis, 1993). Using the BSI, the researchers found that the participants in their sample scored on average higher on all subscales than the non-psychiatric patient sample in the BSI manual (Deragotis, 1993). However, they scored lower on average on all subscales than the outpatient psychiatric patients in the BSI manual (Deragotis, 1993). These results indicated that the CPS workers in this sample were experiencing more distress than the general population, but less distress than outpatient mental health clients. The researchers also compared each participant’s score on each subscale to cutoff scores that were derived from standard mid-point scores for the outpatient psychiatric sample. Using these cutoff scores, they found that 37% of participants were experiencing emotional distress on at least one subscale. Areas of distress included paranoid ideation, obsessive/compulsive distress, interpersonal sensitivity, hostility, psychoticism, and somatization. A significant limitation of this study is the use of the BSI to measure secondary traumatic stress. While the researchers argued that the participants’ reported emotional distress was associated with secondary traumatic stress, they also acknowledged that the distress symptoms may have been the result of other issues such as depression. A strength of this study was the racial diversity in the sample with 67% Caucasian and 31% African American participants.
In another earlier study, Conrad and Kellar-Guenther (2006) examined the prevalence of compassion fatigue, burnout, and compassion satisfaction in a sample of 363 CPS workers in Colorado who were attending a training on secondary trauma. The researchers used the Compassion Satisfaction and Fatigue Test to assess the variables at the beginning of the training session (Stamm, 2002). They found a high prevalence of compassion fatigue among the sample of CPS workers, with 50% of the participants having high or extremely high compassion fatigue. Interestingly, they found a low prevalence of burnout, with only 7.7% of the sample indicating high levels of burnout. Additionally, 70% of the sample had “high potential” or “good potential” for compassion satisfaction. The researchers noted that it is unclear why the levels of burnout in this sample were so low, while levels of compassion fatigue were high. They proposed that it may be because high burnout had a higher threshold than high compassion fatigue on the Compassion Satisfaction and Fatigue Test. Notably, one limitation of this study is the use of the Compassion Satisfaction and Fatigue Test, which is an older version of the ProQOL that had weaker psychometric properties (Stamm, 2010). An additional limitation is that participants in this study were attending a training on secondary trauma, as it is possible that CPS workers experiencing higher levels of secondary traumatic stress may have chosen to attend this training.

**Studies Utilizing the STSS**

Several studies have examined the prevalence of secondary traumatic stress in child welfare professionals using Bride et al.’s (2004) Secondary Traumatic Stress Scale (STSS). Bride (2007) investigated prevalence rates within 282 master’s-level social workers in a southern state. The sample included social workers working in a variety of areas, including mental health and substance abuse (56.6%), health care (20.1%), child welfare (7.2%), schools (4.7%), and other specialties (11.5%). In this sample, 97.8% of participants reported that their client
population had experienced at least mild trauma, while 81.7% indicated that their client population was moderately to very severely traumatized. Using the STSS, the researcher found that 70.2% of the participants indicated experiencing at least one symptom of secondary traumatic stress within the last week, determined by marking “occasionally,” “often,” or “very often” to at least one symptom. Intrusive thoughts about their work with clients was the most commonly endorsed symptom, with 40.5% of participants reporting that symptom. The researcher also found that 15.2% of participants met diagnostic criteria for PTSD from their secondary exposure to their client’s trauma. This was determined using an algorithm approach based on the DSM-IV-TR (APA, 2000), where participants needed to endorse “occasionally” for at least one item on the intrusion subscale, three items on the avoidance subscale, and two items on the arousal subscale. This prevalence rate is concerning, given that the general population experiences PTSD with a lifetime prevalence rate of 8.7% (APA, 2013). A limitation of this study was that the sample was not focused exclusively on child welfare social workers working with foster children, but instead included social workers from areas such as mental health and health care.

Another study by Bride et al. (2007) focused exclusively on CPS workers’ experiences of secondary traumatic stress. In this study of 187 CPS workers, an online survey was distributed to all CPS supervisors and case managers in Tennessee. The sample’s mean of total STSS scores was 38.20, which indicated that they were overall experiencing moderate levels of secondary traumatic stress. However, the authors highlighted that 92% of participants were experiencing at least one symptom of secondary traumatic stress “occasionally” over the last week, while 59% were experiencing at least one symptom “often” over the last week. Additionally, 34% of the sample met diagnostic criteria for PTSD based on the DSM-IV-TR (APA, 2000), which was
determined using a similar algorithm approach to Bride (2007). However, in this study, participants had to endorse “often” or “very often” for items to count within the algorithm, unlike in Bride’s (2007) study where symptoms marked “occasionally” were also counted. Given that the algorithm used in this study is more conservative than in Bride’s (2007) study, it is surprising that 34% of participants met PTSD criteria compared to 15.4% of participants in Bride’s (2007) study. These disparate results provide support that secondary traumatic stress may be more prevalent within CPS workers compared to general social workers.

Reinks (2020) also recently used the STSS in a large study of 1,968 child welfare caseworkers. In the cross-sectional portion of their study, the researcher administered an online survey to all caseworkers employed by public child welfare agencies in three states. In this sample, 29.6% of participants scored over a 49 on the STSS, indicating that they were experiencing severe levels of secondary traumatic stress. In addition, 27.3% of the participants scored between 38 and 48, which indicated moderate or high levels of secondary traumatic stress. The author also noted that the mean total score for this sample was 41.02, which is higher than the mean of 26.69 reported in Bride’s (2007) original prevalence study with social workers. Additionally, the means for each subscale were also higher in this sample compared to Bride’s (2007) sample. The author suggested that this difference may be due to the fact that this study was focused on child welfare professionals who may be experiencing greater levels of secondary traumatic stress, while Bride’s (2007) study was focused more broadly on social workers across a variety of practice areas. Similar to Bride’s (2007) study, intrusive thoughts about work with clients was the most commonly endorsed symptom, with 69% of the sample reporting that symptom. Difficulty sleeping was the second most commonly endorsed symptom, with 58.4% of
the sample indicating they had trouble sleeping. A strength of this study was its large sample size, which was drawn from three states.

Two mixed methods studies have also used the STSS to assess the prevalence of secondary traumatic stress in this population. In their dissertation, O’Bryant (2008) examined secondary traumatic stress in CPS social workers using the STSS. The qualitative portion of their study will be reviewed in the risk and protective factors section below. In the quantitative portion, the STSS was administered to 37 CPS social workers from one county child welfare agency in a Midwestern state. The aggregate mean for the STSS total score was 35.24, which indicated overall mild levels of secondary traumatic stress within the sample. However, the researcher also conducted independent samples t-tests to compare the means of their sample with Bride et al.’s (2004) study. They found that the mean scores for the STSS total score, as well as all three subscales, were significantly higher in their sample compared to Bride et al.’s (2004) sample. The researcher noted that Bride et al.’s (2004) sample consisted only of licensed, master’s-level social workers, while participants in the current sample worked specifically in child protective services and held either bachelor’s or master’s degrees. The differences in total and subscale STSS scores between these groups provides additional evidence that individuals working in child welfare may experience higher levels of secondary traumatic stress compared to social workers in general. Unfortunately, the sample in this study was small and limited to individuals working in one Midwestern suburban city. The participants’ clients lived primarily in suburban areas, which may limit the generalizability to CPS social workers working with urban populations. However, the response rate of 73% was a strength of this study.

An additional mixed methods study by Caringi and Hardiman (2012) utilized the STSS to examine secondary traumatic stress in child welfare workers in New York state. The quantitative
portion of their study consisted of 103 child welfare workers attending a training on secondary traumatic stress. In this sample, 74.7% of participants obtained a score of at least 38 on the STSS, which indicated that they were experiencing moderate to high levels of secondary traumatic stress. In addition, the researchers reported that 76.7% of the participants were experiencing symptoms of PTSD. However, they provided limited information about how that percentage was calculated. It is unclear what algorithm was used and whether the respondents met criteria based on all three subscales. Unfortunately, the researchers did not provide any tables with information on their data, so it is difficult to determine how they arrived at this percentage. Interestingly, the researchers noted that the purpose of this study was not to determine incidence levels of secondary traumatic stress within child welfare workers, despite the fact that they reported on this data. The qualitative portion of their study involved semi-structured interviews with 12 child welfare workers who had completed the initial survey. More details about the qualitative portion of the study will be covered in the protective and risk factors section below. However, the authors noted that the participants discussed secondary traumatic stress symptoms within the interviews, including symptoms from the three DSM-IV-TR criterion areas of PTSD (APA, 2000). A significant limitation of this study was that participants were recruited from a voluntary training on secondary traumatic stress. It is possible that individuals who were experiencing secondary traumatic stress symptoms may have been overrepresented at the training. Additionally, participants completed the STSS at the end of the training. Given that they had learned about secondary traumatic stress during the training, they were likely more familiar with the concept and potentially more (or less) likely to endorse the symptoms.

*Studies Utilizing the ProQOL*
The Professional Quality of Life Scale (ProQOL) (Stamm, 2010) has also been used to
examine secondary traumatic stress in this population. Van Hook and Rothenberg (2009)
surveyed 175 child welfare workers employed by three child welfare organizations in Florida.
The respondents in this study had a variety of work assignments and education levels, and only
31.5% of the sample were social workers with bachelor’s or master’s degrees. Within this
sample, the mean score on the Compassion Fatigue subscale of the ProQOL was 15.17. The
researchers noted that this mean score was higher than the mean scores of prior studies focused
on helping professionals (Stamm, 2005). However, the researchers did not report on whether
they performed any statistical analyses to determine if this difference was statistically significant,
which is a limitation of this study.

In another study conducted in Florida, Salloum et al. (2015) investigated the prevalence
rates of secondary traumatic stress, burnout, and compassion satisfaction in 104 child welfare
case managers and supervisors using the ProQOL-5. In this sample, the mean score on the
Compassion Fatigue (Secondary Traumatic Stress) subscale was 50.06. Importantly, the
responses from 28.8% of the sample indicated high levels of secondary traumatic stress. In
addition, 29.8% of the sample reported high levels of burnout, while 31.7% of the sample
reported low levels of compassion satisfaction. The researchers conducted t-tests and determined
that the case manager and supervisor groups did not statistically differ on the measures of
secondary traumatic stress, burnout, and compassion fatigue. They noted that this result was not
surprising given that 16 out of the 19 supervisors also had a caseload and worked directly with
children. A strength of this study was the racial diversity of the sample, with 55.8% White
participants and 34.6% Black participants. Additionally, the study’s response rate of 78% was
another strength.
The ProQOL-5 was also used in a study in Norway, where Baugerud et al. (2018) examined secondary traumatic stress, burnout, and compassion fatigue in 684 CPS workers. The participants had a mean score of 21.14 on the secondary traumatic stress scale, indicating low levels of symptoms overall. Interestingly, 0% of respondents reported high levels of secondary traumatic stress, while 37% reported moderate levels. Similarly, 0% reported high levels of burnout, while 70% reported moderate levels. Prevalence of compassion satisfaction was higher, with 14.4% reporting high levels and 82.7% reporting moderate levels. The results of this study are interesting, given that studies conducted in the United States overall report higher levels of secondary traumatic stress and burnout within this population. The researchers proposed that the differences in results could be due to better working conditions and preparation for CPS workers in Norway. Norway has a unique bachelor’s degree program focused on child welfare, which may result in graduates who have more knowledge and better preparation compared those who graduate from more general social work programs in the United States. Additionally, the researchers noted that Norway’s child welfare system has a strong supervision culture, as well as sufficient resources for CPS workers. The lower prevalence of secondary traumatic stress and burnout observed in this sample may be explained by these differences, especially given that studies in the United States have consistently demonstrated higher levels within this population.

Going beyond assessing prevalence rates within child welfare professionals, a study by Sprang et al. (2011) used the ProQOL-IV to examine secondary traumatic stress and burnout in a broader sample of helping professionals, which included child welfare workers, inpatient and outpatient behavioral health professionals, school-based psychologists and social workers, and psychiatrists. The researchers used an online survey to assess the concepts in 668 helping professionals in six states, as well as Toronto, Canada. Using two hierarchical regression models,
the researchers found that being employed as a child welfare worker was a significant predictor of both secondary traumatic stress and burnout compared to being employed as any other type of behavioral healthcare professional \((p < 0.001)\). The results from this study go beyond the previous prevalence studies reviewed above, as it provides evidence that child welfare workers in particular are at risk for secondary traumatic stress. A strength of this study is that participants were recruited from six states, as well as one city in Canada. However, recruitment for the child welfare workers occurred through professional organizations and licensing board lists. Given this, the authors noted that the sample of child welfare workers may not be representative of all of the child welfare workers across the country.

**Qualitative Studies**

Several qualitative studies provide additional information on the experience of secondary traumatic stress within child welfare professionals. Dane (2000) conducted two qualitative focus groups with 10 child welfare workers. The focus groups were designed to gather information about stressors that the participants experienced in their jobs, as part of the development of a two-day training curriculum for child welfare workers. The sample had racial diversity, with six African American, two Latino, and two Caucasian participants. The researchers audiotaped the focus groups and used a content analysis procedure to analyze the data. The procedure involved coding the text into themes which were then grouped into thematic categories. A strength of the study was that the themes were reviewed by a consultant, who then met with the researcher and focus group facilitators to reach consensus on the themes. The researcher identified five key themes from the data, one of which was secondary traumatic stress. Within this theme, all of the focus group participants reported experiencing sadness. In addition, they described changing their behavior as a way to cope and avoid stress, which included keeping themselves busy,
accepting their limitations, setting limits around their work, and detaching from their work. A significant limitation of this study is that it is unclear whether the participants’ descriptions actually reflected symptoms of secondary traumatic stress. No quantitative measurement was conducted to determine if the participants were experiencing elevated levels of secondary traumatic stress, which could have provided additional support to the interpretation of the qualitative data. It is possible that the participants’ feelings of sadness and tendency to stay busy and detach from work were simply normal, healthy ways of coping with a difficult job, instead of symptoms of secondary traumatic stress. Additionally, the symptoms may have been attributable to some other factor, such as burnout or depression. An additional limitation was the potential bias resulting from the researcher’s desire to achieve certain results, which was acknowledged by the researcher. This bias may have led the researcher to lead the focus group in a certain direction, for example through the use of leading questions.

In another qualitative study, Stone’s (2011) dissertation focused on understanding the work experiences of foster care caseworkers with secondary traumatic stress symptoms. Semi-structured interviews were conducted with eight foster care caseworkers in Chicago. The data was then analyzed using a phenomenological approach to identify themes of the participants’ experiences. The author concluded that the participants in this study were experiencing intrusive thoughts about their work, which is a symptom of secondary traumatic stress. However, the author based this conclusion on a screening question that was asked of all participants prior to the study: “As a result of work, have there been occasions where you experienced stress or anxiety because of your client experience?” (Stone, 2011, p. 10). All participants indicated a positive response to this question, which led the author to conclude that they had intrusive thoughts about clients when away from work. However, it is unclear whether this question
actually gets at the concept of intrusive thoughts, as it simply asks about stress or anxiety.

Interestingly, the author noted that the purpose of the study was not to determine the prevalence of secondary traumatic stress in this population, despite their claim regarding the prevalence of intrusive thoughts. Similar to the qualitative study above, adding a quantitative instrument to measure secondary traumatic stress may have been helpful in this study. An additional theme that arose from the interviews was the impact that secondary traumatic stress had on the participants’ sleep and personal relationships. Interestingly, only one participant had heard of secondary traumatic stress before the interview, and none of them were aware of existing policies at their offices aimed at addressing secondary traumatic stress. The participants described using several coping mechanisms to deal with the stress of their job, including venting, numbing, depersonalization, taking time off, exercise, and drinking alcohol. This study had several strengths, including the fact that research questions were field-tested before the interviews. Additionally, member checking was used with the participants to ensure that the themes were accurate, and they were also reviewed by the researcher’s mentor. The sample was fairly balanced in terms of gender, although information on the participants’ race and ethnicity was not provided. A limitation of the study was that the researcher may not have been subjective, as they noted that they had been involved in the foster care population throughout their life.

In another qualitative dissertation, Genovese (2013) interviewed 16 child welfare workers from New York state to examine their experience with secondary traumatic stress. Semi-structured interviews were conducted with the participants focused on their job duties, successful and unsuccessful cases, and work-related stress, including the impacts of stress and how they manage it. The author did not identify the specific qualitative methodology used to analyze the data, although they reported that coded ideas from the transcripts were placed into notes, which
were organized into a hierarchy. Several themes emerged from the interviews. First, the participants believed that the unpredictability of their work as child welfare professionals contributed to the development of secondary traumatic stress. Second, the participants described a variety of physical impacts from their work, including sleep issues, changes in weight, alcohol use, and other health conditions. They also described emotion consequences such as anxiety, agitation, being mistrustful of others, being overprotective of their own children, and negative impacts on their relationships. The researcher concluded that all of these physical and emotional impacts were consistent with secondary traumatic stress. The most interesting theme that emerged from the interviews was the participants’ beliefs about the cause of their secondary traumatic stress. The participants noted that while they were exposed to traumatic stories of child abuse and neglect, they expected this as part of their job and did not attribute their secondary traumatic stress symptoms to this exposure. Instead, they viewed the lack of support from supervisors and administrators as a cause of their symptoms. They believed that they would have been able to better manage the exposure to traumatic details if they had been better supported in the workplace. In addition, they believed that their fear of blame if something went wrong with the clients on their caseload also contributed to the development of their secondary traumatic stress symptoms. This study provides a valuable contribution to the literature on secondary traumatic stress in child welfare workers, as it highlights the importance of the work environment on worker’s response to being exposed to child abuse and neglect. This study had several strengths. The author noted that they attempted to reduce the potential impact of their own bias on the results by maintaining field notes and engaging in peer debriefing, although they provided limited details on how they engaged in these strategies. Additionally, they used member checking by having a small focus group review and confirm the themes that emerged
from the interviews. Several limitations exist in this study as well. It was conducted in three counties in rural upstate New York, so the results may have been different with child welfare workers working in urban areas. The participants were also mainly female (88%) and Caucasian (100%), although the researcher noted that this reflects the gender ratio of child welfare workers and the racial make of the geographical area. A final limitation is the lack of a quantitative measure to examine the participants’ levels of secondary traumatic stress. While the research made the connection between the participants’ described symptoms and secondary traumatic stress, it possible that these symptoms could be attributable to other phenomena, similar to the qualitative studies above.

**Summary**

Taken together, these studies provide support for the prevalence of secondary traumatic stress within child welfare workers. Using both the STSS and ProQOL, the quantitative studies reviewed consistently demonstrated elevated levels of secondary traumatic stress within this population. In fact, research suggests that child welfare workers in particular, compared to other helping professionals, are at a higher risk for developing secondary traumatic stress (Sprang et al., 2011). The qualitative studies reviewed also provided evidence in this area, although they had important methodological limitations.

Unfortunately, the quantitative studies reviewed shared many similar limitations. All of the studies were cross-sectional, which did not allow researchers to examine how levels of secondary traumatic stress may change over time. It would be helpful to gather baseline measurements of secondary traumatic stress when child welfare workers enter the profession in order to understand how the symptoms may change over time. Second, many of the samples in these studies were limited to one geographical area, which may limit the ability to generalize the
results across the United States. While the studies cover a variety of geographical areas when taken together, it is possible that certain cultural factors in different parts of the country may influence the prevalence rates. Third, the majority of studies reported samples that were over 80% female and over 75% White. Although this may reflect the demographics of child welfare workers in some areas, the lack of diversity in these samples may limit the generalizability of the findings to male and non-White participants. Fourth, of the studies that reported on their response rates, three of the studies had response rates of 50 – 57% (Bride, 2007; Bride et al., 2007; Cornille & Meyers, 1999). In these studies, it is possible that individuals who did not participate may have differed from those who did. Individuals who were experiencing secondary traumatic stress may have been more likely to respond given the topic. Alternatively, it is possible that individuals experiencing increased secondary traumatic stress may have been too distressed to respond. A final limitation of the studies is the reliance on self-report measures, including the STSS and ProQOL. Child welfare workers may be reluctant to disclose their true symptoms of secondary traumatic stress given the stigma around mental health and their concern about privacy (Molnar et al., 2017). Gathering data from multiple sources, including behavioral observations and reports from supervisors or colleagues, would have strengthened these studies.

The finding that secondary traumatic stress is prevalent within child welfare professionals has important implications for the foster parent population. It is noteworthy that Sprang et al. (2011) found that child welfare professionals were particularly at risk for secondary traumatic stress compared to other helping professionals. Sprang et al. (2011) highlighted the fact that child welfare professionals are frequently exposed to information regarding foster children’s trauma, which includes details regarding the abuse and/or neglect the children may have experienced. Importantly, foster parents are also often exposed to the trauma histories of foster children.
Given that this exposure has resulted in high rates of secondary traumatic stress within child welfare professionals, it is reasonable to assume that similar impacts might occur in foster parents. Initial research on secondary traumatic stress in foster parents, which will be reviewed in detail below, confirms this hypothesis (Bridger et al., 2020; Hannah & Woolgar, 2018; Ottaway & Selwyn, 2016; Whitt-Woosley et al., 2020).

**Risk and Protective Factors of Secondary Traumatic Stress**

Establishing the prevalence of secondary traumatic stress among child welfare professionals is an important first step. Furthermore, it is also important to identify potential risk factors for the development of secondary trauma in this population, as well as potential protective factors. In this section, results from a meta-analysis and two literature reviews will first be discussed. The meta-analysis and first literature review are focused more broadly on those who work with trauma victims, though they can still provide insight into potential risk and protective factors. Additionally, individual studies examining risk and protective factors among child welfare professionals will be reviewed.

**Meta-Analysis and Literature Reviews**

Hensel et al. (2015) conducted a large meta-analysis of 38 studies that analyzed risk factors for secondary traumatic stress. Studies included in the meta-analysis examined the risk factors among professionals who do therapeutic work with victims of trauma, including therapists, counselors, child welfare workers, domestic violence workers, school workers, chaplains, and physicians and nurses working in mental health. Results indicated that several variables had small, positive, significant effect sizes with secondary traumatic stress outcomes: personal trauma history ($r = 0.19$), caseload ratio of trauma cases ($r = 0.19$), caseload volume of number of traumatized clients ($r = 0.16$), and caseload frequency of contact with clients with
trauma \( (r = 0.12) \). In contrast, small, negative, significant effect sizes were found for work support from supervisors and colleagues \( (r = -0.17) \) and social support from family and friends \( (r = -0.26) \). Additionally, several variables had significant but very small effect sizes: length of experience \( (r = -0.07) \), trauma training \( (r = -0.05) \), and age \( (r = -0.05) \). The researchers noted that the small effect sizes for age and experience may be a result of the large sample size of the meta-analysis. Interestingly, demographic factors such as gender and ethnicity did not demonstrate significant effect sizes on secondary traumatic stress outcomes. While this meta-analysis examined a large number of studies across a variety of professions, one limitation is that the various occupational groups examined may have had different risk factors for secondary traumatic stress. In addition, the authors noted that some risk factors were only examined by a few studies and thus not analyzed in the meta-analysis, such as empathy, job demands, organizational climate, and coping style. All of the studies included in the meta-analysis were cross-sectional, which limits the ability to draw causal relationships between the risk factors and secondary traumatic stress outcomes. Finally, while some studies used assessment instruments specific to secondary trauma, others used measures for PTSD which may not have fully captured secondary traumatic stress symptoms.

In 2017, Turgoose and Maddox conducted a narrative review of 32 studies examining predictors of compassion fatigue in mental health professionals. In addition to child welfare workers, the studies included samples of therapists, psychologists, psychiatrists, genetic counselors, and mental health social workers. Out of the studies they reviewed, 23 of the studies utilized the ProQOL and 9 used the CFST to measure compassion fatigue. Eighteen of the studies were conducted in the United States, while the rest were in other countries. Across the studies, three main risk factors for compassion fatigue were found. First, having a history of
trauma was associated with higher levels of compassion fatigue in six studies. Second, having higher levels of empathy was associated with higher levels of compassion fatigue in three studies. Third, three studies provided evidence that having a higher caseload was correlated with more compassion fatigue. Additionally, eleven of the studies found positive correlations between burnout and compassion fatigue, which the authors argued might be due to overlap between the two concepts. Three protective factors were also found across the studies. First, mindfulness was found to have an association with lower levels of compassion fatigue in three studies. However, the authors noted that the studies reviewed were examining dispositional mindfulness (i.e., being aware of what is happening around you), but did not gather data on whether the participants were practicing mindfulness. Second, certain coping styles were found to protect against high levels of compassion fatigue, such as task-focused coping, emotional self-awareness, and having a positive view of the work environment. Finally, eight studies examined the association between compassion satisfaction and compassion fatigue, with six of them finding that higher compassion satisfaction was correlated with less compassion fatigue. The authors noted that there were mixed results regarding the relationship between compassion fatigue and several variables, including age, gender, length of experience, and religion. Similar to Hensel et al.’s (2015) meta-analysis, all of the studies examined in this review were cross-sectional, which limits the ability to establish causality. For example, the authors noted that while empathy and compassion fatigue are correlated, it is unclear which variable might cause the other. The wide variety of mental health professions included in this review is another limitation similar to Hensel et al. (2015), as there may be differences between the groups. An additional limitation of this study is that the sample sizes were small in many of the studies. Finally, the researchers did not use secondary
traumatic stress as a search term when finding studies, so it is possible that they missed relevant studies that used that term instead of compassion fatigue.

While the meta-analysis and narrative review discussed above included studies on child welfare professionals, they also included studies focused on broader populations of professionals that work with trauma victims. A recent systematic review by Molnar et al. (2020) compiled 39 studies on vicarious trauma specifically in child welfare and child protection workers. In this review, the researchers used vicarious traumatization and secondary traumatic stress interchangeably. Out of the studies reviewed, 26 of them examined risk and protective factors for vicarious trauma, which were organized into four categories. First, regarding demographic factors, most studies found that females had higher levels of secondary traumatic stress than males. Additional demographic factors of age and years of experience had inconsistent results across studies, as sometimes older individuals and those with more experience had higher levels of secondary traumatic stress, but sometimes the opposite trend was found. The second category related to an individual’s direct experiences of trauma. Most studies found that having a personal trauma history was associated with a higher risk of developing secondary traumatic stress symptoms. Third, a variety of workplace factors were found to be associated with secondary traumatic stress. Higher levels of secondary traumatic stress were correlated with negative workplace conditions, such as job overload, role ambiguity, and overbearing leaders. Lower levels of secondary traumatic stress were correlated with positive workplace conditions, such as organization satisfaction and support from supervisors and coworkers. The final category was family-level factors. Within this category, studies found that having support from friends and family was associated with lower levels of secondary traumatic stress.

Studies on Child Welfare Professionals
In addition to the meta-analysis and literature reviews discussed above, individual studies focused on child welfare professionals provide additional information about risk and protective factors for secondary traumatic stress. Some of these studies were also reviewed above in the prevalence section, while others focused exclusively on correlates of secondary traumatic stress.

**Personal and Work-Related Predictors of Secondary Traumatic Stress.** An older study by Cornille and Meyers’ (1999) examined correlates of secondary traumatic stress among 183 child protective service workers in a southern state in the United States. Given that this study was older, the researchers did not use either the STSS or the ProQOL to measure symptoms of secondary traumatic stress. As discussed in the prevalence section above, they instead used the Brief Symptom Inventory (Derogatis, 1993) to measure general psychological symptoms, as well as the Impact of Event Scale – Revised (IES-R) (Weiss & Marmar, 1997) to measure levels of distress. The researchers conducted five stepwise multiple regression analyses, one for each of the dependent variables. Higher scores on the Global Severity Index of the Brief Symptom Inventory, which measured overall psychological symptoms, was associated with an increased number of assaults on the job, as well as working over 40 hours per week. The overall IES-R score, as well as the IES-R Intrusive Thoughts subscale score, were associated with experiencing a trauma on the job. The overall IES-R score, as well as the IES-R Hyperarousal subscale score, were associated with being female. Additionally, the IES-R Avoidance subscale score was associated with the average number of hours worked each week. While this was one of the first studies to measure risk and protective factors for secondary traumatic stress within the child welfare population, a significant limitation is its use of the BSI and IES-R, as those measures do not specifically measure secondary traumatic stress.
Bride et al.’s (2007) study on child protective service workers utilized the STSS to study correlates of secondary traumatic stress. Within their sample of 187 child protective service workers in Tennessee, they examined the correlations between several variables and total STSS scores. Four of the variables they measured had small, but statistically significant correlations with secondary traumatic stress. Caseload size ($r = 0.171$) and lifetime trauma history ($r = 0.247$) were both positively correlated with STSS scores. In contrast, peer support ($r = -0.145$) and intent to remain employed in child welfare ($r = -0.388$) were negatively associated with STSS scores. Additionally, three variables they measured did not have significant correlations with STSS scores: personal history of trauma within the last year, length of experience, and administrative support.

The ProQOL was used in a study by Van Hook and Rothenberg (2009), where the researchers examined secondary traumatic stress in 175 child welfare workers in central Florida. Results from a $t$-test indicated that female participants had higher levels of secondary traumatic stress compared to male participants. Results from an ANOVA indicated that younger participants (ages 18-29) also had higher levels of secondary traumatic stress compared to older age groups. In contrast, length of experience (both at the agency and in the child welfare field) was not correlated with levels of secondary traumatic stress. Comparing the three subscales of the ProQOL, the researchers also found that increased compassion satisfaction was significantly correlated with decreased secondary traumatic stress and burnout.

Sprang et al. (2011) also used the ProQOL IV to assess predictors of secondary traumatic stress within a large ($N = 668$) group of helping professionals, which included child welfare workers. It is important to note that they used the fourth version of the ProQOL, which only included two subscales: compassion fatigue and burnout. For the purposes of the study, the terms
compassion fatigue and secondary traumatic stress were both used interchangeably. The researchers examined several potential predictors of secondary traumatic stress using hierarchical regression. As discussed above in the prevalence section, they found that having a job as a child welfare worker significantly predicted higher levels of secondary traumatic stress compared to other helping professions. Gender and age were also both significant predictors of the compassion fatigue subscale, with males and younger professionals experiencing higher levels of secondary traumatic stress. The result regarding gender was inconsistent with many other studies that indicate females typically experience higher levels of PTSD and secondary trauma. However, the researchers noted that 32% of the male sample held jobs as child welfare workers, which may have biased the result because the child welfare workers were experiencing higher levels of secondary traumatic stress. The researchers also found that living location and religious participation were significant predictors of the compassion fatigue subscale. Individuals who lived in a rural location experienced more secondary traumatic stress than those who lived in an urban location, and individuals who did not participate in any religious activity had higher levels than those who did. Finally, the researchers found that race did not significantly predict secondary traumatic stress symptoms. Interestingly, burnout was found to have the same predictors as secondary traumatic stress, except for the fact that living location was not a significant predictor for burnout. A limitation of this study was that it included a variety of helping professionals, such as inpatient and outpatient behavioral health professionals, school-based psychologists and social workers, and psychiatrists. It is possible that the results of the hierarchical regression analysis would have been different if only child welfare professionals were included in the study.
Dagan et al. (2016) examined personal, social, and organizational factors related to secondary trauma using the STSS. Their study included 255 social workers in Israel, where approximately half worked in child protection and the other half were employed in social service departments. The researchers found that the child protection workers, who had greater exposure to child maltreatment, had higher levels of secondary traumatic stress. In a hierarchical regression, they found that previous exposure to trauma and role stress positively predicted STSS scores, while years of work experience and level of mastery negatively predicted STSS scores. That is, as amount of prior trauma exposure and role stress increased, secondary traumatic stress increased. As years of work experience and feeling in control of their environment and future increased, levels of secondary traumatic stress decreased. Taken together, 29% of variance in STSS scores was explained by these variables. Both social support and effectiveness of supervision did not significantly predict STSS scores. The researchers proposed that the lack of contribution of social support might be a result of the social workers being unable to discuss confidential cases outside of work or fearing that others will not understand their work.

