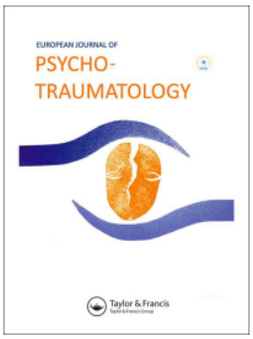

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REVIEW ARTICLE

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Trauma exposure and traumatic stress in foster carers: a scoping review

Sanne G. Helder [a,b,c], Sander J.A. de Vries[b], Petra Helmond[b], Joost Daams [c], Ramón J.L. Lindauer [a,b,c] and Irma M. Hein[a,b,c]

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ABSTRACT

Background: Foster carers provide care for children who have been removed from their primary caregivers due to serious adverse experiences. While considerable research focuses on trauma among foster children, little is known about the traumatic experiences and resulting (secondary) traumatic stress in foster carers themselves.

Objective: To review existing literature on traumatic experiences and traumatic stress among foster carers. Methods: We conducted a scoping review following the methodological framework developed by the Joanna Briggs Institute [Peters, M. D. J., Marnie, C., Tricco, A. C., Pollock, D., Munn, Z., Alexander, L., McInerney, P., Godfrey, C. M., & Khalil, H. (2020). Updated methodological guidance for the conduct of scoping reviews. *JBI Evidence Synthesis*, 18(10), 2119–2126. https://doi.org/10.11124/JBIES-20-00167] and reported it in accordance with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses Extension for Scoping Reviews (PRISMA-ScR) guidelines and checklist. We searched for literature in MEDLINE, Embase and PsycINFO.

Results: We included nine studies (2005–2024) involving over 2,200 foster carers. Results indicate that (1) many foster carers have personally experienced adverse childhood experiences; (2) carers report indirect trauma exposure through their children's narratives and direct exposure, such as threats or violence; (3) a notable portion experience high levels of secondary traumatic stress; and (4) higher levels of trauma exposure are related to higher levels of secondary traumatic stress.

Conclusions: The findings highlight the need for mental health screening, ongoing training, and systemic support for foster carers. Acknowledging carers as both caregivers and trauma-affected individuals is essential to trauma-informed care, as it contributes to the wellbeing of both foster children and foster carers, and helps ensure stable foster placements. Given the limited number of studies, future research should further explore the specific trauma foster carers encounter in their caregiving role, the nature and severity of their secondary traumatic stress symptoms, and how these factors influence their caregiving capacity and the stability of foster placements.

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PALABRAS CLAVE
Acogimiento familiar; estrés traumático; trauma; TEPT; ETS (estrés traumático secundario); ACEs (experiencias adversas en la infancia)

HIGHLIGHTS

- Up to 68% of foster carers report personal histories of adverse childhood experiences (ACEs).
- Foster carers face both direct and indirect trauma exposure during caregiving.
- 15-25% of foster carers report elevated levels of secondary traumatic stress symptoms.

Exposición a trauma y estrés traumático en cuidadores de acogida: una revisión de alcance

Antecedentes: Los cuidadores de acogida brindan cuidado a niños que han sido retirados de sus cuidadores primarios debido a experiencias adversas graves. Aunque existe una cantidad considerable de investigación enfocada en el trauma de los niños en acogida, se sabe poco sobre las experiencias traumáticas y el estrés traumático (secundario) que afectan a los propios cuidadores de acogida.

Objetivo: Revisar la literatura existente sobre experiencias traumáticas y estrés traumático en cuidadores de acogida.

Métodos: Realizamos una revisión de alcance siguiendo el marco metodológico desarrollado por el Instituto Joanna Briggs (Peters et al., 2020) y la reportamos de acuerdo con las directrices y la lista de verificación PRISMA-ScR (Extensión para Revisiones de Alcance de PRISMA). Buscamos literatura en MEDLINE, Embase y PsycINFO.

Resultados: Incluimos nueve estudios (2005–2024) que involucraron a más de 2.200 cuidadores de acogida. Los resultados indican que: (1) muchos cuidadores han experimentado personalmente experiencias adversas en la infancia; (2) los cuidadores reportan exposición indirecta al trauma a través de los relatos de los niños y también exposición directa, como amenazas o violencia; (3) una proporción importante experimenta altos niveles de estrés traumático secundario; y (4) mayores niveles de exposición al trauma se asocian con mayores niveles de estrés traumático secundario.

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Conclusiones: Los hallazgos destacan la necesidad de realizar tamizajes de salud mental, capacitaciones continuas y apoyo sistémico para los cuidadores de acogida. Reconocer a los cuidadores como proveedores de cuidado y como individuos afectados por el trauma es esencial para un enfoque de cuidado informado en trauma, ya que contribuye al bienestar tanto de los niños en acogida como de los cuidadores, y ayuda a asegurar la estabilidad de las colocaciones de acogida. Dado el número limitado de estudios, futuras investigaciones deberían explorar más a fondo el trauma específico que enfrentan los cuidadores en su rol, la naturaleza y severidad de sus síntomas de estrés traumático secundario, y cómo estos factores influyen en su capacidad de cuidado y en la estabilidad de las colocaciones de acogida.

1. Introduction

Children and youth who face serious adverse experiences at home – such as neglect or abuse – often struggle with posttraumatic stress, attachment, emotional, and behavioral issues (Carr et al., 2020; Hunt et al., 2017; Ran et al., 2023). These challenges may manifest as difficulties in forming healthy relationships, managing emotions, and adapting to social environments, ultimately increasing their vulnerability and the risk of psychological issues, such as depression, anxiety, self-harm and oppositional behavior (Doelman et al., 2023; Trinidad, 2021). When safety cannot be ensured within the family, competent authorities (i.e. a court or administrative authority) may intervene with legal measures to protect the well-being of these children by placing them in alternative care (UN General Assembly, 2010).

