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A Population-Based Study on the Correlates of Trauma and Non-Suicidal Self-Injury Behaviors among Adolescents Aging out of Foster Care.

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ABSTRACT

Children in foster care are confirmed victims of maltreatment who may suffer from chronic trauma. These adverse childhood experiences will often increase the risk of physical and psychological adversities such as self-harm (SH), substance abuse, anxiety, post-traumatic stress disorder (PTSD), heart disease, depression, etc. Based on previous and current research studies, youth in foster care are less likely to receive adequate treatment for their self-harm behaviors and mental health needs. Failing to provide proper treatment could lead to harmful activities such as deliberate self-harm and potential suicide. This population-based study focuses on the prevalence of SH among youth in foster care by exploring the self-harm epidemiology in Region 2 Texas foster-care system. The premises of this study emphasize the need for social workers and practitioners to implement a trauma-informed care approach and trauma-specific interventions in clinical practice to reduce the pervasiveness of self-harm among adolescents aging out of foster care.

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In loving memory of my uncle Edwin Spencer Artis

May 20, 1975

April 23, 2019

Thanks for carrying me to Texas

Never to be forgotten

“My good man”

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The probability that we may fail in the struggle ought not to deter us from the support of a cause we believe to be just.

- Abraham Lincoln

I, Jennifer Artis, could not have completed this course of my destiny without the love and support of my Kentucky family and three fellow women: my mother, Ida Artis, my best friend, Tyechia Walton, and my godmother, Vivian Kem. To you all, I share the reward of my graduate-level struggle. Thanks for supporting the cause.

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CHAPTER I

INTRODUCTION

Child maltreatment and non-suicidal self-injury (NSSI) are two of the most salient public health concerns in the United States (ACF, 2017). The Federal Child Abuse Prevention and Treatment Act (CAPTA) (2010) defines child maltreatment as "any act, or failure to act, on the part of a parent or caretaker which results in death, serious physical or emotional harm, sexual abuse, or exploitation which presents an imminent risk of severe damage." Maltreatment is distinct from other types of trauma because it is interpersonal in nature, and it is one of the most notable risk factors for future mental, emotional, and behavioral problems (Fitton & Koehler, 2014; Nixon, Cloutier, & Jansson, 2007; Vaughn, Salas-Wright, Delisi, & Larson, 2015).

In 2012, U.S. state and local child protective services (CPS) received an estimated 3.4 million referrals of children being abused or neglected. CPS estimated that 686,000 children were victims of maltreatment (Centers for Disease Control and Prevention [CDC], 2012). After a case has been confirmed as maltreatment, CPS will remove the victim from the home and place them in a foster care setting.

Foster care is temporary substitute care for children in the legal custody of a child welfare services agency most often because of maltreatment (Texas Department of Family Protective Services, 2018). Foster care is intended to provide a safe, stable living environment while the Department of Family Protective Services (DFPS) makes efforts to reunify children with their birth parents, or to establish permanency or adoption

through legal custody with a relative or qualified caregiver (Teska & McLuckey, 2018). The US Department of Health and Human Services estimates that there were approximately 437,000 children in the United States foster-care system in 2017. The Texas DFPS holds jurisdiction over 3.88% of the children in the US foster care system.

Studies show that 90% of the children in foster care have experienced multiple traumatic events, ultimately putting them at risk of long-term physical and psychological issues such as PTSD, depression, substance abuse, self-harm, suicide, etc. (Fratto, 2016). Recent data suggest that 16% - 25% of the pre-adolescents in foster care have a history of suicidal ideations and self-harm behaviors (Gabrielli et al., 2014).

Non-suicidal self-injury, often called self-harm, is the act of deliberately harming the surface of one's body, such as cutting or burning oneself without suicidal intent. It is considered an intentional act to harm oneself to alleviate stress or regulate emotions with no intent to die (Emelianchik-Key, Byrd, & Guardia, 2016; Fitton & Koehler, 2014). Individuals who work with at-risk youth should be knowledgeable of the prevalence as well as the causes and effects of non-suicidal injury occurring worldwide among the adolescent population.

This research study examines the factors associated with self-harm and trauma and the impact of treatment modalities used to reduce deliberate self-harm occurrences within the Texas foster-care system. This researcher seeks to determine if youth aging out of care have ever received trauma-specific, evidence-based practice interventions and to determine if treatment reduced or eliminated their self-harm behaviors. Based on previous data and a recent field observation, this researcher hypothesizes that young

adults (18-21) aging out of foster care have mental health needs, but only a few obtain the required services (Grenville, Goodman, & Macpherson, 2011).

The second hypothesis predicts that evidence-based, trauma-specific treatments will be more effective in reducing and eliminating self-harm (SH) behaviors than traditional counseling methods.

The following key terms are referenced in this study:

- Self-harm (SH), non-suicidal self-injury (NSSI); self-injury (SI), self-mutilation: often called self-harm: the act of deliberately harming the surface of one's own body, such as cutting or burning oneself without suicide intent.
- Maltreatment: any recent act or failure to act on the part of a parent or caretaker which results in death, serious physical or emotional harm, sexual abuse, exploitation or failure to act which presents an imminent risk of severe damage.
- Foster care: foster care is temporary substitute care for children in the legal custody of a child welfare services agency, most often because of abuse.
- Trauma: a dangerous or distressing experience outside the range of usual human experience that overwhelms the capacity to cope and frequently results in intense emotional and physical reactions of helplessness, powerlessness, and terror.
- Trauma-informed care (TIC): a strength-based framework rooted in understanding the physiological and psychological impacts of trauma.
- Trauma-specific interventions (TSI): evidence-based and best practice treatment models that have been proven to facilitate recovery from trauma.

CHAPTER II

LITERATURE REVIEW

This literature review examines and synthesizes scholarly, peer-reviewed, full-text articles that have been published within the last ten years to address the prevalence of self-harm among the adolescent population. Most of the pieces were extracted from the Abilene Christian University EBSCOhost social work reference center databases using the following keywords: trauma, trauma-informed care, self-harm, non-suicidal self-injury, and foster care. Lastly, the literature review examines the modalities of trauma-informed care and specific interventions that have been proven to facilitate healing and modify behaviors like non-suicidal injury among victims of trauma (Cary & McMillen, 2012; Weiner, Schneider, & Lyons, 2009).

Aging Out Risk and Protective Factors

The term "aging out" pertains to adolescents who have reached the legal age of adulthood and are no longer compelled to remain in DFPS custody. The National Foster Youth Institute estimates that 20,000 youth aged 18 or 21 leave care each year (National Foster Youth Institute, 2017). Recent data shows that only one-quarter of 18-year-olds stay in foster care until their 19th birthday. Youth who are deemed self-sufficient and intellectually sound are given the option to legally emancipate from care at 16, meaning they will leave care without being successfully reunified with their family or connected to another family member through adoption or legal guardianship. Adolescents who feel incompetent and unable to live successfully on their own have the option to remain in

extended care until they are 21 years old (Texas Department of Family and Protective Services, 2017). Extended care provides greater access to resources that will help reduce the typical adverse challenges they may face during their transition from foster care to adulthood.

According to the National Youth in Transition Database (NYTD, 2018), 60% of adolescents aging out of the Texas foster system found themselves in the sex industry via prostitution, exotic dancing, human trafficking etc. NYTD reports that 60% of the young men aging out of care will experience a period of incarceration at some point in their adult life and one out of five will become homeless (Basin Dream Center for Orphans, n.d.). Youth with emotional, behavioral difficulties who are transitioning from care to adulthood are incredibly vulnerable to harm-related risky behaviors, such as human trafficking, gang involvement, incarcerations, dropping out of school, homelessness, substance abuse, unemployment, and self-harm behaviors (Clark & Unruh, 2009).

