



Foster parents exposed to political violence: The role of social support in addressing emotional and functional difficulties



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A B S T R A C T

Background: Being a foster parent is stressful. It becomes even more stressful when foster parents face major threats to their own families and to the foster children in their care, such as during war situations. This study focuses on foster parents' reactions to the war with Gaza in southern Israel that took place in 2014. The first goal of this study was to describe posttraumatic symptoms (PTS) and problems in functioning among foster parents following their exposure to the war. The second goal was to identify background and social support predictors of PTS and functioning problems among these parents. The third goal was to examine the role of formal and informal support received by the parents as a moderator of the association between exposure to war events and PTS and problems in functioning.

Methods: Participants were 354 Israeli foster parents who were exposed to the war. Participants completed structured instruments of exposure to war events, PTS, functioning, and social support.

Results: Exposure to war events was associated with PTS and related functioning problems. Education and religiosity were correlated with PTS and problems in functioning. Contrary to our hypothesis, more formal social support was associated with more PTS. Social support did not moderate the association between exposure to war events and PTS.

Discussion: The unexpected positive correlation between support and PTS was interpreted as either reflecting the fact that foster care agencies targeted foster parents who were most in need, or as a reflection of the inadequacy of the support they received. The findings indicate that foster parents need support during times of major stressful events such as natural disasters and wars, so that they will be able to help the children in their care. Specialized professional training for foster care workers needs to be implemented. Future longitudinal and mix-methods studies are suggested to help address the limitations of the present study.

1. Introduction

Foster care is one of the main sources of out-of-home care for children and young people whose biological parents are unable to fulfill their basic needs (Whenan, Oxlad, & Lushington, 2009; Zeira, Attar-Schwartz, & Benbenishty, 2012). As children who live in out-of-home placements frequently exhibit emotional and behavioral problems (Cole & Eamon, 2007; Vanderfaeillie, Van Holen, Trogh, & Andries, 2012), the role of foster parents in providing a stable and safe environment is essential for these children's psychological health (Blythe, Halcomb, Wilkes, & Jackson, 2013).

Foster parents provide for the ongoing needs of the children and youth in their care. As such, they are responsible for a wide range of tasks and challenges: caring for children with multiple behavioral and emotional difficulties (Van Holen, Vanschoonlandt, & Vanderfaeillie,

2017), interacting and negotiating with birth parents and a variety of professionals, trying to adhere to child welfare agency policies and requirements, and simultaneously caring for their own biological children (Wilson, Sinclair, & Gibbs, 2000). All of these responsibilities are physically and emotionally demanding (Blythe et al., 2013; Brown, Sigvaldason, & Bednar, 2005; Cole & Eamon, 2007).

Consequently, foster care givers are vulnerable to a greater number of emotional and functional difficulties and/or challenges than people in the general population (McCarthy, Janeway, & Geddes, 2003; Murray, Tarren-Sweeney, & France, 2011). These challenges include mental health difficulties such as anxiety (Farmer, Lipscombe, & Moyers, 2005; Morgan & Baron, 2011), depression (Cole & Eamon, 2007), both anxiety and depression (Whenan et al., 2009), and stress (Sinclair, Gibbs, & Wilson, 2004).

Although the literature describes some of the difficulties facing

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foster parents in their regular and everyday care of foster children, little is known about the challenges they face when the circumstances are especially demanding, such as during natural disasters (e.g., hurricanes) and episodes of political violence. Foster families may experience negative consequences deriving from these circumstances, such as post-traumatic symptoms and/or difficulties in everyday functioning, including in the caring of their foster children. These foster parent outcomes may have devastating effects on the foster children, many of whom have prior personal traumatic experiences. The aim of this paper is to describe a study of foster parents in Israel during a period of extreme political violence. In this study, we examined the emotional and functional difficulties associated with exposure to war events, and we also explored the role of social support, both informal and formal, in mediating the effects of exposure. The findings of this study may be relevant to a wider range of situations that tax the resources of foster families, including life-threatening natural disasters such as hurricanes, flooding, and wildfires, all of which have recently occurred in the United States.

1.1. Context: foster care in Israel

In Israel, there are about 8000 children who are placed annually in out-of-home care by the Welfare Ministry. For multiple historical and organizational reasons (Dolev, Ben Rabi, & Zemach-Marom, 2009), only about 30% are placed in foster care, and the rest are placed in a variety of institutions, ranging from small family group homes, with fewer than 10 children, to large institutions with > 100 children. Foster care is facilitated by regional foster care providers (mostly NGOs) that are responsible for recruiting foster families. Prior to being licensed, candidate foster families must first undergo an elaborate screening process and then participate in several training workshops. These families are financially compensated on the basis of the foster child's level of need. The professionals who work in the foster care system are all licensed social workers who engage with the entire foster care triangle: that is, foster parents, foster children, and biological families. They support the foster families and supervise the care that these families provide to the foster children. Foster care agencies provide additional referrals as needed, such as psychological testing and therapy, educational support, medical care, etc.