Foster care is the preferred family-based alternative when parents are unable to care for their children (Konijn et al., 2019; Li et al., 2019). Foster carers may be either relatives of the child (referred to as kinship carers) or carers recruited by care providers. A competent authority is responsible for selecting, monitoring and supervising placements both before and during the care process (Petrowski et al., 2017). An estimated 399 per 100,000 children live in foster care in industrialized countries, adding up to 799,000 children in the industrialized world alone (Petrowski et al., 2017). Most children are placed in care due to inadequate parenting, such as abusive or neglectful behavior, which may often be related to a combination of several factors, such as poverty, psychopathology, intellectual disability, delinquency, or substance abuse of the parent(s) (Dorsey et al., 2012; Schoemaker et al., 2020).

Many foster children have a history of potentially traumatic experiences putting them at risk for posttraumatic stress symptoms and other related issues, such as attachment difficulties and behavioral problems (Dubois-Comtois et al., 2021; Engler et al., 2022; Van der Hoeven et al., 2023). Van der Kolk (2005) introduced the term 'Developmental Trauma Disorder' to describe the complex set of symptoms that some children develop as a result of severe adverse experiences at home. Although Developmental Trauma Disorder, also referred to as Complex Trauma (Cook et al., 2005), is not included in the Diagnostic and Statistical Manual of Mental Disorders 5 (DSM-5; American Psychological Association, 2022; Friedman, 2013), these terms can still be used as a clinical framework to better understand the complex trauma histories and symptomatology of affected children (Cruz et al., 2022; Ford, 2021). Foster carers can be facilitated in understanding the impact of traumatic experiences and how to support their foster children and preventing a breakdown using a trauma-informed care framework.

1.1. Trauma-informed care

The often experienced (complex) trauma of foster children underscores the growing need for trauma-informed care to support their needs in out-of-home placements. If posttraumatic stress symptoms in foster children remain undetected, misunderstood or untreated, it can adversely affect their development (Downey & Crummy, 2022) and may even contribute to placement disruptions (Sullivan et al., 2016). Therefore, trauma-informed care has gained increased attention in social work and welfare sectors (Knight, 2015; Purtle, 2020) as a critical framework for addressing the effects of traumatic experiences on children in care. Trauma-informed care is defined as a practice in which everyone involved in an agency or service system develops and maintains awareness of the impact of traumatic experiences on children, caregivers, and service providers (NCTSN, 2016). Trauma-informed care systems routinely screen for trauma exposure and related symptoms, educate staff and (foster)carers on the potential effects of trauma on child behavior and development, and refer to or provide evidence-based treatment for traumatic stress if needed. A trauma-focused curriculum has been developed for foster parents to enhance their knowledge and skills for providing adequate care for traumatized children (Grillo & Lott, 2010). Educating foster parents on the potential effects of trauma has resulted in better recognition of posttraumatic stress in foster children leading to a higher proportion of children entering trauma-focused

treatment (Konijn et al., 2020). Furthermore, trauma-informed care acknowledges the potential trauma histories of caregivers and the impact this can have on the family (NCTSN, 2016).

1.2. Caregivers' posttraumatic stress symptoms

As noted above, trauma-informed care recognizes that the impact of traumatic experiences is not limited to children in care, but also addresses the impact of traumatic experiences of caregivers on the family system. Psychological trauma is associated with various mental disorders, most notably posttraumatic stress disorder (PTSD) (Hogg et al., 2023). PTSD is characterized by symptoms such as intrusion and re-experiencing (e.g. nightmares, flashbacks), avoidance, altered arousal, cognition, mood and reactivity following exposure to a traumatic event (American Psychological Association, 2022). Trauma exposure can either be direct (experiencing or witnessing the events in person) or indirect (learning of a traumatic event experienced by a close friend or family member).

More specifically, parental PTSD can develop through various pathways: it may result from the parents' personal trauma history (e.g. being the victim of domestic violence, history of adverse childhood experiences) or from traumatic experiences in the parental role, either directly experienced (e.g. witnessing the child having a traffic accident or being attacked by the child) or through indirect exposure (e.g. learning that the child suffered from sexual abuse). A recent meta-analysis estimates that 14.4–17% of parents develop PTSD following direct or indirect exposure to their child's single incident trauma (Wilcoxon et al., 2021).

Even in the absence of diagnosable PTSD, adverse childhood experiences (ACEs) and childhood maltreatment can negatively affect adult mental health, attachment, parenting stress and sensitivity (Jacobvitz & Reisz, 2019; Jaffee, 2017; Lange et al., 2019; Lo et al., 2019; Savage et al., 2019; Yoon et al., 2019). When PTSD is present, the impact on parenting may be more severe. A systematic review reveals that PTSD in parents is associated with impaired functioning, such as elevated parenting stress, reduced parenting satisfaction, impaired parent–child relationships, and more frequent use of negative parenting practices, including overt hostility and controlling behaviors (Christie et al., 2019). Furthermore, meta-analyses indicate that negative parenting practices can worsen PTSD symptoms in children (Williamson et al., 2017) or in case of foster care even lead to a greater risk for placement instability and breakdown (Konijn et al., 2019). Moreover, studies among mental health professionals suggest that having a personal trauma history may increase the risk of developing secondary traumatic stress (Henderson et al., 2025; Whitt-Woosley & Sprang, 2018). In sum, parental PTSD may hinder trauma-informed parenting practices, highlighting the importance of practitioners being aware of how parental trauma may influence parent's mental health, the parent–child relationships and their caregiving behavior.