A recent study by Reinks (2020) also used the STSS to examine secondary traumatic stress in child welfare caseworkers in three states. A strength of this study was that it included both cross-sectional (N = 1986) and longitudinal (N = 653) components. Unfortunately, the sample size decreased at the 3-year longitudinal follow-up due to high levels of worker turnover in the child welfare population. In the cross-sectional analysis, a t-test was used to determine that caseworkers who had a history of personal trauma experience had higher levels of secondary traumatic stress symptoms. However, the researchers noted that they did not assess the type or number of traumas that the caseworkers had experienced, which may have provided more information on this relationship. The cross-sectional component also included several correlation
analyses. Higher levels of burnout were associated with higher STSS scores \((r = 0.60)\), while
more organizational support was associated with lower scores \((r = -0.36)\). Interestingly, no
significant correlations were found between secondary traumatic stress and several variables:
years of experience, caseload size, and frequency of work-related exposure to trauma. The
researchers noted that the lack of correlation between STSS scores and the caseload and
frequency variables may indicate that secondary traumatic stress symptoms are not necessarily a
result of cumulative exposure, but instead more related to the type or intensity of exposure, or an
individual’s ability to cope with the exposure. The relationship between coping strategies and
STSS scores was examined in both the cross-sectional and longitudinal aspects of the study.
Using the baseline data, a significant negative correlation was found between use of coping
strategies and STSS scores. The researchers also split the sample into two groups (high copers
and low copers) and then conducted \(t\)-tests. At baseline and the three-year follow-up, high copers
were found to have lower levels of secondary traumatic stress compared to low copers. It is
noteworthy that the relationship between use of coping strategies and STSS scores continued at
the follow-up. Additionally, high coper individuals were found to use three specific strategies
more than the low copers: establishing a self-care plan, engaging in activities or hobbies, and
using a work-to-home transition plan.

Another recent study assessed risk and protective factors for secondary traumatic stress
across multiple levels, including individual, organizational, and community factors (Strolin-
Goltzman et al., 2020). This study, which utilized the STSS, involved child welfare workers \((N = 
237)\) and mental health providers \((N = 281)\) who worked within the child welfare system in a
rural, northeastern state. The researchers ran the analysis separately for the two groups, so the
focus here will be on the results from the child welfare group. Structural equation modeling was
used to understand the pathways of a variety of variables and their relationship to STSS levels. Higher competency related to secondary traumatic stress was found to be a protective factor against secondary traumatic stress symptoms. Decreased time pressure within their job was also found to be a protective factor against secondary traumatic stress. Interestingly, higher levels of transformative leadership had an indirect effect on secondary traumatic stress through its relationship with time pressure. That is, high levels of transformative leadership were related to lower time pressure which was related to lower secondary traumatic stress symptoms.

Transformative leadership refers to leaders’ ability to prepare their organization for positive change and growth. The authors noted that when leaders are able to efficiently bring an organization through change, it may result in less time pressure for their employees. Additionally, several variables (gender, caseload size, and years in current position) were not found to significantly predict STSS levels.

**Child Welfare Professionals’ Childhood Experiences.** Two studies have specifically examined the relationship between child welfare worker’s own childhood experiences and the later development of secondary traumatic stress symptoms. First, Nelson-Gardell & Harris (2003) used the CFST to examine compassion fatigue in a sample of 166 child welfare workers. As discussed above, the CFST is an older version of the ProQOL which contains two subscales (compassion fatigue and burnout) and demonstrated adequate reliability in this sample (Figley, 1995a). It should be noted that the researchers used the terms compassion fatigue and secondary traumatic stress interchangeably throughout the study. Participants also completed a questionnaire examining their history of childhood trauma, including physical, emotional, and sexual abuse, as well as emotional and physical neglect. All five types of abuse and neglect were found to be positively correlated with scores on the compassion fatigue subscale. The researchers
also conducted a stepwise regression, which suggested that emotional abuse and sexual abuse specifically were the strongest predictors. They also found that having more than one type of abuse or neglect increased an individual’s risk. Results from the stepwise regression also indicated that age was a significant predictor of secondary traumatic stress, in that older child welfare workers had lower compassion fatigue subscale scores. The researchers proposed that this may be due to older individuals demonstrating better coping strategies, or the fact that those who were most at risk for high levels of secondary traumatic stress may have left the profession when they were younger. In contrast, secondary traumatic stress was not found to have a significant correlation with gender, education level, or years of experience.

Using the ProQOL, Hiles Howard et al. (2015) also examined the impact of childhood experiences on future development of secondary traumatic stress. Their study included 192 child welfare professionals who worked in a large city in the southern United States. It is important to note that most participants (59%) in the study indicated that they only provided indirect services to children, and thus were likely not exposed to as much trauma as those providing direct services. Participants in this study completed the Adverse Childhood Experiences (ACEs) questionnaire, which examines negative experiences in childhood such as maltreatment and family issues (Felitti et al., 1998). Interestingly, results from a regression analysis indicated that the number of ACEs did not predict scores on the secondary traumatic stress scale of the ProQOL. However, a higher number of ACEs did predict high compassion satisfaction scores and lower burnout scores. The regression analysis found that both gender and resilience were significant predictors of secondary traumatic stress. Females were found to have more secondary traumatic stress than males, and those with higher resilience had lower levels of secondary
traumatic stress. However, the researchers noted that the Resilience Questionnaire used in this study had limited research regarding its psychometric quality (Rains & McClinn, 2013).

**Unique Predictors of Secondary Traumatic Stress.** A few studies have looked at unique, and fairly specific, predictors of secondary traumatic stress. In a study of 104 child welfare case managers and supervisors in south Florida, Salloum et al. (2015) used the ProQOL to examine the relationship between secondary traumatic stress and trauma-informed self-care (TISC). In contrast to general self-care, TISC involves “being aware of one’s own emotional experience in response to exposure to traumatized clients and planning/engaging in positive coping strategies, such as seeking supervision, attending trainings on secondary trauma, working within a team, balancing caseloads, and work-life balance” (Salloum et al., 2015, p. 54). To measure this construct, the researchers created a 14-item measure about TISC practices based on expert recommendations, as there were not any currently available measures of TISC. While the researchers noted that the measure had good internal reliability, the lack of research on the psychometric properties of the measure is a limitation of this study. Using hierarchical regression analyses, the researchers found that engaging in TISC practices significant predicted higher compassion satisfaction and lower burnout. However, engaging in TISC practices was not a significant predictor for levels of secondary traumatic stress. The researchers suggested that these results indicated that individuals with secondary traumatic stress may need additional intervention, beyond TISC practices, to alleviate their symptoms. However, they also suggested that there may be certain TISC practices that might have a greater impact on secondary traumatic stress symptoms. This could include practices that were least endorsed by the participants in this study, including balancing caseloads, using agency resources, attending secondary trauma trainings, and having a written work-life balance plan. Results from the hierarchical regression
analysis also indicated that age, gender, and amount of experience within the child welfare field were not significant predictors of secondary traumatic stress levels. Additionally, the researchers found significant correlations between higher levels of compassion satisfaction and decreased burnout and secondary traumatic stress. They also found a significant positive correlation ($r = 0.73$) between burnout and secondary traumatic stress.

Another study conducted in Norway with 506 child protective service workers also examined some unique factors as they relate to secondary traumatic stress (Baugerud et al., 2018). In this study, the participants completed the ProQOL, as well as the Nordic Questionnaire for Psychological and Social Factors at Work (National Institute of Occupational Health, 2001) and the Relationship Questionnaire (Bartholomew & Horowitz, 1991), which measures adult attachment style. Using hierarchical regression analysis, the researchers found that the following variables were significant predictors of secondary traumatic stress levels: increased work-family conflict, high workload, high role conflict within their job, and high levels of attachment anxiety. However, these results should be interpreted with some caution given that the study was conducted in Norway, where a specialized undergraduate program in child welfare work exists. Also, as noted above the prevalence section, none of the CPS workers in this sample demonstrated high levels of secondary traumatic stress as measured by the ProQOL, which may have influenced the results.

Purpose in life is another variable that has been examined as a potential protective factor for secondary traumatic stress. Singer et al. (2020) conducted a study with 126 child protective service workers and 166 adult/elder protective service workers. The researchers described purpose in life as “the sense that life has meaning and direction, and that one’s goals and potential are being achieved or are achievable” (Singer et al., 2020, p. 624). To measure this
construct, the researchers utilized the Ryff Purpose in Life Scale, which has been demonstrated to have adequate test-retest reliability and high construct validity (Ryff, 1989). Additionally, the STSS was used to measure secondary traumatic stress symptoms, and the ProQOL was used to measure burnout. Using multiple regression analysis, higher purpose in life was found to significantly predict lower levels of both secondary traumatic stress and burnout, while years of experience and number of hours worked per week were held constant. The researchers suggested these results indicate that having purpose in life may be a protective factor for protective service workers, regardless of how long they had been in the field or how much they were working.

King (2022) conducted an interesting study focused on both primary and secondary trauma exposure within 657 child welfare workers from one state in the United States. Using the STSS, several variables were found to be associated with higher levels of secondary traumatic stress, including being younger, being White, and having experienced a personal trauma within the last year. Researchers initially conceptualized primary trauma to include client perpetuated violence, as well as death or injuries on participants’ caseloads. However, they discovered that death or injuries on participants’ caseloads did not load onto primary trauma or secondary trauma, and instead represented a separate type of trauma, which they labeled caseload trauma. Interestingly, caseload trauma was found to be a significant predictor of higher levels of secondary traumatic stress. The researchers hypothesized that caseload trauma may be associated with secondary traumatic stress partially because participants are exposed to the injury or death of the child, but also because they may experience increased scrutiny and blame from others after the injury or death occurs.

In Stanley et al.’s (2023) study, researchers examined the relationship between early career child welfare worker’s self-care practices and their overall well-being, including
secondary traumatic stress and burnout. This study included 1006 participants who completed surveys after one year of employment as a child welfare worker. Using a regression model, researchers found that the use of emotional self-care activities significantly predicted lower levels of reported secondary traumatic stress. In open-ended responses, participants described a variety of emotional self-care strategies, including hobbies, spending time with loved ones, relaxation, talking with others, and using mental health services. Interestingly, engaging in spiritual or physical self-care activities did not predict secondary traumatic stress levels. However, both emotional and physical self-care activities were significantly associated with lower levels of reported burnout. A significant limitation of this study is that participants were limited to early career professionals, as it is possible that certain self-care practices may become more or less beneficial as individuals progress in their career.

Another recent study specifically examined whether personal therapy and supervision served as protective factors against the development of secondary traumatic stress and burnout (Skar et al., 2023). This study, which took place in Denmark, included 667 professionals who worked with child abuse cases, including social workers, supervisors, police employees, mental health professionals, and administrative personnel. Within this sample, a history of attending therapy served as a protective factor against secondary traumatic stress, as participants who had attended therapy reported lower levels of secondary traumatic stress. Researchers did not find evidence for their hypothesis that attending therapy may have moderated the relationship between history of personal trauma in childhood and secondary traumatic stress. However, receiving case supervision was found to serve as a moderator between exposure to child abuse cases at work and the development of secondary traumatic stress. In other words, when participants did not receive case supervision, those who were exposed to child abuse had
increased secondary traumatic stress. However, when participants did receive case supervision, there was no relationship between exposure to child abuse cases and secondary traumatic stress. Taken together, the results from this study provide support that both personal therapy and case supervision can be helpful factors to protect against the development of secondary traumatic stress.

**Mixed Methods Studies.** Finally, two mixed methods studies also examined risk and protective factors for secondary traumatic stress in child welfare professionals. O’Bryant (2008) conducted their mixed methods dissertation with child protective service workers in a Midwestern state. For the quantitative portion of their study, 37 CPS workers completed the STSS, as well as a demographic questionnaire. Using \( t \)-tests, the researchers found no significant differences in STSS total or subscale scores between males and females, nor between those who did and did not have a personal history of trauma. Additionally, no significant correlations were found between STSS total and subscale scores and several variables: caseload, length of time in profession, length of time at agency, and training level (i.e., number of hours per week spent doing professional education). However, it is important to note the low sample size of 37 participants, which could explain why they did not find any significant relationships with any of these variables. An additional limitation is that the CPS workers in this study primarily worked with suburban (vs. urban) clients, which may have impacted the results. In the qualitative portion of the study, eight CPS workers were interviewed, four with high STSS scores and four with low STSS scores. Individual interviews were conducted using open-ended questions, which were assessed with a pilot group. The researcher used a grounded theory approach to analyze the data. A strength of the qualitative analysis is that a peer reviewer also coded a few of the transcripts to help improve reliability. The participants described several risk factors for the development of
secondary traumatic stress, including lack of education and training, nature of CPS work (e.g., high caseloads, difficult clients), individual traits (e.g., personal issues, over-involvement with clients, family issues), and agency factors (e.g., lack of training). In terms of protective factors, a difference was observed between those who had low levels of secondary trauma vs. those with high levels. Participants with high levels of secondary traumatic stress described externalizing coping strategies, such as reducing high caseloads, obtaining supervision, and getting input from colleagues. Those with lower levels of secondary traumatic stress described internalizing and socially-focused coping strategies, such as having a work-life balance, obtaining social support, and having self-confidence and maturity. Additionally, three supervisors were also interviewed to gain their perspective on risk and protective factors contributing to their employees’ symptoms of secondary traumatic stress. They identified lack of education specific to CPS, nature of CPS work, and individual employee traits as the main risk factors. Interestingly, they believed that individual traits, such as personality characteristics, were the primary risk factor for the development of secondary trauma. They also identified several protective factors, including social support, continuing education, agency factors (such as supervision and collaborative work environment), and positive employee traits (such as maturity and positive attitude).

As discussed in the prevalence section above, Caringi and Hardiman (2012) also conducted a mixed methods study with child welfare workers who were attending secondary traumatic stress trainings in New York. The STSS was administered to 103 attendees at the end of training. From that sample, 12 individuals who had scored high, average, and low on the STSS were recruited for individual, semi-structured interviews. Qualitative content analysis was used to identify key themes within the interviews. The participants identified several factors that they perceived to be influencing levels of secondary traumatic stress within themselves and their
coworkers. First, they believed that having a prior personal history of trauma contributed to the development of secondary traumatic stress symptoms. However, they expressed this concern related to their peers that had experience personal trauma, but not themselves. Second, they identified two coping strategies that they perceived to protect against secondary traumatic stress symptoms: receiving peer support from coworkers and good supervision. Interestingly, the respondents did not believe that their supervisors acknowledged the existence of secondary traumatic stress within the organization. Third, the respondents identified several organizational factors that they believed influenced secondary traumatic stress. Working in a child protective unit, as well as lack of acknowledgement from their agency about secondary traumatic stress, were believed to be associated with increased symptoms. In addition, they believed that having a higher caseload size and working on abuse and high-profile cases also contributed to more symptoms. Overall, this study fills a gap in the literature related to qualitative studies in this area. However, an important limitation of this study is that the interviews were conducted after the participants had attended a training on secondary traumatic stress, which may have influenced their responses.

**Summary.** While the studies reviewed above provide important information on risk and protective factors for secondary traumatic stress in child welfare workers, they share many of the same limitations. In terms of the samples, many of the studies included convenience samples that consisted primarily of White and female participants. Many of the studies also had fairly low response rates, and it is possible that the non-respondents may have differed in important ways from the respondents. The samples also only included current child welfare workers, neglecting to study those who had left the field. Given the high turnover rate in the child welfare profession, examining risk and protective factors for secondary traumatic stress in those who left the
profession is important. The samples were also often limited to one geographical region, which may limit the generalizability of the findings across the United States. In addition, most of the studies utilized the STSS and ProQOL to measure levels of secondary traumatic stress. As discussed above, there are concerns regarding the psychometric properties of the ProQOL, and the STSS has not been updated to reflect the *DSM-5/DSM-5-TR* (APA, 2013; APA, 2022). In addition, the self-report format of these measures may leave out important pieces of information. Another limitation of these studies is their cross-sectional design, which limits the ability to determine a causal relationship between the factors and levels of secondary traumatic stress. For some of the factors, it is possible that the relationship may be reversed, in that experiencing symptoms of secondary traumatic stress may lead to certain risk factors, such as lower social support or decreased use of coping strategies. Each of the studies also only looked at a limited number of variables, oftentimes measured in different ways, so it can be hard to draw comparisons between the studies. An additional limitation is that some of the studies used correlation and *t*-tests to analyze the data, instead of more advanced statistical techniques such as regression analysis (Elwood et al., 2011). Finally, there is an overall lack of qualitative studies on this topic.

Despite these limitations, the studies reviewed above are an important first step in helping to identify which child welfare professionals might be most at risk for developing secondary traumatic stress. There is some evidence that individuals who are younger and female may be at an increased risk for secondary traumatic stress. Having a personal trauma history has been consistently found to put an individual at increased risk, while length of experience in the field has been found to have no correlation with levels of secondary traumatic stress. Other factors, such as caseload size and social support, have produced mixed findings. In addition, a variety of
other factors have been studied as potential risk and protective factors for secondary traumatic stress. However, many of these factors have only been examined in one or two studies, making it difficult to draw conclusions.

The research on risk and protective factors in child welfare professionals also provides important information for the foster parent population. Given the similarities between the two groups, it is plausible that similar risk and protective factors might be observed in foster parents. For example, research should examine whether younger, female foster parents may have a higher risk of secondary traumatic stress compared to foster parents who are older and male. Similarly, it is important to explore the relationship between foster parents’ personal trauma history and their levels of secondary traumatic stress, given that personal trauma history is a risk factor for child welfare professionals. Research on child welfare professionals also provides suggestions for other variables that should be studied in foster parents, such as length of experience as a foster parent, number of children fostered, perceived social support, and coping strategies.

**Secondary Traumatic Stress in Foster Parents**

As reviewed above, there is substantial research establishing the prevalence of secondary traumatic stress in child welfare professionals. This research provides a helpful starting point when examining secondary traumatic stress in foster parents, given the similarities between the two populations. Both foster parents and child welfare professionals are commonly exposed to details about foster children’s trauma histories, either through reading case documents or hearing about the trauma directly from the children or from other individuals involved in their cases. In addition, both populations also likely hear about or witness foster children’s trauma symptoms. Foster parents may be more likely to witness these trauma symptoms directly, while child welfare professions may be more likely to hear about the symptoms from other individuals, such
as foster parents, mental health professionals, or school staff. An additional similarity is that both foster parents and child welfare professionals likely care about the foster children for whom they are responsible. It is probable that most foster parents and child welfare professionals choose their respective roles due to a desire to help foster children.

Despite these similarities, there are also important differences between foster parents and child welfare professionals. Foster parents interact and care for their foster children within their home environment, unlike child welfare professionals who interact with foster children in a work setting. Given this difference, it is likely that foster parents are exposed more intimately to their foster children’s trauma history and trauma symptoms, as they spend a large amount of time with their foster children on a daily basis. They likely frequently encounter the physical and psychological impacts of their foster children’s trauma and are involved in helping their children manage those symptoms. In contrast, while child welfare professionals may be less intimately involved with any one foster child, they are exposed to a much wider range of foster children, which includes the trauma histories of those children. In addition, they are ultimately responsible for ensuring appropriate care of the foster children on their caseload, while foster parents have the option of discontinuing a placement if care of a child becomes too difficult. These differences indicate that studies on child welfare professionals may have important limitations in terms of helping to understand the experience of secondary traumatic stress in foster parents.

While a number of studies have examined general parental stress within foster parents, there is a surprisingly small number of studies examining the concept of secondary traumatic stress in foster parents. Given their likely indirect exposure to foster children’s trauma histories, as well as their direct exposure to foster children’s trauma symptoms, it is logical that foster parents could be affected by secondary traumatic stress. When this dissertation was originally
proposed, only four published studies were found after a thorough search of the literature. Of these studies, only one of them was conducted in the United States. Encouragingly, five additional studies have been published since then, with four of them occurring in the United States. These nine studies, which all provide support for the prevalence of secondary traumatic stress within foster parents, are reviewed below. Additionally, one unpublished study from the United Kingdom, as well as six dissertations and one masters-level thesis, provide additional information on this concept within the foster parent population.

**Published Studies**

Hannah and Woolgar (2018) used an online survey to examine secondary traumatic stress in 131 foster carers in the United Kingdom. Using the ProQOL, the researchers found that 25.2% of foster carers reported high levels of secondary traumatic stress. The STSS was also administered in this study, which demonstrated that 19.8% of foster carers in this study were above the clinical cut-off for secondary traumatic stress symptoms. Additionally, 30.5% of the sample reported high levels of burnout. Importantly, higher levels of secondary traumatic stress and burnout were both found to be associated with decreased job satisfaction and lower intent to continue fostering. The authors noted that these results provide support for the negative impact that secondary traumatic stress symptoms may have on placement stability and retention of foster carers. In this study, 48% of respondents reported being physically harmed by their foster child, which could be impacting their reported symptoms of secondary traumatic stress. The researchers also measured avoidant cognitive styles, including psychological inflexibility and thought suppression. These avoidant cognitive styles were found to be associated with higher levels of both secondary traumatic stress and burnout. The cross-sectional design in this study is
a potential limitation. The sample is also fairly small and respondents were located in one major urban region, which may limit the generalizability of the findings.

In the first published study from the United States, Whitt-Woosley et al. (2020) conducted an online survey with 1,213 foster parents in a rural, southeastern state. Overall, the results suggested that this sample of foster parents was experiencing a moderate level of secondary traumatic stress symptoms. Notably, 15% of the sample reported symptoms that were at or above the level associated with PTSD. The importance of this result is highlighted by the fact that the general United States adult population has 8.7% lifetime and 3.5% 12-month prevalence rates of PTSD (APA, 2013). Additionally, the foster parents in this study indicated that their symptoms of secondary traumatic stress came about through being exposed to their foster children’s trauma histories. It should be noted that this study used an updated version of the STSS that was modified to fit with the new conceptualization of PTSD in the DSM-5 (APA, 2013). Unfortunately, no published studies on the psychometrics of this updated version were able at the time of publication. Interestingly, the foster parents in this study did not exhibit high levels of burnout as measured by the ProQOL, in contrast to the results from Hannah and Woolgar (2018). However, they did demonstrate high levels of compassion satisfaction.

In an effort to examine risk and protective factors for the development of secondary traumatic stress, the authors conducted two hierarchical regression analyses. Foster parents’ dose of exposure to details about the trauma their foster children had experienced was found to be a direct risk factor for the development of secondary traumatic stress. This effect was moderated by the foster parents’ level of compassion satisfaction, as well as their years of experience in the foster parent role. In contrast, foster parents’ perceived practical and emotional support was found to be a beneficial factor helping to prevent the development of secondary traumatic stress.
This effect was moderated by the foster parents’ level of burnout, level of foster care provided (basic, therapeutic, or medically complex), and amount of utilized foster parenting resources. Interestingly, the authors noted that foster parents’ prior trauma history was not found to be a significant moderator. While this study provides valuable information on secondary traumatic stress within foster parents, it is important to note that the sample came from one rural state in the southeastern United States. Given this, the results may not be generalizable to foster care systems across the country. Additionally, the authors noted that the cross-sectional design of the study limits the ability to determine the predictive quality of the relationships between variables (Whitt-Woosley et al., 2020).

In another recent study, Bridger et al. (2020) investigated secondary traumatic stress in 187 British foster carers through an online survey. The respondents included individuals providing foster care in their home, as well as workers caring for foster youth in residential homes. Similar to the Hannah and Woolgar (2018) study, the researchers found that the foster carers had high levels of secondary traumatic stress based on the ProQOL-V. Additionally, foster carers reported high levels of burnout. Using structural equation modeling, the researchers also examined a variety of potential predictors for secondary traumatic stress symptoms. Burnout, compassion satisfaction, and primary trauma were all found to directly predict secondary traumatic stress. The positive relationship between compassion satisfaction and secondary traumatic stress was unexpected. However, the authors suggested that it may be possible that individuals with higher levels of compassion satisfaction may have greater engagement with their role as foster carers. This greater engagement may lead to increased exposure to the foster child’s trauma, which could increase secondary traumatic stress. Other variables examined, including self-care, resilience, and empathy, were not found to directly predict secondary
traumatic stress. However, self-care was found to have an indirect effect on symptoms of secondary traumatic stress. Interestingly, 76.5% of foster carers in this study reported experiencing primary trauma based on interactions with a foster child. Given this finding, the authors noted that it is difficult to separate symptoms that resulted from secondary traumatic stress versus primary trauma in this population. The study also included two qualitative questions about maintaining well-being and needed supports, which were coded through thematic analysis. The responses highlighted the importance of time spent with others, support, personal attitude, and exercise. Overall, this study provides additional support for the prevalence of secondary traumatic stress within foster carers. However, given that sample was non-randomized and volunteer, the authors noted that individuals with higher levels of secondary traumatic stress may have responded more willingly. Additionally, similar to the Hannah and Woolgar (2018) and Whitt-Woosley et al. (2020) studies, the cross-sectional design of the study does not allow direction of the correlations to be determined.

In a qualitative study, Riggs (2021) explored Australian foster parents’ experiences of vicarious trauma. Although this study was focused on vicarious trauma, it is included in this review due to the limited number of published studies on secondary traumatic stress within the foster parent population. The author noted that aspects of secondary traumatic stress were present within the interviews. However, the term vicarious trauma was used as participants described a shift in their worldviews after being exposed to their foster child’s trauma. In this study, semi-structured interviews were conducted with 85 foster parents who were providing long-term foster care to at least one child. Inductive reflexive thematic analysis was used to analyze the interviews, which resulted in four themes. First, the foster parents described their foster child’s behaviors resulting from trauma as unpredictable and requiring constant attention. Second, the
foster parents explained that their foster child’s trauma histories make it hard to connect with them. Third, the foster parents indicated that providing care for a traumatized child can be socially isolating, as the child’s unpredictable trauma behaviors made it hard to navigate other relationships. Fourth, the foster parents described a lack of support from the foster care agency in helping them to understand their child’s trauma. They noted that the information they received during training and as a result of the child’s background was insufficient in preparing them for the trauma behaviors. While this study adds a needed qualitative study to the literature base, there are several limitations. The author argued that both secondary traumatic stress and vicarious trauma were evident in the participants’ responses. However, while the four themes derived from the analysis are helpful in understanding foster parents’ experiences, it is unclear how these themes directly relate to either secondary traumatic stress or vicarious trauma. Additionally, the interviews were part of a larger study on Australian family diversity, so there were not any questions asking specifically about experiences of vicarious trauma. Finally, the author, who was a foster parent themself, conducted the qualitative analysis on their own, which could have impacted their interpretation of the data and led to potential bias in the results.

In a study of foster parents in Romania, Teculeasa et al. (2022) examined the relationships between secondary traumatic stress, the quality of the foster parent and foster child relationship, foster parents’ job satisfaction, and foster parents’ sensitivity towards their child’s symptoms of posttraumatic stress. Using the ProQOL to measure secondary traumatic stress, the researchers conducted an online survey of 165 foster parents. Surprisingly, the majority of participants in this study reported low or moderate levels of secondary traumatic stress, with only two participants reporting high levels. It’s possible that the discrepancy in secondary traumatic stress levels between this study and previous studies could be due to cultural factors, given that
This study occurred in Romania (Bridger et al., 2020; Hannah & Woolgar, 2018; Whitt-Woosley et al., 2020). Despite the lower prevalence of secondary traumatic stress, researchers found that foster parents with more sensitivity to their child’s posttraumatic stress symptoms had increased levels of secondary traumatic stress. Not surprisingly, job satisfaction and secondary traumatic stress had a negative association within this sample. Researchers also found a strong association between levels of secondary traumatic stress and burnout, similar to the associations found in the studies by Bridger et al. (2020) and Hannah and Woolgar (2018). Using structural equation modeling, compassion fatigue (which included both secondary traumatic stress and burnout) was found to mediate the indirect relationship between foster parents’ sensitivity to their child’s trauma and their job satisfaction. Interestingly, the quality of the parent-child relationship was not found to mediate the relationship between sensitivity and satisfaction. In addition to the potential cultural differences between foster care in Romania and the United States, this study has several other limitations. The authors noted that they did not reach the appropriate sample size to achieve adequate power. They also did not use an established measure for sensitivity to child’s posttraumatic stress symptoms. The measure they used was focused on the ability to detect symptoms of posttraumatic stress in their child, which the authors noted does not necessarily equal parents’ sensitivity to the symptoms.

Whitt-Woosley et al. (2022a) conducted a study to assess the impact of the COVID-19 pandemic on experiences of secondary traumatic stress and burnout within foster parents and other helping professionals in the United States. The participants were from a rural, southeastern state and the majority of the sample (73%) consisted of foster parents, though the study also included child welfare professionals, educators, mental health professionals, and medical professionals. The 500 participants in this study completed an online survey in August 2020,
which included the version of the STSS updated for the *DSM-5*. On average, participants reported experiencing a moderate degree of secondary traumatic stress, though 21% of them scored high enough on the STSS to meet the cutoff for PTSD. Interestingly, participants reported experiencing low levels of burnout. Additional analysis was completed on a subset of foster parents (N = 64) who had also participated in a related study in 2019. Though these participants did not experience a significant increase in overall secondary traumatic stress symptoms between 2019 and 2020, their secondary traumatic stress symptoms significantly increased in two areas: intrusive symptoms and alterations in cognitions and mood. Burnout scores were not significantly different between the two timepoints. The authors highlighted that participants may have experienced the COVID-19 pandemic as a traumatic event, which could explain why some of their symptoms of secondary traumatic stress increased. Using regression analysis, secondary traumatic stress was found to be associated with several COVID-19 stressors, including being worried about COVID, experiencing family conflict/violence during the pandemic, and having difficulty with food access. Burnout was associated with being worried about COVID and experiencing family conflict/violence, but it was not associated with food access difficulty. Secondary traumatic stress and burnout were not found to be significantly correlated with other COVID-19 stressors, including disruption to routine, limited access to social support, difficulty accessing medical or mental health care, loss of income or employment, or experiencing a COVID-19 diagnosis. A significant limitation of this study is that the data was collected at one timepoint in August 2020. It is unclear whether foster parents’ symptoms of secondary traumatic stress may have returned to baseline as the pandemic progressed, or whether their symptoms might have continued to increase. Nonetheless, this research provides support that the COVID-19 pandemic had a negative impact on foster parents’ levels of secondary traumatic stress.
Whitt-Woosley et al. (2022b) also published the qualitative results from their study above. In addition to completing the online assessment measures, 357 participants also provided open-ended responses regarding the impact that COVID-19 had on them as foster parents or professionals working with the child welfare system. Using a grounded theory approach, the researchers identified 15 themes within the participants’ responses. Participants described an overall change in their daily routine. They highlighted the difficulty of feeling isolated and losing access to their social support network. They shared about the difficulty of switching to online education, as well as the difficulty of limited childcare being available. Participants reported experiencing stress related to work changes (including loss of employment) and financial difficulties. Unfortunately, participants described a variety of negative impacts on their experience with the child welfare system, including disruptions in visitations, court proceedings, and service provision. They reported a fear of contracting COVID-19, as well as issues with accessing medical and mental health care including COVID-19 testing and protective equipment. Some participants also described emotional difficulties or distress as a result of the pandemic. Additional impacts reported by the participants included frustration with society, marital problems, and grief and loss related to the pandemic. The authors noted that the participants mainly described secondary impacts related to COVID-19 instead of direct impacts of getting ill with the virus. Similar to the quantitative portion of their study, a limitation of the qualitative portion is that these responses reflect participants’ experiences at one timepoint during the pandemic.