The state of Texas recognizes the need to provide extensive services to reduce the risk factors associated with aging out of care. Texas is one of the few states that provide transitional living services like the Preparation for Adult Living (PAL) program and transition centers to youth emerging from care. The Preparation for Adult Living program is designed to provide transitional living services to youth ages 16-21 who are aging out of foster care. It is a community-based program that provides supportive services, programs, and resources to at-risk youth. Each youth is assigned a PAL case manager who will provide life skills training, counseling, educational and vocational services, as well as monetary assistance like the federally funded resources below:

1. Transitional living allowances (TLA) are two personal checks made out to the youth in the amount of $500. TLA checks are to help cover independent living items and expenses after leaving care. Youth must be working and/or in school, and out of paid foster care to receive this service.
2. Aftercare room and board (ACRB) is a $3000 emergency funding source. Youth can access these funds in installments over three years to pay for rent, utilities, and groceries in an emergency.
3. Education Training Voucher (ETV) is a $5000 education stipend awarded to young adults in college. Youth are given $2500 each semester to help cover living expenses while continuing their education. Participants must be at least 16 and/or have aged out of DFPS foster care.
4. Tuition waivers provide the opportunities for youth who have aged out of care to achieve higher education at no cost. An eligible student will receive a letter that waives tuition and fees at any Texas state-supported college or university.
5. Former Foster Care Children Medicaid (FFCC) is a form of Medicaid given to youth who have aged out of care. Youth must remain in foster care until age 18 to receive Medicaid coverage in the state of Texas until their 26th birthday (Texas Department of Family and Protective Services, 2017).

Transitions centers (TC) are "one-stop shops" located throughout the state of Texas that offer the following to individuals and families: food, shelter, computer access, case management, life skills training, mentoring, education services, employment services, parenting classes and family counseling. Each transition center partners with local government and community organizations to ensure that non-duplicated yet

comprehensive services are provided to help the youth become productive members of society (Garcia, 2018). Despite these protective services, adolescents in care inevitably suffer from complex trauma, constant placement changes, attachment disruption, poor relationships, and limited access to mental health services. These limitations can often lead to mental health disorders such as reactive attachment disorder, attention deficit hyperactivity disorder, oppositional defiant disorder, bipolar disorder, conduct disorder, and post-traumatic stress disorder. Children who do not receive adequate treatment to traumatic stress often develop negative coping mechanism such as self-harm and substance abuse.

Trauma Defined

A traumatic event is a dangerous or disturbing event outside of normal human experience that overwhelms the capacity to cope and frequently results in intense emotional and physical reactions of helplessness, powerlessness, and terror (Peterson, 2018). These events include, but are not limited to: assault, sexual assault, mugging, war, robbery, domestic violence, murder, injury, accidents, abuse, loss of a caregiver, a natural disaster, or life-threatening illness etc. (Texas Department of Family and Protective Services; Trauma-informed Care training, 2018).

Neuroscientists have demonstrated through research that traumatic memories permanently alter neurons in parts of the brain and peripheral nervous system (Bessel Van der Kolk, 2015; Porges, 2011). Chronic trauma has been found to leave the sympathetic nervous system in an ever-present state of alert (i.e., hyper-arousal). With hyper-arousal, muscle tension is increased, blood flow is diverted away from the brain and into the body, the heart rate increases, and breathing becomes rapid and shallow. In a

real sense, the trauma survivor is left in a fight, flight, or freeze state (Bessel Van der Kolk, 2015; Porges, 2011). This often leaves trauma survivors anxious and predisposes them to be triggered by any stimuli resembling the traumatic event (Aaron, 2017). Therefore, adolescents who suffer from chronic trauma may avoid feelings, conversations, activities, places, and people that will arouse the recollections of trauma. Trauma survivors tend to have difficulty showing empathy and identifying and describing their emotions. Studies show that a vast amount of youth with traumatic instances tend to demonstrate poor impulse control and decision-making skills, subsequently putting them at risk of substance misuse and delinquent activities. Victims of trauma may also experience physiological arousal they cannot control such as fast heart rate, churning stomachs, sweatiness, sleep disturbances, and eating disorders (Texas Department of Family and Protective Services, Trauma-Informed Care Training, 2018).

The CDC-Kaiser Adverse Childhood Experiences (ACE) Study conducted in the 1990s entailed 17,500 adults with a history of adverse childhood experiences (trauma). ACEs were measured by the exposure to the following: physical, mental, and sexual abuse; neglect; parental separation or divorce, substance abuse; parental mental health issues; domestic violence; and/or incarceration. Kaiser found that 67% of the population had experienced at least one ACE and that 12.6% had four or more ACEs. In addition, they discovered a relationship between ACEs and health outcomes. The higher the ACE score, the worse the health outcome. Individuals exposed to high doses of childhood trauma tripled their lifetime risk of heart disease and lung cancer and had a 20-year difference in life expectancy from people who are not maltreated (Burke Harris, 2015).

Kaiser's study reinforces the notion that adolescents with a history of adverse childhood experiences are more likely to engage in physical self-harm behaviors than a youth with no traumatic memories, subsequently putting them at risk of physiological and psychological impairments (Cloutier, & Jansson, 2007; Fitton & Koehler, 2014; Gabrielle et al., 2014; Vaughn, Salas-Wright, Delisi, & Larson, 2015).

Non-Suicidal Self-Injury

The American Psychiatric Association (2018) defines non-suicidal self-injury (NSSI) as "the intentional self-inflicted destruction of body tissue without suicidal intention and for purposes not socially sanctioned" (Cipriano, Cella, & Cotrufo, 2017, p. 1). Generally, people who self-harm do not wish to kill themselves, whereas suicide is a way of ending life. Conventional methods of self-harm include the following: cutting, carving, burning or scratching the surface of the skin, pulling out large amounts of hair, banging or punching self with objects to the point of bruising or bleeding, or overdosing deliberately on medications when it is not intended for suicide (Mental Health First Aid 2016; Nixon, Cloutier, & Jansson, 2007). Research shows that the most common methods of self-harm among students are cutting, scratching, biting, burning, and hitting. One may use knobs, paper clips, razors, keys, glass, etc., to create superficial wounds or permanent disfiguration in hidden areas such as the stomach or the upper thighs (Fitton & Koehler, 2014; Gabrielli et al., 2014). Emelianchik-Key, Byrd, and Guardia (2016) suggest that males tend to use burning, hitting, and punching type behaviors in sensitive areas such as the chest, face, and genitals, whereas females tend to cut in areas such as arms and legs.

Non-Suicidal Self-Injury Prevalence

Non-suicidal self-injury is an international, cross-cultural epidemic that affects victims of trauma exclusively adolescents and teens. Research data reveals that 13-24% of high school students in the USA, Canada, Portugal, British of Colombia, and Australia have engaged in some methods of NSSI (Fitton & Koehler 2014; Gabrielli et al., 2014; Nixon, Cloutier, & Jansson, 2007; Swannell et al., 2012).

Australian researchers Hu, Taylor, Li, and Glauert (2017) share that 21.7% of the 831 participants in their study attempted at least one method of deliberate self-harm in their lifetime. Participants specified that their hands fingers, arms, legs, feet, and toes were areas of the body used to inflict pain (Hu, Taylor, Li, & Glauert 2017; Xavier Gouveia, & Cunha, 2015). Canadian researchers Nixon, Cloutier, and Jansson (2007) found that 77% of the 568 self-harmers aged 15-19 were female. They report that 40% of the participants claimed to have harmed themselves repeatedly. Out of the 568 participants only 56% expressed that they had sought help or support for their injuries. In addition, data showed that 29% shared they had gotten the idea from a friend. The remainders claimed to have established the idea on their own. (Nixon, Cloutier, & Jansson, 2007).