Most research on parental traumatic stress and traumatic experiences focuses on biological parents and children. Little is known about the personal childhood trauma histories of foster carers, even though such histories may influence their parenting behaviors, attachment styles, and stress levels when caring for vulnerable children, who often experienced serious adverse experiences at home. Therefore, it is important to explore the personal trauma histories of foster carers as it is likely to affect their ability to provide trauma-informed parenting and maintain supportive relationships with their foster children.

1.3. Direct and indirect traumatic stress in foster carers

Since most of the studies regarding parental posttraumatic stress symptoms and their influence are cross-sectional, it is difficult to rule out the possibility that pre-existing or co-occurring risk factors explain the association between parental posttraumatic stress symptoms and parenting. Confounding variables specific to families of origin, such as a poor family environment or substance use, may limit the generalizability of these findings to foster families. In trauma-informed foster care models it is encouraged to explicitly disclose the trauma history of the foster child to the foster parents (Beyerlein & Bloch, 2014). Therefore, foster carers may face an increased risk of indirect trauma exposure, when they learn about traumatic events experienced by their foster child, which can be referred to as secondary traumatic stress.

Secondary traumatic stress is defined as a cluster of stress responses including PTSD-like symptoms, resulting from exposure to the trauma material of clients (Figley, 1995). Over recent decades, research on secondary traumatic stress has primarily focused on professionals working with trauma survivors, such as nurses (Hinderer et al., 2014; Yu et al., 2016), social workers (Michalopoulos & Aparicio, 2012), pediatric health care providers (Rigas et al., 2023) and child welfare workers (Sprang et al., 2011). In addition to indirect exposure, foster carers face an increased risk of direct trauma exposure through for example potential violent behaviors and self-harm displayed by foster children and safety concerns related to the foster children's family of origin (Farmer et al., 2005). These

experiences could, if severe, meet the DSM-5 criteria for PTSD as a result of direct trauma exposure. Thus, specific characteristics of the foster care context are likely to put foster carers at higher risk of experiencing secondary traumatic stress and/or posttraumatic stress symptoms or disorder.

1.4. Aim of this review

A comprehensive understanding of how various traumatic experiences impact foster carers is essential for providing them the appropriate training and support, thereby reducing the risk of negative effects on their parenting, and minimizing the potential impact on the development of the foster child and the risk of placement breakdown. Research suggests that foster carers may have an elevated risk of posttraumatic stress symptoms due to a cumulation of experiences: their own histories, supplemented by both direct and indirect exposure to potentially traumatic events during fostering. These symptoms could negatively affect their functioning as caregivers and potentially hinder foster children's recovery from trauma. This scoping review aims to identify and map the existing literature on posttraumatic and secondary traumatic stress symptoms in foster carers by addressing four key questions:

(1) To what extent have foster carers experienced a personal history of traumatic events?
(2) To what extent are foster carers exposed to indirect and direct traumatic events during fostering?
(3) What is the occurrence of posttraumatic stress and secondary traumatic stress symptoms in foster carers?
(4) What is the relationship between experienced traumatic events and posttraumatic and/or secondary traumatic stress in foster carers?

2. Methods

We conducted a scoping review following the methodological framework developed by the Joanna Briggs Institute (Peters et al., 2020). Scoping reviews are particularly suitable for identifying and mapping evidence in areas that have not been extensively studied and for highlighting research gaps (Anderson et al., 2008; Pham et al., 2014). The review followed five key steps: (1) formulating the research question, (2) identifying relevant studies, (3) selecting relevant studies, (4) charting the data, and (5) collating, summarizing, and reporting the results. The review is reported in accordance with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses Extension for Scoping Reviews (PRISMA-ScR) guidelines and checklist (Tricco et al., 2018).

2.1. Search strategy

In collaboration with a clinical research librarian (JD), we developed a comprehensive search strategy in line with the Joanna Briggs Institute methodology for scoping reviews (Peters et al., 2020). We employed a combination of keywords and Medical Subject Headings (MeSH) terms related to foster care, stress, trauma, PTSD, and secondary traumatic stress (see Appendix for details and search strings). The search was conducted across three databases: PsycINFO, Medline, and Embase, including studies published up to December 2024.

2.2. Eligibility criteria

To ensure the inclusion of relevant articles, this scoping review included quantitative academic articles based on five criteria: the study (a) was an original piece of work, (b) was peer-reviewed, (c) reported findings from a sample composed of foster carers, (d) assessed direct and indirect trauma exposure and/or traumatic stress symptoms, and (e) was written in the English language.

2.3. Study selection

The initial screening of titles and abstracts was performed independently by three reviewers (SdV, IH and SH). Full texts of potentially relevant studies were assessed for eligibility through independent double screening by three reviewers (SdV, IH and SH). Any disagreements were resolved through discussion, with consensus reached among the reviewers. As an additional step, reference lists of all included studies were manually searched to identify further relevant articles (SH). The PRISMA-ScR flow diagram outlining our study selection process is presented in Figure 1.

2.4. Data charting, extraction, and synthesis

Data from the included studies were systematically extracted using a pre-designed data extraction form. For each study, the following information was collected: author(s) and publication year, study population and sample size, measures of traumatic stress, measures of trauma exposure, and key findings related to these measures, including any relevant correlations. All extracted data were independently reviewed to ensure accuracy.