The Ministry of Welfare contracts with these foster care agencies, refers to them the children deemed suitable for foster care by the local public welfare department, and provides the funding for the services rendered by the foster care agencies. The Ministry also monitors and supervises the quality of care provided to these families and children, and is also involved in initiating new services and interventions. A recent foster care law provides the legal framework that governs foster care in Israel.

1.2. Exposure to political violence as a source of stress for Israeli foster parents

Being a foster parent is stressful and it has been shown that the level of foster parents' stress and emotional strain can be heightened by the disruptive behaviour of their foster children (Farmer et al., 2005; Jones & Morissette, 1999; Vanderfaellie, Van Holen, De Maeyer, Gypen, & Belenger, 2016). Wilson et al. (2000) reported on the prevalence of six types of stressful events that foster parents' experience: placement disruption, maltreatment allegations, difficulties with the child's birth parents, an adverse impact of the placement on the foster family, disagreements with social services about the child's placement, and other matters. In addition, the strain that foster parents experience can reduce their capacity to parent well and has been shown to have an adverse impact on placement outcomes (Farmer et al., 2005; Fuentes, Salas, Bernedo, & García-Martín, 2015). There are some indications that this strain also leads to psychological problems, such as depression, for these parents (Cole & Eamon, 2007).

Although foster parents in Israel presumably experience the same kinds of ongoing strains that all foster care givers experience, they may also be exposed periodically to additional distress as a result of war events. In July and August of 2014, Israeli civilians were exposed to severe hostilities taking place between Israel and Gaza. > 4500 missiles from the Gaza Strip landed in Israel, mostly – but not exclusively – near the border (Tangir, Dekel, Lavi, Gewirtz, & Zamir, 2017).

War exposure may be associated with psychological distress in the short term as well as with more long-term psychological disorders, years after the war ends, in the form of post-traumatic stress symptoms (PTS) and other disorders. Post-traumatic stress symptoms are the most common reaction following traumatic events and consist of several clusters of symptoms: re-experiencing the event, avoidance, and hyperarousal (Bleich, Gelkopf, Melamed, & Solomon, 2006). These symptoms are often accompanied by difficulties in daily functioning, such as problems at work and in interpersonal relationships. These symptoms may also develop over time into full-blown post-traumatic stress disorder (PTSD), a disorder which has significant emotional and functional implications.

The ill effects of exposure to political violence have been documented in multiple places across the world, such as in Lebanon (Khamis, 2012), in Gaza (Massad et al., 2011), in Bosnia (Hasanovic, Sinanovic, Selimbasic, Pajevic, & Avdibegovic, 2006) and in the US (Neria, DiGrande, & Adams, 2011). Extensive research in Israel has shown similar effects (Dimitry, 2012; Hobfoll et al., 2008; Slone & Mann, 2016). The consequences are especially severe for individuals living in areas most exposed to danger (Diamond, Lipsitz, Fajerman, & Rozenblat, 2010; Gelkopf, Berger, Bleich, & Silver, 2012; Gil et al., 2016; Nuttman-Shwartz & Dekel, 2009b).

Although ample research has shown how exposure to political violence bears many detrimental consequences for the general population (Nuttman-Shwartz & Dekel, 2009b), and specifically for parents (Schiff & Pat-Horenczyk, 2014; Tangir et al., 2017) and children (Shechory-Bitton, 2013), to the best of our knowledge no research has yet been conducted on the prevalence of war-related emotional and functional difficulties among foster care givers. Furthermore, the stress sensitization hypothesis suggests that individuals' psychological responses to current stressors are influenced by whether they faced previous traumatic events in their lives. Earlier exposure to traumatic events (usually but not necessarily in childhood) has been shown to lower individuals' tolerance to current stressors, even if these current traumatic events were relatively minor (Hammen, Henry, & Daley, 2000; McLaughlin, Conron, Koenen, & Gilman, 2010; Shao et al., 2015). On a regular basis, foster parents face substantial stressors associated with the challenge of raising a foster child who likely experienced childhood trauma, neglect, and the trauma of removal from his/her own home (Lietz, Julien-Chinn, Geiger, & Hayes Piel, 2016). Being their foster child's main source of support may lower foster parents' tolerance of additional stressors, such as war exposure. The literature on other types of “helpers” indicates that the responsibility of helpers to clients during times of shared stress and trauma has negative consequences for these helpers' conflicts (Baum, 2014; Ben-Ezra & Bibi, 2016; Nuttman-Shwartz & Dekel, 2009a).