Not all SH incidents require immediate medical attention; however, it is important to know the difference between a superficial wound and a life-threatening one. Recent data suggest that children with a history of abuse are likely to have self-harm related hospital admissions. Australian researchers Hu, Taylor, Li, & Glauert (2017) found that 11% of 248,448 children with substantiated maltreatment allegations had a deliberate SH hospital admission. They suggest that a greater number of allegations,

length of exposure to maltreatment, and types of abuse will increase the risk of medical attention or hospitalization for a self-harm incident (Hu, Taylor, Li, & Glauert, 2017).

Weismoore and Esposito-Smythers (2009) and Kaess et al. (2013) completed projects that explored the relationship between cognitive distortion, child abuse, and non-suicidal self-injury by targeting adolescent patients in a psychiatric hospital. Weismoore and Esposito-Smythers (2009) found that 75 of the 200 patients admitted for SH reported a history of physical abuse and sexual abuse. Kaess et al. (2013) found that 48 of the 75 patients engaging in non-suicidal self-injury reported at least one case of parental neglect, physical abuse, and or sexual abuse. Child abuse is one of the biggest risk factors leading up to the development of self-harm behaviors and hospital-related admissions. Swannel et al. (2012) concludes that children with a history of violence may select NSSI as a coping strategy because they have learned that blame from others or themselves is paired with or leads to direct physical injury (Swannell et al., 2012).

Non-Suicidal Self-Injury Influences

Self-harm behaviors are often motivated by adverse psychological influences that resulted from a traumatic experience. Adolescents may engage in self-harm behaviors to take the risk, to rebel, to display their individuality, to seek attention, to merely be accepted by peers, and/or to reject their parents' values (Mental Health First Aid USA, 2016). In addition, studies show that individuals who engage in NSSI do so to show their feelings of hopelessness and worthlessness, to combat suicidal thoughts, to reenact or repress traumatic memories, and/or to distract themselves from emotional pain or memories (Fitton & Koehler, 2014; Gabrielli et al., 2014).

Adolescents with low self-esteem who are hypersensitive to rejection and or have never learned to express emotions properly may use SH to relieve tension, anger, anxiety, or feelings of being invisible, lonely, or atypical (Emelianchik-Key, Byrd, & Guardia, 2016). Others may engage in SH to feel calm, numb, or alive, or to increase endorphins and feel euphoria associated with non-suicidal injury. Xavier, Gouveia, and Cunha (2016) suggest feelings of shame, guilt, blame, fear of compassion, self-criticism, daily peer hassles, and depressive symptoms are leading causes of self-harm behaviors. They suggest non-suicidal injury may emerge as an attempt to punish or condemn oneself for being wrong, flawed, unworthy, or undesirable and moreover to regulate negative emotions linked to self-hate and shame (Xavier, Gouveia, & Cunha, 2016).

Although foster care is intended to be a safe place, research studies have led more researchers to conclude that placement types tend to influence self-harm behaviors. Children in foster care are placed with relatives, in non-relative foster homes, in therapeutic foster homes, group homes, residential treatment facilities, or emergency shelters. In 2016, 52% of the children in the US foster care system were placed in non-relative foster homes, while 26% stayed with relatives and 8% were placed in group homes or institutions (Teska & McLuckey, 2018). Greenville, Goodman, and Macpherson (2011) report that youth in temporary custody (e.g., residential treatment facilities, group homes, or emergency shelters) are more likely to self-harm than those who have established permanency or adoption. Grenville, Goodman, and Macpherson (2011) and Gabrielli et al. (2014) point out that youth in residential facilities are more likely to engage in and report self-harm than youth in foster home settings because they

experience significant emotional, intellectual, educational and developmental challenges that youth living with their parents may not face.

Another key contributor to the development of NSSI is mental and behavioral health challenges such as borderline personality disorder (BPD), PTSD, depression, anxiety, emotional dissociation, alexithymia, substance abuse and eating disorders (Fitton & Koehler, 2014; Nixon; Cloutier, & Jansson, 2007; Vaughn, Salas-Wright, Delisi, & Larson, 2015; Weismoore & Esposito-Smythers, 2009). PTSD has been found to be the biggest contributor of SH. It has been shown to mediate the relationship between childhood traumas and self-harm (Vaughn, Salas-Wright, Delisi, & Larson, 2015). Howard, Karatzias, Power, and Mahoney (2016) validate this claim by contributing a study that consisted of interviewing 100 female prisoners with a history of child abuse. Results showed that 58% of the prisoners reported a history of self-harm and a clinical diagnosis of PTSD according to the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM–5*; American Psychiatric Association, 2013)

Research shows that 80% of the children in foster care have significant mental health issues, compared to approximately 18-22% of the general population. Studies reveal that 21.5 % of the children in foster care have been diagnosed with PTSD, 15.3% with major depressive disorder and 9.4% with an anxiety disorder (Mental Health and Foster Care, 2016).

Grenville, Goodman, and Macpherson (2011) examined research data from 1996 to 2010 that claim that most of the youth in foster care have mental health and developmental needs related to a diagnosable difficulty that require an intervention, but few obtain the required services. Current research studies emphasize the need for social

workers and practitioners to implement trauma-informed care and specific interventions in clinical practice to reduce self-harm behaviors in adolescents (Cary & McMillen, 2012; Texas Department of Family and Protective Services, Trauma-informed Care training, 2018; Weiner, Schneider, & Lyons, 2009).

Trauma-Informed Care and Interventions

The Substance Abuse and Mental Health Services Administration (SAMHSA) defines trauma-informed care (TIC) as an approach that can be implemented in any service setting or organization and is distinct from a trauma-specific intervention (TSI), which is designed to specifically address the consequences of trauma and to facilitate healing (Trauma-Informed Care, 2014). Trauma-informed care is a strength-based framework built on the following six core principles: trauma understanding; safety and security; cultural humility and responsiveness; dependability and compassion; collaboration and empowerment; resiliency and recovery. TIC is a person-centered approach that teaches people who have a history of trauma to recognize the presence of trauma symptoms, to acknowledge the role trauma plays in their lives and to help survivors to rebuild a sense of control and empowerment (Texas Department of Family and Protective Services; Trauma-Informed Care Training, 2018).

Trauma-informed care and trauma-specific interventions are two different but related concepts. Trauma-specific treatments are evidence-based, best practice treatment models that have been supported by evidence to facilitate recovery from trauma. The primary goal of a trauma-informed intervention is to promote meaningful changes to the social and emotional well-being of adolescents who have experienced maltreatment. TSI address the impact of injury on an individual's life and aid recovery techniques designed

to treat the actual consequences of trauma (Texas Department of Family and Protective Services (DFPS), Trauma-informed Care training, 2018). TSI includes psychoeducation and the normalization of behavioral and emotional responses to trauma, the development of coping skills, processing of the traumatic event, physical safety, and self-empowerment (Fratto, 2016).

This study emphasizes three evidence-based practice interventions that have been found equally effective in reducing traumatic symptoms in youth in care (Weiner, Schneider, & Lyons, 2009; Trauma informed care project, 2014):

1. Structured psychotherapy for adolescent responding to chronic stress (SPARCS);
2. Trauma-focused cognitive behavioral therapy (TFCBT); and
3. Attachment, regulation, and competency (ARC).