In another study, Steen and Bernhardt (2023) examined secondary traumatic stress and posttraumatic growth among 46 foster parents in the United States. In this sample, 50% of participants scored above the cutoff score on the STSS, indicating that they were experiencing
levels of secondary traumatic stress associated with PTSD. Using multiple regression, the researchers surprisingly found that foster parents who engaged in religious/spiritual help-seeking behaviors to manage foster-parent-related stress had higher levels of both secondary traumatic stress and posttraumatic growth. Interestingly, other help-seeking behaviors were not associated with secondary traumatic stress, including seeking support from friends, family, other foster parents, therapists/counselors, foster care case managers, or religious leaders. Additionally, being younger and White were also found to be risk factors for experiencing higher levels of secondary traumatic stress. In addition to the small sample size, this study’s cross-sectional design does not provide information about the direction of the relationship between religious/spiritual help-seeking behaviors and secondary traumatic stress levels. The authors also noted that the survey questions were worded to ask about support that participants seek during crisis periods instead of support that is used on a regular basis. This distinction may help to explain the discrepancy between the results in this study and Whitt-Woosley’s (2020), where it was found that practical and emotional support was associated with lower levels of secondary traumatic stress.

More recently, Dowdy-Hazlett and Clark (2024) used latent profile analysis to distinguish subpopulations of foster parents in order to better understand placement disruption and foster parent turnover. In this study, 362 foster parents from six states completed measures related to support, parenting practices, stress, and coping. From this data, the researchers identified a three-profile model. The first profile, labeled Resourceful Foster Parents, described 36% of the sample. The Resourceful Foster Parents reported the lowest levels of secondary traumatic stress, burnout, and parenting stress, while also reporting the highest levels of compassion satisfaction, social support, coping, and satisfaction with fostering. Interestingly, these foster parents did not find the preservice training they attended to be useful. The second profile was labeled Disadvantaged
Foster Parents, which described 20% of the participants. Despite finding preservice training to be useful, the Disadvantaged Foster Parents reported the highest levels of secondary traumatic stress, burnout, and parenting stress. Unfortunately, they also reported the lowest levels of compassion satisfaction, social support, coping, and satisfaction with fostering. The researchers noted that this group of foster parents provides support for the idea that ineffective coping and lack of social support can negatively impact foster parents’ ability to manage the stress associated with fostering. Finally, most of the participants (44%) were described by the third profile, Strained Foster Parents. This group of foster parents scored in between the Resourceful Foster Parents and Disadvantaged Foster Parents on secondary traumatic stress, burnout, parenting stress, compassion satisfaction, social support, coping, and satisfaction with fostering. They also described their preservice training as somewhat useful.

After distinguishing these profiles, the researchers added covariates and distal outcomes into the model (Dowdy-Hazlett & Clark, 2024). They found that foster parents who identified as racial minorities were more likely to be a Strained Foster Parent compared to a Resourceful Foster Parent. They also found that foster children’s behavior problems influenced the profiles, as foster parents with foster children who had behavior problems were less likely to be a Resourceful Foster Parent compared to the other two profiles, and also less likely to be a Strained Foster Parent compared to Disadvantaged Foster Parent. Regarding distal outcomes, Disadvantaged Foster Parents reported being more likely to disrupt their placement, followed by the Strained Foster Parents. Similarly, Disadvantaged Foster Parents reported being more likely to discontinue being a foster parent, followed by the Strained Foster Parents. This study is an important contribution to understanding how a variety of variables, including secondary traumatic stress, are associated with intent to disrupt placements or leave fostering altogether.
Similar to other studies, there are limitations regarding determining causality due to the cross-sectional design. Additionally, the authors highlighted that they were only able to measure foster parents’ intent to disrupt or leave fostering instead of their actual behaviors.

**Unpublished Study**

In an unpublished study, Ottaway and Selwyn (2016) examined compassion fatigue with foster carers in the United Kingdom through a mixed methods study using an online survey and focus groups. In their survey of 546 foster parents, the authors found that 25% of foster parents had high levels of secondary traumatic stress, and 50% had moderate levels, as measured by the ProQOL. They also found that working as a foster carer for a longer period of time was associated with higher levels of secondary traumatic stress. Additionally, 26% of foster carers in this sample had high levels of burnout, while 45% had moderate levels. The researchers also conducted four focus groups with a total of 23 participants, which they noted confirmed their findings that foster carers were experiencing secondary traumatic stress. Within the focus groups, participants described secondary traumatic stress as having a negative impact on their mental and physical well-being. They also indicated that their symptoms of secondary traumatic stress impacted the quality of their caregiving, as they were often able to meet only the basic needs of the foster children. Additionally, their responses highlighted the negative impact that secondary traumatic stress has on placement stability and retention of foster carers. The focus group participants also described experiencing primary trauma from their foster children, such as physical assaults on themselves, family members, and pets, as well as emotional abuse. While the themes highlighted from these focus groups are helpful in understanding foster carer’s experiences of secondary traumatic stress, the authors did not provide any information on the
qualitative methodology used to analyze the focus group data, which is a significant limitation of this study.

**Dissertations**

In addition to the above studies, a thesis and several dissertations have focused on secondary traumatic stress within the foster parent population. In McLain’s (2008) dissertation, 201 foster parents in New York were surveyed about their experiences with secondary traumatic stress and burnout. Compared to normative means, this sample demonstrated overall low levels of secondary traumatic stress, overall burnout, work burnout, and client burnout, and overall high levels of compassion satisfaction and personal burnout. However, despite the overall low mean level of secondary traumatic stress, 21.8% of the foster parents were experiencing high levels of secondary traumatic stress symptoms, as measured by the ProQOL. The researcher also found that foster parents’ participation in therapy was associated with higher levels of secondary traumatic stress systems. Other independent variables, such as length of experience as a foster, number of children fostered, and personal trauma history, were not found to be associated with secondary traumatic stress. The researcher noted that secondary traumatic stress and burnout were found to have only a moderate association, which indicated that, despite some overlap, the constructs are separate in this population. Several limitations are evident in this study. First, the researcher conducted a very large number of correlations between variables. It is possible that some of the significant correlations may have occurred by chance, as a result of Type 1 errors. Second, the data was only analyzed using correlations. The use of regression analysis would have aided in understanding the predictive relationships among the independent and dependent variables. Finally, the sample of foster parents was recruited via foster agencies and a department
of human service website. Given this, recruitment may not have reached foster parents who either did not need help or who were too overwhelmed to ask for help.

In a master’s-level thesis, Parker (2009) surveyed 35 foster parents in California regarding their experiences of secondary traumatic stress. In this sample, 40% of the foster parents reported high levels of secondary traumatic stress based on the ProQOL-IV. Years of foster parenting experience was found to correlate positively with secondary traumatic stress levels. However, social support and foster parent training were not found to correlate with secondary traumatic stress. The researchers also found a significant positive correlation between burnout and secondary traumatic stress. While results of this study are in line with other research, this study contains several limitations. The sample for this study was small and limited to one state. Additionally, convenience sampling was used and was limited to foster parents who were involved in foster parent associations, which may limit the generalizability of the findings.

Blanchette’s (2011) dissertation was conducted with 70 therapeutic foster care parents in Virginia. Within this sample, the researcher examined associations between several variables including secondary traumatic stress, burnout, compassion satisfaction, forgiveness, and empathy. They found that high levels of forgiveness were related to lower levels of secondary traumatic stress, as measured by the ProQOL. They also found that higher levels of perspective taking (i.e., empathy) were related to lower levels of secondary traumatic stress. It was hypothesized that both forgiveness and empathy may serve as a buffer to the development of secondary traumatic stress symptoms within the foster parent population. Given that the sample for the study was limited to therapeutic foster care parents, it is unclear how these results would generalize to foster parents in a regular setting. Additionally, the sample in this study was fairly small and lacked diversity in terms of race and gender. Finally, the author noted that the
reliability coefficients of several of the scales used in this study were lower than 0.70, which indicates that they may not have provided reliable measurement of the constructs.

In a qualitative dissertation, Redfern (2013) conducted interviews with 11 foster parents in the United Kingdom. Data from the interviews were analyzed using Interpretive Phenomenological Analysis. The six themes identified indicated that foster parents were experiencing a variety of both negative and positive impacts from fostering. First, the foster parents described the emotional impact from fostering, including feeling overwhelmed and reaching their emotional threshold. However, they also indicated that they found fostering rewarding and identified positive impacts on their emotional well-being. Second, the foster parents described cognitive impacts from fostering, including a sense of injustice, a change in their perception of the world, and increasing doubts about their ability to make a difference. However, they also described feeling satisfaction and pride about fostering. Third, the foster parents discussed the impact of the foster care system. They described the importance of being supported and understood, and highlighted the struggle of being responsible for foster care children without having parental control. They also indicated that they felt that the foster care system did not always meet foster children’s needs. Fourth, the foster parents described the negative impacts of fostering on their families and social lives, while also highlighting some positive impacts on their families. Fifth, the foster parents described their efforts at coping with the difficulties of fostering, including the importance of support and receiving breaks from the foster child. They also highlighted their search for meaning surrounding fostering, as well as feeling a duty to “make a difference” in foster children’s lives. Finally, they described their effort to understand their foster child’s behavior by using information from their foster child’s past experiences, as well as their own past experiences. Overall, this qualitative study provides
important information about the lived experiences of foster parents. The author connected the first theme of emotional impact with the concept of secondary traumatic stress, stating that the reported emotional impact of fostering indicates that foster parents may develop secondary traumatic stress. However, the study did not include any quantitative measurement of secondary traumatic stress, so it is unclear whether the reported experiences are actually connected to the experience of secondary traumatic stress. It is possible that these experiences could be related to other constructs, such as burnout. An additional limitation is the sampling procedure, as only foster parents of foster children receiving mental health services were included in the study. Given this, it is possible that the experiences reported in this study may not be representative of foster parents who are fostering children with less severe mental and behavioral health needs.

Focused on foster parents in Ireland, Reinhardt’s (2016) dissertation utilized a mixed methods approach to examining secondary traumatic stress, burnout, and compassion satisfaction. In the quantitative portion of the study, 99 foster parents completed an online survey using the ProQOL. Compared to normative data, this sample of foster parents was experiencing higher levels of secondary traumatic stress, burnout, and compassion satisfaction. Concerningly, 31% of the sample demonstrated high levels of secondary traumatic stress. Using hierarchical linear multiple regression analysis, the researcher found that secondary traumatic stress levels were predicted by foster parents’ self-care, foster children’s challenging behavior, and total number of children that the foster parent had fostered. In particular, higher levels of stress management as a form of self-care were found to be a predictor of lower levels of secondary traumatic stress. In the qualitative portion of the study, semi-structured phone interviews were conducted with ten foster parents, five who were experiencing low levels of secondary traumatic stress and five who were experiencing high levels. Using inductive thematic analysis to analyze
the interviews, six themes were found. First, the foster parents highlighted the importance of their foster child’s past experiences and current behavioral concerns. Second, the foster parents discussed their role as a foster parent, describing themselves as having a deep connection with their foster child. They also discussed things that interfered with their foster parent role, such as the foster care system and the foster child’s birth parents. Third, the foster parents described the importance of support, including their frustration with the foster care system and their need for more support overall. Fourth, they identified helpful coping strategies, including self-care, problem-focused coping strategies, and emotion-focused coping strategies. Fifth, the foster parents described experiencing a “Big Brother” effect, as they felt like they were under surveillance and controlled by the foster care system. Finally, the foster parents highlighted positive outcomes from fostering on themselves, their family, and the foster child. However, they also described some negative outcomes on their family. The mixed methods design of this study provides a valuable contribution to the literature on secondary traumatic stress in foster parents. In terms of limitations, the authors noted that the response rate to their online survey was low, which may indicate potential bias in the respondents. Additionally, similar to the studies reviewed above, the cross-sectional design of the study limits the ability to determine causality between the variables.

Carew’s (2016) dissertation examined the prevalence of secondary traumatic stress in 40 foster parents in Michigan. The researcher found that 20% of the sample was experiencing secondary traumatic stress at moderate to severe levels. In addition, 12% of foster parents met diagnostic criteria for PTSD from their secondary trauma exposure. Similar to Whitt-Woosley’s (2020) study, an updated version of the STSS was utilized in this dissertation. This version was updated to reflect the PTSD criteria in the DSM-5 through communication with the developer of
the STSS (APA, 2013). However, at the time of Carew’s (2016) dissertation, no studies on this updated version of the STSS had been published. In addition to prevalence rates, the researcher found that having adequate social support and having a personal trauma history were associated with lower levels of secondary traumatic stress. They hypothesized that having a personal trauma history may be serving as a buffer in this population. Other variables, including self-care, years of experience as a foster parent, and frequency of exposure to details regarding their child’s trauma, were not found to be associated with levels of secondary traumatic stress. While this study provides additional evidence for the prevalence of secondary traumatic stress in foster parents, the small sample size from one state may limit the generalizability of these findings.

In a more recent dissertation, Lively Cookson (2022) examined whether using respite care impacted foster parents’ secondary traumatic stress. The sample in this study included 75 foster parents in the United States who completed the ProQOL-5. The researchers found that foster parents who used respite care experienced lower levels of parental self-efficacy. Interestingly, using a simple correlational analysis, the researchers did not find a significant association between using respite care and levels of secondary traumatic stress. However, using multiple linear regression, the researchers found that parental self-efficacy had a significant moderating effect on the association between respite care utilization and secondary traumatic stress. When foster parents had low self-efficacy in their parenting role, using respite care was not significantly associated with secondary traumatic stress. However, when foster parents had high parental self-efficacy, using respite care had a significant negative relationship with secondary traumatic stress. That is, among foster parents with high self-efficacy, those who used respite care had lower levels of secondary traumatic stress. While the cross-sectional design of this study limits the ability to determine causality, the results from this study highlight the
potential benefit of providing respite care to foster parents who have high self-efficacy in their parenting role. An important limitation of this study is that the sample only included foster parents who had children between the ages of 3 and 12. Given that many foster children are older or younger than this age range, the results from this study may not accurately represent the experiences of many foster parents in the United States (HHS, 2022).

Summary

The studies reviewed above provide preliminary evidence for the existence of secondary traumatic stress among foster parents. Utilizing both the STSS and ProQOL, researchers have found that secondary traumatic stress is prevalent in this population, with a subset of foster parents having symptoms at the level associated with PTSD (Bridger et al., 2020; Hannah & Woolgar, 2018; Ottaway & Selwyn, 2016; Steen & Bernhardt, 2023; Whitt-Woosley et al., 2020; Whitt-Woosley et al., 2022a). Interestingly, in addition to experiencing secondary traumatic stress, there is evidence that foster parents experience primary trauma from their foster children as well (Bridger et al., 2020; Hannah & Woolgar, 2018; Ottaway & Selwyn, 2016). This appears to be a common experience, as Bridger et al. (2020) found that 76.5% of foster parents reported a history of primary trauma from their foster children. This finding complicates the examination of secondary traumatic stress in this population, given the overlap in symptoms between secondary traumatic stress and PTSD. Finally, many of the studies reviewed above have examined risk and protective factors for the development of secondary traumatic stress in foster parents. Unfortunately, many of the factors were only examined in one study, and those that were examined in multiple studies often produced conflicting results. While additional research is needed to further explore these factors, these studies overall provide compelling evidence that secondary traumatic stress is an important issue within the foster parent population.
Gaps in Research

Despite the studies reviewed above, it is clear that there is an overall lack of research on secondary traumatic stress in foster parents, as only nine studies have been published to date. Notably, all nine of these studies have been published since 2018, which suggests that researchers have begun to recognize the gap in the literature. Importantly, when this dissertation study was designed, there was an overall lack of studies conducted in the United States. While three dissertations and a master’s-level thesis had examined the topic within United States foster parents, only one published study had occurred in the United States (Whitt-Woosley et al., 2020). Encouragingly, four additional studies from the United States have been published since then. Interestingly, four studies of the existing published and unpublished studies have occurred with foster parents in the United Kingdom. In England, 66% of children in foster care enter the system due to abuse or neglect, which is comparable to the rates in the United States (Department of Education, 2021; HHS, 2021). Similar to the United States, foster parents in the United Kingdom receive pre-approval foster training (i.e., preservice training), as well as ongoing training (i.e., in-service training) (FosterCare UK, n.d.). While there are likely many similarities between the experiences of fostering in the United States and the United Kingdom, there may also be important cultural differences which could influence how foster parents experience secondary traumatic stress. For example, the culture in the United Kingdom can be more reserved than the United States, which could lead to more stigma around mental health and less willingness from foster parents to share their experiences with secondary traumatic stress (Havis, 2017). Given this, it is possible that studies conducted in the United Kingdom may not be generalizable to foster parents in the United States. Additionally, there is a lack of focus on culture overall in the studies that have been published to date. Even within the United States, foster parents’
experiences of secondary traumatic stress may be influenced by cultural variables, such as race/ethnicity, gender, socioeconomic status, religion, and geographical region. Unfortunately, research on secondary traumatic stress in foster parents has not yet thoroughly examined the impact of these cultural differences.

An additional gap in the research is a lack of longitudinal studies, as all but one of the available quantitative studies are cross-sectional. While Whitt-Woosley et al. (2022a) assessed longitudinal data to determine the impact of COVID-19 on foster parents’ levels of secondary traumatic stress, it is questionable whether their results could be generalizable to experiences outside of COVID-19. More general longitudinal studies would provide helpful information on how secondary traumatic stress might develop and change over time in foster parents. As the current cross-sectional studies only provide a snapshot of foster parents’ secondary traumatic stress symptoms, it is unknown whether these symptoms are stable or fluctuate over time. Relatedly, there is a need to examine the experience of secondary traumatic stress within foster parents who have discontinued fostering. Given the high rate of turnover of foster parents, it is important to understand if and how symptoms of secondary traumatic stress might play a role in an individual’s decision to leave fostering (Gibbs & Wildfire, 2007). This is especially important given that two studies have found that foster parents with higher levels of secondary traumatic stress were more likely to report intent to discontinue fostering (Dowdy-Hazlett & Clark, 2024; Hannah & Woolgar, 2018).

While the existing research has established the prevalence of secondary traumatic stress in foster parents across several samples, more research is needed to determine which factors put an individual most at risk for developing symptoms. The existing studies have examined a variety of factors, including social support, self-care, years of fostering experience, personal
trauma history, primary trauma experience, empathy, cognitive styles, frequency of exposure to details about a child’s trauma, number of children fostered, foster children’s challenging behavior, training, sensitivity to foster child’s posttraumatic stress symptoms, religious/spiritual help-seeking behaviors, and certain COVID-19 stressors. However, only a few of these factors have been examined in multiple studies, and those that have often produce conflicting results depending on the study. For example, social support has been found to have no relationship with secondary traumatic stress in two studies, while it was associated with decreased levels of secondary traumatic stress in two other studies. Similarly, length of experience as a foster parent has been found to have no association, as well as a positive association, with secondary traumatic stress depending on the study. One important variable of interest, foster parents’ own personal trauma history, has also demonstrated inconsistent results. Both Whitt-Woosley et al. (2020) and McLain (2008) found that personal trauma history was not associated with secondary traumatic stress levels, while Carew (2016) found that personal trauma history was associated with lower levels of secondary traumatic stress. These results are interesting given that having a personal trauma history has been consistently found to put child welfare professionals at an increased risk for secondary traumatic stress symptoms (Hensel et al., 2015; Molnar et al., 2020; Reinks, 2020). Clearly, more research is needed to determine the relationship between these two variables among foster parents. Overall, the literature base would benefit from additional studies examining the risk and protective factors for secondary traumatic stress among this population.

An additional gap in the literature relates to the measurement of secondary traumatic stress. The current studies have all relied on self-report measures, including the STSS and ProQOL. Due to social desirability bias, foster parents may be reluctant to share their true experiences with secondary traumatic stress, which makes relying solely on self-report measures
problematic. It would be helpful for studies to include behavioral observations of foster parents or reports from other individuals in the foster parents’ lives, such as spouses, other children, and child welfare workers. In addition, the STSS and ProQOL were developed for and normed on helping professionals, such as social workers and healthcare professionals. Given the potential differences between foster parents and those who work with traumatized clients as part of their job, it is unclear whether these norms can be appropriately applied to foster parents as well. Development of a secondary traumatic stress measure specific to foster parents’ experiences should be a focus of future research. Relatedly, an additional gap in the literature is the lack of studies examining how secondary traumatic stress impacts foster parents’ functioning. As discussed earlier, the STSS and ProQOL do not assess for impact on functioning. It is important to understand how symptoms of secondary traumatic stress might impact a foster parent in different areas of their life, such as work or social relationships. In addition, it is important to understand how foster parents’ parenting might be impacted by symptoms of secondary traumatic stress, as well as how the symptoms might affect their foster child. Using structured clinical interviews with foster parents, possibly through using the STS-CA, may be a way to assess for impact on functioning.

A final gap in the literature is the lack of qualitative studies on secondary traumatic stress within foster parents in the United States. There are currently only two published qualitative studies, one which was conducted with foster parents in Australia and one which was conducted with foster parents in the United States focused on COVID-19. The remaining qualitative studies (two dissertations and one unpublished study) were conducted in the United Kingdom and Ireland. As discussed above, qualitative studies are needed in this area, given that foster parents may experience secondary traumatic stress differently compared to other helping professionals,
such as child welfare workers. Foster parents may have difficulty separating their “work” and personal lives, and they may also experience primary trauma from their foster child. In addition, foster parents may witness and be responsible for managing their foster child’s trauma symptoms. They may also be more intimately exposed to their child’s trauma compared to those who are exposed in a work setting. These potential differences may limit the usefulness of studies on child welfare professionals in advancing understanding of foster parents’ experiences of secondary traumatic stress. Given this, there is a need for more qualitative studies on secondary traumatic stress in foster parents to better understand their unique experience and better support them as they parent children with trauma.
Chapter 3: Methodology

Overview of Consensual Qualitative Research

This study used Consensual Qualitative Research (CQR) methodology to analyze data from semi-structured, individual interviews with foster parents to understand their experiences of secondary traumatic stress. CQR was initially developed by Hill et al. (1997), with later refinements by Hill et al. (2005, 2012). More recently, Hill and Knox (2021) provided updated recommendations on conducting CQR studies.

CQR contains both constructivist, as well as postpositivist, elements (Hill et al., 2005). From a constructivist perspective, CQR researchers recognize that there is no one “truth,” but instead multiple versions of the “truth” exist, which are socially constructed (Hill & Knox, 2021). They aim to use participants’ words, gathered through interviews, as well as the context of those words, to gain understanding of different topics (Hill & Knox, 2021). In addition, CQR researchers recognize that the researcher and participants exert mutual influence on each other throughout the research process (Hill & Knox, 2021). Given this, it is understood that biases from researchers will occur, and it is thus important for these biases to be discussed among the research team and set aside as much as possible (Hill & Knox, 2021).

From a postpositivist perspective, CQR researchers aim to develop the best representation of the data by using their multiple perspectives to arrive at consensus among team members (Hill & Knox, 2021). The use of an external auditor also aids in this process by providing an additional perspective not influenced by groupthink. In addition, a standard interview protocol is created, so that the same questions are used across all participants to collect consistent data (Hill & Knox, 2021).
As the name implies, a central component of CQR is its reliance on consensus among team members, which sets it apart from other qualitative methodologies (Hill et al., 1997; Hill & Knox, 2021). To gain a deep understanding of the complex topic being studied, multiple researchers, including an auditor, are involved in the project, which allows different perspectives to be provided and the biases of any one researcher to be limited (Hill et al., 1997). The use of consensus and multiple researchers increases the trustworthiness of results from CQR studies (Hill & Knox, 2021). Another important feature of CQR is the systematic and rigorous process for analyzing the data, as will be described below. In addition, it is common for researchers to go back to the data (i.e., the participants’ words) during the data analysis process to make sure that they are staying close to and accurately representing the data (Hill & Knox, 2021).

**Rationale for Consensual Qualitative Research**

The principal investigator selected the CQR methodology for this study for several reasons. First, this study aimed to gain an in-depth understanding of foster parents’ lived experiences related to secondary traumatic stress, which fits well with CQR (Hill & Knox, 2021). Experiencing secondary traumatic stress is an internal event, and the methodology of CQR allowed this experience to be examined deeply through the voices of the participants (Hill & Knox, 2021).

Second, as discussed above, there is an overall lack of research on secondary traumatic stress in foster parents. CQR can be helpful in the early stages of studying a phenomenon, especially when there is a lack of quantitative measures (Hill et al., 1997; Hill & Knox, 2021). While instruments for measuring STSS exist, they were developed for helping professionals and have not yet been normed on foster parents. Using a qualitative methodology, such as CQR, can help to develop a deeper understanding of how foster parents experience this phenomenon.
Third, CQR has both constructivist and postpositivist elements, which aligns with the research paradigm of the principal investigator (Hill et al., 2005). Finally, CQR is a rigorous method which produces trustworthy data. Unlike some qualitative methods, the methodology of CQR is clearly established and consistent data collection is used across participants (Hill et al., 2005; Hill & Knox, 2021. In addition, as mentioned above, the use of multiple researchers and the importance of consensus adds to the trustworthiness of data analyzed using CQR.

Research Team

The primary research team initially consisted of three team members. The principal investigator was a 37-year-old White female who was a counseling psychology doctoral student at Marquette University. The principal investigator had clinical experience working with children in foster care, as well as experience participating on three other CQR research teams. The principal investigator also had a personal interest in foster care, as she hoped to become a foster parent in the future. The two other team members were also counseling psychology doctoral students in the same program as the principal investigator. One team member was a 48-year-old White female who had experience working with foster children and their families during her clinical training. The other team member was a 34-year-old White female who had professional experience working with foster children as a school principal. She had also previously fostered three children and adopted one child from foster care. All three team members were familiar with CQR and had previously worked together on another CQR project.

Unfortunately, the 48-year-old team member had to discontinue their role on the team due to personal circumstances after the domaining process (described below) was completed. A 23-year-old White female in her first year of counseling psychology doctoral studies then joined the team for the core idea and cross-analysis processes. The new team member had professional
experience with foster care through a role where she edited family court evaluations. She also had personal experience with a family member being in foster care. The new team member did not have prior experience with CQR, so she was encouraged to review literature that outlined the CQR methodology (i.e., Hill et al, 1997; Hill et al., 2005; Hill & Knox, 2021). The primary investigator also met with the new team member to provide an overview of CQR and to update her on the progress made by the initial team. In addition to the primary team, the principal investigator’s doctoral advisor also served as an auditor for the research team. This individual had significant research experience using CQR, as well as clinical experience working with foster youth. The auditor reviewed the interview protocol and audited the data analysis process, as outlined below.

**Biases**

In CQR research, it is important for the research team to discuss and address their expectations and potential biases in order to limit their influence on the data analysis process (Hill & Knox, 2021). Expectations refer to the team members’ beliefs about how participants may respond to the interview, which can develop from reading background literature and preparing the interview protocol (Hill et al., 1997). In contrast, biases refer to characteristics of a team member, such as their beliefs, cultural background, or demographic variables, which may influence their ability to objectively analyze the data (Hill et al., 1997). In addition to having a discussion about biases and expectations at the beginning of the project, it was important for the team to check in about biases and expectations during team meetings throughout the project, in an effort to hold themselves accountable to ensure that they were staying as objective as possible (Hill & Knox, 2021).
The principal investigator led a discussion about expectations and biases at the beginning of the project with the initial primary team. First, the team discussed their expectations about how participants might respond to the interview questions. The team members all expected that participants might report feeling unsupported and frustrated at the foster care system. The principal investigator explained that she expected that participants would express frustration at the lack of training they received, while the 48-year-old team member shared that she thought participants would report feeling ill-equipped to deal with their foster child’s trauma. The 34-year-old team member stated that she wondered whether participants might discuss having concerns about their own physical safety due to their foster child’s behaviors. All three team members agreed that they expected that participants might become emotional during the interviews due to not previously having had space to share this type of information with others. Additionally, the principal investigator stated that she expected that some participants would discuss how this experience led them to want to stop fostering.

Next, the team members discussed their biases. The 34-year-old team member expressed her own bias and frustration against the foster care system as a former foster parent. All three team members, who identified as White, also discussed their biases against White foster parents who are fostering Black or Brown foster children and who use language that pitied the foster child and promotes White saviorism. The team also agreed on the importance of foster parents advocating for reunification of the foster child and their biological family, and the team acknowledged potential bias against foster parents whose motivation to foster was solely to adopt from foster care. Relatedly, the team discussed the need for better support for biological parents and their bias against foster parents and others in the child welfare system who speak poorly of biological parents. Finally, the team members also collectively acknowledged their
own biases as psychologists-in-training who had received clinical training in how to work with children who had experienced trauma. The team agreed on the importance of remembering that their knowledge of trauma and how to deal with trauma would likely differ from the foster parents in this study who had not received that same level of clinical training.

A second discussion regarding biases was conducted when the composition of the team changed after the domaining process. The original two team members discussed their biases that had come up while reading the transcripts during the domaining process. The principal investigator shared that her bias about the inadequacy of the foster care system’s support of foster children and foster parents had been reinforced by what participants had shared in the interviews. The 34-year-old team member acknowledged that she had a lot of emotions arise while reading the transcripts and it was difficult to not interpret participants’ experiences through her own lens as a foster parent. The new team member discussed her bias of whether what participants shared would be considered secondary traumatic stress or just a normal reaction to what they had experienced. In an effort to stay as objective as possible while analyzing the data, the team continued to check in regarding biases throughout the core idea and cross-analysis processes.

Participants

Eligibility Criteria

In order to be eligible for participation in this study, participants had to meet the following inclusion criteria:

1. live in the United States,
2. held a license as a foster parent within the last year,
3. fostered a child at least five years old with trauma for at least one month within the last year,

4. experienced symptoms of secondary traumatic stress within the last year.

This list of inclusion criteria was developed in an effort to obtain a homogeneous sample (Hill et al., 1997; Hill & Knox, 2021). The first inclusion criterion indicated that participants must have lived within the United States. International participants were not recruited due to the potential cultural differences that could impact results, as well as potential differences in the structure of foster care systems across different countries.

Secondly, participants needed to have held a license as a foster parent within the last year. Importantly, this study focused on foster parents, not kinship parents, given the likely different experiences between the two groups. The third inclusion criterion was aimed at recruiting participants who had fostered a child with trauma. The age limit of requiring the child to be at least five years old was established so that all participants would have fostered a child who could have potentially verbalized the trauma they had experienced. The requirement that the child had lived with the foster parent for at least one month was based on the assumption that it may have taken time for the foster parent to learn about their child’s trauma and observe their trauma symptoms.

The final inclusion criterion was aimed at recruiting foster parents who were knowledgeable about and had relevant experience related to secondary traumatic stress (Hill & Knox, 2021). The concept of secondary traumatic stress was defined and described in the Recruitment Letter (Appendix A) so that foster parents were able to determine whether they met this criterion. The recruitment process relied on foster parents self-identifying as having experienced secondary traumatic stress, and their responses on the Secondary Traumatic Stress
Scale confirmed that all participants were experiencing secondary traumatic stress (see below for more detailed information). The last two criteria indicated that participants must have had these experiences within the last year. This timeframe was set given the desire to recruit participants who had a relatively recent experience with secondary traumatic stress and who would therefore have an easier time remembering the experience and providing rich, meaningful data (Hill et al., 1997).

**Demographic and Background Information**

Recruitment resulted in 14 foster parent participants for this study. Eleven participants identified as female, while three participants identified as male. Twelve participants identified as White or European American and two participants identified as Black or African American. Participants ranged in age from 30-54 years \( (M = 36.57, SD = 6.39) \). Eight participants were married, while six participants reported being single caregivers. Participants were geographically dispersed across the United States, with six participants from the South, four participants from the Midwest, two participants from the West Coast, and two participants from the East Coast.