3. Results

3.1. Included studies

The initial search yielded 9,800 articles. After removing duplicates, a total of 6,886 articles remained for

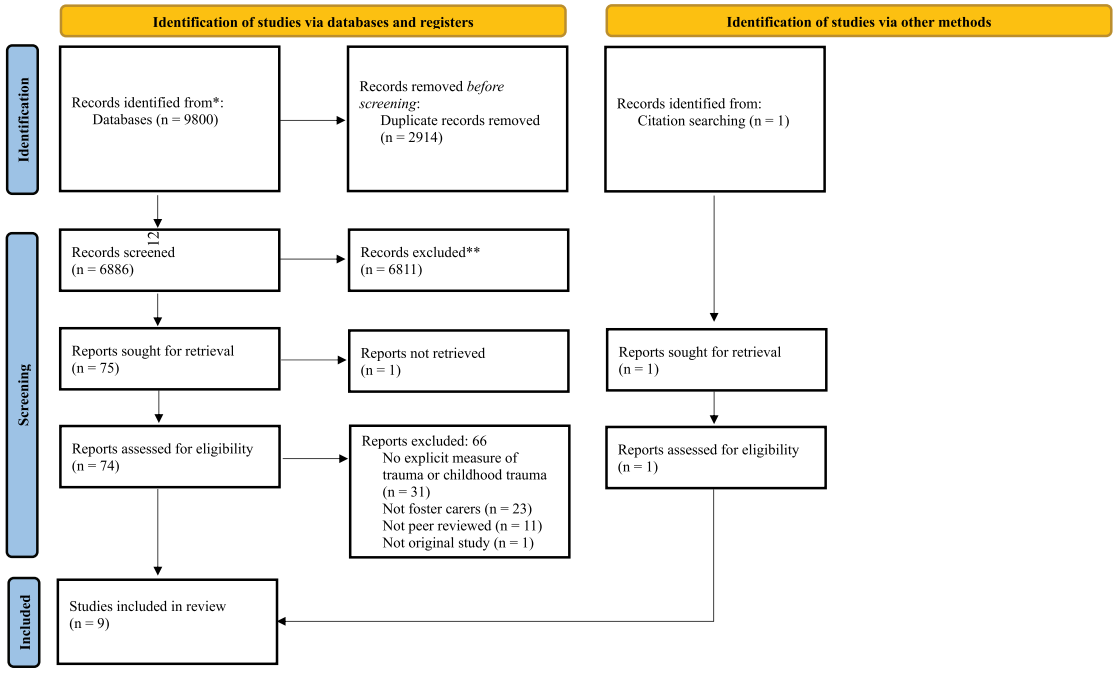

Figure 1. Search flowchart.

screening. The initial screen based on the title and abstract led to an exclusion of 6,811 articles. One article could not be retrieved. The remaining 74 articles were analyzed at full-text and independently considered for eligibility. The reasons for exclusion of full-text screened articles are detailed in Figure 1. After selecting the final articles, the reference lists of these studies were manually searched, resulting in the inclusion of one additional article. A total of nine articles met the criteria and were included in the scoping review.

3.2. Overview of results

Study characteristics. The included studies were published between 2005 and 2024, with the majority published in 2020 ($n = 4$). Five studies were conducted in the United States of America, two in the UK, one in Australia and one in Romania. The country or origin is specified in the result section if it is not the USA.

Participants. A total of 2,296 foster carers participated in the studies included. The majority of participants identified as women (82%); one study did not report gender. Regarding ethnicity, most participants were White ($n = 1,384$), though three studies did not report details on ethnicity. The mean age was approximately 43.6 years (reported range: 22–76) with two studies not providing a mean age. Participants had been foster carers for an average of 5.2 years ($n = 1,841$), with four studies not reporting the average years of foster care experience.

Measures for traumatic experiences and stress. The nine studies varied in focus regarding traumatic experiences and stress, with some exploring personal trauma experiences ($n = 7$), others addressing current traumatic stress symptoms ($n = 2$), and three studies reported on both aspects (Table 1).

Five studies reported on carers' childhood trauma history. Two studies used the Adverse Childhood Experience (ACE) Questionnaire (Adkins et al., 2020; Cooley et al., 2020), and two used the Childhood Trauma Questionnaire (CTQ) (Cole, 2005; Cole & Eamon, 2007). These instruments are validated for assessing trauma history and demonstrate good psychometric properties (Hoeboer et al., 2025; Mei et al., 2022). Another study utilized an unofficial questionnaire based on Criterion A of the DSM-5, asking whether foster carers had ever been confronted with a traumatic event, which could have occurred either during childhood or adulthood (Whitt-Woosley et al., 2020). Notably, this was the only study to incorporate both the severity of the foster child's trauma history and the foster carer's exposure to that trauma as independent variables (Whitt-Woosley et al., 2020). Thus, it was the only study that measured indirect trauma exposure during fostering among foster carers.

Regarding direct trauma exposure during fostering, one study used the Trauma History Screen (THS) (Bridger et al., 2020), a validated instrument with good psychometric properties (Carlson et al., 2011). Another study asked participants whether they had been physically hurt or threatened by a young person in their care (Hannah & Woolgar, 2018).

The most commonly used instrument to measure current secondary traumatic stress symptoms was the Professional Quality of Life (ProQOL; Stamm, 2010) with the subscale Secondary Traumatic Stress

Table 1. Included articles examining sources and symptoms of traumatic stress in foster carers.