Structured psychotherapy for adolescents responding to chronic stress (SPARCS) is a group intervention designed to address the needs of chronically traumatized adolescents who have suffered from chronic stress. The primary focus of SPARCS is mindfulness, coping, and interpersonal skills, which makes it an ideal treatment for adolescents transitioning to into adulthood. Children with traumatic stress may have a hard time finding purpose and meaning to their lives. In addition, he or she may struggle with impulsivity, anxiety, identity, avoidance, co-dependency, and affect regulation. SPARCS aims to enhance adolescents' ability to cope more effectively now, to cultivate consciousness and to create connections and meanings.

Trauma-focused cognitive behavioral therapy is a psychosocial treatment model crafted to treat PTSD, emotional, and behavioral health problems in children and adolescents ages three to 18. TFCBT was initially developed to address problems

associated with childhood sexual abuse; however, it has now expanded to treating multiple areas of trauma such as domestic violence, traumatic loss, commercial sexual exploitation, and the complex trauma experienced by children in foster care and war victims. TFCBT is also appropriate for traumatized children whose parents or caregivers were not the perpetrator. Cohen, Mannarino, Kliethermes, and Murray (2012) promote TFCBT as a complex trauma support intervention to successfully treat youth with an array of traumatic experiences. In their study, TFCBT was provided to 30 youth with multiple traumatic experiences. Results showed a significant improvement in alleviating PTSD symptoms in children, military families, and victims of sex trafficking.

Cary and McMillen (2012) completed a systematic review of ten studies that measured the effectiveness of TFCBT and its ability to reduce symptoms of PTSD, depression, and behavior problems in children and youth who have survived traumatic instances. Results identified TFCBT as an effective intervention for the treatment of PTSD in children as well as reducing symptoms of depression and problem behaviors (Cary & McMillen, 2012).

Lastly, the attachment, regulation, and competency (ARC) model is a flexible, comprehensive, evidence-based intervention framework empirically supported for the treatment of adolescents with a history of child maltreatment. It is a theoretical framework designed for youth and families who have experienced chronic trauma (Fratto, 2016). The ARC model emphasizes building and rebuilding the core domains of well-being by implementing education workshops and therapeutic interventions that pertain to cognitive behavioral therapy, relaxation, art expression and movement techniques to

increase social skills that will strengthen relationships in victims of trauma (Gregorowski, & Seedat, 2013).

Trauma-informed care and non-suicidal injury are prominent research topics that can be found using Google, YouTube and any academic database; however, there is a very small number of research studies done on the correlates of trauma, foster care, and self-harm. The foster care system impacts every level of society; therefore, it is important for social workers and practitioners to take a comprehensive approach to understanding the dynamics of this system so that practitioners can better serve the needs of children in care.

CHAPTER III

METHODOLOGY

The purpose of this study is to explore the prevalence of self-harm among youth aged 18 to 21 who are aging out of the Texas foster care system. The goal of this study is to determine if young adults aging out of foster care have ever received any evidence-based, trauma-specific treatments and/or traditional counseling sessions that have helped reduce or eliminate self-harm behaviors.

Design

This is an exploratory, descriptive study that uses a cross-sectional survey to correlate the impact of trauma with the risk factors of self-harm among confirmed victims of child maltreatment. The survey also explores the use of trauma-specific interventions used to treat those who self-harm

Population and Sampling

The study investigates a convenience sample of young adults ages 18 to 21, male and female, who are aging out of the Region 2 Texas foster care system. The respondents are participants of the BCFS Health and Human Services Preparation for Adult Living Program (PAL). The participants in this study are seen as a vulnerable population due to the client-worker relationship established with the principal investigator. To reduce the possibility of coercion and undue influence, a special population approval was granted by the Abilene Christian University Institutional Review Board (Appendix A) as discussed in further detail below.

Instrumentation

The data was collected using a 21-item survey developed by the researcher. The instrument includes both quantitative and qualitative research questions to investigate self-harm behaviors, foster care experiences, and treatment efforts. Demographic variables such as age, race, gender, age placed in foster care, the level of care, placement types, current living situations, and mental health diagnoses are used to examine the influences of self-harm consistent with the literature. Specific questions regarding self-harm behaviors, methods, treatments and hospitalizations will be used to explore the rate of self-harm and to discover any treatment efforts he or she may have received and to determine whether the intervention helped reduce or eliminate the self-harm behaviors (Appendix B).

Procedures

Permission to investigate PAL youth 18 and older was granted by BCFS Health and Human Services in region 2 Abilene, Texas (Appendix C). The BCFS efforts to outcomes (ETO) database was used to identify potential participants meeting the age criteria for the study. Background information as well as the purpose of the study were provided to each participant before and during the actual consent process. Each person was informed of the minimal risk and benefits pertaining to the study. All participants were informed that participation or non-participation would not affect their PAL benefits nor the services they receive through the BCFS Health and Human Services. To ensure privacy and confidentiality, each client was given the choice to either sign their name or provide an identification number on the consent form before completing the survey.

Human Subjects IRB Approval

The Abilene Christian University Institutional Review Board has reviewed and approved this study as exempt (Appendix A). The potential participants in this study are considered a special population because of the client-worker relationship established with the principal investigator. In order to reduce the possibility of coercion and undue influence, a special population approval was granted by the IRB for the researcher to investigate the potential participants who have a history of traumatic events and who have also revealed non-suicidal, self-injurious behaviors.

To ensure the highest level of confidentiality and privacy, all information collected from the participants was de-identified and coded by the researcher. Survey responses were locked in a secure filing cabinet inside an alarmed facility. Hard copy responses will be destroyed upon the completion of the study. A password-protected computer will be used to create an electronic data file to store information pertaining to this study. The electronic data file will be deleted three years after the completion of the study.

The de-identified data will be analyzed using a Microsoft Excel spreadsheet and then transferred into the Statistical Package for the Social Sciences (SPSS) for analysis. The data will then be analyzed and interpreted to inform results.

CHAPTER IV

RESULTS

This study sought to explore the prevalence of non-suicidal self-injury among youth aging out of the Region 2 Texas foster care system and to also examine the correlates of trauma, SH and the impact of trauma-specific interventions used to treat trauma-related behaviors. The hypothesis predicted that TSI will produce greater outcomes in helping adolescents cope with self-harm behaviors in contrast to those receiving conventional treatment methods. A 21-item, cross-sectional survey compiled of both quantitative and qualitative research questions was used to investigate self-harm behaviors, foster care experiences, mental health diagnosis, and treatment efforts. Table 1 presents demographic characteristics of the sample.

Table 1

Demographic: Characteristics of Sample

	N	Percent
Gender		
Male	17	54.8%
Female	14	45.2%
Reason For Removal*		
Neglect	25	80.6%
Emotional	13	41.9%
Sexual	12	38.7%
Physical	9	29.0 %

* More than 100%

A total of 40 participants aged 18 to 21 were invited to participate (representing a small portion of the youth aging out of the Region 2 Texas foster care system). The final

study sample comprised 31 adolescents with a mean age of 18.74 years. The convenience sample consisted of 17 males and 14 females. Each participant reported CPS involvement at some stage in their childhood developmental years with the median age of 12 for CPS entry. Every confirmed victim reported at least one if not multiple forms of maltreatment that led to their removal. The most common form of trauma viz., reason for removal reported was neglect (*n*= 25) 80.6% followed by emotional abuse (*n*=13) 41.9 % physical abuse (*n*=12) 38.7% and sexual abuse (*n*= 9) 29% (Table 1).