Regarding their history as foster parents, participants reported having 0.5 to 3 \( (M = 1.76, SD = 0.83) \) years of experience as licensed foster parents. On average, participants had fostered 2.29 foster children in total \( (range = 1-6 children, SD = 1.54) \). At the time of the interview, seven participants had foster children currently living in their home. Additionally, three participants had children who they had adopted currently living in their home, while two participants had biological children living in their home. Thirteen participants reported that they had received training on trauma during the foster parent licensing process. These participants rated how prepared they felt to parent children with trauma based on that training on a 5-point scale \( (1 = \text{Not At All Prepared}, 5 = \text{Very Prepared}) \) and the mean rating was 2.85 \( (SD = 0.56) \). Only four
participants reported that they had received training on secondary traumatic stress during the licensing process. When asked to rate how prepared they felt to deal with secondary traumatic stress based on that training on a 5-point scale (1 = Not At All Prepared, 5 = Very Prepared), the four participants reported a mean rating of 2.0 ($SD = 0.82$).

Participants also reported on demographic information regarding the foster child that they discussed during the interview. Eleven of the foster children were female, two foster children were transgender, and one foster child was male. The foster children ranged in age from 9-17 years ($M = 12.86, SD = 2.88$). Eleven of the foster children had had previous foster care placements before living with the participant, while three of the children had no previous placements. The length of the foster children’s placement with the participants ranged from 3-36 months ($M = 14.57, SD = 8.99$). Eight of the foster children were still placed with the participant at the time of the interview, while six of the foster children no longer lived with the participant. Of those who no longer lived with the participant, three children were moved to a higher level of care (e.g., residential facility, psychiatric facility). Additionally, one foster child had run away from the participant’s home, while two of the foster children were removed from the participant’s home due to the participant deciding to end the placement.

**Secondary Traumatic Stress Scale**

As part of the Demographic Form (Appendix C, described in more detail below), participants completed the Secondary Traumatic Stress Scale (STSS) updated for the *DSM-5* (APA, 2013; Bride, 2013; Bride et al., 2004). On average, participants had a total STSS score of 60.36 ($SD = 8.80$). While there are not currently established guidelines for cutoff scores of the updated version of the STSS, Sprang et al. (2021) found that having a score of 46 or higher on the updated STSS was associated with meeting criteria for PTSD. Given this, a score of 46 or
higher was used to indicate high levels of secondary traumatic stress in Whitt-Woosley’s (2022) study with professionals working in the child welfare system (including foster parents). Using this same interpretation, participants’ total STSS scores in the current study ranged from 49-76, indicating that all of the participants had experienced high levels of secondary traumatic stress while parenting their foster child. Items on the STSS are on a 5-point scale (1 = Never, 5 = Very Often). The five items with the highest scores across participants were: “I expected something bad to happen” ($M = 4.21, SD = 0.80$), “I thought about caring for my foster child or their experiences of trauma when I didn’t intend to” ($M = 4.00, SD = 0.96$), “I was easily annoyed” ($M = 3.93, SD = 0.92$), “I felt discouraged about the future” ($M = 3.93, SD = 0.73$), and “I had trouble concentrating” ($M = 3.86, SD = 0.95$).

**Measures**

**Informed Consent**

Participants were emailed a copy of the informed consent document (Appendix B) to review prior to the interview. In accordance with ethical standards outlined by the American Psychological Association (2017, Section 8), the informed consent document contained information regarding purpose and procedures of the study, risks and benefits of participation, limits of confidentiality, the voluntary nature of participation, compensation for completing the study, and contact information for the principal investigator. The informed consent document was also reviewed with participants at the beginning of the virtual interview to ensure their understanding and answer any questions. Verbal consent was obtained by the principal investigator prior to beginning the recording.

**Demographic Form**
Participants were also emailed a link to a demographic form (Appendix C), which was hosted on Qualtrics survey software, to complete prior to the interview. This form gathered demographic information on the participant. It also gathered information on their history of being a foster parent, including length of time as a foster parent, number of children cared for, and experience with foster parent training. In addition, the form gathered information on the foster child they planned to discuss during the interview. Finally, the participants completed the Secondary Traumatic Stress Scale (STSS) as part of the demographic form (Bride, 2013; Bride et al., 2004). The revised version of the STSS was used in this study, which reflects updated PTSD criteria in the DSM-5 (APA, 2013). This version, which has also been used by Carew (2016), Whitt-Woosley (2020), and Whitt-Woosley et al. (2022a), was obtained through email communication with the developer of the STSS (Bride, 2013). The STSS was developed for helping professionals, so wording of the items was modified to reflect participants’ experiences as foster parents. The STSS indicates that “client” can be substituted with another noun to better represent participants’ work, and additional modifications were made to describe the role of foster parents. For example, “I thought about my work with clients when I didn’t intent to” was changed to “I thought about caring for my foster child or their experiences of trauma when I didn’t intend to.” On the original measure, participants are instructed to indicate how frequently the items were true for them within the past seven days. In this study, participants were asked to indicate how frequently the items were true while parenting the foster child they were going to discuss during the interview with no timeframe specified.

**Interview Protocol**

The semi-structured interview protocol (Appendix D) consisted of questions related to the foster parent’s experience of secondary traumatic stress. A key feature of CQR interviews is
that each question is asked of each participant, so that consistent and in-depth information is gathered across participants (Hill et al., 1997; Hill & Knox, 2021). The interview questions were all open-ended, in an effort to encourage participants to reflect upon their experiences (Hill & Knox, 2021). Unscripted probes were also used by the principal investigator in situations where the participant needed additional prompting to encourage exploration (Hill & Knox, 2021). The interview questions were developed in part from a review of literature related to secondary traumatic stress in foster parents. As Hill et al. (1997) recommended, while the literature was used in the creation of the questions, the principal investigator attempted to bracket this information during the interview and data analysis process so that it did not influence the data.

The interview protocol was emailed to participants, which allowed them an opportunity to review the questions and think about their experiences prior to the interview (Hill et al., 1997; Hill & Knox, 2021). The interview protocol contained five sections: Foster Child Trauma and Caregiver Experience/Symptoms, Impacts of Secondary Traumatic Stress, Managing Secondary Traumatic Stress, Other Experiences of Trauma, and Closing Questions. In the first section, participants were asked about their foster child’s trauma history, as well as their child’s emotional and behavioral trauma symptoms. They were also asked to describe a typical day or week with their foster child focusing on what it was like to manage their foster child’s trauma symptoms. This section also contained questions focused specifically on the foster parents’ experiences of secondary traumatic stress. Participants were asked about their symptoms, including emotions, thoughts, or physical symptoms, that they experienced when hearing about their foster child’s traumatic experiences or observing and managing their foster child’s trauma symptoms. Their answers on the STSS were also reviewed, and they were asked to expand upon their experiences with those symptoms.
The second section of questions focused on the impact of secondary traumatic stress, including how it influenced participants’ overall functioning, how they cared for their foster child, and their desire to continue fostering. In the third section, questions then shifted to how the participants managed their symptoms of secondary traumatic stress, including how they took care of themselves, how they utilized social supports, what made it easy or difficult to manage their symptoms, and how the child welfare system supported them. In the next session, participants were asked about additional experiences of trauma and how it may have influenced their experiences of secondary traumatic stress, including their own personal history of trauma and any primary trauma from their foster child that was experienced by themselves or family members.

Finally, the questions in the Closing Questions section were designed to allow participants to reflect broadly on their experience of secondary traumatic stress (Hill & Knox, 2021). In this section, they were asked about their ideas for how the child welfare system could have better supported them. Additionally, they were asked to reflect on what it was like to participate in the study and were provided space to ask questions of the principal investigator.

**Data Collection Procedures**

**Pilot Interviews**

Per Hill and Knox’s (2021) recommendation, the principal investigator conducted pilot interviews with two individuals. The pilot interviews provided information on the types of responses that might be elicited from the questions and how participants might react to the interview (Hill et al., 2005). In addition, the pilot interviews allowed the principal investigator to practice using the interview protocol. The first pilot interview was conducted with the 34-year-old member of the primary research team, who was a current counseling psychology doctoral
student. This individual had experience as a foster parent, and thus provided a valuable perspective. The second pilot interview was conducted with a licensed professional counselor who had experience working with foster children and their foster parents through an outpatient counseling clinic. After these individuals reviewed the demographic form and completed the pilot interview, they were asked to provide feedback on the wording and flow of the questions, as well as their overall reaction to the interview. The individuals made several suggestions regarding the interview protocol, including rewording questions, changing the order of questions, and adding one question. For example, one individual suggested adding the following question: “How did these symptoms affect or influence your functioning such as your relationships with family and friends, work life, and self-care?” These suggestions were reviewed by the principal investigator and auditor and incorporated into the final version of the interview protocol.

**Participant Recruitment**

As is common in qualitative research, a relatively small number of participants were recruited to study their experiences in-depth (Hill & Knox, 2021). Hill et al. (1997) originally recommended a sample size of 8 to 15 participants for CQR studies. However, recent recommendations indicate that a sample size of 13 to 15 participants is ideal, as this size allows for data saturation and consistency across participants (Hill & Knox, 2021). Given this, the principal investigator attempted to recruit a sample of 13 to 15 foster parents, ultimately obtaining a sample of 14 participants.

Recruitment for this study was accomplished through the use of social media, including Instagram, Facebook, Reddit, and LinkedIn. In addition to posting on their personal social media pages, the principal investigator posted information about the study on Reddit and on several Facebook foster parent online support groups. Two Instagram pages focused on foster care
shared information about the study with their followers after being contacted by the principal investigator. Additionally, the principal investigator reached out to several in-person foster care parent support groups to assist with recruitment. Out of the 14 participants, six were recruited from Reddit and six were recruited from a large foster care Instagram account who shared the study with their followers. Additionally, one participant was recruited from LinkedIn and another was recruited through word of mouth after the principal investigator shared information to her personal Facebook page.

Interested participants were directed to a Qualtrics survey page, which contained the Recruitment Letter (Appendix A) describing the study and inclusion criteria. Participants were then asked to provide their contact information in the Qualtrics survey, including their name, phone number, email address, and preferred mode of contact. They were also asked to indicate whether they met the inclusion criteria. The principal investigator reached out to interested participants via email to send the Informed Consent (Appendix B) and Interview Protocol (Appendix D) documents, as well as the link to the Demographic Form (Appendix C). In this email, the principal investigator also began the process of scheduling the interview with participants.

**Interview**

Individual interviews with participants took place over Microsoft Teams video conferencing. Video interview format was selected over in-person interviews because it was hypothesized that participants would find it less threatening and more comfortable to discuss their potentially sensitive experiences of secondary traumatic stress in this format (Hill et al., 2005). Recruitment also took place across the United States and traveling for in-person interviews was not logistically feasible. Additionally, video interviews were preferred over
phone interviews given that the principal investigator had the ability to view participants’ nonverbal data, which added important information (Hill & Knox, 2021). Interviews were expected to last approximately 45 to 60 minutes. Depending on the participants’ response styles, interviews lasted from 30 to 100 minutes ($M = 57.93, SD = 20.11$).

All interviews were conducted by the principal investigator to help ensure consistency across interviews (Hill et al., 1997). The principal investigator had training and experience in conducting both clinical and research interviews, as is recommended by Hill et al. (1997). At the beginning of the interview, the informed consent document was reviewed with participants, including consent to record the interview. Participants were also reminded that the principal investigator’s contact information was available on the informed consent form that was emailed, in case they had any follow-up questions or needs after the interview. Interviews were video recorded using Microsoft Teams video conferencing software. Recordings were then transferred to a secure computer. Code numbers were given to each interview to ensure confidentiality of the data.

In addition to the video recordings, the principal investigator took notes during and after the interview, per Hill and Knox’s (2021) suggestion. Notes taken during the interview helped the principal investigator to stay involved during the interview process, and they also served as a backup in case the recordings were not clear. After the interview, the principal investigator also took notes regarding what the interview was like and any noteworthy information, which provided additional context during the data analysis process.

Given the sensitive and potentially distressing nature of the interview questions, the principal investigator debriefed with participants at the end of the interview to check in on their emotional state (Hill & Knox, 2021). The principal investigator had referral resources on hand in
order to make immediate referrals as needed, including the Psychologist Locator tool from the American Psychological Association, the Counselor Find tool from the National Board for Certified Counselors, and the 988 National Suicide and Crisis Lifeline. All participants reported no concerns regarding their emotional state and no referrals had to be made.

Compensation

Upon completion of the interview, participants were offered a $25 gift card to Target or Walmart as a thank you and compensation for their time. In order to receive the gift card, participants had to complete the Informed Consent document, Demographic Form, and interview. Thank you letters (Appendix E) and gift cards were mailed or emailed to participants, depending on their preference. In addition, the principal investigator offered to provide a copy of the final research article to participants as a way of saying thank you for their participation. All fourteen participants indicated interest in receiving a copy of the article.

Transcription

Interviews were transcribed verbatim by the principal investigator using the recorded video files. Minimal encouragers, other utterances, and all potentially identifying information (e.g., participants’ names, foster children’s names) were removed from the transcripts. Each transcript was assigned a code number in order to ensure confidentiality of the data.

Data Analytic Procedures

Domains

Data analysis was conducted using the three steps of CQR: domains, core ideas, and cross-analysis (Hill et al., 1997; Hill & Knox, 2021). In the domaining step, data was organized into domains (i.e., topic areas). The team worked together to develop the list of domains, which covered all of the important topic areas discussed in the interviews. To create the initial domain
list, the team read through the interview protocol and came up with a list of possible domains together. The team then used this initial domain list to organize the data from the first two transcripts. The team reviewed the organization of the first two transcripts together to reach consensus, which resulted in one additional domain being added to the list. Throughout the domaining process, additional changes were made to the domain list, including renaming domain titles and clarifying what was included in each domain.

After the domain list was developed, all of the data from each transcript was placed into at least one domain (Hill & Knox, 2021). Some data was occasionally double- or tripled-coded into different domains, although the team attempted to do this infrequently. Team members independently coded data into domains and then met as a team to review, discussing disagreements until consensus was reached. After domaining was complete, a consensus version was created for each transcript, which involved placing all of the data into the agreed upon domains.

**Core Ideas**

In the next step of data analysis, core ideas were developed for the data in each domain for each participant (Hill et al., 1997; Hill & Knox, 2021). Creating core ideas involves summarizing the content of each domain into a concise and clear format, which makes it easier to compare data across participants (Hill & Knox, 2021). The summaries should stay close to the participants’ words and should capture the “essence” of what was said (Hill et al., 2005). The principal investigator took responsibility for creating core ideas for each case, which were then reviewed independently by the other two team members. Next, the team members met to give feedback on the core ideas for each case, discussing feedback and differences until consensus
was reached. The auditor then reviewed and provided feedback about the core ideas, which were considered by the team and incorporated as appropriate.

**Cross-Analysis**

Cross-analysis was the final step of data analysis, which involved generating common themes or categories across core ideas from all participants within each domain (Hill et al., 1997; Hill & Knox, 2021). To complete this task, a large word document was created containing the core ideas from each participant organized by domain (Hill & Knox, 2021). The cross-analysis was then completed domain by domain. After reviewing all of the core ideas within a domain, the principal investigator took the lead on developing a list of possible categories and placing each core idea into at least one category. The team then met to discuss the suggested categories and placement of data, making changes until consensus was reached on the structure and names of the categories. Some core ideas did not fit into a category and were thus placed into an “Other” category. The “Other” category was reviewed at the end of the cross-analysis process to determine whether the data fit into any of the categories, or whether a new category might emerge from the data within the “Other” category (Hill & Knox, 2021). Some core ideas were identified to move into existing categories, but no new categories emerged. Similar to the previous step, the auditor reviewed the cross-analysis and provided feedback to the team. In this step of the process, the auditor reviewed and provided feedback on the cross-analysis for each domain as it was completed. In addition, they reviewed the final version of the cross-analysis with all of the domains to provide feedback.

A final step in the data analysis process was indicating frequency labels for each category to denote their representativeness across participant, per Knox and Hill’s (2021) recommendations. Categories were labeled as general (i.e., applies to all or all but one of the
cases), typical (i.e., applies to more than half of the cases up until the cutoff for general), or variant (i.e., applies to at least two cases up to half of the cases).

**Auditing**

As described above, the auditor was involved in providing feedback throughout the data analysis process (Hill & Knox, 2021). The quality of CQR studies, as well as the trustworthiness of the results, is greatly enhanced by having an auditor on the team (Hill & Knox, 2021). The auditor plays an important role, as they are able to introduce a perspective that is not influenced by groupthink, as may happen within the primary team (Hill et al., 2005). In addition, they can challenge the team to approach the data in new ways and can provide a “check” for the team to ensure they are on the right track (Hill & Knox, 2021). At each timepoint when the auditor provided feedback, the team met to review the feedback and reach consensus on whether to make the changes recommended by the auditor. While there were some instances where the team did not make changes recommended by the auditor, the team considered all feedback from the auditor and made sure any decision to disregard their feedback was grounded in the data (Hill & Knox, 2021). In addition, the process between the primary team and auditor was iterative at times, with several versions going back and forth until consensus was reached (Hill & Knox, 2021).
Chapter 4: Results

The results of this study are divided into five major sections. First, contextual findings regarding the participant’s exposure to their foster child’s trauma history and trauma symptoms are presented. This section includes a description of the foster child’s traumatic experiences and trauma symptoms, along with how the participant learned about the trauma history and how they managed the trauma symptoms. These findings present background information that provides context for the secondary traumatic stress experienced by the participants. Second, findings regarding the participants’ secondary traumatic stress symptoms/reactions are reviewed. The third section contains findings related to how secondary traumatic stress impacted participants’ lives, including their parenting and desire to continue fostering. Next, findings on factors that influenced participants’ experiences of secondary traumatic stress are explored. This section contains helpful and challenging factors related to this experience, as well as ways that the child welfare system was helpful and unhelpful to participants. In the final section, participants’ suggestions for the child welfare system, as well as their reaction to participating in the interview, are provided. Per Knox and Hill’s (2021) recommendation, frequency labels were indicated for each category to denote their representativeness across participants. Based on 14 cases total, categories were labeled as general (i.e., 13-14 cases), typical (i.e., 8-12 cases), or variant (i.e., 2-7 cases). Themes that emerged in only one case were placed into “Other” and are not described in this manuscript.

Contextual Findings

As context for their secondary traumatic stress, participants were asked to share about the trauma that their foster child had experienced, as well as how they learned about the child’s trauma. They also described the child’s trauma symptoms and other negative symptoms. Next,
the participants shared about strategies they used to help manage the child’s trauma symptoms.

Participants were also asked about any primary trauma they experienced from the foster child and how that impacted them. Taken together, these domains provide context for the symptoms of secondary traumatic stress that participants experienced, which is discussed in the next section.

These findings are presented in Table 1.

### Table 1

**Domains, Categories, and Frequencies of Contextual Findings regarding Participants’ Exposure to their Foster Child’s Traumatic Experiences and Trauma Symptoms**

<table>
<thead>
<tr>
<th>Domains</th>
<th>Categories</th>
<th>Frequencies*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foster child’s traumatic experiences</td>
<td>Experienced abuse</td>
<td>Typical (12)</td>
</tr>
<tr>
<td></td>
<td>Physical abuse</td>
<td>Typical (12)</td>
</tr>
<tr>
<td></td>
<td>Verbal and/or emotional abuse</td>
<td>Typical (11)</td>
</tr>
<tr>
<td></td>
<td>Sexual abuse</td>
<td>Typical (9)</td>
</tr>
<tr>
<td></td>
<td>Experienced other adverse events within their biological family</td>
<td>Typical (10)</td>
</tr>
<tr>
<td></td>
<td>Experienced neglect</td>
<td>Typical (9)</td>
</tr>
<tr>
<td></td>
<td>Experienced trauma related to their foster care placement(s)</td>
<td>Typical (9)</td>
</tr>
<tr>
<td></td>
<td>Experienced instability in their living situation with biological family</td>
<td>Typical (9)</td>
</tr>
<tr>
<td>How foster parent learned about foster child’s traumatic experiences</td>
<td>FC disclosed their trauma history</td>
<td>General (13)</td>
</tr>
<tr>
<td></td>
<td>The child welfare system shared information about FC’s trauma history</td>
<td>Typical (9)</td>
</tr>
<tr>
<td></td>
<td>Little to no information was shared with P about FC’s trauma history</td>
<td>Variant (7)</td>
</tr>
<tr>
<td></td>
<td>P learned more about FC’s trauma history over time</td>
<td>Variant (5)</td>
</tr>
<tr>
<td></td>
<td>FC’s extended family members shared FC’s trauma history</td>
<td>Variant (3)</td>
</tr>
<tr>
<td></td>
<td>Disclosure of FC’s trauma history occurred through court hearings</td>
<td>Variant (3)</td>
</tr>
<tr>
<td>Foster child’s trauma symptoms and other negative symptoms</td>
<td>Displayed challenging behavioral symptoms</td>
<td>General (14)</td>
</tr>
<tr>
<td></td>
<td>Displayed emotional symptoms</td>
<td>Typical (12)</td>
</tr>
<tr>
<td></td>
<td>Biological family or personal challenges triggered behavioral/emotional reactions</td>
<td>Typical (11)</td>
</tr>
<tr>
<td></td>
<td>Experienced social difficulties</td>
<td>Typical (10)</td>
</tr>
<tr>
<td></td>
<td>Experienced sleep disturbances</td>
<td>Typical (8)</td>
</tr>
<tr>
<td></td>
<td>Struggled academically</td>
<td>Typical (8)</td>
</tr>
<tr>
<td>Foster parent’s management of foster</td>
<td>Managed FC’s environment and routine</td>
<td>Typical (9)</td>
</tr>
<tr>
<td></td>
<td>Worked with FC to manage their emotions</td>
<td>Typical (8)</td>
</tr>
</tbody>
</table>
child’s trauma symptoms

<table>
<thead>
<tr>
<th>Established limits/boundaries with FC</th>
<th>Variant (6)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Offered unconditional love or reassurance to FC</td>
<td>Variant (5)</td>
</tr>
<tr>
<td>Gave FC autonomy to make decisions</td>
<td>Variant (3)</td>
</tr>
</tbody>
</table>

Primary trauma from foster child

| P experienced abuse from FC | Typical (9) |
| Physical abuse or threats of physical abuse | Variant (6) |
| Verbal or emotional abuse | Variant (6) |
| P did not experience any primary trauma from FC | Variant (4) |
| FC was aggressive toward P’s family | Variant (2) |

* 14 total cases. General = 13-14, Typical = 8-12, Variant = 2-7

Note. P = Participant, FC = Foster child

_Foster Child’s Traumatic Experiences_

When asked to describe their foster child’s trauma history, participants typically reported that their foster child had experienced abuse. Three subcategories emerged to further elaborate this abuse, with participants typically describing physical abuse that their child had experienced. One participant shared that their foster child had experienced “extensive physical abuse with years of being beaten by their dad.” Similarly, another participant noted that their foster child’s physical abuse involved her father “locking her in closets and throwing her into walls.”

Typically, in the second subcategory, participants also described verbal and/or emotional abuse experienced by their foster child. As one participant noted, “there was psychological abuse, threats to withhold food.” In the third typical subcategory, participants reported that their foster child had experienced sexual abuse. For example, one participant shared that their foster child had experienced “sexual abuse at the hands of one of his mother’s boyfriends when he was 4-ish. And then also sexual abuse from a father’s girlfriend when he was 7 to 8-ish.”

In a typical category, participants shared that their foster child had experienced other adverse events within their biological family, such as domestic violence, parental substance abuse, death of a parent, and family conflict. For instance, one participant stated, “She witnessed a lot of DV [domestic violence], physical, screaming. At one point her mom had been locked in a
closet for days at a time.” Another participant noted that their foster child’s mother struggled with substance abuse and “would play games with them drinking alcohol, pay them money for drinking shots and if they didn’t throw up.” Participants also typically described neglect that their foster child had experienced. One participant noted that their foster child’s mother “would leave them for days at a time,” while another participant shared that their foster child “spent a lot of time making ends meet and feeding the family and taking care of things.”

Participants typically reported that their foster child had experienced trauma related to their foster care placement(s). One participant shared that their foster child “had been in 14 foster homes and three residential facilities” in a span of 18 months, while also stating that “the separation and removal of her from her parents did a number on her.” Typically, participants described instability that their foster child had experienced in their living situation with their biological family, including experiencing homelessness and frequent moves. For instance, a participant stated:

The younger one had kind of been passed back and forth between the mom and the dad or between other family members because she is pretty oppositional. And so if they couldn't handle her for a few weeks, then she would go somewhere. And so she hadn't had a lot of consistency.

**How Foster Parent Learned about Foster Child’s Traumatic Experiences**

Six categories emerged related to how participants learned about the trauma their foster child had experienced. Generally, participants reported that their foster child had disclosed their trauma history to them, though there was variability in how quickly that occurred. For example, one participant stated, “immediately she just like told me everything,” while another participant shared that their foster child “opened up” about their trauma history “the more I got to know him.” Participants typically indicated that the child welfare system also shared information about
their foster child’s history. One participant explained that, while they learned some information from their foster child, “a lot of it we heard from caseworkers involved.”

In the first variant category, participants described receiving little to no information about their foster child’s trauma history. To illustrate, one participant stated that they “knew very little when they were placed with us.” Another participant expressed frustration that:

We got a little bit of information from the caseworker, but I think the first time we found out more serious information was close to a year into caring for her. Which is like “Oh thanks, thanks for that guys.” So that's when we found out about domestic abuse, that she's seen some of that.

In another variant category, participants reported that they learned more about their foster child’s trauma history over time. One participant noted that “over the course of months, we got little bits and pieces” about their child’s trauma history. Another participant described the difficulty of learning this information over time:

I just find new things out like nearly every day at this point, which is wonderful that he's good opening up. But I really wish I knew all of it, so I could just not step in it all the time and push him to do things that are actually harmful, or accidentally say something that triggers something.

Participants also variantly learned about their foster child’s trauma history through their foster child’s extended family members. One participant has kept in touch with their foster child’s biological aunt, noting that they “learn a lot from her, she pieces lots of details together.” Finally, court hearings were variantly an avenue through which foster parents learned about their child’s trauma history. One participant attended a court hearing that “told everything in major detail” to the point where:

I couldn't actually listen to it, I had to walk away and put my hands over my ears and hum real loud so I couldn't hear everything that was happening. My husband listened to it though, and he said it was pretty bad. I got enough that I knew it was really bad.

Foster Child’s Trauma Symptoms and Other Negative Symptoms
When asked to describe their foster child’s trauma and other symptoms, one general and five typical categories emerged. Participants generally reported that their foster child displayed challenging behavioral symptoms including physical or verbal aggression, tantrums, defiance, lying, manipulation, sexually age-inappropriate behavior, and self-harm. One participant noted that “physical behaviors” were their foster child’s biggest struggle, as their foster child “punched a hole through her bedroom door” and “kicked holes in her walls.” Another participant described “big, explosive tantrums” that their foster child displayed, noting that their foster child would be “yelling and screaming how much they hate you and how horrible you are and how you’re the worst person in the entire world and the worst foster parent.” Similarly, one foster child “started to lie about what was happening in the home,” which caused the participant to disrupt the placement because they were concerned that the foster child was “sabotaging the potential adoption” of their other foster child. Some of the foster children’s behavioral issues also occurred at school, with one participant noting that their foster child “would get in arguments with school staff throughout the day, she would skip classes.”

In the first typical category, participants shared that their foster child displayed emotional symptoms. One participant reported that their foster child had “constant anxiety,” while another described “severe panic attacks” that their foster child experienced. One participant shared about their foster child’s difficulty being left alone:

She is extremely clingy and could not be alone by herself for the first year and a half or so that she was with us. So she was with an adult all the time and we would have very extreme reactions if she was going to be by herself. Like crying, screaming, not being able to communicate, things like that. And so that was pretty intense.

Participants discussed receiving texts or calls at work when their foster child was upset or anxious, with one participant sharing that their foster child would call when “she wanted to go home, she wasn’t feeling good, she was feeling anxious, she was feeling like she’s gonna have a
panic attack,” and another participant remarking that they sometimes would “get a phone call of a sobbing teenager on the other side.” Another participant stated that dissociation was their foster child’s “biggest coping mechanism.”

In the second typical category, participants noted that their foster child was behaviorally or emotionally triggered by their biological family or personal challenges. Participants described contact with their biological family as triggering for their foster child, with one participant reporting that their foster child had “complete meltdowns” with “crying, bawling” that lasted for hours after visitation with their biological family. Another participant shared that the potential of seeing biological family at upcoming court hearings “can trigger additional anxiety” in her foster child. One participant indicated that “having firm boundaries and house rules” triggered symptoms in their foster child, while another participant stated that their foster child “just could not handle being told no.” As another example, one participant shared that their foster child’s biggest trigger was “not knowing what’s going to happen,” as their foster child would get a plan in her head and if “something changes from that plan, that’s when she explodes.”

Next, participants typically indicated that their foster child experienced social difficulties, including “pushing” people away. One participant shared that “people tend to come and go pretty quickly” in their foster child’s life, explaining further:

She pushes people away behaviorally. She has trouble maintaining friends and she'll say harsh things sometimes. And we'll talk about it later and she just doesn't want people, people always leave, and so she doesn't want people to get closer cause then they leave and that hurts.

Typically, participants shared about sleep disturbances that their foster child experienced, with one participant reporting that her foster child had “severe night terrors.” Describing her foster child’s sleep difficulty, another participant stated, “She will not sleep in the dark. She has to sleep with lights on and so she still sleeps with her overhead light on even now.”
Finally, participants typically reported that their foster child struggled academically. One participant explained that their foster child was “so far behind” in school that he had to repeat a grade. Additionally, another participant reported that their foster child was “failing everything because she simply wouldn’t do any work.” Thus, while many participants described their foster child’s symptoms that occurred in the home, symptoms also occurred in the school setting.

Foster Parent’s Management of Foster Child’s Trauma Symptoms

Given all of the trauma symptoms described by participants above, it is not surprising that participants sought to manage their foster child’s trauma symptoms. Two typical and three variant categories emerged in this area. In the first typical category, participants discussed managing their foster child’s environment and routine. One participant shared that their foster child needs “lots of routines, lots of schedule,” which helps their foster child “feel that security of knowing what to expect.” Another participant reported that their foster child “had a history of self-harm, so we had to lock up knives and keep a close watch on sharps.” Participants also typically worked with their foster child to help them manage their emotions. When their foster child became dysregulated, one participant recalled talking to their foster child in a “monotone, like very smooth, calming voice” and encouraging their foster child to do deep breathing.

Variantly, participants established limits and boundaries with their foster child. Several participants noted setting limits regarding technology use, with one participating stating, “Pornography was a big, big concern and she lost technology access, internet access several times because it was really bad.” Participants also variantly tried to offer unconditional love or reassurance to their foster child. One participant noted that because “foster children experience so much abandonment and not stable situations,” they felt like “the best thing we can do is to be unconditional and just say ‘We’re here for you. We’re not budging. We’re doing everything.’” In
a final variant category, participants described giving their foster child autonomy to make
decisions. For example, when their foster child’s biological father died, one participant shared,
“She didn’t want to go to the funeral and I didn’t make her.” She further elaborated that she
decided:

She’s been through a lot of trauma and she’s been forced to either see people she doesn’t
want to see or she’s been kept from people she did want to see. So I’m gonna give her
choices I’m allowed to give her right now.

**Primary Trauma from Foster Child**

Given the severity of their foster child’s trauma symptoms, participants also indicated
experiencing primary trauma from their foster child. Participants typically reported that they
experienced abuse from their foster child, with two subcategories emerging under this larger
category. First, participants variantly described experiencing physical abuse or threats of physical
abuse from their foster child. For instance, one participant noted, “There's certainly been physical
abuse. She will, in these heightened episodes, she will punch and kick and bite and scratch. My
arms have a lot of evidence of that.” Another participant stated:

She grabbed me so hard that she sprained all the ligaments in my arm. She would attack
me while I was driving, like I'd have to pull over and it would be so bad that I'd have to
call 911 and she'd have to be brought to the emergency room and medicated.