It is reasonable to suggest, based on the stress sensitization hypothesis, that foster parents might be especially vulnerable to the added stresses of war exposure (Zvolensky et al., 2015). In the present study we therefore explored how foster parents responded to war exposure and how this exposure was associated with difficulties in functioning, both as parents of their own biological children and as care providers for foster children.

1.3. Factors associated with the consequences of war exposure

In the present study we aimed to go beyond describing the consequences of war exposure among foster parents and to explore which of the parents was more vulnerable. Prior research indicates that PTS

and PTSD are associated with a number of factors, and the extent of posttraumatic reactions is correlated with levels of exposure to war events. For instance, exposure to war events was strongly associated with high PTS among Israeli citizens at the time of the war between Israel and Gaza (Gil et al., 2016; Tangir et al., 2017). In addition, certain demographic characteristics have been found to be associated with more vulnerability to emotional reactions following exposure to stressful events. For instance, females reported a greater number of and more severe PTS symptoms compared with males (Tolin & Foa, 2006). Also, adults are more likely to develop PTSD in middle adulthood than in older or younger adulthood (Ford, 2009), and a higher level of education was found to be protective against the development of PTS (Schnurr, Lunney, & Sengupta, 2004). Regarding the association between PTS and religiosity, the literature is inconsistent (Ankri, Bachar, & Shalev, 2010). Some research points to the positive impact of religiosity on resiliency when individuals face traumatic events (Schiff, 2006; Tuval-Mashiach & Dekel, 2014), whereas other studies show the opposite, indicating that religious (Bryant-Davis & Wong, 2013) or Ultraorthodox Jewish individuals suffered from more PTS in comparison with the general population (Ankri et al., 2010).

In the present study we examined whether exposure level, gender, age, level of religiosity, and education were associated with PTS and related functional difficulties among a group of foster parents in Israel. Furthermore, based on extensive research on the effects of social support on those exposed to stress (Kaniasty et al., 1993), we explored the role of formal and informal support in moderating the impact of war exposure on foster parents' symptoms and functioning.

1.4. The importance of formal and informal support for foster parents exposed to war

Social support can act as a protective factor against the negative consequences of stressors such as war exposure (Betancourt & Khan, 2008; Dimitry, 2012; Tol, Song, & Jordans, 2013). Social support may be of particular importance to foster families, because support from others is central to the parents' handling of the foster child's behaviour and is associated with greater parental satisfaction and a better response to the foster child's needs (Denby & Rindfleisch, 1996; Pasztor & Wynne, 1995; Rhodes, Orme, & Buehler, 2001; Vanderfaillie et al., 2016; Whenan et al., 2009).

Foster parents may receive formal support from professional services and agencies, as well as informal support from partners, spouses, other supportive adults, and from extended social support networks (Blythe, Wilkes, & Halcomb, 2014; Cole & Eamon, 2007). There is evidence that foster parents who received formal support from professional helpers experienced less stress (Farmer et al., 2005). Enhanced support from a professional foster care social worker has also been shown to moderate the effects of strain (Fuentes et al., 2015; Hudson & Lvasseur, 2002; Kirton, 2001; MacGregor, Rodger, Cummings, & Leschied, 2006).

Informal social support, such as help from friends, also emerged as an important antidote to strain. For foster parents, increased availability of social support from adults within the home and from extended social support networks has been found to buffer the effects of stress on depressive symptoms resulting from health problems and the multiple responsibilities of providing foster care (Cole & Eamon, 2007).

Social support may play several different roles in times of traumatic events such as exposure to political violence. First, social support may have a *direct effect* in reducing the distress experienced during traumatic events. The direct effects model suggests that social support has positive effects on psychological health that are independent of the stress process (Kaniasty et al., 1993; Schiff, Pat-Horenczyk, & Peled, 2010). The stress-buffering model (Cohen & Wills, 1985; Kaniasty et al., 1993), on the other hand, posits social support as a *buffer* for the negative consequences of exposure to trauma (Cohen & Wills, 1985; Kaniasty et al., 1993). The buffering model suggests that social support in times of

trauma can protect individuals from the negative consequences of stressful conditions (Kaniasty et al., 1993).

This latter model is also supported by the Conservation of Resources (COR) theory (Hobfoll, 1989; Hobfoll, Johnson, Ennis, & Jackson, 2003). According to this theory, the loss of supportive social networks, or even the threat of such a loss, is a major source of psychological distress after a traumatic event, sometimes even more so than the event itself (Schiff, Pat-Horenczyk, Benbenishty, et al., 2010). Therefore, we expected that formal and informal social support received by foster parents would moderate the association between exposure to war events and PTS, such that the more support received, the weaker the association.