Authors	Participants (*n*)	Measures of trauma exposure	Measures of traumatic stress	Important findings
Adkins et. al. (2020)	Foster carers from Texas, USA (89)	ACE questionnaire	–	Foster carers have a higher ACE exposure than the general population, especially 4 or more ACEs (19.8% versus 12.5% respectively). Younger foster carers report more ACEs than older foster carers.
Bridger et al. (2020)	British foster carers (187)	Trauma history screen	STS from ProQOL	Mean score on ProQOL STS was 25. 25% of carers scored > 29. Female foster carers reporting higher levels of STS than males. Mean score of Trauma History Screen was 1.82, with 76.5% of foster carers reporting incidence of primary trauma.
Cole (2005)	Foster carers from USA (46)	Childhood Trauma Questionnaire	–	Group means for abuse and neglect was fairly low overall. Level of abuse in all areas varied from none to extreme in individual participants. The severity of sexual abuse reported in childhood was greater than other types of abuse.
Cole and Eamon (2007)	Foster carers from Illinois, USA (204)	Childhood Trauma Questionnaire	–	More than half of the foster carers (55%) experienced an event related to at least one of three types of maltreatment (emotional abuse, neglect and/or physical neglect).
Cooley et al. (2020)	Foster carers across USA (150)	ACE questionnaire	-	68% of foster carers experienced at least one ACE. 26% reported 4 or more ACEs.
Hannah and Woolgar (2018)	British foster carers (131)	Exposure to physical harm	STS from ProQOL STSS	48% of foster carers experienced physical harm from a young person in their care. Mean score on STS from ProQOL not reported. 25% of foster carers ($n = 33$) scored high levels of secondary trauma (>75th percentile). 20% scores above the clinical cut-off (38) on STSS ($n = 26$). Mean STSS total 31.
McLaren et al. (2024)	Australian foster carers (116)	-	STS from ProQOL	26% of foster carers ($n = 30$) scored high on STS from ProQOL. Moderate correlation found between gender and secondary traumatic stress: females higher STS than males.
Teculeasa et al. (2022)	Romanian foster carers (165)	-	STS from ProQOL	Mean score on STS from ProQOL was 20. Two participants reported high levels of STS (1%).
Whitt-Woosley et al. (2020)	Foster carers from USA (1213)	Child trauma severity Dose of exposure Personal trauma history	STSS-5	78% of foster carers endorsed exposure to details of their children's trauma experiences, 30% ranked their dose as high. 78% of foster carers experienced distressing thoughts or feelings about their child's trauma for more than 30 days, 26% of them described this distress as moderate to extreme. Mean STSS total was 35. 15% scored above clinical cut-off (46). No details of personal trauma history mentioned.

(STS). Four studies used this questionnaire (Bridger et al., 2020; Hannah & Woolgar, 2018; McLaren et al., 2024; Teculeasa et al., 2022). One study used the ProQOL and the Secondary Traumatic Stress Scale (Hannah & Woolgar, 2018), and another study used the revised STSS for DSM-5 (STSS-5) (Whitt-Woosley et al., 2020). Both the ProQOL and the STSS are validated instruments with strong psychometric properties for measuring secondary traumatic stress (Bride et al., 2004; Geoffrion et al., 2019; Singh et al., 2024). Importantly, none of the included studies assessed posttraumatic stress symptoms, posttraumatic stress disorder (PTSD), nor used PTSD-specific instruments. All studies reporting on current traumatic stress symptoms focused exclusively on secondary traumatic stress.

Personal childhood traumatic experiences in foster carers. This section addresses the first research question, which explored the personal childhood trauma histories among foster carers.

A study by Adkins et al. (2020) involving 89 participants using the ACE Questionnaire reported that 66% of foster carers had experienced at least one ACE, and 20% had experienced four or more ACEs. Similarly, Cooley et al. (2020) found that among 150 foster carers, 68% had experienced at least one ACE, and 26% reported four or more ACEs. Both studies reported emotional abuse and mental illness in the household as prevalent ACEs. Adkins et al. (2020) reported higher rates of physical neglect and household incarceration, whereas Cooley et al. (2020) found higher rates of sexual abuse, substance abuse in the household, parental divorce, and emotional neglect.

Another study involving 204 participants used the Childhood Trauma Questionnaire and found that 55% of foster carers had experienced at least one form of significant childhood trauma, including emotional abuse, emotional neglect, and physical neglect (Cole & Eamon, 2007). A smaller study with 46 participants reported lower prevalence rates of ACEs using the Childhood Trauma Questionnaire (Cole, 2005). While overall mean scores for abuse and neglect were relatively low, levels of abuse among individual participants ranged from none to extreme.

In sum, three out of four studies reported that having experienced childhood traumatic events is quite prevalent in foster carers.

Indirect and direct trauma exposure among foster carers. This section addresses the second research question, which investigated indirect and direct exposure to traumatic events in foster carers' caregiving roles. Two studies reported on direct and one study on indirect trauma exposure among foster carers.

A British study by Bridger et al. (2020) examined direct trauma exposure in 187 foster carers, which was defined as incidences of deliberate harm to self or others by a member of the household during fostering, carried out by either the foster child or someone else in the household. The study showed that 76% of foster carers reported such experiences, with a mean score of 1.82 ($SD = 1.43$, range: 0–5) on the Trauma History Screen. Another British study with 131 participants examined the exposure to physical harm (Hannah & Woolgar, 2018). Foster carers were asked whether they had been physically hurt or threatened by a young person in their care and 48% of the foster carers reported to have experienced such direct trauma exposure.

A study with 1,283 participants investigated foster carers' exposure to their foster children's traumatic experiences, which qualifies as indirect trauma exposure (Whitt-Woosley et al., 2020). The study found that 78% of foster carers reported being exposed to their foster children's trauma histories, with 30% rating their dosage of exposure as high.

In sum, although based on a limited number of studies, both indirect and direct trauma exposure appear to be common experiences among foster carers.

Occurrence of traumatic stress in foster carers. This section addresses the third research question concerning the frequency of traumatic stress symptoms among foster carers. None of the included studies reported on posttraumatic stress symptoms or diagnosed PTSD. Five studies assessed secondary traumatic stress symptoms among foster carers.