Additionally, verbal or emotional abuse was variantly discussed by participants as another form
of primary trauma. Describing their foster child’s behavior, one participant commented that
emotional abuse is “basically how I would categorize her attitude towards me and her behavior
towards me.” This participant later gave the example:

She had called me from school, complained about one of the teachers. I asked if she
wanted me to pursue it with the administration and she’s like “No, fuck them and fuck
you” and hung up on me. And I just broke down and I looked at my husband and I said,
“I can't keep doing this.” And I was just hysterically sobbing.
Importantly, participants variantly reported that they did not experience any primary trauma from their foster child. As one participant shared, “I told people I had a lot in my house, the one thing I did not have, and I never had, was physical. We never had any physical violence or yelling and screaming, really, for that matter.” A final variant category emerged which indicated that the participant’s foster child was aggressive towards members of the participant’s family. As an example, after a disagreement about what to watch on TV, one participant’s foster child was aggressive towards their biological daughter and “grabbed her by her ankles and drug her off the couch and out of the room,” which scared their biological daughter.

**Foster Parent’s Secondary Traumatic Stress Reactions**

The second section contains findings related to the participants’ symptoms of secondary traumatic stress. Participants were asked to describe the emotions, thoughts, and physical symptoms that they experienced while learning about their foster child’s traumatic experiences, as well the emotions, thoughts, and physical symptoms that they experienced while observing and managing their foster child’s trauma symptoms. Participants were also asked to expand upon their responses to the Secondary Traumatic Stress Scale that they completed as part of the Demographic Form, which provided an additional avenue for participants to reflect on their symptoms. Taken together, the reactions discussed in response to these questions provided a description of the participants’ secondary traumatic stress symptoms. The findings for this domain are presented in Table 2.

**Table 2**

*Domains, Categories, and Frequencies of Foster Parent’s Secondary Traumatic Stress Reactions*

<table>
<thead>
<tr>
<th>Domains</th>
<th>Categories</th>
<th>Frequencies*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foster parent’s STS Reactions</td>
<td>Experienced negative emotions</td>
<td>General (14)</td>
</tr>
<tr>
<td></td>
<td>Developed a negative view of themselves, others, or the world</td>
<td>General (13)</td>
</tr>
<tr>
<td></td>
<td>Experienced negative physical symptoms</td>
<td>Typical (12)</td>
</tr>
<tr>
<td>Symptom</td>
<td>Frequency</td>
<td></td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>------------</td>
<td></td>
</tr>
<tr>
<td>Frequently thought about FC (including FC’s trauma history/symptoms)</td>
<td>Typical (11)</td>
<td></td>
</tr>
<tr>
<td>Wanted to avoid thinking about or interacting with FC</td>
<td>Typical (11)</td>
<td></td>
</tr>
<tr>
<td>Was less physically or socially active</td>
<td>Typical (10)</td>
<td></td>
</tr>
<tr>
<td>Had trouble concentrating</td>
<td>Typical (9)</td>
<td></td>
</tr>
<tr>
<td>Felt on edge or jumpy</td>
<td>Typical (8)</td>
<td></td>
</tr>
<tr>
<td>Suppressed their internal reactions to FC’s experience</td>
<td>Variant (4)</td>
<td></td>
</tr>
</tbody>
</table>

* 14 total cases. General = 13-14, Typical = 8-12, Variant = 2-7

Note. STS = Secondary traumatic stress, FC = Foster child

In total, nine categories emerged related to participants’ symptoms of secondary traumatic stress. In the first general category, participants described experiencing a variety of negative emotions, such as sadness, anger, anxiety, frustration, helplessness, shame, guilt, and heartbreak. For example, one participant shared that “mostly my heart just breaks for her,” while another participant felt “sadness for them that a huge portion of their childhood was effectively stolen, a lot of their innocence stolen.” Relatedly, one participant reported feeling helpless “because I couldn’t protect her in those times in her life.” As another example, one participant described being in a “very anxious state pretty much from the beginning,” with another participant noting that as the placement went on she “would start feeling anxious because I knew it was about time to leave work” and return home to manage her foster child’s behaviors. Similarly, one participant stated, “We were just parents running on empty. We were irritable. We were annoyed. We were afraid of what could happen.” One participant felt “a lot of sadness and anger and frustration towards lots of people” because their foster child “has dealt with some of the scariest, shittiest stuff imaginable.” To highlight the variety of emotions experienced by participants, one participant described this experience as “the most emotionally roller coaster part of my life, just up and down.”
In the second general category, participants reported that they developed a negative view of themselves, others, or the world. Concerningly, one participant shared, “I've been feeling horrible about myself as a person, as a mother, as a foster mother, at work, just all the way around.” Another participant reported feeling “anger at the shitty people who have done these kids wrong, like at this horrible world that would let this happen.” Another participant echoed feeling anger at the world after learning what their foster child had gone through and knowing “that hers isn’t even the worst story.” One participant highlighted the anger she felt towards the child welfare system:

Anger at the system that doesn't take better care of kids who, I mean it's not even like they fall through the cracks, like the system technically worked how it was supposed to. They eventually came into care. But not before lots of horrendous things happened to them.

Typically, participants reported experiencing negative physical symptoms such as a high heart rate, upset stomach, not eating well, difficulty sleeping, and feeling exhausted. For example, when reading a police report on their foster child, one participant recalled that “finding out that there were photos of her actually handcuffed to a piece of furniture, that physically made me ill.” Another participant described having a high heart rate “especially towards the end when I was just burned out and afraid of confrontation.” One participant shared about the exhaustion they experienced:

And then it’s just exhausting. Like we have one of those days where there's lots of stuff brought up emotionally on their end. I mean it exhausts us, like it's hard enough to parent, but when you're parenting somebody with all this complex trauma and all these questions, it's just mentally and physically exhausting.

Participants also typically indicated that they frequently thought about their foster child, including their foster child’s trauma history and trauma symptoms. One participant reported that
thoughts regarding their foster child “randomly pop into my brain just throughout my day to
day,” while another participant shared:

It always seems like there was always a next level, always another surprise. But when
you think this has to be the worst thing that could have happened to them, then they tell
you something else and they say it so calmly, so matter of factly. And you're like, this is
even just the next level. Like I can't believe that this now happened. So there's specific
things that they've said that I'll keep thinking about. And there's no purpose to thinking
about it, I mean I can’t fix it, but it definitely like just keeps replaying sometimes.

Interestingly, participants also typically described wanting to avoid thinking about or interacting
with their foster child. For instance, one participant noted, “I try to, unfortunately, avoid her a
little bit when things are bad, because it feels like I’m losing myself. That like I’m going into this
depressive state that I don’t wanna be in.” Another participant shared about her desire to avoid
thinking about information she had learned about her foster child’s trauma:

But you know, it would, like then the new information would pop in my head every now
and then. It's just like “God, I just like don't wanna think about this. This is terrible. Like
just don't want to know it or think about it.” But obviously it's there.

In another typical category, participants reported being less physically or socially active.

“I don’t wanna go out, I don’t wanna see anyone,” remarked one participant. Another participant,
who used to be an active runner, shared about their struggle with being physically active:

I'm struggling so hard to do any of that because any time I get time to myself I can't
move. I'm just like ‘I just need to lay here. Like I have an hour this morning, I just need
to lay in bed and just lay here and not do anything.’ And I know I will feel better if I get
up and move and do something. It doesn't need to be running a marathon, but some form
of activity. But I cannot convince myself to do it. Like I'm trying really hard and I just
cannot do it.

Trouble concentrating was another symptom typically reported by participants. For instance, one
participant stated, “Trouble concentrating at work? Absolutely. Trouble concentrating just in
conversations even with my husband? Yeah. And times when I’m like ‘I just don’t want to think
about this anymore,’ it was impossible.”
Typically, participants also described feeling on edge or jumpy, with one participant reporting feeling “on edge for like 10 months now.” One participant noted locking their bedroom door due to being concerned about their foster child “being violent.” Another participant described being alert to what her foster child’s possible behaviors:

I was constantly thinking “Is there a way she can hurt herself? Is there a way she can hurt herself? Is there a way she’s gonna hurt me?” She has hurt me. I was constantly covered in bruises. She sprained this whole section of my arm. She almost caused a car accident. So that hyper alertness of what's going to make her snap and, if she snaps, how do I make her safe? Like I had to constantly be on.

Finally, participants variantly shared that they felt like they needed to suppress their internal reactions to their foster child’s experience. When their foster child shared about their trauma history, one participant recalled, “It’s kind of always that internal ‘Oh my god, I can’t believe it.’ But you can’t show that to them because you need to be like a stable, positive, calm person.”

Impact of Secondary Traumatic Stress

The third section presents findings related to how secondary traumatic stress impacted participants’ lives. Participants described how symptoms of secondary traumatic stress affected their overall functioning, including their work-life, relationships with family and friends, and self-care. Participants also explained ways that secondary traumatic stress influenced how they parented and cared for their foster child. Additionally, participants shared about how their symptoms of secondary traumatic stress influenced their desire to continue fostering. These findings are displayed in Table 3.

Table 3

Domains, Categories, and Frequencies regarding Impact of Secondary Traumatic Stress on Foster Parent’s Life, Parenting, and Desire to Continue Fostering

<table>
<thead>
<tr>
<th>Domains</th>
<th>Categories</th>
<th>Frequencies*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Impact of STS on foster parent’s life</td>
<td>Work was negatively affected</td>
<td>Typical (12)</td>
</tr>
<tr>
<td></td>
<td>Was less effective</td>
<td>Typical (9)</td>
</tr>
<tr>
<td></td>
<td>Had difficulty concentrating</td>
<td>Typical (8)</td>
</tr>
</tbody>
</table>
**Impact of Secondary Traumatic Stress on Foster Parent’s Life**

Six categories emerged to describe the overall impact that secondary traumatic stress had on participants’ lives. First, participants typically reported that their work was negatively affected. Three subcategories emerged here, providing details about how participants’ work was impacted. In the first subcategory, participants typically described being less effective at work. For example, when asked about areas of their life that were impacted, one participant described:

Work was the most impacted, where I would do a couple hours and then I just had to log off and be like ‘Sorry, can’t do it.’ Or where I would start late because I just needed more time before I could face work.
In the second subcategory, participants typically had difficulty concentrating at work. For example, one participant reported:

I definitely had some work things that were impacted because I was having trouble concentrating. And mostly it would be like there was something I was supposed to do, forgot that I was supposed to do it, and then it shows back up two weeks later not done.

In the third subcategory, participants variantly described feeling irritable or annoyed at work. One participant reported being “extremely irritable” with her students at work, while another participant recalled that they “bit somebody’s head off very quickly” during a work meeting.

Participants also typically noted that their self-care was negatively affected. One participant shared that their “self-care went down the drain” during their foster child’s placement, as the participant would focus on what their foster child needed “even at the cost of not paying attention to what my body needs.” Similarly, another participant stated, “Self-care was nonexistent, just nonexistent. Everything I did was trying to take care of them, figure out how to for us to function.” Some participants described attempting to do self-care, though their attempts were “less successful” during this experience.

In another typical category, participants shared that their relationships with family and friends were negatively affected. Two subcategories emerged to further elaborate. In the first subcategory, participants variantly described not spending as much time with their family and friends. To illustrate, one participant shared that their life is now entirely focused on their foster child, so they “certainly devote less time to relationships.” Another participant noted that they had friends who would come over, but when their foster child’s mood and behavior changed, “I stopped asking them to come over because I didn’t want them to have to deal with what I was dealing with.” In the second subcategory, participants variantly explained that they constantly talked about their foster child when around their family and friends. One participant shared that
their foster child “was the topic of conversation for months, and I was tired of it. In my head, my friends were tired of it. I don't know if they really were. But it was constant.” Similarly, another participant shared about how their mother helped them realize how much they were talking about their foster child:

And I looked back at other conversations I was having and every opportunity I had to get out and spend time with friends or whatever, like the whole thing was dominated with what is going on with this situation. And it just felt like I was never escaping it. Even when I had opportunities to walk away, it still was at the forefront of my mind and was still the only thing to talk about.

In the final typical category, participants indicated that their personal/emotional life was adversely affected during this experience. This experience affected “all parts of everything” in one participant’s life, with another participant sharing that “It took me a long time to get back to feeling something like myself. I still don’t really feel like myself.” One participant highlighted the overall negative impact that this experience had on their personal life: “Do I think I did a great job? Absolutely. Do I think that it was in any way, shape, or form healthy for me? Absolutely not. Like I depleted all my resources on caring for her.”

In a variant category, participants reported that their relationship with their significant other was negatively impacted. One participant reported that their relationship with their husband started “going down the drain,” while another noted that their “marriage started to disintegrate.” One participant became tearful during the interview while describing how this experience caused her and her husband to consider divorce, noting that she’ll “always resent that she [foster child] brought us to that point, that I had to say that word.” Finally, participants variantly experienced a strengthening of their relationships. For example, one participant reported developing a closer relationship their parents, as their parents “were huge in helping me with her.”

**Impact of Secondary Traumatic Stress on Foster Parent’s Parenting**
Regarding how secondary traumatic stress impacted participants’ parenting, two typical and three variant categories emerged. Participants typically reported experiencing interpersonal difficulties with their foster child. “I’m pretty cranky, where I feel like I’m snapping at her and always fault finding, which I feel horrible about,” one participant stated. Another participant described the conflict they experience after their foster child “pinpoints my insecurities and goes after them,” sharing:

But I’m somehow supposed to forgive her. I’m somehow supposed to still love her. And we’ve had some really tough times where it took me months to really become okay with her again. And I remember she came to me looking for comfort, something happened at school. And I remember she was really upset over it and she came to me and was like “What should I do?” And it was like I just had this really weird experience where I was like “I don’t like you right now. I don’t really want to help you. But okay, I guess back when I did love you a ton, I guess this is how I would comfort you.”

Participants also typically reported working hard to reduce conflict or triggering situations with their foster child. For instance, one participant shared:

There were certainly environments and people that we knew triggered our daughter. And so we definitely avoided certain people, certain things, and certain activities that we would have loved to have done. But in that particular circumstance, we just felt that it was going to be too much for her.

Another participant stated, “I just was afraid to express any level of negativity at all. And I was just giving in to every whim and smiling at every conversation and doing basically whatever she said, just to keep from the hostility.” Similarly, one participant noted that when they were going through a “really rough patch” with their foster child:

We made the choice to basically be pushover parents. We just sort of let our kiddo get away with whatever for the time being because we knew that focusing on that day was more important than any sort of conflict that could lead to hospitalizations. So we just sort of pulled back for a while.

In the first variant category, participants described how they stopped, or wanted to stop, trying to parent their foster child. After an incident where their foster child yelled at them
“nonstop for like 15 minutes,” one participant explained that “after that I always feared confrontation with her and my husband had to take over any parenting, I just could not. I was burned out.” Similarly, another participant described giving up on parenting:

I mostly towards the end just kind of gave up. I just kind of let her do, you know? We still fought for communication. I still had, you know, I still talked to her, I still had conversations with her, I still interacted with her. But like my heart wasn't in it anymore. And I just, I felt so beaten down.

In another variant category, participants explained that they felt like they were not being a good parent during this experience. One participant described how they approached a difficult period of time with their foster child:

There was a time essentially where we made the active decision that instead of being good parents and trying to teach good lessons and making corrections where needed, it was just avoid conflict at all costs because we know that any small thing could lead to a massive blow up . . . And we knew that we were not being great parents, effective parents. But at that time, we were basically just in survival mode.

Another participant explained their concern about whether they are teaching their foster children right from wrong:

It’s hard because I think I’m a really good listener, I’m very accepting, but I don’t necessarily know, I guess, if I’m that good at being a parent. Cause I do feel really scared to punish her, to really parent her, to tell her things are not okay. Because that’s when she’s gonna rage. That’s when she’s going to, you know, I’m terrified of the blowback. And sometimes it can get really bad that I just, so I don’t. And in my mind I’m like “Okay, parents are supposed to teach you right from wrong. Am I really doing that? I don’t know if I really am”. And so that’s what really freaks me out.

Finally, participants variantly discussed overcompensating as a parent due to their foster child’s background. One participant described that they sometimes “go the opposite way” to make sure that their foster children “never have any of those gaps that they used to have.” As a result, this participant noted that “I feel like I'm trying to overcompensate sometimes just to make sure that they don't have those negative experiences again.”

**Impact of Secondary Traumatic Stress on Foster Parent’s Desire to Continue Fostering**
When participants were asked how secondary traumatic stress impacted their desire to continue fostering, participants typically reported that they planned to continue engaging as a foster parent. One participant shared that this experience “doesn’t change my view on fostering at all. Like I would still do it in a heartbeat.” In discussing their commitment to continue fostering their foster child, another participant explained that:

We signed up for this to help, to be there, and we're committing to them. And we're saying “Hey, you can trust us. We are trustful adults.” And so it's like, no, we made a commitment, we gotta stick with it.

However, participants also typically reported that they stopped or reduced their fostering as a result of their secondary traumatic stress. Some participants described disrupting the placement with their foster child, with one participant sharing, “I had to end the placement because I just couldn't see any way out of it. I couldn't see any way forward. Like it was just an endless, ceaseless negativity all the time.” Another participant described needing to take a break after this experience:

I never thought I wanted to stop, but I definitely had to take a pretty long break. So I took like 5 months with no placements and then I said I only wanted to do respite and emergency at first.

Unfortunately, some participants reported that they had decided to discontinue fostering altogether. One participant explained, “We’ve decided we’re never going to do this again,” noting that “there’s nothing about this that makes us wanna be a part of this whole process again.”

Three additional variant categories emerged. First, foster parents variantly reported that they planned to change what type of foster care placements they accept in the future. Participants indicated that they will be more selective when accepting future placements, with one participant sharing that “there are probably a lot of referrals that I would not say yes to” in the future “now
that I’ve been doing this for a second and have a little bit better idea of how I respond.”

Similarly, another participant noted that they are open to taking additional placements, although:

> After this experience, and I know they don't always have the information, I will ask them very pointed questions before I accept a child. And I have received full time placement calls that I have said no to, that I think before this experience I may have said yes to. It does not serve that child and it does not serve me if I am in constant adrenaline mode, right? It doesn't serve me. It's not fair to me. It's not fair to the child for me to be.

Variantly, participants also reported that they didn’t feel like they could accept other foster care placements because they needed to focus on caring for their foster child. When asked about fostering in the future, one participant stated, “I can’t even see beyond this one right now because this one is gonna very likely be permanent to adulthood, so I don't know.” Another participant, who had recently adopted their foster child from foster care, noted:

> But we closed our home to being foster parents because we said we only have so much like bandwidth and that took all of it. And so just can't take on anymore. And if it had, I think the trauma and the stress things that we think of are what takes up that bandwidth.

Participants also variantly felt uncertain about whether they wanted to foster in the future. When asked how secondary traumatic stress influenced their desire to continue fostering, one participant explained:

> Definitely called it into question. There are days that I want nothing to do with this, that I wanna go back to my old life kind of. It was safe, it was happy, I was I feel like at my prime. I was doing the best that I’ve ever done. And so going through it is rough. It feels like I’m on this roller coaster that I have absolutely no control over. That I’m just on the ride and I have to deal with it. And then when it’s good, it feels, it’s the most amazing thing in the world, like I’m so glad that I know her, I’m so glad that we have this relationship, I’m really proud that we’re doing this, that we’re helping her and all these things. But it’s just rough to be on that.

**Factors that Influenced the Experience of Secondary Traumatic Stress**

In the next section, findings on factors that influenced participants’ experiences of secondary traumatic stress are reviewed. Participants shared about both helpful and challenging factors related to managing their experience of secondary traumatic stress. They also reported on
ways that the child welfare system was helpful and unhelpful to participants as they managed their secondary traumatic stress. These findings are presented in Table 4.

Table 4

Domains, Categories, and Frequencies of Factors that Influenced the Experience of Secondary Traumatic Stress

<table>
<thead>
<tr>
<th>Domains</th>
<th>Categories</th>
<th>Frequencies*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Helpful factors in managing this experience</td>
<td>P received support from others</td>
<td>General (14)</td>
</tr>
<tr>
<td></td>
<td>P engaged in active coping</td>
<td>General (13)</td>
</tr>
<tr>
<td></td>
<td>Practiced self-care activities</td>
<td>Typical (10)</td>
</tr>
<tr>
<td></td>
<td>Attended therapy</td>
<td>Typical (9)</td>
</tr>
<tr>
<td></td>
<td>Used cognitive coping strategies</td>
<td>Variant (7)</td>
</tr>
<tr>
<td></td>
<td>P’s trauma history informed their perspective</td>
<td>Variant (7)</td>
</tr>
<tr>
<td></td>
<td>Helped P empathize with FC</td>
<td>Variant (6)</td>
</tr>
<tr>
<td></td>
<td>Positively influenced how P parented FC</td>
<td>Variant (2)</td>
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<tr>
<td></td>
<td>FC attended therapy</td>
<td>Variant (5)</td>
</tr>
<tr>
<td></td>
<td>FC’s school partnered with P</td>
<td>Variant (4)</td>
</tr>
<tr>
<td></td>
<td>P received prior training on trauma</td>
<td>Variant (2)</td>
</tr>
<tr>
<td></td>
<td>P received medication to manage symptoms</td>
<td>Variant (2)</td>
</tr>
<tr>
<td>Challenging factors in managing this experience</td>
<td>P lacked social support</td>
<td>Typical (12)</td>
</tr>
<tr>
<td></td>
<td>P felt isolated</td>
<td>Typical (12)</td>
</tr>
<tr>
<td></td>
<td>Some of P’s family and friends were actively unsupportive</td>
<td>Typical (9)</td>
</tr>
<tr>
<td></td>
<td>Foster parenting is complex and demanding</td>
<td>Typical (11)</td>
</tr>
<tr>
<td></td>
<td>P struggled to take care of themselves</td>
<td>Typical (9)</td>
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<tr>
<td></td>
<td>FC’s trauma history/symptoms caused P to recall their own trauma history</td>
<td>Typical (8)</td>
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<tr>
<td></td>
<td>P did not recognize they were experiencing STS</td>
<td>Variant (4)</td>
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<tr>
<td></td>
<td>P put pressure on themselves to be a good foster parent</td>
<td>Variant (4)</td>
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<tr>
<td></td>
<td>P didn’t feel confident as a first-time foster parent</td>
<td>Variant (3)</td>
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<tr>
<td></td>
<td>Cultural differences between P and FC caused difficulties</td>
<td>Variant (3)</td>
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<tr>
<td></td>
<td>Limited childcare services were available</td>
<td>Variant (2)</td>
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<tr>
<td></td>
<td>P was concerned about replicating their own trauma history with FC</td>
<td>Variant (2)</td>
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<tr>
<td>Helpful involvement of the child welfare system</td>
<td>Provided support and assistance to P and FC</td>
<td>Typical (12)</td>
</tr>
<tr>
<td></td>
<td>Foster care training prepared P for fostering</td>
<td>Variant (2)</td>
</tr>
<tr>
<td>Unhelpful involvement of the child welfare system</td>
<td>STS was not adequately addressed</td>
<td>Typical (11)</td>
</tr>
<tr>
<td></td>
<td>Support from the child welfare system was inadequate</td>
<td>Typical (10)</td>
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<tr>
<td></td>
<td>Using respite was difficult or created additional challenges</td>
<td>Variant (6)</td>
</tr>
<tr>
<td></td>
<td>Important information about FC was not communicated to P</td>
<td>Variant (5)</td>
</tr>
<tr>
<td></td>
<td>The handling of placement decisions was not in FC’s best Interest</td>
<td>Variant (4)</td>
</tr>
</tbody>
</table>
Training did not provide relevant information about foster parenting

* 14 total cases. General = 13-14, Typical = 8-12, Variant = 2-7

Note. P = Participant, FC = Foster child, STS = Secondary traumatic stress

Helpful Factors in Managing this Experience

Regarding factors that were helpful as participants managed this experience, two general and five variant categories emerged. First, participants generally reported receiving support from others, including their significant other, family, friends, work colleagues, and other foster parents. For example, one participant shared that they had friends “who stepped up and really want to be involved in the process and involved in this journey with us.” Another participant described building a community of other foster parents on social media, remarking that those connections were “pretty much the only thing that got me through” this experience.

In another general category, participants described engaging in active coping. Here, three subcategories emerged to further elaborate their coping. In the first typical subcategory, participants reported practicing self-care activities. One participant explained that they are “learning to devote more time to hobbies and things I enjoy doing,” while another participant noted that starting to exercise again “was something I really needed to do for self-care and that was really good.” In the second subcategory, participants also typically reported attending therapy during this experience. For example, one participant remarked that “therapy is the number one thing” they did related to self-care. Another participant indicated that therapy “was really important for my emotional well-being in terms of being able to talk about everything that was going on.” In a variant subcategory, participants reported using cognitive coping strategies. When their foster child “says things and does things that she doesn’t mean” during periods of emotional dysregulation, one participant explained that they “try and take it in context that she’s
not in control of herself during these episodes.” As another example, one participant noted that they are “giving myself permission to not be okay or not be productive for certain periods of time.”

In the first variant category, participants shared that their own trauma history informed their perspective as a foster parent. Within this category, two subcategories emerged. First, participants variantly noted that their own trauma history helped them to empathize with their foster child, with one participant sharing that their trauma history “allows me to sympathize and try to understand a little bit what the kids are going through.” Second, participants variantly indicated that their own trauma history positively influenced how they parented their foster child. In reflecting on how they were treated by their parents as a child, one participant recalled “vowing that I would never treat my kids the way my parents were treating me.” She further elaborated that:

When I started fostering I basically took the step of “okay, I'm gonna be a good listener. I'm gonna find out from them, what do they want?” That sort of thing because that's all I wanted as a kid, honestly, I wanted them to listen, I wanted them to understand a bit.

In another variant category, participants described that their foster child attending therapy was helpful, with one participant stating:

The girls’ therapist has worked with the girls for the whole two years and both of them have shown tremendous progress in how much they have opened up. And anytime I talk to the therapist about what's going on with them, I think you wind up processing a little bit what's going on, like your experience of what's happening with the kid. And so I think that that's helpful.

Participants also variantly noted that their foster child’s school partnered with them during this experience. For example, one participant reported that their foster child’s school was “highly invested,” further elaborating that “Her teacher would typically call me every day after school. Her school psychologist would call me after school if he felt it was necessary. Literally so much
kudos to those people. They really wanted this to work for her.” Variantly, participants identified having received prior training on trauma as helpful. One participant, who works at a Title One school, noted that they had attended trauma trainings which discussed secondary traumatic stress. In a final variant category, participants reported that they had received medication to manage their symptoms. One participant shared that they “have a really good doctor” who prescribed “anxiety medicine which helps a lot with the irritability and just being short tempered.”

**Challenging Factors in Managing this Experience**

Four typical and six variant categories emerged related to challenging factors that participants identified during this experience. Typically, participants shared that they lacked social support during this experience. Two subcategories emerged under this larger category. In the first typical subcategory, participants described feeling isolated. Some participants discussed the difficulty of starting to foster during the COVID-19 pandemic, with one participant noting that “some of the natural social events that happen among foster parents weren’t happening. And so I didn’t have a way to get that network.” Another participant discussed feel isolated as a single foster parent, sharing that while their family was supportive, “it’d be nice to have that support in the house with you.” As another example of feeling isolated, one participant shared about the difficulty of not being able to talk with others about their foster child:

In our training we were told not to disclose too much about the foster children, especially to family, because then when they interact with the child they might interact with them differently. And so the training, basically they said to keep a lot of things that we know about the child to ourselves or not discuss it with family. So I don't think we reached out too much.

In a second typical subcategory, participants reported that some of their family and friends were actively unsupportive during this experience. One participant explained that their mother and other family members “struggle to understand the effects of trauma on kids,” further explaining
that “it’s hard for them to be supportive if they don’t understand.” As another example, one participant shared about their family and friends reacting negatively to their decision to foster:

It was really surprising how many people were like, “Oh, you're ruining your life.” And it's just like, whoa, it’s discouraging. And then when we're going through issues, it's like, “Well, you signed up for this.” I guess I feel like there's a lot of factors that are fighting against us in this. There's not a lot of support. There's a lot of negativity that discouraged us from doing this.

Typically, foster parents noted that foster parenting is complex and demanding. One participant stated, “It’s not normal parenting,” which was echoed by another participant who shared, “Things that might be super easy for traditional biological families are just not easy for us because of the complexity and the trauma.” Participants described the complexity of foster parenting, noting that “the hits keep coming” and “they live in your home so you can’t separate from it.” One participant explained the unique experience of being a foster parent:

Most people think parenting is stressful. But I don't think that people think very much that hearing your kid talk about what happened to them or hearing your kid try to talk about, even try to talk about and not be able to talk about it, is just stressful and creates your own versions of horror stories in your head of what they’ve gone through.

In another typical category, participants described that they struggled to take care of themselves during this experience. One participant reported, “I don’t do enough to take care of myself,” while another shared, “I have admitted now that I waited way too long to get into therapy and I waited way too long to ask for help.” Participants also typically reported that their foster child's trauma history and trauma symptoms caused them to recall their own trauma history. As one participant noted that their own trauma history “just added to and elevated all this stuff I thought had settled. Like thinking about her and thinking about knowing how that affected me in my life, compounded what was happening.” Similarly, another participant described the difficulty of recognizing their own trauma:
I think one thing that's been hard is like it makes me realize some of my own traumas that I've had in the past and some things that trigger me from my foster kiddos. And then it's just, “Oh, I have triggers too. I haven't dealt with some of that in my past, and I gotta deal with it right now.” So I think that's probably one of the trickiest things, where it's like, “Oh, there is a little more trauma in my past than I maybe recognize. And I've been harboring that deep inside and now it's open, I'm ready to deal with it. I don't want to, but I've gotta.”

In the first variant category, participants indicated that they did not recognize they were experiencing secondary traumatic stress, which made it more difficult to manage. One participant explained, “It wasn’t until not that long ago where I’m like ‘Oh yeah, secondary trauma. Yeah, I got it. I have it.’” Another participant shared that they didn’t realize they were experiencing secondary traumatic stress until they learned about this study. Variantly, participants also explained that putting pressure on themselves to be a good foster parent made this experience more difficult. For example, one participant noted that a lot of their difficulty “had to do from my own pridefulness and wanting to seem like I had it together. Cause like you wanna be a good parent, right?” Similarly, another participant stated:

It was probably all self-inflicted. Like I felt like I should have been able to handle it on my own, so that's why I didn't ask for help. There's also this thing in your head where, or I'll just say a thing in my head, where like, “I took classes, I signed up for this, I said I wanted to do this. So just suck it up, it's hard.”

Participants also variantly reported not feeling confident related to being a first-time foster parent. One participant described the thoughts they had related to being a new foster parent:

This was my very first placement. I'm not a bio parent, so it's my first parenting experience ever and this overwhelming feeling of “Am I messing this up? Am I making this worse for them? Would it have been better if I had said no and if they had gone somewhere else?”

Additionally, participants variantly noted that cultural differences between themselves and their foster child caused difficulties. For instance, one participant shared that they and their foster child had “a lot of cultural differences regarding how we fight.” Variantly, participants
reported that limited childcare services were available for their foster child. One participant indicated that it was “extremely hard to find natural supports for teenagers,” as their foster child did not have a job and was not involved in sports or extracurriculars. This participant elaborated by stating, “I feel like it would be different because daycare, summer camp, those kinds of things just naturally exist for younger kids.” Finally, participants variably shared that they felt concerned about replicating their own trauma history with their foster child, with one participating sharing:

I grew up with a mom with Munchausen by proxy disorder. And so I had a lot of fear surrounding the fact that when I was bringing her to the ER, when I was bringing her to the crisis center . . . I had a lot of fear around “Am I blowing all of this out of proportion for myself?” And I had to constantly ask the people in my circle like, “Is this me acting out of my own trauma?”