The study also examined foster care placement types, traumatic reasons for removal (neglect, physical, emotional and sexual abuse) and mental health diagnostics. Respondents indicated that they had resided in multiple care units while in CPS custody. Table 2 illustrates the placement types and percentages of respondents who lived in a foster care establishment with traditional foster care being the most common followed by RTC.

Table 2

Placement Types

	Percent	*N*
Traditional Foster Care	64.0%	20
Kinship	38.7%	12
Group Home	35.5%	11
Residential Treatment Center	41.95	13
Other –Emergency Shelter	12.9%	4

Note: total greater than 100%; multiple placements reported by most subjects

Table 3 summarizes the frequency of certain mental health disorders that have been found to influence self-harm behaviors. As the table indicates, most participants were experiencing some depressive symptoms and alexithymia symptoms. About half of

the participants were experiencing anxiety and attention deficit hyperactivity disorder symptoms.

Table 3

Mental Illness Frequency

	Percent	*N*
Depression	71.0%	22
Anxiety	51.6%	16
PTSD	22.6%	7
ADHD	51.6%	16
Other		

*Total greater than 100% dual diagnosis reported by subjects

	Always	Sometimes	Never
Dissociative*	*N*=1 (3.2%)	*N*=6 (19.4%)	*N*=23(74.2%)
Self-Blame**	*N*=10 (32.3%)	*N*=16 (51.6%)	*N*=5 (16.1%)

	Yes	No
Alexithymia***	*N*=18 (58.1%)	*N*=13 (48.9%)

*Based on two items from the Dissociative Experience Scale (year)
**Based on one item from the Self-Blame Brief COPE Questionnaire (year)
***Based on one yes or no item from the Toronto Alexithymia Scale (year)

Self-Harm and Treatment Report

Specific questions regarding self-harm behaviors, methods, treatments, and hospitalizations were used to discover the frequency and severity of self-harm instances among youth aging out of care. Two items from The Child and Adolescent Self-Harm in Europe (CASE) survey (2008) were used to determine the prevalence of self-harm among the available sample. Analysis revealed that 48.4% (*N*=15) of the 31 participants reported performing non-suicidal bodily injury to themselves. Among those who self-harmed, the

most prevalent method recorded were cutting, scratching and self-hitting, followed by ingesting medication and illicit drugs (Table 4).

Table 4

NSSI Prevalence and Type

Self-Harm Prevalence	Yes	No
Have you ever harmed yourself in a way that was deliberate but not intended to take your life?	48.40%	51.60%
Type of Harm		**Percent**
Cutting, scratching, self-hitting		64.50%
Ingesting a medication more than prescribed		16.10%
Ingesting an illicit drug or alcohol to harm yourself		16.10%
Other, please specify		3.20%

Data revealed that only 16.1% (*N*=5) of those who claimed to self-harm received hospitalization or medical treatment for their efforts. Out of the 15 self-harm respondents ten reported specific locations they would cut and why. Eight of the 10 stated that they would prefer to cut on their arm, whereas three out of 10 emphasized areas such as thighs and stomach. Table 5 lists replies provided by the participants.

Table 5

Reason and Areas for Cutting Reported by the Participants

Where	Why
A. Arm	No reasons provided by two respondents
B. Arms, hips, thighs, ribs, stomach, and legs	(1) because it allowed the feeling of bleeding just to know you're alive while keeping it hidden. (2) because no one could see the marks (3) because I was fat (4) attention
C. Wrist & legs	(1)The wrist because it was close enough where I thought I could take my life, the legs cause no one could see it (2) to be the cause of my own pain (3) so my real parents could see my pain
D. Arm & all over	To see and feel it reminds you that you are alive and you don't forget your mistakes

Treatment History

The last section of the survey covered specific treatment efforts used to help victims of trauma cope with trauma-related challenges. Question 16 provided a brief description of trauma-informed care followed by a description of Trauma-specific interventions (TSI). Respondents were asked to indicate if they had experienced TSI as part of their treatment. Out of the 31 participants, only 19.4% (*N*=6) claimed to have received a TSI: trauma-based cognitive behavioral therapy (TFCBT), structured psychotherapy for adolescents responding to chronic stress (SPARCS), and/or attachment regulation and competency (ARC). Traditional counseling efforts included: eye movement desensitization and reprocessing (EMDR), motivational interviewing (MI), group therapy, play therapy, child-parent psychotherapy (CPP), and cognitive behavioral therapy (CBT). Table 6 presents the frequencies of these interventions:

Table 6

Treatment History

	Percent*	*N*
Trauma-Specific Intervention	19.40%	6
Non-TSI Reported		
Eye Movement Desensitization	9.70%	3
Group Therapy	19.40%	6
Play Therapy	6.50%	2
Child-Parent Psychotherapy	9.70%	3
Cognitive Behavioral Therapy	12.90%	4
Motivational Interviewing	9.70%	3
Other	16.10%	5

*Total greater than 100%; multiple treatments reported by most subjects

To determine whether the intervention helped reduce or eliminate the self-harm behaviors, the survey asked closed-ended questions such as: "Did counseling help you to cope with the desire to self-harm?" and "Did treatment help you to stop harming yourself?" The study showed that 14.3% felt that counseling helped cope with the desire to self-harm, whereas only 21.4% indicated that treatment enabled them to stop harming themselves. Table 7 outlines the percentages to treatment helping in contrast to treatment not helping.

Table 7

Treatment Outcomes

	Yes	No
Did counseling help you cope with a desire to self-harm?	14.3%	85.7%
Did treatment help you stop harming yourself?	21.4%	78.6%

The last question in the survey ("If you answered no to either of the above questions, have you found help in dealing with the desire or acts to harm yourself from some other source?") was designed to solicit information that could be used to help practitioners understand what is helping the young adults recover from deliberate self-harm. Most of the participants reported family (*N*=6), music (*N*=6), therapy (*N*=3), self-determination (*N*=4) and animals (*N*=2) as true means to reducing and eliminating deliberate self-harm. See Appendix D for a detailed listing of qualitative responses provided by the participants.

Table 8

NSSI Recovery Tools

Means	*N*
Music	6
Therapy	3
Self-determination	4
Animals	2

Hypothesis Testing

This study tested two hypotheses. The first hypothesis suggested that TSIs will produce greater outcomes in helping adolescents cope with self-harm behaviors in contrast to those receiving conventional treatment methods. To test this hypothesis, a cross-tabulation was conducted (Table 9). The cross-tabulation analysis proposes that a third (33.3%) of those receiving TSIs indicated it helped them cope with SH compared to 9.1% of those receiving traditional therapies. The results of this analysis are consistent with the first hypothesis and current studies that predict TSIs to be more useful in reducing SH behaviors.

Table 9

Cross-Tabulation of TSIs to Coping with SH Behaviors

Help Cope	Non-TSI	TSI
N	90.90%	66.70%
Y	9.10%	33.30%
Total	100.00%	100.00%

The second hypothesis suggests that the use of a trauma-specific interventions will increase the chance of eliminating self-harm behaviors more so than the use of traditional therapies. To test this hypothesis, a cross-tabulation of Non-TSIs to TSIs were

conducted (Table 10). Analysis showed TSIs as one times (33.3%) more likely to stop SH behaviors than the18.2% who reported other treatment alternatives as a means to stopping SH. The results are consistent with the hypothesis that assume TSIs to be more useful in reducing and eliminating self-harm behaviors.