In a British study of 187 foster carers, Bridger et al. (2020) reported a mean score on the ProQOL STS subscale of 25 ($SD = 6$, range: 12–42), with 25% of foster carers scoring above the 75th percentile, indicating elevated secondary traumatic stress. Interestingly, this study also found that female carers reported higher levels of secondary traumatic stress than males (Bridger et al., 2020). Similarly, an Australian study reported that nearly 26% of foster the carers scored above 75th percentile on the ProQOL STS subscale (mean and SD not reported), with again females exhibiting significantly higher secondary traumatic stress levels than males (McLaren et al., 2024). Comparable findings were observed in another British study by Hannah and Woolgar (2018) with 131 participants, where 25% of foster carers scored in the high range (>75th percentile) on the ProQOL STS subscale, and nearly 20% scored above the clinical cut-off of 38 for secondary trauma measured with the STSS ($M = 30.58$, $SD = 12.03$). Another study with 1,213 participants using the STSS-5 found that 15% of foster carers scored above the clinical cut-off of 46 ($M = 34.74$, $SD = 11.1$) (Whitt-Woosley et al., 2020).

In contrast, a Romanian study of 165 foster carers, using the ProQOL STS subscale, reported notable lower rates of secondary stress symptoms (Teculeasa et al., 2022). Most participants rated themselves as having a moderate level of secondary traumatic stress ($M = 19.73$, $SD = 6.14$). Only 2 out of 160 participants rated themselves as high on the STS subscale and 12 rated themselves as low (Teculeasa et al., 2022).

In sum, four out of five studies suggest that secondary traumatic stress symptoms are relatively common among foster carers, with approximately 15–25% reporting elevated or clinically significant levels of secondary traumatic stress.

Relationship between traumatic experiences and traumatic stress. This section addresses the fourth research question by examining the relationship between traumatic experiences of foster carers and traumatic stress symptoms.

In the British study with 187 foster carers, Bridger et al. (2020) found that secondary traumatic stress was directly and positively predicted by direct trauma exposure ($\beta = 0.20$, $p < .001$), which was defined as direct exposure to incidences of deliberate harm to self or others by a member of the household during fostering, carried out by either the foster child or someone else in the household.

Whitt-Woosley et al. (2020) found in their study with 1,213 participants that nearly 78% of foster carers experienced distressing thoughts or emotions about their children's trauma experiences for more than 30 days. Among them, 26% described their distress as moderate to extreme. Furthermore, 33% and 31% reported impairments in relational and work functioning, respectively, due to this distress. In a hierarchical regression analysis, the dose of exposure to children's trauma histories remained a significant predictor of secondary traumatic stress, even after controlling for trauma severity, personal trauma history, job satisfaction and years of experience ($\beta = 0.181$, $p < .001$). Notably, personal trauma history was not significantly related to secondary traumatic stress (Whitt-Woosley et al., 2020).

In sum, the two studies that examined the relationship between trauma exposure and secondary traumatic stress showed positive associations, indicating that higher levels of trauma exposure are related to more serious symptoms of secondary traumatic stress among foster carers.

4. Discussion

Despite the extensive research on trauma and the growing emphasis on trauma-informed care and clinical practice, a systematic search into traumatic experiences and traumatic stress among foster carers has not previously been conducted. A total of nine studies including over 2,200 foster carers met our inclusion criteria and were reviewed. Four studies examined the prevalence of foster carers' childhood traumatic events, three studies investigated exposure to direct and indirect traumatic events within the caregiving context, five studies addressed current traumatic stress symptoms, and only two studies explored the relationship between trauma exposure and secondary traumatic stress. Results of this scoping review reveal a limited body of research on trauma exposure and traumatic stress symptoms among foster carers. Nonetheless, by summarizing these studies, this review contributes valuable insights into trauma-related experiences among foster carers.

4.1. Trauma histories of foster carers

The first research question focused on the prevalence of personal traumatic experiences among foster carers. Findings from multiple studies indicate that a substantial proportion of foster carers – over half – have experienced one or multiple adverse childhood events (ACEs) or forms of childhood abuse. Foster carers in the reviewed studies reported levels of ACE exposure comparable to those found in the CDC-Kaiser ACE study (Felitti et al., 1998), a large-scale epidemiological study conducted from 1995 to 1997 with over 17,000 participants, as well as in the more recent national ACE survey by Merrick et al. (2018). The prevalence of experiencing at least one ACE is quite similar between of foster carers (66%-68%) and the general population (64%, Felitti et al., 1998). However, the percentage of foster carers experiencing four or more ACEs (19.8%; 26%) was notably higher than in the general population (12.5%, Felitti et al., 1998). One potential explanation proposed by Adkins et al. (2020) is the 'wounded healer' phenomenon, in which individuals who have experienced trauma themselves are drawn to helping or caregiving roles (Jamieson & Scherman, 2014; Straussner et al., 2018). Another explanation for these high rates could be that the study samples included kinship carers, carers who are biologically related to the child and may have grown up in similar environments. However, in the study of Adkins et al. (2020) only one participant (2%) reported being a kinship carer, and kinship status was not reported in Cooley et al. (2020).

ACEs and childhood traumatic experiences are known risk factors of negative adult outcomes, including both physical and mental health issues, as well as maladaptive social-emotional functioning (Felitti et al., 1998; Norman et al., 2012), PTSD (Guo et al., 2021), and secondary traumatic stress (Hensel et al., 2015). ACEs may influence parenting through direct and indirect pathways, such as poorer mental health, elevated stress, maladaptive behaviors and unhealthy coping mechanisms, which can manifest in practices such as corporal punishment (Wattanatchariya et al., 2024). One reviewed study found a direct positive relation between foster parents' ACEs and foster children's social-emotional difficulties (Adkins et al., 2020), while another study among foster carers found associations between ACEs and increased parenting stress, attachment difficulties and dysfunctional parent–child interactions (Reisz et al., 2023).