1.5. The current study

Whereas there is ample evidence to suggest that both formal and informal support are essential for parents, contribute to their well-being, and help them provide for their children's needs, no research has yet been conducted into the particular context of providing care for non-biological children, and the role of support for foster parents during times of political violence. The present study was the first to look at foster parents' reactions to political violence and the role of social support in relation to the consequences of such violence. The findings could be relevant for a better understanding of the unique situation of parents who are responsible for their own children as well as for the other children in their care, during times of extreme stress, such as flare-ups of political violence and natural disasters. The findings could therefore serve as a basis for developing strategies to support foster families in similar situations around the world.

In summary, this study focused on foster parents' PTS and their related functional problems following exposure to war in Israel. In this study we described the foster parents' PTS and functional impairment, and we examined their associations with parents' levels of war exposure and demographic characteristics. Further, we tested whether support had a direct effect on distress in traumatic circumstances. We also tested the prediction that higher levels of formal and informal support, compared with lower levels of support, would weaken the association between war exposure and symptoms.

2. Methods

2.1. Population and sample

The research population consisted of foster parents – that is, both mothers and fathers – who were affiliated with three non-profit foster care agencies in Israel during the war with Gaza in southern Israel in 2014. The fourth agency operating in Israel, located in the north of the country, was not under immediate threat during the war and preferred not to participate.

Between two and six months after the war, we approached all of the foster families affiliated with these three agencies and requested that they join the study. Of all of the estimated 950 eligible families, 354 foster parents (representing 224 families) agreed to participate. We do not have background information to examine whether the consenting parents were different in various domains from those who decided not to participate.

About two thirds (65.2%) of the sample participants were females. Their average age was 50.0 ($SD = 11.05$), and their average number of years of education was 13.4 ($SD = 2.8$). Out of 218 foster mothers who reported on their religious level, 30.8% were traditional (i.e., they observed some of the Jewish rituals but did not define themselves as religious), 25.4% were secular, 22.3% were religious, and 17.4% were Ultraorthodox. The average age of the 119 fathers in the sample was 52.4 ($SD = 10.9$), and their average number of years of education was 13.5 ($SD = 2.9$). Out of 115 foster fathers who reported on their religious level, 32.8% were secular, 25.2% were religious, 21% were

Ultraorthodox, and 16% were traditional. Based on the mothers' reports, the families' years of experience serving as foster families ranged from less than a year (10%) to 15 years and more (10%). The median was four years, and the mean = 6.46 years (SD = 6.43).

2.2. Procedure

The study was approved by the ethics committee of one of the authors' universities and by the ethics committee of the Ministry of Social Affairs and Social Services. Data collection took place between November 2014 and February 2015. The foster care workers identified all of the families in their caseloads who met the eligibility criteria of the study. In order to monitor, over time, families who suffered from war-related distress, each potential participant was assigned a code, and the list of names and codes was kept under lock and key at the agencies. The foster care workers then talked to each relevant foster family during their monthly meeting, told them about the study goals, and offered them the chance to participate. The workers clarified that the individuals were not required to participate, that no negative consequences would ensue if they decided not to participate, and that if they did participate, their responses and identities would be kept confidential. The researchers asked participants to indicate whether they would be interested in receiving services if their responses warranted such services. If they answered positively and were identified in the study as experiencing PTSD, and if they requested help, their code was sent to the agency so that they could be identified and thus receive the appropriate services. If the foster parents agreed to participate, the foster care worker distributed the questionnaires, which were completed by the foster parents privately (that is, not in the social worker's presence). All of the completed questionnaires were later put in sealed envelopes and sent to the research team.

2.3. Measures

2.3.1. Demographic questionnaire

This questionnaire elicited information about variables such as gender, age, education, level of religiosity, and years of experience as foster parents.

2.3.2. Exposure to war events

This scale included nine items addressing various aspects of exposure to war, such as "a missile fell close to me" and "my home or property was damaged by a missile." The responses scale ranged from 0 = *never happened* to 2 = *happened more than once*. The number of different events to which participants were exposed at least once was used as an index of exposure to war events (its correlation with the mean frequency of exposure was $r = 0.91$). This scale is in line with prior work done in similar contexts of regions exposed to acts of armed conflict (Schiff et al., 2012; Schiff & Fang, 2014). This prior work also supports the validity of the scale, showing the relationship between the scale and objective information on levels of exposure to missile terror attacks in various regions in Israel. In the present study, we also ask participants to report the distance of their residence from the border. The exposure scale was correlated $r(186) = -0.435$ ($p < 0.001$) with the distance between the family's location and the border.