Table 10

Cross-Tabulation of TSIs to Stopping SH Behaviors

	Non-TSI	TSI
N	81.80%	66.70%
Y	18.20%	33.30%
Total	100.00%	100.00%

CHAPTER V

DISCUSSION

Review of Findings

The results of this study support previous and current research developments that promote trauma-informed care and trauma-specific interventions as evidence-based practice methods used to facilitate healing and modify behaviors such as non-suicidal injury among victims of trauma (Cary & McMillen, 2012; Weiner, Schneider, & Lyons, 2009). The findings in this study were consistent with the hypothesis that assumed TSIs would produce greater outcomes than conventional treatment methods in the essence of reducing and eliminating self-harm behaviors. The convenient sample in the project consisted of 31 participants with a history of maltreatment; 15 of these respondents reported acts of non-suicidal self-injury. Out of the 15 self-harmers, only six indicated that they received a trauma-specific intervention during foster care. Surprisingly, 78.6% stated that treatment did not help reduce or eliminate their SH behaviors; however, in a cross-tabulation of TSIs to traditional therapies, TSIs showed greater efficacy in reducing self-harm behaviors as evidenced by the 21.4% who indicated that TSI helped stop deliberate self-harm. Even though the participants in this study felt that counseling did not help, they report family, music, art expression, therapy, self-determination and animals to be effective tools in reducing and eliminating deliberate self-harm as evidenced by the responses given by the participants.

Although the frequency of NSSI was not measured, results showed that 64.5% of self-harmers preferred methods of cutting, scratching and self-hitting. Out of the 15 SH respondents, ten reported specific locations they would inflict harm and why. Eight of the ten stated they would prefer to cut on their arm, whereas three of the ten emphasized areas such as thighs and stomach. Two of the participants reported SH engagement as an act to feel alive, which validates the claim that individuals may enact to feel calm, numb, or alive, or to increase endorphins and feel euphoria associated with non-suicidal injury. (Xavier, Gouveia, & Cunha, 2016). One of the subjects conveyed self-harm as an act of "remembering your mistakes," which supports the idea that adolescents who enact NSSI tend to suffer from self-blame. Analysis showed that 51.6% of the participants in this study reported feelings of self-blame for the traumatic experiences in their lives. The outcomes in this study contributes the body of knowledge that explores the causes of NSSI as well as age of onset, risk factors, and cutting locations.

One of the key findings in this study supports the literature that suggests mental health as one of the core contributors if not the underlying cause of SH instances. Results reveal that 71% of the respondents had been clinically diagnosed with depression while 58.1% admitted to having signs and symptoms of alexithymia. PTSD has been proven to be one of the most significant contributors to SH. PTSD is known to mediate the relationship between childhood traumas and self-harm. Studies show that 21.5 % of youth in foster care are diagnosed with PTSD (Vaughn, Salas-Wright, Delisi, & Larson, 2015). The findings appear to be consistent with current studies as evidenced by the 22.60% (*N*=7) of youth who reported a PTSD diagnosis. This idea contributes to the body of literature that emphasizes maltreatment as one of the most potent risk factors for future

mental emotional and behavioral problems (Fitton & Koehler, 2014; Nixon, Cloutier, & Jansson, 2007; Vaughn, Salas-Wright, Delisi, & Larson, 2015).

Another critical phenomenon in this study revealed that most of the adolescents aging out of the Region 2 Texas foster care system might not receive adequate treatment for trauma related mental health needs. This concept justifies the notion in historical and current research studies that implies that the majority of the youth in foster care have mental health and developmental needs related to a diagnosable difficulty that requires intervention; however, few obtain the necessary services (Grenville, Goodman, & Macpherson, 2011). During the initial stages of this project, the researcher interviewed Family-Based Safety Services Supervisor William Meiron, who stated:

> One of the largest struggles with providing adequate care to children in CPS custody is lack of services. Many regions are very rural. The caseworkers who work these areas have very few resources. Often the children need to be transported over an hour away to find a service provider. Stretching thin both the caseworker's and caregiver's time. Even then, there are often few counselors or therapists who contract with the Department. What ends up happening is children are placed on a waiting list. They are not engaged while still in crisis or while going through the trauma. So, the child goes on and heals how they think fit or how the environment shapes them until they can begin to receive the care they need. (W. Meiron, personal communication, September 26, 2018)

One of the biggest results contrasted with recent data that suggest children with a history of abuse are likely to have SH-related hospital admissions (Hu, Taylor, Li, & Glauert, 2017). Current research studies show that 45% of the people who SH seek

medical treatment for their conditions; however, data in this study revealed that 16.1% of the self-harmers (*N*=5) reported receiving medical treatment or hospitalization for their efforts. This outcome could be contingent on several things such as shame, attitude, cutting severity, health care cost, service availability, perceived absence of caring adult, and the youth's fear of repercussions, such as placement removal and revocation of individual right and privileges.

Study Limitations

Limitations of this study include sample size, geographic location, and survey validity. The instrument in this study was used to measure the correlates of SH and traumatic instances among youth aging out of foster care. The principal investigator took precautionary measure in designing a survey with face validity that could measure the concepts while protecting the client's confidentiality and relationship. The sample size in this study is a significant limitation. In August 2018, DFPS reported that there were over 16,000 children in CPS custody with 700 of them placed in Region 2 therefore, the 31 participants in this study cannot represent the general population of children living in the Texas foster-care system. The number of participants was not strong enough to formulate a statistical analysis; however, the findings placed great significance on informing and improving clinical practice.

CHAPTER VI

CONCLUSION

Implications for Practice

Individuals who provide direct services to victims of trauma should be aware of the prevalence of NSSI, the risk factors associated with NSSI, and the neurological impact it has on the human body. Practitioners should be more diligent in assessing for SH instances in distinct populations such as foster youth. Recommendations for clinical practice suggest:

- Implementation of TSIs by encompassing systematic reviews of evidence-based practice interventions, TIC trainings and education workshops that will strengthen skill sets of professionals who work with trauma survivors.
- Clinical workers take a collaborative approach to integrating trauma-specific interventions, alongside traditional therapies in everyday practice to reduce the prevalence of self-harm among youth in foster care.
- Encourage social service agencies in rural areas take a community-based approach to implementing a TIC approach that could possibly create greater access to resources and programs for adolescent emerging from foster-care. A TIC approach could increase skill sets that will help non-profit agencies provide quality cost-effective services to low-income consumers ultimately creating greater outcomes for victims of trauma.

Policy Implications

This study promotes the need for governmental agencies to support the community mental health disparities by providing funding and program to reduce the rate of suicide, hospitalizations, and incarcerations among individuals with mental illness. Advocate for non-profit grants that will employ clinical workers and therapists to provide TSIs to victims of trauma in one-stop shops, such as BCFS transition centers throughout the state of Texas. This research study provides evidence that support the DFPS 2019 Fiscal Year Business Plan for Child Protective Services (CPS) and their ongoing initiatives to improve the program by integrating TIC, TSIs and treatment contracts to better serve children in foster care

Further Research

This exploratory study merits continued research that should investigates the frequency of self-harm, triggers, age of onset and risk factors using a larger randomized sample over a long period of time to increase the probability of gaining a statistical analysis. A comprehensive approach that will examine treatment efforts and outcomes by including the ideas and the perspectives of professionals who are involved in the foster care network is recommended.

This study aimed to contribute to the body of literature pertaining to the comprehensive framework of trauma-informed care and to bridge the gap between the correlates of trauma, and self-harm occurring among youth aging out of foster care. The findings in this study showed that TSIs would produce greater outcomes than conventional treatment methods in the essence of reducing and eliminating self-harm behaviors among adolescents emerging from foster care.