**Helpful Involvement of the Child Welfare System**

When describing ways that the child welfare system helped participants during this experience, two categories emerged. Typically, participants indicated that the child welfare system provided support and assistance to them and their foster child. Some participants described using respite care for their foster child. One participant shared that their “case manager was so incredible” and they “couldn’t have done it without her.” Describing their caseworker, another participant noted, “We were in it together. I knew I could call her, I knew I could text her, I knew I could email her, and we were gonna figure it out together. So I definitely felt supported in that way.” One participant’s agency had a “24/7 hotline” that foster parents could call, with that participant noting “we were talking to them like every other day” and they were “always a huge support.”

Variantly, participants reported that they found foster care training useful in preparing them for fostering. For instance, when their foster child shared about their traumatic experiences,
one participant felt like “I was prepared through the training, I knew what was going on, I could respond in the situation.”

**Unhelpful Involvement of the Child Welfare System**

Two typical and four variant categories emerged related to ways that the child welfare system was unhelpful during this experience. In the first typical category, participants reported that secondary traumatic stress was not adequately addressed by the child welfare system. For example, one participant shared that there was “not much” that the child welfare system did to address secondary traumatic stress, as evidenced by the fact that “I don’t think any of my caseworkers have even brought it up.” Participants also discussed how secondary traumatic stress was not covered within their foster parent training classes, with one participating noting, “I had never heard of it before. It wasn’t something that anyone mentioned in the classes.” Another participant described the inadequacy of the training that they did receive on secondary traumatic stress:

I mean, foster parent training is a joke to begin with. And my training on it was, if foster parenting training is a joke, the training on this was a bad joke. It was like 3 slides during a talk. It was 3 slides during a training session. And just here's what it is and it's important you have people who take care of you or you have ways to take care yourself. But that was it.

In another typical category, participants explained that support from the child welfare system was inadequate. One participant explained that her social worker “messed up so much stuff and made it so hard,” while another participant shared that “the high rate of [social worker] turnover has been really difficult.” Likewise, another participant shared that the “lack of support from my agency and from the county the child came from” left them feeling “cast adrift and very alone.”

Variantly, participants found that using respite was difficult or created additional challenges. Some participants discussed the difficulty of getting respite services, with one
participant reporting that there was not “a good system in place” for requesting respite. Other participants described the difficulties that using respite would create, with one participating sharing that respite was recommended, but they felt:

I can’t put her in respite. She will come back one hundred times worse because we’ve put her somewhere else for the weekend. That’s not even worth it . . . Like she’ll find a way to get back at us for doing that to her.

Participants also variantly discussed how important information about their foster child was not communicated to them by the child welfare system. One participant described missing court dates or family planning meanings because no one had told them, while another participant shared, “We didn’t know she had been in 12 different placements. We didn’t know that anger was the reason she left all of those placements. So we were wildly unprepared for our experience.” In another variant category, participants felt like the handling of placement decisions was not in their foster child’s best interest. One participant remarked that her foster child “never should have been in my home” and should have been in residential care instead. In the final variant category, participants noted that foster care training did not provide them with relevant information about foster parenting. To illustrate, participants described the training as “useless” and “a joke.”

**Suggestions and Reactions**

The final section contains findings related to the closing questions asked of participants. First, participants were asked to provide suggestions on how the child welfare system could have better supported them as they experienced secondary traumatic stress. Additionally, participants were provided space to reflect on what it was like to participate in this interview. Two domains emerged from these questions, and the findings from these domains are displayed in Table 5.
Table 5

Domains, Categories, and Frequencies of Suggestions for the Child Welfare System and Reactions to Interview

<table>
<thead>
<tr>
<th>Domains</th>
<th>Categories</th>
<th>Frequencies*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suggestions for the child welfare system</td>
<td>Provide support and resources to foster parents</td>
<td>Typical (12)</td>
</tr>
<tr>
<td></td>
<td>Improve quality of foster parent training</td>
<td>Variant (5)</td>
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<tr>
<td></td>
<td>Facilitate and encourage respite</td>
<td>Variant (4)</td>
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<tr>
<td></td>
<td>Provide more effective social workers</td>
<td>Variant (3)</td>
</tr>
<tr>
<td></td>
<td>Provide therapy for foster parents</td>
<td>Variant (2)</td>
</tr>
<tr>
<td></td>
<td>Coordinate connections amongst foster parents</td>
<td>Variant (5)</td>
</tr>
<tr>
<td></td>
<td>Provide appropriate therapy for foster children</td>
<td>Variant (2)</td>
</tr>
<tr>
<td></td>
<td>Implement structural changes in the foster care system</td>
<td>Variant (2)</td>
</tr>
<tr>
<td>Foster parent’s reaction to interview</td>
<td>Had a positive experience participating in the interview</td>
<td>Typical (11)</td>
</tr>
<tr>
<td></td>
<td>Found it challenging to participate in the interview</td>
<td>Variant (7)</td>
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<tr>
<td></td>
<td>Wanted people to know what is going on in foster care</td>
<td>Variant (4)</td>
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<tr>
<td></td>
<td>Hoped that this study will help others (including foster parents)</td>
<td>Variant (3)</td>
</tr>
<tr>
<td></td>
<td>Gained insight about their experience during the interview</td>
<td>Variant (2)</td>
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</table>

* 14 total cases. General = 13-14, Typical = 8-12, Variant = 2-7

Note. P = Participant, FC = Foster child

Suggestions for the Child Welfare System

Regarding suggestions for the child welfare system, participants typically indicated that more support and resources should be provided to foster parents, with one participant noting, “I still wish, if I had a million dollars and a million wishes, I’d wish that they would check in more often.” Within this category, four subcategories emerged. Participants variantly noted that the quality of foster parent training should be improved. One participant, for instance, indicated that it “would be so incredible” if secondary traumatic stress was covered in foster parent training because “I don’t think this is anything anyone’s prepared for.” Another participant shared about their wishes for foster parent training:

I don't think they talked about it [secondary traumatic stress] at all in our foster care training. I mean, since this is anonymous, the training was useless. Like we were like uniquely pre-educated with just our backgrounds professionally. But even if we hadn't
known that it really didn't teach us anything. And so, I mean, even a trauma informed
care training would have been helpful. I don't think we talked about secondary trauma,
that that was a thing. And so, I mean education, a better ongoing support, and even just
having something to label it would be really helpful for people who aren't in that field. I
mean I kind of feel like we're at zero, so anything beyond that would have been really
helpful.

Variantly, participants suggested that the use of respite should be facilitated and encouraged by
the child welfare system. One participant recommended, “Make respite required. Put a system in
place to make it easier to get respite,” as they identified that foster parents “need to be able to
disconnect and take time away.” Participants also variantly reported that more effective social
workers should be provided to foster parents. For example, one participant, who noted that they
don’t believe their caseworker “has any clue” about secondary traumatic stress, shared:

Educating caseworkers about it [secondary traumatic stress] would be really, would be
very important, so that they are mindful of how they speak to foster parents and the
advice that they give . . . and the services that they can offer.

In a final variant subcategory, participants suggested that therapy should be provided to foster
parents. As one participant commented, “I wish almost therapy had been a requirement or that it
was available at low to no costs. I don’t know how people do this without that honestly. Like it’s
insanely difficult.”

Variantly, participants suggested that connections amongst foster parents should be
coordinated by the child welfare system. One participant noted that they “would love to see a
more concerted effort to have more organized meet ups, get togethers, between foster families”
in order to “have the opportunity to have those shared experiences.” Participants also variantly
noted that appropriate therapy for foster children should be provided. One participant discussed
that their foster child has not been able to receive mental health therapy, and they highlighted
that “the biggest problem is there’s no therapists” available for foster children. Finally,
participants variantly shared that they believed structural changes should be implemented within
the foster care system. For example, one participant remarked, “I think not only does the system need a lot of help, it needs to be restructured and kind of come at from a different way.” Echoing similar thoughts, another participant shared that “it would be great if our state could adequately pay and provide benefits” to those working for the child welfare system. However, this participant also stated, “States don’t have the budget, they don’t prioritize social services. Kids fall through these cracks. Well, the gaping holes.”

*Foster Parent's Reaction to Interview*

When participants were asked about their experience participating in the interview, five categories emerged. Typically, participants shared that they had a positive experience participating in the interview. One participant reported that “it was really nice to have somebody who understands what’s going on,” while another participant noted:

> It's cool that somebody's interested in it [secondary traumatic stress] because it makes it seem like this will be read, this will be talked about, and maybe people will see other sides of things and maybe some things will start to get a little better.

However, participants also variantly discussed that it was challenging to participate in the interview. For example, one participant shared, “It’s challenging to go back and think about these things.” Another participant reported that they “could feel my tears well for a second” during the interview, noting that “it’s a little raw, I think, to realize how much this stuff is affecting me of recent days.”

> Variantly, participants reported wanting people to know what is going on in foster care. One participant indicated, “I think one of the biggest things is just like the news needs to get out that secondary trauma is real.” Similarly, another participant shared, “I'd rather people know what's going on in foster care. I would rather have things exposed or things discussed, misconceptions discussed. I'd rather have that information out there.” Participants also variantly
described gaining insight about their experience during the interview. One participant reported that it was “eye-opening” to participate in the interview. This participant noted that when they saw their responses to the Secondary Traumatic Stress Scale, they thought, “Oh snap. All of that’s happening?” Finally, participants variantly hoped that the study would help others, including other foster parents. While one participant noted that they don’t like thinking about their experience with secondary traumatic stress, they shared that it was worth it “if it means that we can make something better for tomorrow. That’s what I want. That’s all I want.”
Chapter 5: Discussion

This study explored foster parents’ experiences of secondary traumatic stress as they parented foster children with trauma. Given their level of exposure to details about their foster child’s trauma history, as well as their child’s trauma symptoms, foster parents may be particularly susceptible to developing secondary traumatic stress. Indeed, recent quantitative research suggests that secondary traumatic stress is prevalent within the foster parent population, with some foster parents experiencing symptoms at a level associated with PTSD (Bridger et al., 2020; Hannah & Woolgar, 2018; Steen & Bernhardt, 2023; Whitt-Woosley et al., 2020; Whitt-Woosley et al., 2022a). It is important to examine foster parents’ unique experiences of secondary traumatic stress given that their experiences may differ from those of other helping professionals, such as child welfare workers. The purpose of this study was to develop an in-depth understanding of foster parents’ experiences of secondary traumatic stress. Through filling the gap in the literature related to this topic, the hope was that this study would help child welfare and mental health professionals to better support foster parents and, ultimately, the children in their care.

Overall findings suggest that participants in this study were experiencing significant symptoms of secondary traumatic stress. Participants described a variety of secondary traumatic stress symptoms, which spanned the domains of intrusion, avoidance, alterations in mood and cognition, and alterations in arousal and reactivity. In addition to participants’ descriptions of their symptoms, their responses on the STSS confirmed that they were experiencing high levels of secondary traumatic stress, with all participants reporting secondary traumatic stress symptoms at a level associated with meeting criteria for PTSD (Sprang et al., 2021).
Perhaps the most significant findings from this study relate to participants’ descriptions of the impacts of secondary traumatic stress. Participants shared details of the negative impacts across different areas of their life, including their work, self-care, relationships, and overall personal/emotional life. Participants’ parenting of their foster child was also negatively impacted in a variety of ways, such as experiencing interpersonal difficulties with their foster child, wanting to stop trying to parent their child, and feeling like they were not being a good parent. Additionally, participants’ desire to continue fostering was impacted. While most participants noted that they planned to continue engaging as a foster parent, participants also shared that they stopped or reduced their fostering, were unsure about future fostering, or planned to be more selective about future placements. Participants’ descriptions of how secondary traumatic stress impacted various areas of their life demonstrates the importance of addressing secondary traumatic stress in this population.

Additional findings suggest possible areas of focus for alleviating secondary traumatic stress in foster parents. Participants described factors that were both helpful and challenging as they navigated this experience. They also identified ways that the child welfare system was helpful and unhelpful during this experience, as well as suggestions for how the child welfare system could have better supported them. The sections below discuss these and other findings in more detail, beginning with contextual findings related to participants’ exposure to their foster child’s traumatic experiences and trauma symptoms. Additionally, limitations of the study, implications, and directions for future research will be reviewed.

**Contextual Findings**

Secondary traumatic stress develops as a result of indirect exposure to another individual’s trauma. This indirect exposure can include both hearing about a traumatic
experience that someone else has endured and witnessing their resulting trauma symptoms (Sprang et al., 2019). Given this, it was important to understand what participants had learned about their foster child’s traumatic experiences, as well as how they learned this information. Most participants shared that their foster child had experienced abuse, including physical abuse, verbal and/or emotional abuse, and sexual abuse. Many participants also indicated that their foster child had experienced neglect by their biological parents. Unfortunately, these experiences of abuse and neglect are common for children in foster care (Greeson et al., 2011; HHS, 2022; Oswald et al., 2020; Salazar et al., 2013; Vasileva & Petermann, 2017). It is noteworthy that the foster children discussed by participants had often experienced multiple types of abuse or neglect, which is also consistent with previous research (Oswald et al., 2020). Additionally, most participants shared about other adverse events that their foster child had experienced within their biological family. Many of these adverse events, such as domestic violence, parental substance abuse, death of a parent, and family conflict, constitute adverse childhood experiences (ACEs), which are also known to be common among foster children (Turney & Wildeman, 2017). Taken together, these findings suggest that participants were exposed to information regarding a variety of different traumatic experiences that their foster child endured, which may have increased their risk for developing secondary traumatic stress.

Concerningly, most participants reported that their foster child had continued to experience trauma once they were in foster care, including being separated from their siblings and experiencing placement instability. These experiences likely added to the traumatic experiences that these foster children had already endured that had led to their placement in foster care. In addition, these experiences may have caused the foster children to be apprehensive
about the safety and stability of their current foster placement, potentially increasing the
difficulty of their placement with the participants.

When sharing about their foster child’s trauma history, it is important to note that
participants often described specific stories of their child’s trauma, suggesting that participants
had been exposed to detailed information about the trauma. This detailed exposure is important,
as previous research has found that the dose of exposure to details about their foster child’s
trauma is a direct risk factor for secondary traumatic stress within foster parents (Whitt-Woosley
et al., 2020). Learning detailed information about their foster child’s trauma likely increased
participants’ distress and put them at further risk for developing secondary traumatic stress.

Almost all participants reported that they learned about their foster child’s trauma history
from the child themselves. It is likely that participants’ foster children were able to provide more
details about the trauma they had experienced compared to other individuals who might have
shared information with the foster parent, such as child welfare workers. As discussed above,
hearing this detailed information may have put participants at increased risk for secondary
traumatic stress (Whitt-Woosley et al., 2020). Additionally, it is possible that participants
experienced more empathic concern when hearing about the trauma directly from their foster
child, which is a proposed pathway through which secondary traumatic stress develops (Figley,
2002; Ludick & Figley, 2017). Participants may have had a stronger reaction to hearing about
these experiences when the information came directly from the child who had endured it
compared to other individuals, which may have resulted in increased symptoms of secondary
traumatic stress.

In addition to learning about the trauma from their foster child, most participants also
described receiving at least some information about the trauma from individuals within the child
welfare system, such as caseworkers. However, some participants also shared that they felt like they learned little to no information about their foster child’s trauma history, which may have made it difficult for them to understand their foster child’s trauma symptoms and triggers. Other studies have echoed this finding, with foster parents noting the difficulty of not being provided with important information about their foster child and their history (Findley & Praetorius, 2021; Heller et al., 2002; Jones & Morissette, 1999). Interestingly, some participants indicated that they had learned more information about their foster child’s trauma history over time. This continued exposure over time may have increased participants’ overall exposure to their foster child’s trauma, which could have potentially increased their risk of developing secondary traumatic stress (Whitt-Woosley et al., 2020).

In addition to learning about another individual’s traumatic experiences, secondary traumatic stress can also develop from witnessing the impact that those experiences have on an individual (i.e., their trauma symptoms; Sprang et al., 2019). Given this, it was important to understand the trauma symptoms that participants’ foster children had experienced. All participants indicated that their foster child displayed challenging behavioral symptoms, such as physical or verbal aggression, tantrums, defiance, lying, manipulation, sexually age-inappropriate behavior, and self-harm. Given the trauma that the foster children had experienced within their biological family, as well as within their experience of being in foster care, it may have been difficult for the children to determine whether their current placement with the participants was safe. This uncertainty may have contributed to the challenging behavioral symptoms displayed by the foster children. This finding regarding challenging behaviors is not surprising, as children in foster care often struggle with externalizing behavior symptoms (Greeson et al., 2011; Turney & Wildeman, 2016; Vasileva & Petermann, 2018). Foster
children’s externalizing behaviors have consistently been found to be associated with general parental stress in foster parents across studies (Goemans et al., 2020; Harding et al., 2018; Jones & Morissette, 1999; McKeough et al., 2017; Morgan & Baron, 2011; Vanderfaeillie et al., 2013; Vanschoonlandt et al., 2013). Likewise, the challenging behaviors from participants’ foster children also likely increased their risk for secondary traumatic stress, as has been demonstrated in research (Dowdy-Hazlett & Clark, 2024; Reinhardt, 2016).

While all participants discussed externalizing behaviors, most participants also shared that their foster child displayed emotional symptoms, which is also consistent with previous research on foster children (Greeson et al., 2011; Turney & Wildeman, 2016; Vasileva & Petermann, 2018). It is probable that these emotional symptoms may have been difficult for foster parents to observe and may have led to increased distress, as foster children’s emotional instability has been found to be a source of general stress for foster parents (Jones & Morissette, 1999). Participants also reported symptoms in other areas that are often challenging for children in foster care, including social difficulties (Harden, 2004), academic difficulties (Gypen et al., 2017), and sleep disturbances (Lehmann et al., 2021). Given that both social difficulties and academic difficulties have been identified as sources of general stress in foster parents, it is possible that those symptoms also contributed to participants’ development of secondary traumatic stress (Goemans et al., 2020; Jones & Morissette, 1999). It appears that many of the foster children were experiencing trauma symptoms across multiple domains of their life, which may have increased participants’ overall exposure to the trauma symptoms and put them at further risk for secondary traumatic stress.

In addition to the specific symptoms described by participants, it is noteworthy that participants identified various situations that triggered behavioral or emotional reactions in their
foster child, such as being in contact with their biological family, having limits set, or not feeling like they were in control. These descriptions highlight that foster parents may have been very sensitive to what could possibly trigger their foster child’s trauma symptoms, which is important given that recent research has shown that increased sensitivity to foster children’s posttraumatic stress symptoms is associated with increased secondary traumatic stress in foster parents (Teculeasa et al., 2022).

In their role as a foster parent, participants were responsible for managing their child’s symptoms discussed above. Participants described using a variety of strategies to manage their foster child’s trauma symptoms, including managing their environment and routine, helping them to manage their emotions, establishing limits and boundaries, and offering unconditional love or reassurance. These strategies suggest that participants were closely involved with managing their child’s trauma symptoms on a daily basis, leading to additional exposure to their child’s trauma symptoms and a likely increased risk of secondary traumatic stress (Whitt-Woosley et al., 2020). It is noteworthy that participants likely felt a lot of responsibility for the day-to-day management of their child’s trauma symptoms, which is one way that their experience of secondary traumatic stress may differ from professionals within the child welfare system.

In addition to witnessing and managing their foster child’s trauma symptoms, most participants also reported experiencing abusive behaviors from their foster child directed towards themselves or members of their immediate family. These abusive behaviors, which included physical abuse, threats of physical abuse, and verbal or emotional abuse, are considered forms of primary trauma. Unfortunately, this experience is not uncommon for foster parents, with research suggesting that between 48 to 77% of foster parents experience primary trauma from their foster child (Bridger et al., 2020; Hannah & Woolgar, 2018). Importantly, one study found that
experiencing primary trauma from their foster child was a predictor for the development of secondary traumatic stress in foster parents (Bridger et al., 2020). As will be discussed in more detail below, these experiences of primary trauma complicate the picture of secondary traumatic stress given its overlap in symptoms with PTSD.

The findings reviewed above provide context for the secondary traumatic stress symptoms that participants developed, which will be discussed next. Participants had significant exposure to both their foster child’s trauma history and trauma symptoms, which are pathways through which STS can develop (Sprang et al., 2019). Participants described being exposed to information about multiple traumatic experiences that their foster child endured, and they indicated that they learned about the traumatic experiences from a variety of sources, including from the child themselves. Additionally, participants were exposed to a variety of trauma symptoms that their foster child displayed, and they experienced further exposure as they helped their foster child to manage these symptoms. It seems that participants were inundated with information about their foster child’s trauma history, as well as their foster child’s trauma symptoms. Given this, it is not surprising that they developed significant symptoms of secondary traumatic stress.

**Foster Parent’s Secondary Traumatic Stress Reactions**

Participants reported experiencing a variety of secondary traumatic stress symptoms, such as negative emotions, physical symptoms, frequent thoughts about their foster child, avoidance, difficulty concentrating, and feeling on edge. This finding is consistent with previous quantitative research which indicates that foster parents experience moderate to high levels of secondary traumatic stress (Bridger et al., 2020; Hannah & Woolgar, 2018; Steen & Bernhardt, 2023; Whitt-Woosley et al., 2020; Whitt-Woosley et al., 2022a). Additionally, participants’
descriptions of significant secondary traumatic stress symptoms were consistent with their responses on the STSS, which suggested that all participants had secondary traumatic stress symptoms at a level associated with meeting criteria for PTSD (Sprang et al., 2021). In the literature, secondary traumatic stress has been conceptualized as paralleling the symptoms of PTSD, which are divided into four symptom clusters: intrusive symptoms, avoidance, alterations in mood and cognition, and alterations in arousal and reactivity (Figley, 1995a; Sprang et al., 2019). The symptoms reported by participants spanned all four of these symptom clusters. The two most common symptoms reported by participants fit within the symptom cluster of negative alterations in cognitions and mood. First, all participants reported experiencing negative emotions during this experience, such as sadness, anxiety, frustration, helplessness, and guilt. It is understandable that hearing about their foster child’s trauma history could have resulted in these negative emotions, especially given that participants were not able to control what had happened to their foster child in the past. Additionally, it was likely distressing for participants to witness and attempt to manage their foster child’s trauma symptoms, which could have also led to these negative emotions. Second, almost all participants shared that their view of themselves, others, or the world shifted to become more negative. It appears that being exposed to their foster child’s trauma history and trauma symptoms may have decreased participants’ beliefs that others can be trusted and that the world is a safe place, similar to the shift that can happen when individuals experience PTSD. The finding that this exposure also caused a negative shift in participants’ view of themselves suggests that participants may have begun to internalize the difficulties they were experiencing. Additionally, participants’ descriptions of being less physically or socially active also fit within this symptom cluster. Taken together, these symptoms suggest that participants experienced a negative change in both their thoughts and emotions.
while parenting their foster child with trauma, which is consistent with previous research (Redfern, 2013).

Within the symptom cluster of intrusion symptoms, most participants shared that they frequently thought about both their foster child’s trauma history, as well as their foster child’s trauma symptoms. Participants’ descriptions of these intrusive thoughts were similar to the recurrent and involuntary thoughts/memories that occur during PTSD (APA, 2013). This finding suggests that participants had difficulty separating themselves from their foster child’s experiences, which is understandable given the significant role that they played within their child’s life. Furthermore, some of the negative physical symptoms that participants described experiencing fit within the intrusion symptom cluster, such as having a high heart rate and upset stomach. It appears that participants’ distress related to hearing about their foster child’s trauma history and observing their trauma symptoms was significant enough to activate their sympathetic nervous system, resulting in these physical symptoms.

Given the intrusive symptoms reported by participants, it is not surprising that most participants also described symptoms within the third symptom cluster of avoidance. Participants shared that they found themselves wanting to avoid thinking about their foster child, which was likely a response to the intrusive thoughts they were experiencing described above. In addition, they indicated that they wanted to avoid interacting with their foster child, which is an understandable, though unfortunate, response given the symptoms they were experiencing as a result of their exposure to their foster child’s trauma symptoms. Overall, it appears that participants were experiencing significant distress from their other secondary traumatic stress symptoms, and their avoidance symptoms were likely an attempt to reduce further exposure to
their foster child’s trauma history/symptoms and the associated distress that they were experiencing.

Finally, most participants reported experiencing a variety of symptoms related to the fourth symptom cluster: alterations in arousal and reactivity. They described having difficulty concentrating, feeling on edge or jumpy, and having difficulty with sleep. Additionally, some of the negative emotions they experienced fit within this symptom cluster, namely feeling irritable and angry. As will be described below, these arousal and reactivity symptoms had a particularly negative impact on participants’ work lives.

Taken together, these findings suggest that participants were experiencing a variety of difficult secondary traumatic stress symptoms in response to their exposure to their foster child’s trauma history and trauma symptoms. Participants’ descriptions of their symptoms suggest that this experience was extremely distressing and negatively impacted their internal lives. It appears that participants were in tremendous pain, and it is noteworthy that many of the symptoms they described were similar to those experienced in PTSD. Unfortunately, as will be discussed below, these symptoms had a significant impact on various domains of participants’ lives.

As discussed earlier, many participants reported experiencing primary trauma from their foster child. Not surprisingly, participants described developing trauma reactions as a result of this primary trauma. Two of the symptoms in particular, experiencing negative emotions and feeling on edge/jumpy, were noted by participants to also be related to their primary trauma. This experience of primary trauma and the associated trauma symptoms complicates the picture of secondary traumatic stress. As other researchers have noted, it is difficult to differentiate between secondary traumatic stress and PTSD symptoms given their overlap, and it is possible that PTSD symptoms could be impacting participants’ reporting of their secondary traumatic stress.
symptoms (Bridger et al., 2020; Hannah & Woolgar, 2018). This complexity is particularly relevant for foster parents, given the high rate of primary trauma that they experience from their foster children (Bridger et al., 2020; Hannah & Woolgar, 2018). The experience of secondary traumatic stress and primary trauma are comingled, which was common to participants’ experiences in this study. While there is no easy solution to differentiating secondary traumatic stress and PTSD symptoms in foster parents, it is important to note the difficulty this causes in operationalizing secondary traumatic stress within this population.

**Impact of Secondary Traumatic Stress**

**Impact of Secondary Traumatic Stress on Foster Parent’s Life**

As research in secondary traumatic stress advances, researchers have discussed the importance of clarifying how symptoms of secondary traumatic stress impact individuals’ personal lives (Walsh et al., 2017). Unfortunately, participants reported that their secondary traumatic stress impacted their lives across a variety of areas, including work, self-care, relationships, and their overall personal/emotional life. Given the symptoms that participants reported, it is not surprising that their lives were impacted, though it is alarming. Most participants noted negative impacts from secondary traumatic stress on their functioning at work. Participants reported having difficulty concentrating at work, which may have been due to frequently thinking about their foster child’s trauma history of symptoms. Their negative physical symptoms, such as difficulty sleeping and feeling exhausted, may have also made it more difficult to concentrate on work tasks. Participants also endorsed feeling irritable or annoyed at work, which is consistent with the negative emotions that they reported experiencing. Perhaps participants had less patience to deal with work issues given all that they were experiencing at home. The reported symptom of developing a negative view of others or the
world could have also led to irritability or annoyance when interacting with others at work. Given the important role that work plays in people’s lives, it is concerning that many participants also described feeling like they were less effective at work. It is possible that these impacts on work functioning could lead to additional downstream impacts, such as wanting to discontinue being a foster parent due to the negative impact on work or deciding to quit a work environment that had become too stressful due to performance issues.

Additionally, participants reported that their relationships with their family, friends, and significant others were negatively impacted by their secondary traumatic stress. This negative impact on relationships is supported by the literature on secondary traumatic stress in child welfare professionals (Genovese, 2013; Stone, 2011), as well as a qualitative study on foster parents (Redfern, 2013). Participants reported that they constantly talked about their foster child when with family and friends, which is consistent with the intrusion symptom discussed above of frequently thinking about their foster child. It appears that participants found it difficult to remove their focus from their foster child even when spending time with others in their life, which speaks to the intensity of their intrusion symptoms. Participants also described not spending as much time with their family and friends, which is related to the symptom discussed above of being less socially active. Perhaps participants’ secondary traumatic stress symptoms were so overwhelming that they lacked the emotional capacity to engage with their family and friends. Alternatively, participants may have felt unsure about how to share about their experience of secondary traumatic stress with others in their life, and they may have found it easier to withdraw from their social relationships instead of trying to explain their experience. Given the important purpose that social relationships serve in people’s lives, it is alarming that those relationships were negatively impacted by participants’ secondary traumatic stress.
Most participants also described negative impacts from secondary traumatic stress on their ability to take care of themselves, as well as on their overall personal/emotional life. Participants made powerful statements about the impact of secondary traumatic stress on their lives, noting it impacted “everything” and was “very destructive” on their lives. It appears that participants felt a pervasive and significant impact on their lives, which highlights the level of distress they were experiencing. This impact is consistent with previous research on general parenting stress in foster parents, which found that experiencing parenting stress negatively impacted foster parents’ overall well-being (Ottaway & Selwyn, 2016; Sharda, 2022). Again, this finding is concerning, not only for the significant impact that it had on participants’ lives, but also for the potential downstream impacts it could have on their foster children. Overall, these findings are important because studies often neglect to assess the impact of secondary traumatic stress on individuals’ functioning. From these results, it is clear that participants are not only experiencing symptoms, but that these symptoms are having a significant impact on their functioning across a variety of areas.

**Impact of Secondary Traumatic Stress on Foster Parent’s Parenting**

Considering the secondary traumatic stress symptoms described by participants, as well as the significant impact that the symptoms had on their personal lives, it is understandable that participants’ parenting of their foster child was also impacted. Research has shown that general parental stress in foster parents is associated with poorer parenting practices (Farmer et al., 2005; Leathers et al., 2019; Lipscombe et al., 2004; Vanschoonlandt et al., 2013). For example, foster parents with more general parental stress are less sensitive, committed, and engaged in their parenting. Similar results were found in the present study. Most participants shared that their relationship with their foster child was negatively impacted, with participants noting that they
experienced interpersonal difficulties with their foster child. This finding may elaborate a finding from Riggs’ (2021) study, which suggested that foster parents found it hard to connect with their foster children given their trauma histories. The result from the present study highlights the possibility that foster parents’ secondary traumatic stress may be a contributing factor to foster parents’ difficulty connecting with their foster child. However, while it is likely that participants’ secondary traumatic stress symptoms (e.g., negative emotions, desire to avoid interacting with their foster child) played a role in these interpersonal difficulties, it is also possible that participants’ symptoms interacted with the trauma symptoms displayed by their foster child (e.g., challenging behaviors, social difficulties) to create these difficulties.

Many participants also reported that they worked hard to reduce conflict with their foster child, as well as to avoid situations that might have triggered their foster child. It is likely that this impact on parenting is related to several of the participants’ reported secondary traumatic stress symptoms, such as feeling on edge or jumpy, wanting to avoid interacting with their foster child, and experiencing negative emotions. Participants understood that conflict and other triggering situations could lead to a lot of negative outcomes for themselves and their foster child, so they attempted to prevent those situations as much as possible. Unfortunately, this means that participants may have been less effective in using the management strategies described above, as some participants reported “giving in” and being “pushover parents” as a way to avoid conflict. For example, due to their secondary traumatic stress, participants may not have been establishing consistent limits or boundaries with their foster child, which was a management strategy described by some participants. As a result, their foster child may have displayed more trauma symptoms (e.g., increased challenging behaviors), which may have led to
even more secondary traumatic stress symptoms in the participants. In this way, this impact on parenting may have continued the cycle of secondary traumatic stress.