2.3.3. Posttraumatic stress symptoms (PTS) (Foa, Cashman, Jaycox, & Perry, 1997)

Foster parents completed the posttraumatic stress disorder (PTSD) scale. The instrument includes 17 items, to be ranked on a 4-point Likert-type scale (0 = *not at all*, 1 = *only once a week*, to 3 = *almost all the time*), assessing hyper-arousal, intrusion, and avoidance symptoms associated with PTS, as well as with a measure of likelihood of PTSD. We used the averaged summed symptoms scores in the analysis and described the prevalence of likelihood of PTSD in the descriptive analyses. This scale has been used extensively in Israel to study such

reactions to war events (e.g., Pat-Horenczyk et al., 2009). The internal consistency of this scale in the present study was Cronbach's $\alpha = 0.92$.

2.3.4. Functional impairment

To measure functional impairment, we used relevant items from the Posttraumatic Diagnostic Scale - PDS (Foa et al., 1997). This scale refers to nine areas of potential impairments in social, occupational, or other important areas of functioning, such as relationships with friends, work and school, and marital relationships. To this scale, we added the domain of treatment of the foster child. Participants were asked to indicate (yes-no) whether they had experienced each functional impairment. The number of areas that the participant indicated as ones in which he/she was experiencing difficulties was used as an index of functional impairment. Due to the fact that the various areas of difficulties in functioning form, rather than reflect (Jarvis, MacKenzie, & Podsakoff, 2003), the index of functioning difficulties, internal consistency was not considered to be a relevant psychometric parameter. It should be noted that difficulties in functioning are strongly associated with PTS ($r = 0.55$, $p < 0.001$), suggesting strong concurrent validity. Similar to Foa et al. (Foa et al., 1997; Powers, Gillihan, Rosenfield, Jerud, & Foa, 2012), we did not calculate inter-item reliability for functional impairment.

2.3.5. Social support

Participants were asked: "To what extent have you received support from each of the following sources?" They were provided with a list of seven sources of potential support, including both formal support from the foster care agency, and informal support from sources such as the spouse and friends. The scale ranged from 1 = *not at all* to 5 = *very much*. Two scores were computed: a) "informal" support, e.g., provided by the spouse, family, and friends (Cronbach's $\alpha = 0.83$), and b) "formal" support (i.e., support for the role, specifically, of foster parent), such as foster care agency support, other professional support, and support from other foster families ($\alpha = 0.67$). The scale has been used in prior work in similar contexts and has shown good reliability (Schiff, Pat-Horenczyk, Benbenishty, et al., 2010).

2.4. Analytic plan

We used descriptive statistics to describe the distribution of the study variables. The bivariate associations between the PTS and functional problems and the independent variables were tested using analyses of variance (for categorical independent variables) and correlations (for continuous variables). A hierarchical multivariate regression was used first to test the direct effects of exposure and social support after controlling for background variables. We then tested the moderation hypothesis by adding an interaction term to the regression.

It should be noted that due to the structure of the sample that included many pairs of parents, the number of independent observations is lower than the sample size. We therefore used a conservative estimate of the degrees of freedom – the number of families in the study $n = 242$ – rather than the individual participants ($n = 345$). Levels of missing data were low, we did not substitute for missing data, and we used pairwise deletion in our analysis except for regressions in which we used listwise deletion.

3. Findings

We first examined exposure to war events. The largest number of participants (45%) resided up to 40 km from Gaza (considered an immediate war zone, exposed to short-range missiles); 28.4% resided between 40 and 70 km from Gaza (exposed to longer-range threats); and 26.6% resided farther away from the war zone. The most frequent type of exposure was being in a place where a warning siren sounded (90.4%), and 54.5% heard, saw or felt the house tremble due to a missile landing, more than once. About 24% were exposed to a direct

Table 1
Prevalence of post-traumatic symptoms.

	Once a week		Between 2–4 times a week		Almost all the time	
	N	%	N	%	N	%
Having upsetting thoughts or images about the war that came into your head when you didn't want them to	62	18.5	32	9.6	17	5.1
Having bad dreams or nightmares about the war	37	10.8	10	2.9	2	0.6
Reliving the traumatic event, acting or feeling as if it was happening again	70	20.8	18	5.4	9	2.7
A sense of panic, anger, sadness, guilt, and so forth	77	22.6	21	6.2	6	1.8
Experiencing physical reactions when reminded of the war (sweating, increased heart rate)	22	6.5	13	3.8	1	0.3
Trying not to think or talk about the traumatic event	46	13.5	17	5.0	3	0.9
Trying to avoid activities, people, or places that remind you of the traumatic event	21	6.2	5	1.5	3	0.9
Not being able to remember an important part of the traumatic event	25	7.4	8	2.4	2	0.6
Having much less interest or participating much less often in important activities	36	10.6	12	3.5	2	0.6
Feeling distant or cut off from people around you	15	4.4	3	0.9	2	0.6
Feeling emotionally numb (for example, being unable to cry or unable to have loving feelings)	11	3.3	5	1.5	2	0.6
Feeling as if your future plans or hopes will not come true (for example, you will not have a career, marriage, children, or a long life)	17	5.0	4	1.2	1	0.3
Having trouble falling or staying asleep	56	16.6	12	3.6	7	2.1
Feeling irritable or having fits of anger	50	14.8	7	2.1	6	1.8
Having trouble concentrating (for example, drifting in and out of conversations, losing track of a story on television, forgetting what you read)	40	11.8	9	2.7	2	0.6
Being overly alert (for example, checking to see who is around you, being uncomfortable with your back to a door, etc.)	38	11.2	9	2.6	10	2.9