Although the risk is higher, it is important to note that not all individuals with ACES experience negative outcomes. Protective factors, such as a safe and stable family, community or social network or previous successful trauma treatment can mitigate the impact of early trauma (Madigan et al., 2023). This could explain the finding from one included study, in which prior trauma history was not a significant predictor of secondary traumatic stress (Whitt-Woosley et al., 2020). The authors hypothesized that the experienced personal trauma of foster carers might be different from their children's trauma, and thus may not activate their own traumatic responses as intensely.

4.2. Trauma exposure during fostering

The second research question explored foster carers' direct and indirect trauma exposure during their caregiving. The study that investigated indirect trauma revealed that foster carers are often exposed to the traumatic experiences of the children in their care, often at moderate to high levels (Whitt-Woosley et al., 2020). Direct exposure was defined as deliberate harm to self or others by a member of the household in the study of Bridger et al. (2020) and as the exposure to physical harm or threats by a young person in their care in the study of Hannah and Woolgar (2018). The studies revealed that approximately three quarters to half of the foster carers respectively, reported to have experienced such events. These findings suggest that the risks faced by foster carers may not be solely vicarious but can involve direct encounters with aggression or violent behavior from children who have experienced significant trauma.

This supports the findings of a qualitative study by Ottaway and Selwyn (2016), which reported that many foster carers had experienced primary or direct trauma as a result of fostering. The presence of both indirect as well as direct trauma exposure is concerning, as it can increase the likelihood of foster carers meeting the DSM-5 criteria for PTSD, potentially complicating

their ability to provide effective care and support for the children (Franz et al., 2022). Given the high rates of indirect and direct trauma exposure reported, it is vital that foster carers receive adequate training and support to cope with these challenges while maintaining a safe environment for both themselves and their foster children.

4.3. Secondary traumatic stress symptoms in foster carers

The third research question examined the extent to which foster carers experience symptoms of traumatic stress. While no studies measured PTSD directly, five studies examined current secondary traumatic stress symptoms. Across most reviewed studies, approximately 15-20% of foster carers exceeded the clinical threshold for secondary traumatic stress, showing that secondary traumatic stress is a considerable concern within the foster care system. An exception was found in a study conducted in Romania, where only 1% of foster carers reported high secondary traumatic stress levels. This finding was explained by the authors as a cause of the perceived quality of the relationship between foster parent and child and of the high levels of compassion satisfaction, which is the positive feeling that derives from helping others or providing care (Teculeasa et al., 2022).

Notably, higher secondary traumatic stress scores were more commonly reported among female foster carers. While this finding aligns with broader trauma research indicating that women are more likely to report trauma-related symptoms (Olff, 2017; Visser et al., 2025; Xu et al., 2024), it also raises the question of whether this gender effect among foster carers is biologically driven or instead reflects caregiving dynamics. Since women are more likely to serve as primary caregivers within foster families (Wulleman et al., 2024), their increased exposure to caregiving-related stressors may partly explain the elevated secondary traumatic stress scores.

Given that a notable proportion of foster carers experience secondary traumatic stress symptoms, this raises a concern about the potential impact on their parenting capacities. Traumatic stress can impair emotional availability and reduce sensitivity, which are essential to support foster children with complex trauma (Christie et al., 2019). Elevated secondary traumatic stress, possibly resulting in lower parenting quality, may therefore be a risk factor for placement stability or even contribute to breakdowns (Konijn et al., 2019).

4.4. Relationship between trauma exposure and traumatic stress

The fourth research question explored the relationship between trauma exposure and traumatic stress. The exposure to children's traumatic histories, indirect exposure, was associated with secondary traumatic stress (Whitt-Woosley et al., 2020). Direct exposure was also positively associated with secondary traumatic stress (Bridger et al., 2020; Hannah & Woolgar, 2018).

These findings align with previous research, which shows that both direct and indirect exposures to trauma can contribute to psychological distress and secondary traumatic stress symptoms (Farmer et al., 2005; Hinderer et al., 2014). Importantly, fosters carers might experience both direct and indirect trauma exposure simultaneously, which could lead to high stress levels and intensify traumatic stress, affecting their parenting qualities, especially in the absence of adequate support and coping resources.

Interestingly, none of the included studies measured current PTSD symptoms, despite the well-established link between ACEs and PTSD (Downey & Crummy, 2022; Rameckers et al., 2021). Since ACEs and unresolved personal trauma are known risk factors for PTSD, the lack of PTSD measurements in the reviewed literature represents a gap. Carers with unresolved personal trauma may be more vulnerable to emotional dysregulation or re-traumatization when confronted with children's trauma (Henderson et al., 2025).

4.5. Implications for practice and policy

The results of this review have several practical implications. First, the elevated levels of childhood traumatic experiences and secondary stress among foster carers, underscore the need for targeted mental health screening and support within foster care programs. An understanding of the personal (traumatic) histories and experiences of foster carers can inform strategies to enhance the support they receive, thereby enabling them to deliver optimal care. In light of these findings, foster care organizations could consider implementing routine screening for potential traumatic experiences and PTSD symptoms in foster carers during the assessment process. Psycho-education on potential traumatic experiences, traumatic stress symptoms and trauma-informed therapy possibilities should be part of the preparation and support process.

Furthermore, encouraging foster carers to reflect on their own childhood experiences, coping styles, and stress management approaches may contribute to their overall well-being and caregiving effectiveness. Foster carers may therefore benefit from trauma-informed preparation, therapy, and training through supervision or peer support.

Third, policies should recognize that carers are both support providers and individuals who might need support themselves. Acknowledging this dual

role is essential to sustaining stable and resilient caregivers, and minimizing the risk for breakdown.