Another important finding is that some participants noted that they stopped (or wanted to stop) trying to parent their foster child, which is consistent with research indicating that foster parents with more general parental stress are less involved with their foster children (Lopez et al., 2023). This impact on parenting appears to be related to participants’ symptoms of wanting to avoid thinking about or interacting with their foster child. Alternatively, this impact may be connected to the negative emotions that participants reported experiencing, which they likely did not want to direct at their foster child. Similarly, some participants felt like they were not being a good parent, which may have been related to their secondary traumatic stress symptom of developing a negative view of themselves. A related finding was highlighted in another study, where foster parents reported that their secondary traumatic stress impacted the quality of their parenting because they were only able to meet the basic needs of their foster children (Ottaway & Selwyn, 2016). Both of these impacts suggest that participants were not having a positive experience in their foster parenting role, which could potentially lead to a desire to discontinue fostering.

Overall, these results indicate that secondary traumatic stress was impacting the parenting of participants. Unfortunately, the literature suggests that when foster parents have lower quality parenting practices, there is an increased risk for placement instability for their foster children (Koihn et al., 2019). The possibility that foster parents’ secondary traumatic stress symptoms could negatively impact their parenting and thus lead to increased placement instability is noteworthy given the numerous negative impacts of placement instability on foster children (Chambers et al., 2018; Clemens et al., 2018; Jonson-Reid & Barth, 2000; Koihn et al., 2019;
Impact of Secondary Traumatic Stress on Foster Parent’s Desire to Continue Fostering

Surprisingly, many participants planned to continue fostering despite the secondary traumatic stress symptoms they had experienced. It is possible that other factors outweighed their secondary trauma, such as their commitment to their foster child, their desire to make a difference, or the importance of their identity as a foster parent. Alternatively, it is possible that they had not yet experienced secondary traumatic stress for a long enough period of time to have had an impact on their commitment to fostering.

However, participants also reported negative impacts on their desire to continue fostering. Many participants noted that they stopped or reduced their fostering, while other participants indicated that they felt uncertain about whether they wanted to continue fostering in the future. For these participants, it appears that their secondary traumatic stress and the associated impacts on their lives were distressing enough that they believed discontinuing or reducing their fostering may have been necessary in order to reduce their symptoms. Additionally, some participants shared that they planned to be more selective in the types of foster care placements they accept in the future. This finding suggests that participants may not accept placements for foster children that have high levels of trauma or trauma symptoms in the future, which may make it even harder for the child welfare system to find placements for children with high needs related to trauma.

These findings shed additional light on previous research which has found that foster parents with high levels of secondary traumatic stress have lower satisfaction with fostering (Hannah & Woolgar, 2018; Teculeasa et al., 2022), increased risk for placement disruption...
(Dowdy-Hazlett & Clark, 2024; Ottaway & Selwyn, 2016), and increased likelihood of discontinuing fostering (Dowdy-Hazlett & Clark, 2024; Hannah & Woolgar, 2018; Ottaway & Selwyn, 2016). In the present study, the negative impacts from secondary traumatic stress on foster parents’ desire to continue fostering are on a continuum, ranging from being selective about future placements to feeling uncertain about future fostering to reducing or stopping fostering altogether. Foster parents who experience secondary traumatic stress may initially decide to be selective about future placements or feel uncertain about whether they want to continue fostering. However, they may move further along this continuum as their symptoms continue or intensify over time, or as they experience additional challenging factors related to this experience, as discussed below. It is possible that intervening to address secondary traumatic stress when foster parents are on the less severe end of this continuum may help with foster parent retention, as it might prevent foster parents from reaching the decision to discontinue their fostering. These results are especially important considering the current shortage of foster parents and high turnover rates of existing foster parents (Adams, 2020; Browder, 2022; Gibbs & Wildfire, 2007; Washington Post Editorial Board, 2020). Furthermore, the negative impact of secondary traumatic stress on foster parents’ intent to continue fostering also relates to the well-being of foster children, given the negative impacts that frequent moves can have on foster children (Chambers et al., 2018; Clemens et al., 2018; Jonson-Reid & Barth, 2000; Konihm et al., 2019; Newton et al., 2000; Rubin et al., 2004; Rubin et al., 2007; Stott, 2012; Unrau, et al., 2008; Villodas et al., 2016).

Factors that Influenced the Experience of Secondary Traumatic Stress

Helpful Factors in Managing this Experience
Participants shared about a variety of factors that were helpful as they managed their experience of secondary traumatic stress. Social support, active coping, and their own trauma history were noted to be important factors by many participants. First, receiving social support from others in their lives was reported to be helpful by all participants. This social support came from a variety of individuals, including significant others, family, friends, work colleagues, and other foster parents. Participants described receiving emotional support, as well as practical support (e.g., receiving help to watch their foster child). The emotional support that participants received may have given them a place to process their secondary traumatic stress and helped them to know that they were not alone during this experience. It is possible that receiving this emotional support allowed participants to share the burden of their experience with others, thereby reducing the impact that this experience had on them. The practical support that participants received likely allowed them to take a break from their foster child, and potentially gave them time to engage in self-care activities. Additionally, this practical support indicates that participants may have received assistance with managing their foster child’s trauma symptoms, which would have decreased their overall exposure to the trauma symptoms.

The importance of social support was identified in Ludick and Figley’s (2017) multidimensional model of secondary traumatic stress, where social support was suggested to be a pathway through which individuals can maintain resilience against developing secondary traumatic stress. Indeed, social support from family and friends has consistently been found to be associated with lower levels of secondary traumatic stress in studies on child welfare professionals (Hensel et al., 2015; Molnar et al., 2020). Similarly, most research on foster parents has also found that social support, in particular emotional support, can be a protective factor against developing secondary traumatic stress (Carew, 2016; Dowdy-Hazlett & Clark, 2024;
Whitt-Woosley et al., 2020). This finding has been echoed in other research, where foster parents have described the importance of social support in helping them to maintain their well-being (Bridger et al., 2020; Redfern, 2013). Thus, the findings in the current study are consistent with the existing literature and highlight the important role of social support in helping foster parents manage secondary traumatic stress.

Engaging in active coping was another factor that almost all participants identified as helpful during this experience, which included practicing self-care activities, attending therapy, and using cognitive coping strategies. Given the focus that these participants had on parenting their foster child and helping them to manage their trauma symptoms, perhaps these active coping strategies brought participants’ focus back to their own well-being. It is possible that these strategies helped to address specific secondary traumatic stress symptoms that participants were experiencing. For example, attending therapy and using cognitive coping strategies could have addressed participants’ negative emotions, as well as their negative view of themselves, others, or the world. Self-care practices were included in Ludick & Figley’s (2017) multidimensional model as a proposed source of resilience against secondary traumatic stress. Interestingly, mixed results have been found in the literature regarding the usefulness of engaging in self-care as a way to protect against secondary traumatic stress. In research on foster parents, one study found that secondary traumatic stress was predicted by self-care (Reinhardt, 2016), while another study found an indirect effect of self-care on secondary traumatic stress (Bridger et al., 2020) and another found no relationship between the variables (Carew, 2016). These three studies all measured self-care in different ways, which may have contributed to the conflicting results. In the literature on child welfare professionals, more consistent results have been found, with emotional self-care activities and coping strategies (e.g., engaging in activities
or hobbies) associated with lower secondary traumatic stress (Reinks, 2020; Stanley et al., 2023). The results from the present study provide additional support for the important role of self-care activities in helping foster parents manage their experience of secondary traumatic stress.

Regarding attending therapy, research on child welfare professionals has suggested that attending therapy can be a protective factor against the development of secondary traumatic stress (Skar et al., 2023; Stanley et al., 2023). However, a study on foster parents found that participating in therapy was correlated with increased secondary traumatic stress (McLain, 2008). It is unlikely that attending therapy causes secondary traumatic stress; rather, individuals with high levels of secondary traumatic stress may be more likely to seek out therapy. Indeed, in the current study, while participants indicated that attending therapy was helpful, they still reported experiencing many symptoms of secondary traumatic stress. It is possible that attending therapy alone was not enough to alleviate participants’ secondary traumatic stress, especially given that their exposure to their foster child’s trauma history and trauma symptoms was ongoing.

Participants’ personal trauma history was another important factor during this experience. Some participants noted that their trauma history was helpful, as it informed their perspective as a foster parent. Specifically, some participants noted that their trauma history helped them to empathize with their foster child. It appears that participants were able to better understand their foster child’s experiences, and subsequent trauma symptoms, as a result of experiencing trauma themselves. A couple of participants reported that their trauma history positively influenced how they parented their foster child. In these participants, it is possible that the positive impact of their own trauma history on their parenting may have offset the negative impact on their parenting from their secondary traumatic stress symptoms. Interestingly, participants also
identified ways that their trauma history made this experience challenging, which will be discussed in more detail below.

Additionally, some participants noted that their foster child attending therapy was a helpful factor during this experience. Participating in therapy may have decreased their foster child’s trauma symptoms, which would have also decreased participants’ overall exposure to the trauma symptoms. Therapy may have also provided their foster child with a safe place to talk about their trauma history, potentially decreasing the frequency that the child talked about their trauma history with the participant. Similarly, some participants found it helpful that their foster child’s school partnered with them. Perhaps this partnership helped participants to feel less isolated during this experience, as they had other individuals who were helping them to manage their foster child’s trauma symptoms.

**Challenging Factors in Managing this Experience**

In addition to helpful factors, participants also shared about factors that were challenging as they managed this experience. Interestingly, some of the helpful factors noted above were also described as challenging factors in other ways. As discussed above, all participants indicated that receiving social support was helpful during this experience. However, most participants unfortunately also reported feeling like they had a lack of social support. Most participants indicated that they felt isolated during this experience, which was due to a variety of factors including fostering during the COVID-19 pandemic, being a single foster parent, not being able to talk with others about their foster child, and not having a community of other foster parents. This feeling of social isolation was also discussed by Riggs’ (2021) participants, who noted that their foster child’s unpredictable behaviors made it difficult to navigate other relationships. In addition to feeling socially isolated, many participants in the current study also shared that some
of their family and friends were actively unsupportive during this experience, which is unfortunate. These findings further support the important role that social support plays in helping foster parents to manage their secondary traumatic stress, as it was more difficult for participants to manage this experience when social support was lacking. It appears that the social support that participants received was not enough, as it did not negate the fact that participants still felt isolated during this experience.

In addition to finding that a lack of social support was unhelpful for participants, it is notable that participants also felt like their experience of secondary traumatic stress negatively impacted their relationships. Therefore, it is possible that social support and secondary traumatic stress have bidirectional influences on each other. Lacking social support from family and friends may have led to an increase in secondary traumatic stress symptoms. At the same time, experiencing secondary traumatic stress, particularly the symptom of being less socially active, may have caused participants to withdraw from their social relationships, making them feel like they lacked support and were isolated. Regardless, it is clear that social support was an important factor for participants, indicating that it could play an important role in interventions to address secondary traumatic stress.

Another challenging factor discussed by most participants was that foster parenting is complex and demanding. Participants described foster parenting as being different than normal parenting, and they highlighted complex factors that they dealt with on a daily basis. For example, participants discussed that it was difficult to not know when they might learn new information about their foster child’s trauma history or when their child’s trauma symptoms might be triggered. Given that foster parents have been found to have higher levels of general parental stress compared to biological parents, it is not surprising that participants viewed their
role as a foster parent as complex and demanding (Bergsund et al., 2020; Lohaus et al., 2017). As discussed above, the foster children that participants were parenting had complex trauma histories, which resulted in significant trauma symptoms. Witnessing these trauma symptoms, as well as attempting to manage them using a variety of strategies, was likely a source of general stress for participants. Importantly, this source of stress is not dealt with by parents who are parenting children without trauma, which lends support to the idea that foster parenting is complex.

Two additional factors that participants identified as challenging may also relate to the finding that participants viewed foster parenting as complex and demanding. First, some participants shared that they put pressure on themselves to be a good foster parent, which made this experience more challenging for them to manage. While it is understandable that participants wanted to do well as a foster parent, it is possible that these high expectations were especially problematic given the complexity of the foster parent role. Second, a few participants noted that being a first-time foster parent made them feel less confident during this experience. Again, the fact that the foster parenting role is complex and demanding likely added to the difficulty of being a first-time foster parent. Overall, the fact that most participants viewed their role as complex and demanding speaks to the support and resources that they need as they foster children with trauma.

As discussed above, most participants reported that engaging in active coping was helpful in managing their secondary traumatic stress. However, many participants also shared that they struggled to take care of themselves, which made this experience more challenging. Dowdy-Hazlett and Clark’s (2024) research is consistent with this finding, as their results indicated that foster parents with higher levels of secondary traumatic stress reported lower levels of coping.
Given the trauma symptoms that participants were managing in their foster child, as well as their own symptoms of secondary traumatic stress, it is not surprising that they found it hard to prioritize their own well-being during this time. It is possible that participants were overwhelmed with the level of self-care that was necessary to adequately address their secondary traumatic stress symptoms while also parenting their foster child. Similar to the factor of social support discussed above, the finding regarding coping is complicated given that participants also identified that their self-care was negatively impacted by their secondary traumatic stress symptoms. Thus, the direction of this relationship is unclear. It may be that secondary traumatic stress negatively impacts participants’ ability to engage in coping, or it may be that participants who have difficulty coping have increased levels of secondary traumatic stress. Clearly, more research is needed in this area.

While some participants identified ways that their own trauma history was helpful during this experience, some participants also described ways that their own trauma history made this experience more challenging. Many participants shared that they recalled their own trauma history as a result of their exposure to their foster child’s trauma history and symptoms, which was difficult. Perhaps participants had experienced a similar trauma to their foster child, so they were reminded of their own experience. Similarly, participants may have recognized trauma symptoms in their foster child that they themselves had previously experienced. Additionally, a couple of participants reported that they felt concerned that they might be replicating their own trauma history with their foster child, which was another way that their own trauma history made this experience more challenging. These findings suggest that participants’ own trauma history may have been reactivated during this experience, which may have further complicated their
current experiences of both secondary traumatic stress and primary trauma from their foster child.

Personal trauma history has been examined in many studies on secondary traumatic stress. In Ludick and Figley’s (2017) multidimensional model on secondary traumatic stress, memories from an individual’s own trauma history are a proposed risk factor for developing secondary traumatic stress. Indeed, having a personal trauma history has been found to put child welfare professionals at an increased risk for secondary traumatic stress symptoms across studies (Hensel et al., 2015; Molnar et al., 2020; Reinks, 2020; Turgoose & Maddox, 2017). However, findings from studies with foster parents are more inconsistent. Two studies have found no relationship between foster parents’ personal trauma history and their secondary traumatic stress level, while one study found that having a personal trauma history was associated with lower levels of secondary traumatic stress in foster parents (Carew, 2016; McLain, 2008; Whitt-Woosley et al., 2020). Results from the present study provide a possible explanation for these research findings, which differ from the research on child welfare professionals. Participants reported ways that their trauma history was helpful during this experience, but they also reported ways that their trauma history made this experience more challenging. It is possible that these helpful and unhelpful aspects of their trauma history negated each other, which would be consistent with the finding from two studies that having a personal trauma history is not associated with either increased or decreased secondary traumatic stress in this population (McLain, 2008; Whitt-Woosley et al., 2020). Additional research to further understand the relationship between foster parents’ personal trauma history and their secondary traumatic stress symptoms would be beneficial.
Another challenging factor reported by some participants was that they did not recognize they were experiencing secondary traumatic stress as they went through this experience. It is possible that participants may not have been aware that their symptoms aligned with secondary traumatic stress, given the finding discussed below that they received limited training and information about secondary traumatic stress during their foster parent training. Alternatively, participants may have been so focused on their foster child and their symptoms that it was difficult to direct their attention to themselves and recognize their own symptoms. Regardless of the reason, this is a notable finding because foster parents are unlikely to seek help for secondary traumatic stress if they do not recognize that they are experiencing it.

**Involvement of the Child Welfare System**

In addition to general helpful and challenging factors related to this experience, participants also shared about ways that the child welfare system was both helpful and unhelpful as participants managed their secondary traumatic stress. Most participants indicated that the child welfare system provided them and their foster child with support and assistance. This support included providing resources, such as respite care and foster parent support groups, as well as providing emotional support and being available to help the participants figure out how to handle situations with their foster child. In Redfern’s (2013) study on secondary traumatic stress in foster parents, participants similarly described the importance of being supported by the child welfare system. It is likely that participants found this support important to help them manage both the secondary traumatic stress symptoms they were experiencing, as well as the trauma symptoms that their foster child was displaying. Additionally, the child welfare system is a complex system, so having support from within the system may have been essential for participants.
Unfortunately, most participants indicated that they did not feel like secondary traumatic stress was adequately addressed by the child welfare system. Participants noted that the child welfare system did not support them in managing their secondary traumatic stress, as they did not provide support or resources to address secondary traumatic stress and they did not check in with participants about their secondary traumatic stress. Participants also shared that secondary traumatic stress either was not covered at all during their foster parent training, or it was not covered adequately. In fact, a couple of participants indicated that they had not heard of secondary traumatic stress until this study. This finding may explain why some participants did not recognize they were experiencing secondary traumatic stress as it was happening. The lack of training and support around secondary traumatic stress from the child welfare system is a significant gap in the services they provide to foster parents. Presumably, professionals in the child welfare system should have the best understanding of secondary traumatic stress compared to other individuals in the participants’ lives. Given this, a foster parent interaction with the child welfare system could provide an opportunity both for secondary traumatic stress to be identified and interventions to be implemented, and it appears that this opportunity was missed for participants. Foster parents spoke of similar concerns in Murray et al.’s (2011) study on general parental stress, where participants noted their difficulty managing their own well-being and their desire for more training and support in that area from the child welfare system. An interesting conundrum is that child welfare professionals are also at a high risk for experiencing secondary traumatic stress, so they may be trying to support foster parents with secondary traumatic stress while experiencing secondary traumatic stress themselves (Bride et al., 2007; Caringi & Hardiman, 2012; Reinks, 2020; Salloum et al., 2015; Sprang et al., 2011). Clearly, addressing the
secondary traumatic stress of both foster parents and child welfare professionals is important in order to support the children in their care.

While most participants indicated that they received support and assistance from the child welfare system during this experience, many participants also unfortunately reported that they felt like the support they received was inadequate, a finding that is consistent with other studies on general parental stress and secondary traumatic stress in foster parents (Findley & Praetorius, 2023; Murray et al., 2011; Reinhardt, 2016). Some participants described feeling unsupported by those within the child welfare system, and others noted feeling like their well-being as a foster parent was not being addressed. Other participants discussed issues with poor communication and high social worker turnover, which is consistent with results found in Findley and Praetorius’s (2023) study. Taken together, this finding suggests that the child welfare system was not providing enough support for participants’ needs. It is possible that the level of support provided to participants would have been adequate for foster parents experiencing no or low secondary traumatic stress, but these participants may have needed a higher level of support given their high levels of secondary traumatic stress. Related to the previous finding, if professionals within the child welfare system are not recognizing and addressing secondary traumatic stress within foster parents, they may not have recognized how much support and resources these participants actually needed. It is also possible that professionals within the child welfare system did recognize the participants’ needs but were unable to provide a higher level of support due to their high caseloads and limited resources. Overall, this finding suggests that additional overall support from the child welfare system is needed, especially for foster parents experiencing high levels of secondary traumatic stress.
Respite care, which provides care for foster children in order to give foster parents a break, is presumably one way that the child welfare system supports foster parents. However, some participants noted that using respite was difficult or created additional challenges. Participants described difficulty with the process for obtaining respite, which could have discouraged them from trying to utilize it. Participants were dealing with their own secondary traumatic stress, as well as trying to manage their foster child’s trauma symptoms, so it may have felt especially burdensome when it was difficult to get respite set up. Additionally, participants noted that they did not feel comfortable sending their foster child to respite due to their trauma and background. Perhaps these participants decided that the benefits they could have received from using respite did not outweigh the risks, as overall it may have added to the stress they were experiencing. The hesitation to use respite may also be related to the previous finding that participants worked hard to reduce conflict or triggering situations with their foster child, as they may have been avoiding using respite due to a fear that it might create additional conflict or difficult situations with their foster child. Unfortunately, it appears that respite care was not as useful to some participants as one might expect.

Participants discussed two other challenging aspects while working with the child welfare system related to communication and placement decisions. Some participants shared that important information about their foster child was not communicated to them, including information about their child’s background and current needs. This gap in communication likely caused participants to feel ill-equipped to parent their foster child and manage their needs. Frustration about the lack of information provided by the child welfare system has also been reported by foster parents in prior studies (Heller et al., 2002; Jones & Morrisette, 1999). Some participants also expressed that they felt like the placement decisions regarding their foster child
were not handled in a way that was in the child’s best interest. This may have been particularly distressing for participants given that they knew the trauma and hardships that their foster child had already been through. It appears that the deficit in communication, as well as the mishandling of placement decisions, was stressful to participants and may have added to the distress they were already experiencing related to secondary traumatic stress.

While participants discussed disappointment with foster parent training specifically related to secondary traumatic stress, they also mentioned foster parent training more generally. A couple of participants found that their foster care training prepared them for fostering, while some other participants felt like their training did not provide them with relevant information regarding foster parenting. Concerningly, these participants described the training as “useless” and a “joke.” In the United States, the laws surrounding foster parent training requirements vary by state, given that licensing is done at the state level (CWIG, 2018). As researchers have noted, there is an overall lack of research on the effectiveness of foster parent training programs, so it is possible that the effectiveness of training programs might differ across states (Rork & McNeil, 2011). Some studies have found that preservice training programs do not focus on teaching parenting skills, which is a potential limitation given that foster parents may have children with high levels of trauma placed with them immediately after the training (Benesh & Cui, 2017; Cooley et al., 2019). Despite this, research suggests that foster parent training has a positive effect on parenting skills and knowledge (Cooley et al., 2019; Solomon et al., 2017). However, research on foster parents’ satisfaction with the training programs tells a different story. Across research, foster parents have identified a need for better training given that they did not feel prepared for their role based on the training they received, which was also endorsed by some participants in the current study (Findley & Praetorius, 2023; Kaasboll et al., 2019; Murray et al.,
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2011; Riggs, 2021). Clearly, more attention to foster parent training is needed in order to ensure that foster parents feel prepared for their role. As Cooley et al. (2019) noted, research should be conducted to determine the essential components of training programs, particularly for foster parents who parent children with high levels of trauma. Notably, the results from this study suggest that training on secondary traumatic stress should be one of those components.

Suggestions and Reactions

Participants provided suggestions on how the child welfare system could better support foster parents who are experiencing secondary traumatic stress. Most participants discussed the importance of more support and resources being provided to foster parents, which aligns with their views discussed above that the support they had received from the child welfare system during this experience was inadequate. Within this suggestion, participants highlighted several specific areas where more support and resources should be provided. First, some participants spoke of a need for the quality of foster parent training to be improved, with a few participants noting the importance of including training on secondary traumatic stress. Perhaps these participants recognized that they might have been better prepared to handle secondary traumatic stress if they had learned about ways to manage it during their training. Second, participants suggested that respite should be facilitated and encouraged by the child welfare system. While some participants noted challenges regarding using respite as discussed above, it appears that some participants still recognized the usefulness of receiving breaks from their foster child. Third, providing more effective social workers was another suggestion by some participants. These participants likely understood the important role that social workers played in the lives of themselves and their foster child and recognized that their experience was made more difficult by not having inadequate social work support. These participants may have also identified that
effective social workers could be a source of increased support to help them manage their secondary traumatic stress. As discussed above, a factor that may complicate this suggestion is that social workers are also at risk for experiencing secondary traumatic stress (Bride et al., 2007; Caringi & Hardiman, 2012; Reinks, 2020; Salloum et al., 2015; Sprang et al., 2011). Thus, it may be difficult for some social workers to support foster parents with secondary traumatic stress while they are also experiencing it themselves. Finally, a couple of participants indicated the importance of therapy being provided to foster parents. Both of these participants had noted the helpfulness of attending their own therapy during this experience, so it is understandable that they also recommended this support for other foster parents. Interestingly, these suggestions regarding more support from the child welfare system are very similar to those found in Bridger et al.’s (2020) study on secondary traumatic stress, where participants indicated the need for time off/respite, professional support, improved social workers, specific training, and therapeutic support. Clearly, these areas are important to consider when addressing secondary traumatic stress in foster parents.

Additionally, some participants suggested that the child welfare system should coordinate connections amongst foster parents. Given that most participants reported feeling isolated during this experience, perhaps they recognized the importance of connecting with other foster parents going through a similar experience. It seems that participants believed that connecting with other foster parents could have helped them to manage their secondary traumatic stress, potentially through making them feel less alone in their experience, providing them with ideas for how to take care of themselves, or helping them to navigate the child welfare system. Given that some participants had family and friends who were actively unsupportive during this experience,
participants may have understood that connecting with those who could truly understand their experience would have been beneficial.

Providing appropriate therapy for foster children was another suggestion from a couple of participants, which aligns with the finding that participants’ foster child attending therapy was a helpful factor during this experience. Given the level of trauma symptoms experienced by participants’ foster children, therapy is clearly a needed resource to help those children. Interestingly, therapy for foster children could also have an indirect effect on foster parents’ secondary traumatic stress symptoms as they would presumably be exposed to less trauma symptoms from their foster child. Finally, a couple of participants spoke of the importance of structural changes being implemented within the foster care system. It appears that they noticed flaws within the system that were contributing to their experience of secondary traumatic stress.

As part of the closing interview questions, participants were asked about their reaction to participating in the interview, which elicited mixed responses. Most participants described having a positive experience while participating in the interview. Participants shared that it was helpful to talk through their experience with someone, with one participant noting it was “cathartic” to process their experience during the interview. It appeared that participants found it validating that someone wanted to hear about their experience related to secondary traumatic stress, given that professionals within the child welfare system had not provided support in this area. As another positive, a couple of participants shared that they had gained insight into their experience during the interview, suggesting that the questions they were asked encouraged them to think about their experience in a new way.

In contrast, half of participants reported that it was challenging to participate in this interview. Some participants noted the difficulty of thinking through their experience, suggesting
that they may not have previously processed what they had gone through. Additionally, some participants were currently experiencing these secondary traumatic stress symptoms, so it is not surprising that they found it difficult to reflect on their experience. Interestingly, it is possible that participants’ negative reactions to the interview might have been related to their secondary traumatic stress symptom of wanting to avoid thinking about their foster child, as participating in the interview forced participants to confront, instead of avoid, their experience.

Participants also highlighted their motivation for wanting to participate in this interview. Some participants shared that they wanted other people to know about what is going on in foster care, while other participants described their hope that this study would help others, including other foster parents. These responses suggested that participants wanted their experience to mean something, and that they had hope that things could change for foster parents in the future. Thus, despite their negative experiences with secondary traumatic stress, participants still believed that there were ways to address secondary traumatic stress and improve foster parents’ experiences.

**Limitations**

While the findings discussed above contribute valuable knowledge to the literature on secondary traumatic stress in foster parents, it is important to highlight the limitations of this study. First, all participants had high levels of secondary traumatic stress as measured by the STSS (range = 49-76; Sprang et al., 2021). In fact, the symptoms reported by all participants were at the level associated with meeting criteria for PTSD. Of note, many participants in this study also experienced primary trauma from their foster child, further complicating their reported secondary traumatic stress symptoms. While it is not surprising that those with high levels of secondary traumatic stress self-selected to participate in this study, their experiences may have been different from foster parents who were experiencing low or moderate secondary traumatic
stress. Given this, the results from this study may not be found with all foster parents who are experiencing secondary traumatic stress.

A second limitation is that all participants were fairly new to foster parenting, so they had limited experience with the foster parent role. Likewise, they had only fostered two children on average. Given this, the findings from this study may be more consistent with the experiences of foster parents who are early into their fostering career compared to foster parents with more years of experience. It is possible that foster parents with many years of experience may have discussed different secondary traumatic stress symptoms and impacts on their lives, as they may have found ways to manage their experience over time. Similarly, the majority of participants were current foster parents. While a couple of participants had decided to discontinue fostering, findings may have been different if the entire sample was comprised of participants who had experienced secondary traumatic stress and decided to stop fostering.

A third limitation is that participants were recruited via social media (i.e., Instagram, Facebook, Reddit, and LinkedIn). While this method of recruitment was helpful in yielding participants from across the United States, it is possible that participants may have had different experiences compared to foster parents who are not connected to social media. For example, these participants may have had the opportunity to form connections with other foster parents through social media, which could have served as a form of social support.

Fourth, the age range of foster children that were discussed in this study was limited, with the children ranging from 9 to 17 years old. The findings from this study may not reflect the experiences of foster parents with children of different ages. In particular, foster parents who are parenting younger children may have different experiences with secondary traumatic stress, given the differences in trauma symptoms that those foster children might display and the level
of parental management needed for younger children. Additionally, younger foster children may not be able to talk about their traumatic experiences as easily as the foster children discussed in this study, which is why the eligibility criteria for this study were limited to foster parents with a foster child who was at least five years old.

Fifth, participants discussed their fostering experience from early 2022 to early 2023, so their experience may have been impacted by the COVID-19 pandemic. In fact, several participants mentioned the pandemic during the interview, noting different ways that it impacted their experience. Previous research has found that foster parents experienced an increase in specific secondary traumatic stress symptoms (i.e., intrusive symptoms and alterations in cognitions and mood) six months into the pandemic (Whitt-Woosley et al., 2022a). Additional studies have highlighted specific stressors and impacts that foster parents experienced related to the pandemic (Findley, 2023; Whitt-Woosley et al., 2022b). As such, if this study was conducted prior to the pandemic, or farther after the pandemic ended, different results may have been obtained.

A sixth limitation is that the participants had heterogeneous experiences related to the current placement of the foster child they discussed. Some participants discussed their experience with foster children that they were still currently fostering or had adopted, while others discussed children who had been removed from their home either due to the foster parent disrupting the placement or the child moving to a higher level of care. Relatedly, some participants discussed secondary traumatic stress symptoms that they were currently experiencing, while others were further removed from the experience (though all participants were discussing an experience that had occurred in the last year). The heterogeneity in the
sample may have influenced the results, as participants may have provided responses that were more varied than if they had had similar experiences.

Seventh, the use of the STSS in this study could be considered a limitation. Having participants complete the STSS provided valuable data and helped participants reflect on their symptoms, which was important given that secondary traumatic stress is not a widely understood phenomenon. However, the STSS has not been normed on foster parents, and the wording of questions had to be modified to reflect participants’ experiences as foster parents. Additionally, having participants complete this measure and discuss it during the interview may have influenced the results, particularly regarding the symptoms that they reported. It is possible that there may have been other important secondary traumatic stress symptoms that participants were experiencing that were not discussed due to their absence from the STSS.

An eighth limitation is that the principal investigator had a disproportionate role in the CQR process, as they completed the interviews with participants, led the domaining process, developed the core ideas, and completed the initial cross analysis. While this is common in CQR dissertations, the responsibilities are often shared more evenly among team members in other CQR studies. Given this, it is possible that the principal investigator, and their related biases, may have more heavily influenced the data compared to other team members. When reviewing the data, the other team members were reviewing it through the lens of the principal investigator’s interpretation, which may have ultimately influenced how they viewed the data.

A final limitation is that the composition of the team changed between the domaining and core idea/cross-analysis processes, as one of the initial team members had to discontinue their role on the team. While this change in team members was unfortunate, the principal investigator met with the new team member to update her on the progress made by the initial team. The
decision was made to not redo the entire domaining process, but it is possible that the study may have yielded different results if the team composition had stayed consistent through the study.