Note. The category of “not at all” is omitted.

and personal war threat, such as being near a site where a missile landed. A much smaller number of foster parents (7.6%) reported either knowing people who were injured or having their homes or cars damaged by a missile strike (3.2%). Exposure levels ranged between 0 and 9 instances of exposure, $M = 2.54$ (confidence interval 95% = 2.41–2.70), $SD = 1.30$, skewness = 0.62, kurtosis = 1.07.

Table 1 presents the prevalence of each of the PTS items (the category of 0 = not at all is not presented). The most common symptoms were experiencing unwanted depressing thoughts or images of the war (33.1%); experiencing a sense of panic, anger, sadness, guilt, etc. (30.5%); and re-experiencing the event or feeling that it was happening again (28.9%). Overall, the mean sum of symptoms (on a scale of 0–17) was 2.72 (confidence interval 95% = 2.41–2.70); $SD = 3.60$; the median was one symptom; 20% had at least five symptoms; and 5% had > 10 symptoms. The distribution was moderately and positively skewed = 0.77 and kurtosis was negative = -0.52, indicating that the numbers of participants with very low and very high levels of PTS were slightly higher than expected for a normal distribution. We also examined whether foster families met the criteria of PTSD (as defined in the DSM – IV). We found that 5.5% of the participants met the criteria.

The examination of functional impairments indicated that the participant complaint reported most commonly was experiencing problems in leisure activities during the last month (21.2%). Problems at work or at school were experienced by 9.9%, and only a few (5.3%) reported problems in taking care of their foster children. Overall, 28.4% reported at least one problem in functioning, and 4.1% reported at least five problems in functioning. The mean (scale 0–10) was 0.83, (confidence level 95% - 0.63–1.01), $SD = 1.80$, skewness was 2.83, and Kurtosis was positive and very high - 8.39, indicating that there were very few participants who had more extreme (i.e., much lower or much higher than the mean) levels of problems in functioning.

There was a strong positive significant correlation between PTS and functional problems, $r = 0.54$, $p < 0.001$. Next, we examined the association between exposure variables and the two dependent variables – PTS and functional problems. The results confirmed our hypothesis: Exposure was significantly associated with PTS, $r = 0.30$, $p < 0.001$, and with problems in functioning, $r = 0.264$, $p < 0.001$. In addition, distance from Gaza was also associated with PTS, $F(2,238) = 11.966$, $p < 0.01$, and with functional problems, $F(2,238) = 11.827$, $p < 0.001$. A post hoc Scheffe analysis indicated that the source of the significant difference was the higher levels of PTS and functional

problems among parents in the region closest to the border, compared with the other two regions. We also examined how PTS and functional impairment were associated with background variables. Low negative significant associations were found between years of education and PTS and functional problems, $r = -0.15$, $p < 0.01$, and $r = -0.15$, $p < 0.01$, respectively. Levels of religiosity were significantly associated only with PTS, $F(2,326) = 4.40$, $p < 0.01$. A post hoc Scheffe analysis indicated that the source of the significant difference was the higher levels of PTS among foster parents who observed religious rituals but did not see themselves as religious (“traditional”). The Ultraorthodox had lower levels of PTS compared to this first group, and the secular parents had the lowest levels of PTS. Gender, age, and years of experience as a foster parent were not associated with PTS and problems in functioning.

Table 2 presents the bi-variate correlations between the relevant variables. The table indicates that both PTS and problems in functioning were associated with exposure to war ($r = 0.30$, and $r = 0.26$, respectively, both $p < 0.001$). Interestingly, foster parents who had more years of experience in fostering reported receiving more support around their role as foster families than did those who had fewer years of fostering experience ($r = 0.42$, $p < 0.001$).

Table 3 presents a hierarchical regression predicting PTS. In step 1 we entered participants' background variables; in the second step we entered exposure to war; and in the third step we entered the two forms of support, formal and informal. Background variables explained 9.3% of the variance in PTS, due to the role of years of experience as a foster parent and being “traditional” in their religious orientation. Exposure

Table 2
Intercorrelations among study variables.