Fourth, since direct and indirect trauma exposure can increase the risk of developing posttraumatic stress symptoms, greater emphasis should be placed on preventing such exposure. This includes early identification of trauma-related symptoms in foster children, reducing these trauma-related behaviors through therapeutic interventions, and providing pyscho-education for foster carers to help them understand and manage the challenges.

Finally, posttraumatic and secondary traumatic stress symptoms in carers should be routinely monitored. Agencies might consider implementing structured assessments of carers' emotional well-being, particularly following difficult placements or crises. Systemic efforts to prevent placement disruptions must include care for the carers themselves, since breakdown could be explained by lack of training and support (Eltink et al., 2025).

4.6. Limitations and implications for future research

While this review provides valuable insights into traumatic histories and stress among foster carers, there are several limitations to consider. The included studies were heterogeneous in methodology, sample size, and measurement tools, limiting direct comparability. Longitudinal studies are needed to examine the long-term impact of trauma exposure on foster carers' mental health and caregiving abilities. Additionally, the studies reviewed largely focus on Western contexts, specifically on the USA, with limited representation from non-Western countries. Future research should explore how cultural differences influence foster carers' experiences with trauma and stress, as well as how trauma-informed practices can be adapted to different cultural contexts.

Our search strategy was comprehensive and developed in collaboration with a clinical research librarian, capturing studies using broad terms related to stress and traumatic experiences. Although PTSD was included as a keyword, the search did not include subject headings specifically for PTSD or related symptoms (e.g. depression, anxiety). Consequently, while we did not identify studies explicitly measuring current PTSD symptoms among foster carers, we cannot conclusively determine that such studies do not exist. Nonetheless, the absence of identified studies highlight that PTSD symptoms remain an under-researched area in this population. Future research should therefore include validated PTSD screening tools in addition to secondary traumatic stress measures to better understand the full spectrum of trauma-related symptoms in foster cares.

Another important direction for future research is the exploration of protective factors that may buffer foster carers from the negative effects of trauma exposure. Identifying factors such as social support, resilience, and coping strategies that foster carers use to manage stress could inform the development of interventions designed to prevent or reduce secondary traumatic stress. Lastly, more research is needed to examine the intersection between foster carers' personal trauma histories and their ability to provide trauma-informed care, particularly in relation to specific forms of childhood trauma and the severity of caregiving stress.

5. Conclusion

This scoping review highlights that foster carers frequently report both personal trauma histories and trauma exposure during caregiving. A significant proportion of carers report symptoms of secondary traumatic stress related to their caregiving role, particularly when exposed to direct or indirect trauma. These findings underscore the importance of trauma-informed support systems for foster carers, including training, supervision, and access to mental health resources. Future research should further explore the interplay between personal trauma histories, caregivers' traumatic stress, and resilience to better inform policy and practice.

Author contributions

All authors contributed to the study conception and design. J.D. performed the literature search, and S.d.V, I.H. and S.H. screened and selected the studies. S.d.V. and S.H. conducted the analyses. S.H., P.H., R.J.L.L. and I.M.H. wrote the first draft of the manuscript. All authors read and approved the final manuscript.

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No potential conflict of interest was reported by the author(s).

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Data availability statement

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

Declaration of interest statement

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Appendix

Search strategies

Ovid MEDLINE(R) ALL <1946 to December 04, 2024>		
1	foster home care/ or child, foster/	4129
2	((foster adj2 (care* or giver? or parent* or grandparent? or famil* or child* or youth? or juvenile? or infan* or boy? or girl? or home?)) or fostering or kinship care or (adoptive adj2 (parent? or grandparent? or famil*)) or resource parent?).ab,kf,ti.	27203
3	1 or 2 [I Foster Care]	28863
4	stress, psychological/	139243
5	(trauma* or posttrauma* or ptsd or ptss or psychological stress* or mental stress* or compassion or empath* or (adverse adj2 (experience? or event?)) or (life? adj3 chang*) or burnout or burn out).mp.	972648
6	4 or 5 [II traumatic event exposure / compassion fatigue]	1084777
7	3 and 6	2620
Embase Classic+Embase <1947 to 2024 December 03>		
1	foster care/ or foster child/	6127
2	((foster adj2 (care* or giver? or parent* or grandparent? or famil* or child* or youth? or juvenile? or infan* or boy? or girl? or home?)) or fostering or kinship care or (adoptive adj2 (parent? or grandparent? or famil*)) or resource parent?).ab,kw,ti.	30133
3	1 or 2 [I Foster Care]	32260
4	*mental stress/	39754
5	(trauma* or posttrauma* or ptsd or ptss or psychological stress* or mental stress* or compassion or empath* or (adverse adj2 (experience? or event?)) or (life? adj3 chang*) or burnout or burn out).mp.	1568692
6	4 or 5 [II traumatic event exposure / compassion fatigue]	1568692
7	3 and 6	3188
APA PsycInfo <1806 to November 2024 Week 5>		
1	foster care/ or foster children/ or foster care/	8291
2	((foster adj2 (care* or giver? or parent* or grandparent? or famil* or child* or youth? or juvenile? or infan* or boy? or girl? or home?)) or fostering or kinship care or (adoptive adj2 (parent? or grandparent? or famil*)) or resource parent?).ab,id,ti.	34512
3	1 or 2 [I Foster Care]	35352
4	psychological stress/	10078
5	(trauma* or posttrauma* or ptsd or ptss or psychological stress* or mental stress* or compassion or empath* or (adverse adj2 (experience? or event?)) or (life? adj3 chang*) or burnout or burn out).mp.	317209
6	4 or 5 [II traumatic event exposure / compassion fatigue]	317209
7	3 and 6	3992