**Implications**

Findings from the present study suggest several notable implications related to foster parents’ experiences of secondary traumatic stress. Most importantly, participants highlighted the need for more support related to secondary traumatic stress from the child welfare system. Findings from this study and prior research suggest that experiencing secondary traumatic stress puts foster parents at risk for deciding to discontinue fostering, so it is imperative that this issue is addressed by the child welfare system (Dowdy-Hazlett & Clark, 2024; Hannah & Woolgar, 2018; Ottaway & Selwyn, 2016). At a minimum, secondary traumatic stress should be covered in foster parent training, and it is very concerning that most participants reported that this topic was not addressed in their training. Foster parent training should include education on what secondary traumatic stress is, the associated symptoms, strategies to mitigate its development (e.g., self-care and seeking support from others), and when to seek additional professional support.

In addition to improving training on secondary traumatic stress, child welfare professionals should prioritize providing more general support regarding foster parents’ potential secondary traumatic stress. It is important for child welfare professionals to acknowledge that foster parents experience this phenomenon, and that it can have a significant impact on their life and how they parent their foster child. Simple check-ins with foster parents about their overall well-being, while probing for secondary traumatic stress symptoms, could be helpful. Encouraging foster parents to use respite, and making respite easy to obtain, is another way that child welfare professionals could provide support to foster parents experiencing secondary
traumatic stress. Additionally, it could be helpful to develop foster parent support groups that address secondary traumatic stress, so that foster parents can connect with other parents going through a similar experience.

Given that some participants indicated that they did not recognize they were experiencing secondary traumatic stress, it could be helpful for the child welfare system to develop screening protocols to monitor foster parents for the development of symptoms. This screening could be done using the STSS or a measure designed specifically for foster parents (as discussed below). Screening for secondary traumatic stress might allow it to be addressed early on, thereby reducing the variety of negative impacts that participants described. Additionally, a focus on developing interventions aimed at reducing secondary traumatic stress in foster parents is important, though future research is clearly needed in this area. These interventions could not only improve the well-being of foster parents, but they could potentially improve outcomes for foster youth by improving foster parent retention and reducing placement instability.

This study also suggests specific ways that foster parents can manage their secondary traumatic stress, which should be encouraged by child welfare and mental health professionals. First, foster parents should be encouraged to seek support from others, whether that is family, friends, their religious community, or other foster parents. While some participants noted that family and friends were occasionally unhelpful, the majority of participants noted the importance of social support, while also indicating that they felt isolated during this experience. Ensuring that foster parents have a strong support system may help them to cope with their secondary traumatic stress. Additionally, foster parents should be encouraged to seek out mental health therapy. Ideally, foster parents should engage in therapy even before secondary traumatic stress symptoms develop, as therapy may help foster parents to develop skills to both prevent
symptoms and manage them if they do arise. Finally, foster parents should be encouraged to
engage in self-care practices in order to help them manage potential secondary traumatic stress.
It is especially important for foster parents to establish a solid self-care plan given that
participants noted that it was difficult to take care of themselves during this experience.

Another avenue for addressing secondary traumatic stress in foster parents is to focus on
reducing trauma symptoms in their foster child. While foster children’s traumatic experiences are
unfortunately not able to be changed, there are ways to decrease their trauma symptoms.
Providing therapy for foster children is an important component to this, which was noted by
some participants. Additionally, improving foster parent training to focus on parenting skills to
manage foster children’s trauma behaviors may be helpful. Decreasing foster children’s trauma
symptoms would decrease foster parents’ exposure to these symptoms, thereby potentially
reducing their risk of secondary traumatic stress.

**Future Research**

In addition to the overall implications discussed above, the findings from this study also
suggest areas for future research. As discussed above, it may be helpful for the child welfare
system to screen foster parents for secondary traumatic stress, given that some participants noted
that they did not recognize that they were experiencing secondary traumatic stress while it was
happening. While the STSS was used in this and other studies, future research could focus on
developing a secondary traumatic stress measure specifically for foster parents. A separate
measure could be helpful given the differences between foster parents and other helping
professionals.

Additionally, longitudinal studies to examine how secondary traumatic stress changes
over time could be helpful, as most quantitative studies on this topic have been cross-sectional. It
is noteworthy that the participants in the current study were fairly new to fostering, so it is possible that the findings may have been different if they were interviewed when they had additional years of experience. Research examining how foster parents’ secondary traumatic symptoms and the related impact change over time would be beneficial. Additionally, it would be useful to understand whether the factors that participants found helpful and unhelpful might change as foster parents gain years of experience.

Relatedly, future research should focus on understanding the experience of secondary traumatic stress in foster parents who have decided to discontinue fostering. The findings from this study suggest that secondary traumatic stress has a negative impact on foster parents’ desire to continue fostering, ranging from being selective about future placements to feeling uncertain about future fostering to reducing or stopping fostering altogether. Understanding more about how foster parents move along this continuum to eventually deciding to discontinue fostering is important.

Additional research on secondary traumatic stress risk and protective factors in foster parents should also be prioritized. The participants in the current study identified a variety of factors that could be the focus of future research, including social support, coping/self-care, their own trauma history, support from the child welfare system, and foster parent training. As noted above, some of these factors were also noted by participants to be impacted by their symptoms of secondary traumatic stress, so research examining the direction of the relationships between these variables and secondary traumatic stress would be beneficial. The need for future research on risk and protective factors is highlighted by the existing literature, where many factors have only been examined in one study, and those that have been examined in multiple studies often produce conflicting results.
Related to risk and protective factors, future research should examine the impact of foster parents having biological or other children living in their home on their experience of secondary traumatic stress. This area of research is especially relevant given that some participants in the current study noted that their foster child had been aggressive towards the participants’ family, which may have complicated their own experience of secondary traumatic stress. Additionally, it would be beneficial for future research to examine how fostering as a single parent versus fostering with a partner might impact the experience of secondary traumatic stress for foster parents. Notably, some of the single foster parents in the current study described feeling isolated as a single parent. Future research should also explore how foster parents’ early perceptions of fostering (e.g., their hopes for foster parenting) might influence their experience with secondary traumatic stress. In particular, it would be interesting to understand how the potential discrepancy between foster parents’ hopes for fostering and the reality of being a foster parent might contribute to their overall distress and the development of secondary traumatic stress.

A final area of future research is developing and testing an intervention for secondary traumatic stress in foster parents, which would be informed by the research suggested above. For example, an intervention could be developed that involves providing more training on secondary traumatic stress to foster parents, as well as more supportive check-ins from the child welfare system with referrals to mental health therapy as needed. As with any intervention, research would be needed to test its’ effectiveness on secondary traumatic stress symptoms. While this type of research would be a large undertaking, it is clear that wide-scale interventions could be beneficial in addressing the negative impacts of secondary traumatic stress on foster parents and the foster children in their care.

Conclusions
In summary, this study explored foster parents’ experiences of secondary traumatic stress as they parented foster children with trauma. The findings from this study add to the growing literature base suggesting that secondary traumatic stress is an important issue within the foster parent population. Participants reported experiencing a variety of secondary traumatic stress symptoms across the domains of intrusion, avoidance, alterations in mood and cognition, and alterations in arousal and reactivity. One of the most significant findings from this study was the negative impact that secondary traumatic stress had on participants’ lives. These impacts spanned many areas including work, self-care, relationships, and overall emotional/personal life. Therefore, this study demonstrated that not only are foster parents experiencing secondary traumatic, but that their symptoms are having a significant impact on their functioning, which is an important addition to the literature.

If that is not reason enough to address secondary traumatic stress in foster parents, participants also reported negative impacts on their parenting, as well as their desire to continue fostering. These findings suggest that foster children may be negatively impacted when their foster parent experiences secondary traumatic stress. The finding that secondary traumatic stress had a negative impact on some participants’ desire to continue fostering is especially concerning given the difficulty with foster parent retention and the negative impacts of placement instability on foster children. Clearly, addressing secondary traumatic stress within foster parents could also be beneficial for the foster children in their care.

Additional research is needed in this area to further understand risk and protective factors for secondary traumatic stress in foster parents. This research could lead to the development of proactive interventions focused on preventing secondary traumatic stress, as well as reactive interventions focused on treating secondary traumatic stress. Participants highlighted important
areas for future study, including social support, self-care, and their personal trauma history. They also suggested concrete ways that the child welfare system could better support foster parents, with providing more overall support and resources being the most common suggestion.

The findings from the current study also highlight the importance of understanding the difference between secondary traumatic stress and PTSD. Experts have argued that secondary traumatic stress is directly related to, or potentially mirrors, symptoms of PTSD (Sprang et al., 2019). Additionally, they noted that secondary traumatic stress may reach a clinically significant level and cause impairments similar to PTSD. However, these experts also argued that it is not appropriate to simply reduce secondary traumatic stress to PTSD given that secondary traumatic stress can develop with indirect exposure to traumatic details that is not necessarily repeated or extreme, which is a criterion for the development of PTSD (Sprang et al., 2019). It is important for the field to further explore how secondary traumatic stress differs from PTSD, or to determine whether secondary traumatic stress is simply a dimension of PTSD. This distinction is particularly relevant for the foster parent population, given that foster parents also often experience primary trauma from their foster child.

Overall, this study suggests that secondary traumatic stress in foster parents is an issue that clearly needs more attention. The foster parents in this study were understandably struggling with their secondary traumatic stress symptoms and it is disappointing that so many of them felt isolated and unsupported. As Henri Nouwen noted, “Who can take away suffering without entering it?” As has been made clear through this study, when foster parents enter into the suffering and trauma of their foster children, they themselves suffer. We owe it to them to provide better support as they care for some of the most vulnerable members of our society.
References


https://doi.org/10.1176/appi.books.9780890425596


https://doi.org/10.1176/appi.books.9780890425787


https://doi.org/10.1037//0022-3514.61.2.226


https://doi.org/10.1093/bjsw/bcx002


https://doi.org/10.1177/0886260518759657
https://doi.org/10.1111/cfs.12713

https://doi.org/10.1177/0265407595123009


Bridger, K.M., Binder, J.F., & Kellezi, B. (2020). Secondary traumatic stress in foster carers:


Centers for Disease Control and Prevention. (2021, April 6). *About the CDC-Kaiser ACE Study.* [https://www.cdc.gov/violenceprevention/aces/about.html](https://www.cdc.gov/violenceprevention/aces/about.html)


among foster parents: Prevalence and association with resilience, coping, satisfaction as a foster parent, and intent to continue fostering. *Children and Youth Services Review, 109.*

https://doi.org/10.1016/j.childyouth.2019.104679


https://doi.org/10.1177/0886260518799502


https://doi.org/10.1016/j.chiabu.2015.10.008


Professional quality of life normative benchmarks. *Psychological Trauma: Theory, Research, Practice, and Policy, 10*(2), 225–228. [https://doi.org/10.1037/tra0000263](https://doi.org/10.1037/tra0000263)


Goemans, A., van Geel, M., & Vedder, P. (2018). Foster children’s behavioral development and
foster parent stress: Testing a transactional model. *Journal of Child and Family Studies*, 27(3), 990-1001. [https://doi.org/10.1007/s10826-017-0941-z](https://doi.org/10.1007/s10826-017-0941-z)


Hiles Howard, A. R., Parris, S., Hall, J. S., Call, C. D., Razuri, E. B., Purvis, K. B., & Cross, D.


https://doi.org/10.1002/jclp.20741


https://doi.org/10.1016/j.chiabu.2019.03.012


Lively Cookson, L. W. (2022). *The effects of respite care on foster caregivers’ self-efficacy and*
compassion fatigue. (Order No. 30244529) [Doctoral dissertation, California School of Professional Psychology at Alliant International University]. ProQuest Dissertations & Theses Global.


McLain, K. B. (2008). The impact of burnout, compassion fatigue, and compassion satisfaction
on foster parenting (Order No. 3320475) [Doctoral dissertation, State University of New York at Buffalo]. ProQuest Dissertations & Theses Global.


Disentangling the relationship between problem behaviors and number of placements.

*Child Abuse & Neglect*, 24(10), 1363-1374. [https://doi.org/10.1016/S0145-2134(00)00189-7](https://doi.org/10.1016/S0145-2134(00)00189-7)


Ottaway, H., & Selwyn, J. (2016). “No-one told us it was going to be like this”: Compassion fatigue and foster carers summary report. Fostering Attachments Ltd.

[https://doi.org/10.13140/RG.2.2.33955.45606](https://doi.org/10.13140/RG.2.2.33955.45606)


https://doi.org/10.1371/journal.pone.0136730

https://doi.org/10.1177/1468017319853057

https://doi.org/10.1037/trm0000372

https://doi.org/10.1177/1077559516679514


traumatic stress and compassion satisfaction: A systematic literature review. *Trauma, Violence & Abuse*. Advanced online publication.

https://doi.org/10.1177/15248380231209438


https://doi.org/10.1177/08862605211044961


https://proqol.org/proqol-manual


https://doi.org/10.1080/15548732.2022.2036293

Stone, S. B. (2011). *A phenomenological study of the work experiences of foster care*
caseworkers with indications of secondary traumatic stress disorder (Order No. 3445188) [Doctoral dissertation, Capella University]. ProQuest Dissertations & Theses Global.


Turney, K., & Wildeman, C. (2017). Adverse childhood experiences among children placed in
and adopted from foster care: Evidence from a nationally representative survey. *Child

moves: A journey of loss and hope. *Children and Youth Services Review, 30*(11), 1256–
1266. http://dx.doi.org/10.1016/j.childyouth.2008.03.010

U.S. Department of Health and Human Services, Administration for Children and Families,
Children’s Bureau. (2022). The Adoption and Foster Care Analysis and Reporting
System (AFCARS) Report #29.
https://www.acf.hhs.gov/sites/default/files/documents/cb/afcars-
report-29.pdf

U.S. Department of Health and Human Services, Administration for Children and Families,
https://www.childwelfare.gov/topics/outofhome/foster-care/

and burnout in child welfare workers: A study of the child welfare workers in community

Children placed in long-term family foster care: A longitudinal study into the
development of problem behavior and associated factors. *Children and Youth Services


https://doi.org/10.1093/bjsw/bcz117


https://doi.org/10.1016/j.childyouth.2013.07.012


http://doi.org/10.1037/trm0000124

Wax-Thibodeaux, E. (2019, December 30). ‘We are just destroying these kids’: The foster children growing up inside detention centers. The Washington Post. 
https://www.washingtonpost.com/national/we-are-just-destroying-these-kids-the-foster-children-growing-up-inside-detention-centers/2019/12/30/97f65f3a-eaa2-11e9-9c6d-436a0df4f31d_story.html

http://www.ptsd.va.gov/


https://doi.org/10.1016/j.childyouth.2020.105361


https://doi.org/10.2105/AJPH.2019.305554
Appendix A

Recruitment Letter

Hello,

My name is Sarah Boeding, and I am a doctoral student in counseling psychology at Marquette University. As part of my dissertation, I am looking to interview foster parent volunteers about their experiences of secondary traumatic stress.

The interview will be focused on understanding foster parents’ experiences of secondary traumatic stress as a result of parenting a foster child who has experienced trauma, such as physical, emotional, or sexual abuse, neglect, death of a loved one, witnessing domestic violence, or being exposed to other forms of violence. Secondary traumatic stress refers to trauma symptoms that caregivers may develop in response to hearing about their foster child’s trauma or witnessing the effects of the trauma on the child. These symptoms may include a) distressing or uncontrollable thoughts, memories, or dreams, b) avoidance of thoughts, memories, locations, or situations associated with your foster child or their trauma, c) negative changes in your thinking or mood, and/or d) changes in your physical and emotional reactions.

In addition to secondary trauma, foster parents sometimes also experience primary trauma from their foster child, such as physical harm, threats of physical harm, or emotional abuse. The interview will have a specific question focused on that experience as well.

The interview questions will be focused on exploring foster parents’ experiences and reactions to parenting a foster child with exposure to trauma. It is important to understand the context of these experiences, which includes an individual’s own personal trauma experiences. Given this, participants will also be asked a little bit about their own personal trauma history and how that might have influenced their experience.

For this interview, participants will be asked to focus on a specific child that they have fostered within the last year who had experienced trauma, and which led to development of their [the foster parent’s] own secondary trauma symptoms. Criteria for participating in this study include the following: (1) you live in the United States; (2) you held a license as a foster parent within the last year; (3) you fostered a child at least five-years-old who had experienced trauma; (4) you fostered this child for at least one month within the last year; and (5) you experienced symptoms of secondary traumatic stress within the last year.

Participation in this study will involve completing a 45-to-60-minute video interview with the researcher, as well as completing a demographic form with information about you and your foster child. The interview questions and procedures would be sent to you ahead of time to give you a chance to review them before the interview.

As a thank you for your time, foster parents who complete the interview will be mailed a $25 gift card.
If you are interested in participating in this study, please fill out the form below and a researcher will contact you with additional information. Alternatively, please feel free to contact me at sarah.boeding@marquette.edu or (608) 692-0716 with any additional questions regarding the study.

Thank you for your consideration,
Sarah Boeding, M.S.

Contact Information

Your Name: ___________________________________________________

Your Phone Number: ____________________________________________

Your Email Address: ____________________________________________

Preferred Mode of Contact: Phone or Email

Yes or No: I meet the criteria to participate in the study outlined below.

• (1) I live in the United States;
• (2) I held a license as a foster parent within the last year;
• (3) I fostered a child at least five-years-old who had experienced trauma;
• (4) I fostered this child for at least one month within the last year;
• (5) I experienced symptoms of secondary traumatic stress within the last year.
  o Note: Secondary traumatic stress refers to trauma symptoms that caregivers may develop in response to hearing about their foster child's trauma and witnessing the effects of the trauma on the child. These symptoms may include a) distressing or uncontrollable thoughts, memories, or dreams, b) avoidance of thoughts, memories, locations, or situations associated with your foster child or their trauma, c) negative changes in your thinking or mood, and/or d) changes in your physical and emotional reactions.

Where did you hear about this study?

• Word of mouth
• Social media account
  o Who: _______________
Appendix B

Informed Consent

MARQUETTE UNIVERSITY
AGREEMENT OF CONSENT FOR RESEARCH PARTICIPANTS

Understanding Foster Parents’ Experiences of Secondary Traumatic Stress
Sarah Boeding, M.S., M.Ed.
Department of Counselor Education and Counseling Psychology

You have been invited to participate in this research study. Before you agree to participate, it is important that you read and understand the following information. Participation is completely voluntary. Please ask questions about anything you do not understand before deciding whether or not to participate.

PURPOSE:
- The purpose of this study is to better understand foster parents’ experiences of secondary traumatic stress as a result of parenting a foster child with trauma.
- You will be one of approximately 10 to 15 participants in this research study.

PROCEDURES:
- You will be asked to complete one 45-to-60-minute interview with study investigators.
- Prior to the interview, you will be asked to complete a demographic form which will gather background information about yourself and your foster child. This form will be completed via Qualtrics, an online survey software.
- You will receive the interview questions prior to the interview so that you may be familiar with both the general topics of the interview as well as specific questions you will be asked to answer during your interview.
- You will be asked questions regarding your foster child’s trauma history and trauma symptoms, your experience hearing about your foster child's trauma history, your experience observing and managing your foster child’s trauma symptoms, your symptoms of secondary traumatic stress and the impact of those systems, the impact of your own personal history of trauma, experiences of primary trauma from your foster child, and what helped or hindered you from managing your secondary traumatic stress symptoms. You’ll also have the opportunity to share advice for other foster parents who are experiencing secondary traumatic stress, as well as advice for the child welfare system.
- The interview will take place videoconferencing at a mutually agreeable time.
- You will be video-recorded during the interview portion of the study to ensure accuracy. The tapes will later be transcribed. Digital recordings will be erased upon completion of the study. The electronic files of the recording transcriptions will be kept and destroyed after 3 years beyond the completion of the study.
- For confidentiality purposes, your full name will not be recorded and any name references will be removed during transcription.
DURATION:
- Your participation will consist of one 45-to-60-minute videoconference interview, as well as completing the demographic form prior to the interview.

RISKS:
- The risks associated with participation in this study are minimal, although it is possible that you may experience some feelings of discomfort upon reflecting on your experience of secondary traumatic stress. We will provide you with the research questions prior to your interview, helping you to be prepared for the types of questions included in the interview. In addition, we will debrief with you immediately following the interview. If needed, we will provide referral information for outside clinicians and/or the National Suicide and Crisis Lifeline.
- As described below, a number of processes will be followed to keep your data confidential. However, there is a risk of breach of confidentiality of your information that is used in this study. Collection of data and survey responses using the internet involves the same risks that a person would encounter in everyday use of the internet, such as hacking or information being unintentionally seen by others.
- Although your privacy is very important, if you talk about actual or suspected abuse, neglect, or exploitation of a child or elder, or if you talk about hurting yourself or others, the researcher or other study team member must and will report this to the relevant state authorities (e.g., Bureau of Milwaukee Child Welfare, the Wisconsin Department of Children and Families Services, or other state authorities based on your location).

BENEFITS:
- There are no direct benefits to you for participating in this study. This research may benefit society by helping clinicians and child welfare agencies understand how to better support foster parents who are experiencing secondary traumatic stress.

CONFIDENTIALITY:
- Data collected in this study will be kept confidential.
- All your data will be assigned an arbitrary code number rather than using your name or other information that could identify you as an individual.
- The principal investigator will maintain an electronic copy of the key linking participant names and codes. This key will be stored separate from the data on a password protected computer in the principal investigator’s Marquette University office. Once the data analysis has been completed and the manuscript is written, the file linking names and codes will be deleted.
- Information from the demographic form will be downloaded and kept on a password-protected, encrypted USB flash drive which will be kept in a locked safe. All demographic forms will be de-identified and assigned a code number by the principal investigator before demographic forms are shared with research team members.
- Digital recordings of video interviews will be kept on a password-protected, encrypted USB flash drive which will be kept in a locked safe. Digital recordings will be electronically erased upon completion of the study.
- All transcriptions will be de-identified and assigned a code by the principal investigator before transcripts are shared with research team members.
• Transcripts will be stored on a password-protected, encrypted USB flash drive which will be kept in a locked safe.
• The data collected in this study will not be used or distributed for future research even if they have been deidentified.
• The data will be destroyed by shredding paper documents and deleting electronic files 3 years after the completion of the study.
• When the results of the study are published, you will not be identified by name.
• Direct quotes from interviews may be included in reports or publications but your name will not be attached to any quotations.
• Your research records may be inspected by the Marquette University Institutional Review Board or its designees, and (as allowable by law) state and federal agencies.

COMPENSATION:
• You will receive one $25.00 gift card via mail upon completion of the research interview.

VOLUNTARY NATURE OF PARTICIPATION:
• Participating in this study is completely voluntary and you may withdraw from the study and stop participating at any time without penalty or loss of benefits to which you are otherwise entitled.
• If you withdraw from the study, your data will be destroyed and will not be used.
• You may skip any questions you do not wish to answer.
• Your decision to participate or not will not impact your relationship with the investigators or Marquette University.

ALTERNATIVES TO PARTICIPATION:
• There are no known alternatives other than to not participate in this study.

CONTACT INFORMATION:
• If you have any questions about this research project, you can contact Sarah Boeding, M.S., M.Ed. (sarah.boeding@marquette.edu), or Dr. Alan Burkard, Ph.D. (alan.burkard@marquette.edu).
• If you have questions or concerns about your rights as a research participant, you can contact Marquette University’s Office of Research Compliance at (414) 288-7570.

I HAVE HAD THE OPPORTUNITY TO READ THIS CONSENT FORM, ASK QUESTIONS ABOUT THE RESEARCH PROJECT AND AM PREPARED TO PARTICIPATE IN THIS PROJECT.

____________________________________________
(Printed Name of Participant)

Verbal Consent Obtained:  Yes  No

____________________________________________
Date
(Printed Name of Individual Obtaining Consent)

____________________________________________              ________________________
(Signature of Individual Obtaining Consent)                               Date
Appendix C

Demographic Form

Before completing this form, please read through the Informed Consent document, which was sent to you by email.

Thank you for your interest in participating in our study on secondary trauma symptoms experienced by foster parents due to parenting a foster child who has experienced trauma. This form contains background information on you, as well as one of your foster children. For this study, we are interested in learning about your experience parenting a foster child who had experienced trauma, which then led to the development of your own secondary trauma symptoms. These symptoms may include a) distressing or uncontrollable thoughts, memories, or dreams, b) avoidance of thoughts, memories, locations, or situations associated with your foster child or their trauma, c) negative changes in your thinking or mood, and/or d) changes in your physical and emotional reactions. For the child section below, please focus on a child you have fostered within the last year who had experienced trauma. If you have fostered more than one child with trauma, please focus on the child with the more severe experience of trauma.

By completing this demographic form, you are confirming that you have read the Informed Consent document (which was sent by email), you are 18 years old or older, and you agree to participate in this study.

Contact Information

Your Name: ___________________________________________________

Background on Foster Parent

Age: ___

Gender: _________________

Race/Ethnicity:

- American Indian or Alaska Native
- Asian
- Black or African American
- Latinx
- Middle Eastern or North African
- Native Hawaiian or Other Pacific Islander
- White or European American
- Multiracial
- Other:_______
How many caregivers live in the home? ___
   Who: ____________________

How many years have you been licensed as a foster parent? ___

How many children have you fostered over the years? ___

Of these foster children, approximately how many have experienced trauma? ___

Do you have any foster children currently living in your home? Yes / No
   If yes, how old are they? ____________________

Do you have any biological children in your home? Yes / No
   If yes, how old are they? ____________________

Do you have any adopted children in your home? Yes / No
   If yes, how old are they? ____________________

As part of your licensing, did you receive training on parenting children with trauma?
   Yes / No
   If yes, how prepared to parent children with trauma did you feel based on this training?

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Not at all prepared</td>
<td>Very prepared</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

As part of your licensing, did you receive training on the potential effects on foster parents of parenting a child with trauma? Note: This is sometimes known as secondary traumatic stress. Yes / No
   If yes, how prepared to deal with secondary traumatic stress did you feel based on this training?

<table>
<thead>
<tr>
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<th>3</th>
<th>4</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Not at all prepared</td>
<td>Very prepared</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

**Background on Foster Child**

Age: ___

Gender: ____________________

How long was the child placed with you? ____________________
Is the child still placed with you? Yes / No
If no, please describe the reason for the change in placement.
________________________________________________________________________
________________________________________________________________________

Did the child have any previous foster care placements? Yes / No / Unknown
If yes, please describe.
________________________________________________________________________

**Foster Parent Experience**

When parenting children with trauma, caregivers sometimes develop their own trauma symptoms in response to hearing about the child’s trauma or witnessing the effects of the trauma on the child. The following is a list of statements made by people who have been impacted by their care of a foster child who has experienced trauma. Please read each statement and then indicate how frequently the statement was true for you while parenting the foster child you described above.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Never</th>
<th>Rarely</th>
<th>Occasionally</th>
<th>Often</th>
<th>Very Often</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I felt emotionally numb</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2. My heart started pounding when I thought about caring for my foster child or their experiences of trauma</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>3. It seemed as if I was reliving the trauma(s) experienced by my foster child</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4. I had trouble sleeping</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>5. I felt discouraged about the future</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>6. Reminders of caring for my foster child or reminders of their experiences of trauma upset me</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>7. I had little interest in being around others</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>8. I felt jumpy</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>9. I was less active than usual</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>10. I thought about caring for my foster child or their experiences of trauma when I didn’t intend to</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>11. I had trouble concentrating</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<td></td>
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<tr>
<td>12. I avoided people, places, or things that reminded me of caring for my foster child or their experiences of trauma</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>13. I had disturbing dreams about caring for my foster child or their experiences of trauma</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>14. I wanted to avoid spending time with my foster child</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>15. I was easily annoyed</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>16. I expected something bad to happen</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>17. I noticed gaps in my memory about caring for my foster child or their experiences of trauma</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>18. I experienced intense negative emotions</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>19. I engaged in reckless or self-destructive behavior</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>20. I unrealistically blamed others for the cause or consequences of the traumas experienced by my foster child</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>21. I had negative expectations about myself, others, or the world</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
Appendix D

Interview Protocol

Introduction:
Thank you for your participation in our study on secondary trauma symptoms experienced by foster parents due to parenting a foster child with trauma. We are grateful for your contributions to this project and hopeful that the results of this study will help us better support foster parents and children in foster care.

Our interview will be focused on your experience of secondary traumatic stress as a result of parenting a foster child who has experienced trauma, such as physical, emotional, or sexual abuse, neglect, death of a loved one, witnessing domestic violence, or being exposed to other forms of violence. Secondary traumatic stress refers to trauma symptoms that caregivers may develop in response to hearing about their child’s trauma or witnessing the effects of the trauma on the child. These symptoms may include a) distressing or uncontrollable thoughts, memories, or dreams, b) avoidance of thoughts, memories, locations, or situations associated with your foster child or their trauma, c) negative changes in your thinking or mood, and/or d) changes in your physical and emotional reactions.

In addition to secondary trauma, foster parents sometimes also experience primary trauma from their foster child, such as physical harm, threats of physical harm, or emotional abuse. We will have a specific question focused on that experience as well.

The interview questions will be focused on exploring your experience and reactions to parenting a foster child exposed to trauma. It is important to understand the context of your experience, which includes your own personal trauma experiences. Given this, I will ask a little bit about your own personal trauma history and how that might have influenced your experience.

For this interview, I will ask you to focus on a specific child that you have fostered within the last year who had experienced trauma, which then led to development of your own trauma symptoms. Do you have any questions before we begin?

Interview Protocol:

Foster Child Trauma and Caregiver Experience/Symptoms

1. To the best of your knowledge, what trauma had your foster child experienced?

2. When hearing about your foster child’s traumatic experiences, what did you experience in terms of emotions, thoughts, or physical symptoms?

3. Trauma can show up in a lot of different ways in children. What trauma reactions/symptoms, both emotional and behavioral, did you see in your foster child?
4. Please describe a typical day or week with your foster child that represented what it was commonly like to manage their trauma symptoms.

5. When actually observing and managing your foster child’s trauma symptoms, what did you experience in terms of emotions, thoughts, or physical symptoms?

6. On your demographic form you marked several symptoms you experienced while parenting this child: [List symptoms from demographic form]. Can you tell me more about your experience with these symptoms?

**Impacts of Secondary Traumatic Stress**

7. How did these symptoms affect or influence your functioning such as your relationships with family and friends, work life, and self-care?

8. How did experiencing symptoms of secondary traumatic stress influence how you parented and cared for your foster child?

9. How did experiencing symptoms of secondary traumatic stress influence your desire to continue fostering?

**Managing Secondary Traumatic Stress**

10. How did you take care of yourself or reach out to others for support to help you manage the effects of fostering a child with trauma?

11. What, if anything, made it more difficult to manage your secondary traumatic stress?

12. What, if anything, made it easier to manage your secondary traumatic stress?

13. How, if at all, did professionals within the child welfare system support you in managing your secondary traumatic stress?

**Other Experiences of Trauma**

14. If you have experienced your own trauma in the past, how, if at all, do you think this history may have influenced your reactions or experience of hearing about your foster child’s trauma or witnessing their trauma symptoms?

15. Did you or your family members experience any primary trauma from your foster child, such as physical harm, threats of harm, or emotional abuse? If so, what were these experiences and how did they impact you?

**Closing Questions**
16. How could the child welfare system have bettered supported you as you experienced secondary traumatic stress?

17. Is there anything else you would like to add?

18. What was it like to participate in this interview?

19. Do you have any questions for me?
Appendix E

Thank You Letter to Participants

Dear [Name of Participant],

Thank you for participating in our study examining secondary traumatic stress in foster parents. You have made a valuable and important contribution to our research.

As a token of our appreciation, please accept the enclosed gift card. We are grateful for your time and participation in our project.

Sincerely,

Alan Burkard, Ph.D., and Sarah Boeding, M.S.
Dept. of Counselor Education and Counseling Psychology
College of Education
Marquette University Milwaukee, WI 53201
(414) 288-3434
Alan.Burkard@marquette.edu