	1	2	3	4	5	6
1. Exposure to war events	1.00					
2. Years of experience as foster parents	0.09*	1.00				
3. Informal social support	0.21***	-0.05	1.00			
4. Formal support	0.15**	0.42***	-0.04	1.00		
5. Functioning problems	0.26***	-0.02	0.04	0.05	1.00	
6. PTS (posttraumatic stress)	0.30***	0.09	0.09	0.19**	0.55***	1.00

* $p < 0.05$.

** $p < 0.01$.

*** $p < 0.001$.

Table 3
Hierarchical regression predicting PTS by background, exposure, and social support.

	Step 1			Step 2			Step 3		
	B	Std. error	Beta	B	Std. error	Beta	B	Std. error	Beta
Gender ^a	− 0.81	0.53	− 0.11	− 0.82	0.50	− 0.11	− 0.82	0.50	− 0.11
Age	0.00	0.03	− 0.01	0.01	0.03	0.02	0.00	0.03	0.00
Education	− 0.06	0.09	− 0.05	− 0.06	0.09	− 0.04	− 0.02	0.09	− 0.02
Religiosity ^b	1.83	0.66	0.20**	1.43	0.64	0.15*	1.15	0.65	0.12
Years of experience as a foster parent	0.01	0.00	0.18*	0.01	0.00	0.14	0.01	0.00	0.16*
Exposure				0.75	0.18	0.29***	0.73	0.18	0.28***
Informal support							− 0.11	0.09	− 0.10
Formal support							0.24	0.11	0.19*
F	F (5,193) = 3.86**			F (6,193) = 6.46***			F (8,193) = 5.51***		
R ²	0.093			0.172			0.193		

^a Male = 1, female = 0.

^b “Traditional” religious affiliation = 1, other = 0.

* $p < 0.05$.

** $p < 0.01$.

*** $p < 0.001$.

had a contribution of 7.9% to the explained variance above and beyond the background variables. The table indicates that support related to being a foster family (i.e., formal support) was significantly associated with PTS ($\beta = 0.19$, $p < 0.05$). Other forms of informal personal support were not associated with PTS.

In order to examine the hypothesized moderating role of social support, we conducted a similar hierarchical regression and added a step with the interaction term between the two types of social support with exposure. These terms did not have a significant independent contribution to the explained variance, and therefore did not support the hypothesis that social support would moderate the effects of exposure to war events.

4. Discussion

In the present study we examined posttraumatic stress symptoms and functional difficulties among Israeli foster parents following the 2014 war with Gaza in southern Israel. The findings indicated that despite the extensive exposure to war events, the prevalence of post-traumatic symptoms was not high, and only a small proportion of the parents (5.5%) developed PTSD. This finding is similar to findings regarding the proportion of Israeli students (6%) who experienced PTSD as a result of their exposure to terror attacks (Amir & Sol, 1999). However, when we examined the mean PTS in the present study ($M = 2.72$), we found that it was higher than the results in previous studies that were conducted in Israel. For instance, in Gil et al.'s (2016) study, the level of PTS at T1 was $M = 0.53$, and at T2 it was $M = 0.43$. Similarly, mean levels of PTS among mothers in Sderot, a city close to the Gaza border, was $M = 1.84$, and among mothers in *kibbutzim*, communal communities close to the Gaza border, the mean level of PTS was $M = 1.44$ (Tangir et al., 2017). This rather high rate of PTS among foster parents as compared to the general population – a finding which was consistent with our expectations – might be related to the additional stresses associated with the role of being a foster parent. It should be said, however, that although the results point to the potentially serious stress that parents may have felt due to their exposure to the hostilities, only a small number of them felt that this stress negatively influenced their ability to provide proper care for their foster children. This finding may reflect the participants' strong commitment to treating their foster children as their own.

In terms of vulnerability to PTS and difficulties in functioning, similar to other studies conducted in Israel (Gil et al., 2016; Tangir et al., 2017), the current findings indicate that those who were exposed to a greater number of war events experienced more symptoms. This finding has clear implications for the foster care agencies in terms of

prioritizing their efforts. Although quite a few Israeli citizens were under stress during the 2014 war – as many of them had relatives living in the war zone, and a considerable number had relatives and friends serving as combat soldiers in the war – those individuals who had higher levels of exposure in terms of closeness to the battle zone and firsthand experiences of missile attacks were at greater risk for developing symptoms.

These findings may be relevant to other places where citizens often find themselves caught in the crosshairs of war, for instance in Lebanon (Khamis, 2012) and Gaza (Massad et al., 2011). Furthermore, the findings may be relevant to foster families exposed to extreme stress situations such as natural disasters. Interestingly, although there have been quite a few studies conducted on the impact of natural disasters such as hurricanes (Harville et al., 2011; Sattler et al., 2002; Tracy, Norris, & Galea, 2011), we could not find studies focusing specifically on foster care givers, a very important group of carers.