REFERENCES

Aaron, N. (2017). *Trauma-Informed care* [Scholarly project].

American Psychiatric Association Foundation. (n.d.). Retrieved October 2018, from https://apafdn.org/

Basin Dream Center for Orphans. (n.d.). Retrieved November 12, 2018, from https://basindreamcenterfororphans.org/

Burke Harris, N. (2015, February 17). *How childhood trauma affects health across a lifetime* [video file]. Retrieved from https://youtu.be/95ovIJ3dsNk

Cary, C. E., & McMillen, J. C. (2012). The data behind the dissemination: A systematic review of trauma-focused cognitive behavioral therapy for use with children and youth. *Children and Youth Services Review, 34*(4), 748-757. doi:10.1016/j.childyouth.2012.01.003

Children's Bureau (CB). (n.d.). Retrieved from https://acf.hhs.gov/cb

Child Abuse and Neglect Prevention Violence Prevention Injury Center|CDC." *Centers for Disease Control and Prevention*, Centers for Disease Control and Prevention, www.cdc.gov/violenceprevention/childabuseandneglect/index.html.

Child Maltreatment 2017. *ACF*, www.acf.hhs.gov/cb/resource/child-maltreatment-2017.

Child Welfare Outcomes." *ACF*, 2017, www.acf.hhs.gov/cb/research-data-technology/statistics-research/cwo

Cipriano, A., Cella, S., & Cotrufo, P. (2017). "Nonsuicidal self-injury: a systematic review." *Frontiers in Psychology. 8*(1946). pp. 1-14. doi: 10.3389/fpsyg.2017.01946

Clark, H. B., & Unruh, D. K. (2009). *The transition of youth & Young adults with emotional or behavioral difficulties: An evidence-supported handbook*. Baltimore, MD: Paul H. Brookes Pub.

Cohen, J., Mannarino, A., Kliethermes, M., & Murray, L. (2012). Trauma-focused CBT for youth with complex trauma. *Child Abuse and Neglect, 36*, 528-541. doi: 10.1016/j.chiabu.2012.03.007

Emelianchik-Key, K., Byrd, R. J., & Guardia, A. C. (2016). Adolescent Non-suicidal self-Injury: Analysis of the youth risk behavior survey trends. *The Professional Counselor, 6*(1), 61-75. doi:10.15241/kk.6.1.61

Fitton, V., Ph.D., & Koehler, R., LMSW (2014). *Adolescent Self-harm and Suicide Ideation* [Scholarly project]. Retrieved August 5, 2018. https://socialwork.msu.edu/ceu/docs/Adolescent_Self_Harm_Powerpoint.pdf

Fratto, C. M. (2016). Trauma-Informed care for youth in foster care. *Archives of Psychiatric Nursing,* 439-446. Doi:10.1016/j.apnu.2016.01.007

Gabrielli, J., Hambrick, E. P., Tunno, A. M., Jackson, Y., Spangler, A., & Kanine, R. M. (2014). Longitudinal Assessment of Self-Harm Statements of Youth in Foster Care: Rates, Reporters, and Related Factors. *Child Psychiatry & amp; Human Development, 46*(6), 893-902. doi:10.1007/s10578-014-0529-4

Garcia, C. (2018, September). *BCFS Health and Human Services community service division and CARF Accreditation* [Scholarly project]. Retrieved October 2018.

Gregorowski, C., & Seedat, S. (2013). Addressing childhood trauma in a developmental context. *Journal of child and adolescent mental health*, *25*(2), 105–118. doi:10.2989/17280583.2013.795154

Grenville, J., Goodman, D., & Macpherson, A. K. (2011). Characteristics of self-harm behavior among identified self-harming youth in Care. *International Journal of Mental Health and Addiction, 10*(5), 646-659. doi:10.1007/s11469-011-9361

Howard, R., Karatzias, T., Power, K., & Mahoney, A. (2016). From childhood trauma to self-Harm: An investigation of theoretical pathways among female prisoners. *Clinical Psychology & Psychotherapy, 24*(4), 942-951. doi:10.1002/cpp.2058

Hu, N., Taylor, C. L., Li, J., & Glauert, R. A. (2017). The impact of child maltreatment on the risk of deliberate self-harm among adolescents: A population-wide cohort study using linked administrative records. *Child Abuse & amp; Neglect, 67*, 322-337. doi:10.1016/j.chiabu.2017.03.012

Kaess, M., Parzer, P., Mattern, M., Plener, P. L., Bifulco, A., Resch, F., & Brunner, R. (2013). Adverse childhood experiences and their impact on frequency, severity, and the individual function of non-suicidal self-injury in youth. *Psychiatry Research, 206*(2-3), 265-272. doi:10.1016/j.psychres.2012.10.012

Mental Health and Foster Care. May 2016, www.ncsl.org/research/human-services/mental-health-and-foster-care.aspx. Accessed 22 Apr. 2019.

Mental health first aid USA: For adults assisting young people. (2016). Washington DC: National Council for Behavioral Health.

Nixon, M. K., Cloutier, P., & Jansson, S. M. (2007). Nonsuicidal self-harm in youth: A population-based survey. *Canadian Medical Association Journal, 178*(3), 306-312. doi:10.1503/cmaj.061693

Non-Profit Organization." *National Foster Youth Institute*, www.nfyi.org/.

NYTD. www.acf.hhs.gov/cb/research-data-technology/reporting-systems/nytd. Accessed 22 Apr. 2019.

Peterson, Sarah. "What Is Child Trauma?" *The National Child Traumatic Stress Network*, 25 May 2018, www.nctsn.org/what-is-child-trauma.

Porges, S. (2011). The polyvagal theory: Neurophysiological foundations of emotions, attachment, communication and self -regulation New York: W.W. Norton.

Swannell, S., Martin, G., Page, A., Hasking, P., Hazell, P., Taylor, A., & Protani, M. (2012). Child maltreatment, subsequent non-suicidal self-injury and the mediating roles of dissociation, alexithymia, and self-blame. *Child Abuse & Neglect, 36*(7-8), 572-584. doi:10.1016/j.chiabu.2012.05.005

Teska, J., MSW, & McLuckey, L. (2018). Child maltreatment and foster care military families in the United States.

Texas Department of Family and Protective Services, & HHSC. (2017). Texas Department of Family and Protective Services (DFPS). Retrieved from http://www.dfps.state.tx.us/

Texas Department of Family and Protective Services (DFPS). (n.d.). Retrieved October 2, 2018, from http://www.dfps.state.tx.us/Training/Trauma_Informed_Care/begin.asp

Texas Foster Care Handbook for Children, Youth, and Young Adults. (n.d.). Retrieved January 15, 2018, from https://www.dfps.state.tx.us/txyouth/documents/foster-care-handbook.pdf

The Child Abuse Prevention and Treatment Act (CAPTA) 2010. (n.d.). Retrieved December 04, 2018, from https://www.acf.hhs.gov/cb/resource/capta2010

The National Youth in Transition Database. youth.gov/feature-article/national-youth-transition-database. Accessed 22 Apr. 2019.

Trauma Informed Care. (n.d.). Retrieved from http://traumainformedcareproject.org/

(2014, April 25). Trauma-informed approach and trauma-specific interventions. Retrieved from https://www.samhsa.gov/nctic/trauma-interventions

"Trauma-Informed Care - New Publication." *SAMHSA News - Trauma-Informed Care - New Publication*, www.samhsa.gov/samhsaNewsLetter/Volume_22_Number_2/trauma_tip/index.html.

Van der Kolk, B. (2015). *The Body Keeps the Score: Brain, Mind, and Body in the Healing of Trauma*. New York: Penguin

Vaughn, M. G., Salas-Wright, C. P., Delisi, M., & Larson, M. (2015). Deliberate self-harm and the nexus of violence, victimization, and mental health problems in the United States. *Psychiatry Research, 225*(3), 588-595. doi:10.1016/j.psychres.2014.11.041

Weiner, D. A., Schneider, A., & Lyons, J. S. (2009). Evidence-based treatments for trauma among culturally diverse foster care youth: Treatment retention and outcomes. *Children and Youth Services Review, 31*(11), 1199-1205. doi:10.1016/j.childyouth.2009.08.013

Weismoore, J. T., & Esposito-Smythers, C. (2009). The role of cognitive distortion in the relationship between abuse, assault, and non-suicidal self-Injury. *Journal of Youth and Adolescence, 39*(3), 281-290. doi:10.1007/s10964-009-9452-6

Xavier, A., Gouveia, J. P., & Cunha, M. (2016). Non-suicidal self-injury in adolescence: The role of shame, self-criticism, and fear of self-compassion. *Child & Youth Care Forum, 45*(4), 571-586. doi:10.1007/s10566-016-9346-1

Xavier, A., Cunha, M., & Gouveia, J. P. (2015). Deliberate self-harm in adolescence: The impact of childhood experiences negative affect and fears of compassion. *Revista de Psicopatología y Psicología Clínica. 20*(1), 41-49. doi:10.5944/rppc.vol.1.2015.1447

APPENDIX A

Abilene Christian University Institutional Review Board Approval Letter

ABILENE CHRISTIAN UNIVERSITY
Educating Students for Christian Service and Leadership Throughout the World

Office of Research and Sponsored Programs
320 Hardin Administration Building, ACU Box 29103, Abilene, Texas 79699-9103
325-674-2885

October 11, 2018

Jennifer Artis

Department of Social Work

Dear Jennifer,

On behalf of the Institutional Review Board, I am pleased to inform you that your project titled
"Self-harm and Trauma- informed care among youth in care"

(IRB# 18-079)is exempt from review under Federal Policy for the Protection of Human Subjects.

If at any time the details of this project change, please resubmit to the IRB so the committee can determine whether or not the exempt status is still applicable.

I wish you well with your work.

Sincerely,

Megan Roth

Megan Roth, Ph.D.
Director of Research and Sponsored Programs

APPENDIX B

Self-Harm and Treatment Questionnaire

Age:
Race:
Gender:

1. At what age were you placed in foster care?
2. Why were you removed? Select all that apply
    a. Neglect
    b. Physical abuse
    c. Emotional abuse
    d. Sexual abuse
3. What level of care where you in? If you are in extended care what level are you classified as?
    a. Moderate
    b. Specialized
    c. Basic
    d. intense
4. What type of foster care did you receive? Circle all that apply
    a. Traditional foster home
    b. Kinship
    c. Group home ‘
    d. Residential treatment center
    e. Other (please specify)
5. What was your last placement before aging out of foster care?
    a. Traditional foster home
    b. Kinship
    c. Group home
    d. Residential treatment center
    e. Other (please specify)

6. What is your current living situation?
    A. Foster parent
    B. Kinship
    C. Renting
    D. Residential treatment center (RTC)
    E. Transitional Living Placement (TLP)
    F. Supervised Independent Living (SIL)
    G. College dorm
    H. Other (please specify)

7. Have you ever been diagnosed with any of the following? circle all that apply.
    a. Depression
    b. Anxiety
    c. PTSD
    d. ADHD
    e. Borderline personality disorder

8. Sometimes people feel that other people objects and the world around them are not real. How often does this happen to you? *Please check one.*
    a. Always
    b. Sometimes
    c. Never

9. Sometimes people feel that their body does not belong to them how often does this happen to you? *Please check one.*
    a. Always
    b. Sometimes
    c. Never

10. Do you find it difficult to find the right words for your feelings? *Please circle one.*
    YES NO

11. When you are stressed how often do you blame yourself for things that happened? *Please check one.*
    a. Always
    b. Sometimes
    c. Never

12. Have you ever harmed yourself in a way that was deliberate but not intended to take your life? *Please circle one, if no this is the end of the survey.*
    YES NO

13. If yes which statement best describe this self-harm behavior
    A. Self-injury such as cutting, scratching, self-hitting etc.
    B. Ingesting a medication more than the prescribed or generally therapeutic dose
    C. Ingesting a recreational or illicit drug or alcohol to harm yourself
    D. Other please specify

14. Where did you prefer to cut and why?

15. Has this behavior ever resulted in hospitalization or injury severe enough to require medical treatment? *Please circle one.*
    YES NO

16. Trauma Informed care (TIC) is one of the most recent approaches to counseling that involves helping people understand, recognize and respond to the effects of all types of trauma. Trauma Specific interventions are designed to help survivors rebuild a sense of control and empowerment. Have you been counseled by someone using any of the following methods? Trauma-based cognitive behavioral therapy (TFCBT) Structured Psychotherapy for adolescents responding to chronic stress (SPACRCS) or Attachment, regulation and competency (ARC)
    YES NO

17. Have you ever received any of the following treatment interventions?
    A. EMDR (eye movement, desensitization and reprocessing)
    B. motivational interviewing
    C. group therapy
    D. play therapy
    E. Child parent psychotherapy (CPP)
    F. Cognitive behavioral therapy
    G. Other Please list

18. Have you ever received any other form of therapy not listed above? If yes, please describe.
    YES NO

19. Did counseling help you cope with the desire to self-harm?
    YES NO

20. Did treatment help you stop harming yourself?
    YES NO

21. If you answered no to either of the above questions, have you found help in dealing with the desire or acts to harm yourself from some other source? If yes, please describe:

YES NO

This is the end of the survey. Thank you for participating 😊

APPENDIX C

Agency Approval

BCFS
Health and Human Services • Est. 1944

303 S. Pioneer Dr., Suite #200
Abilene, TX 79605
(325) 692-0033
Fax (325) 692-4501
www.Discover BCFS.net

October 10, 2018

Abilene Christian University
School of Social Work
1600 Campus Court
Abilene, TX 79699

To Whom it May Concern:

This letter is concerning Jennifer Artis' study on "Trauma-informed care efforts geared to reduce the prevalence of self-harm amongst youth aging out of care."

BCFS Health and Human Services accepts approval of this study of human subjects under the following conditions; all youth interviewed are between the ages of 18-21, must receive informed consent and must be informed that they have the option not to participate. Additionally, all interviews must be conducted outside of her Case Management duties, while off the clock.

We are pleased to support Jennifer Artis in her pursuit of her thesis. If you have any questions or need additional information, please do not hesitate to contact me directly. You may reach me at 325-718-3340 or aj3318@bcfs.net.

Sincerely,

Alana Jeter
Regional Director – North Texas

APPENDIX D

Self-Harm Recovery Methods

What Works!
1. My daughter came
2. Decided that I didn't want to do it anymore
3. Family, music, singing, poetry, self-motivation, self determination
4. There is no true source just what helps like music, and other stuff
5. Music, animals,' art, sleep, cleaning, helping other, and playing with dogs
6. Family, friends, coworkers genuine listener someone who can relate
7. Overcame on my own
8. Going to a new counselor and good support
9. Because I really just got help in therapy for my anger but used the advice to cope with my anger to help resolve my issue
10. I try and find ways but it don't completely work if it do work just temporarily
11. My own mental determination the fact that no matter what happens in life I have to handle this alone
12. Friends, music and family help me cope