As has been found in previous research with regard to risk factors for PTS (Schnurr et al., 2004) and for foster parent burden (Fuentes et al., 2015), a low level of education was found to be predictive of PTS. Similar to other findings in the literature, in which the relationship between religiosity and PTS was not consistent, the present study also indicated a complex relationship between PTS and religiosity. On the one hand, secular participants presented the lowest levels of PTS. On the other hand, the highest levels of PTS were not presented by the religious and Ultraorthodox participants, but rather by those participants who identified themselves as “traditional,” meaning neither religious nor secular. This finding may suggest that religiosity in and of itself may not be the factor that makes a difference as a risk factor for PTS. Rather, perhaps other background characteristics associated with suffering with PTS – characteristics that might be different in different contexts – may account for this difference. The inconsistency in the relationship between religiosity and PTS as a response to traumatic events in different contexts is therefore not surprising. In regard to demographic risk factors, although we found significant ones, they seemed to be less influential than exposure to war events. This pattern suggests that under circumstances of war, foster parents may be more similar than different in their responses to the traumatic events, and all of these individuals should be targeted for support.

Although the role of social support in reducing the negative consequences of war exposure has been established in several studies, its impact specifically on foster parents and other foster care professionals has not previously been investigated. In the present study, we examined personal support (i.e., “informal support”) and support related to the parents' foster care role (i.e., “formal support”), separately. We found that support related to the foster parent role was *positively* associated

with PTS. Social support that includes emotional assistance, validation, and listening is associated with positive mental health outcomes. However, in times of stress, social support may include elements of taking control away from the individual or distracting him/her from the issues at hand – elements that might contribute to an individual's psychological distress (Scarpa, Haden, & Hurley, 2006). Although not examined in the present study, positive associations between social support and PTS might stem from the fact that this social support more closely resembled the “controlling” and “distracting” type of support rather than the listening, validating, and emotionally-enhancing type.

Furthermore, there was no evidence to suggest that a greater amount of support moderated the relationships between war exposure and PTS. This set of findings does not support our hypothesis, which was based on the existing literature (e.g., Kaniasty et al., 1993; Schiff, Pat-Horenczyk, Benbenishty, et al., 2010), suggesting that support would be helpful in alleviating or preventing negative responses to war exposure. The current study was the first one to examine the effects of formal support on foster parents exposed to extreme war-related stress. As such, it is important to understand this finding in light of these particular circumstances.

Based on Norris and Kaniasty's (1996) work, we would suggest that perhaps these foster parents experienced the support offered and provided as threatening to their images of themselves as competent foster parents, or perhaps the way in which it was delivered may not have been effective. Alternatively, according to COR theory (Hobfoll, 1989), as help-seeking occurs when the individual's loss of resources is too much to handle on his/her own, he/she may feel the need to turn to and lean on social resources (Hobfoll et al., 2003). With this latter theory in mind, the negative correlation between PTS and support provided by social workers may be understood as the outcome of having accurately targeted the foster care parents most in need. Clearly, these two contrasting interpretations have different implications for practice. The first interpretation suggests that the foster care agencies in question should re-examine and improve the ways they provide professional support to foster families. The alternative interpretation, that the families who were most in need were actually the ones who received more support, suggests that the agencies did what they were mandated to do. Regardless of the interpretation, one would expect that, over time, the support provided by the agencies would make a difference and help alleviate symptoms. There is a clear need for mixed-methods longitudinal studies to examine the long-term effects of formal support and the ways in which this support is perceived and utilized by foster families.

This study has several limitations. First, as this study focused on only one specific time point, we did not have a baseline for the period before the war, and therefore could not control for the “pre-war” status of the families. We also do not have more long-term reports on the families' recovery processes after their war exposure. Another limitation was that we had only one source of information, the foster families themselves, and could not validate this information via other sources, such as the foster care workers. Finally, many foster families chose not to participate in this study, limiting the generalizability of our findings. Despite these limitations, we believe that this study is helpful in exploring an issue that has theretofore not been studied and whose findings, unfortunately, may become relevant to other areas in the world.

4.1. Implications for practice and policy

Our study suggests that foster families exposed to war-related events experience heightened stress and difficulties in functioning. Consequently, it is important that foster care agencies have a plan for how they will support foster families in the event of emergencies, such as natural disasters (e.g., floods, earthquakes, wildfires). Such a plan must take into account the foster families' multiple needs, including the need to balance the care they provide for their own biological children

with the care they provide for their foster children. Further, formal support needs to be tailored to this specific group – that is, foster parents are carers who are not professionally trained to do their “jobs.” They may therefore need special coaching in how to buffer their foster children from outside stresses, so as not to potentially harm these already vulnerable children.

Conflict of interest

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