TRAUMA MATTERS

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Core Principles of Trauma Informed Care (Part 6)

This final article will conclude the series describing some of the elements of Trauma Informed Practices. The previous five articles have addressed domains of safety (physical & emotional), trustworthiness, choice, collaboration and empowerment (Fallot & Harris, 2006). Additional areas address formal policies, screening/assessment, administrative support, staff training/education and human resource practices (Fallot & Harris, 2006)

It has become clear that trauma affects not only consumers or clients but the entire system of care. Administrators frequently struggle to develop programs that address complex consumer needs while balancing budgetary limits, burdensome and often shifting regulations, and high rates of staff turnover. Staff members, both direct service providers and support staff, also face multiple, sometimes conflicting obligations in their efforts to be responsive to consumer recovery goals. In short, it is not only accurate but useful to think of the care system itself as traumatized. When we adopt this vantage point, much of what we have learned about individual trauma recovery can be applied to the larger context of care.

The focus of this article will address the importance of staff care and the necessity of including the health of our workforce in the delivery of a trauma informed system of care. It is not possible to create a trauma informed environment for survivors/consumers/clients without paying attention to signs of distress in our own working environments. In other words, in order to create/provide care that is based on the principles of safety, trustworthiness, choice, collaboration and empowerment, each one of us must be working in an environment that is safe, trustworthy, provides choice, encourages collaboration and empowers employees to be effective.

In workshops previously labeled *Self-Care* and newly titled as *Staff-Care*, Eileen Russo uses a three-layered approach to the dilemma of how to create a healthy work force. The first layer is our own self-care as staff members and provides a solid foundation for good client care. It is often the simple things we recommend to clients that are lacking in our own lives—rest, nutrition, exercise, sleep and a balanced lifestyle. The middle layer is professional care, such as training, education, quality supervision and supporting our colleagues. The third layer is the organizational culture. This culture can promote staff self-care and professional care but, very importantly, can establish an environment that is based on safety, trustworthiness, choice, collaboration and empowerment.

In previous articles we outlined specific questions and suggestions to use in order to evaluate/assess client care in relation to these domains. As we have traveled throughout the state and listened to the concerns of those providing direct care, we offer the questions below as a way to evaluate employees' views on the extent to which these principles are in operation in the agency. As with consumer/client care, in which an assessment is only as good as the amount of input obtained from consumers/clients, this assessment, too, is only as good as the quality and amount of feedback obtained from employees.

Safety (emotional and physical)

- Does staff feel physically safe? Are policies that address if and when a staff member may be in the building or on duty alone in place and followed? Are there policies that govern home or community based services? Are there incident reviews following verbal or physical confrontations? Do these lead to effective plans to reduce staff vulnerability? Is the physical environment safe--with accessible exits, readily contacted assistance if it is needed, and enough space for people to be comfortable?
- Does staff feel emotionally safe? Is staff comfortable bringing clinical stuck points, vulnerabilities, and emotional responses to client care to team meetings, supervision sessions or a supervisor? Does the program attend to the emotional safety needs of support staff as well as those of clinicians?

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Core Principles of Trauma Informed Care Part 6 (Continued)

Trustworthiness

- Does management have an understanding of the work of direct care staff? Is there an understanding of the emotional impact (burnout, vicarious trauma, compassion fatigue) of direct care?
- Is self-care encouraged and supported with policy and practice?
- Does all staff receive clinical supervision that attends to both consumer and clinician concerns in the context of the clinical relationship? Is this supervision clearly separated from administrative supervision that focuses on such issues as paperwork and billing?
- Does agency administration follow through on announced plans? Can superiors be trusted to listen respectfully to supervisees' concerns—even if they don't agree with some of the possible implications?

Choice

- Is there a balance of autonomy and limits in performing job duties?
- When possible, are staff members given the opportunity to have meaningful input into factors affecting their work: size and diversity of caseload, hours and flex-time, when to take vacation or other leave, kinds of training that are offered, approaches to clinical care, location and décor of office space?

Collaboration

- Does the agency have a thoughtful and planned response to implementing change that encourages collaboration?
- Is staff encouraged to provide suggestions, feedback and ideas to their team and the larger agency?
- Are opinions valued even if not always implemented?

Empowerment

- Are strengths and skills utilized to provide the best quality care to consumers/clients and a high degree of job satisfaction to each staff member?
- Is staff offered development opportunities to assist with work related challenges and difficulties?
- Does all staff receive annual training in areas related to trauma?
- Does the program's administrator and supervisors adopt a positive, affirming attitude in encouraging staff, both clinicians and support staff, to fulfill work tasks?
- Is there appropriate attention to staff accountability and shared responsibility or is there a "blame the person with the least power" approach? Is supervisory feedback constructive, even when critical?

We are very aware of the pressures—for all programmatic levels--of providing consumer/client care in the face of increasing demands and shrinking resources. However, while staff may voice concerns (ok, complain about) high work loads and paperwork, the reason they generally leave a job or become ineffective is because they do not feel heard, supported, understood and valued. We encourage any agency/team/supervisor to conduct a staff survey based on the principles and questions above and see if what you discover surprises you.

Submitted by:
Eileen M. Russo, MA,LADC
Roger Fallot, PhD

Treating Children with Trauma

Children are just as affected as adults by a disaster or traumatic event. Some may be affected even more, but no one realizes it. Without intending to, parents, may send children a message that it is not all right to talk about the experience. This may cause confusion, self-doubt, and feelings of helplessness for a child. Children need to hear that it is normal to feel frightened during and after a disaster or traumatic event. When you acknowledge and normalize these feelings for children, it will help them make peace with their experience and move on. Following exposure to a disaster or traumatic event, children are likely to show signs of stress that include sadness and anxiety, outbursts and tantrums, aggressive behavior, a return to earlier behavior that was outgrown, stomachaches and headaches, and an ongoing desire to stay home from school or away from friends. These reactions are normal and usually do not last long. Whether the child is a preschooler, adolescent, or somewhere in between, you can help them.

Children begin the healing process as they express their thoughts, concerns, hopes, and dreams in clearly defined age-appropriate activities. Some of these resources are available from The National Institute for Trauma and Loss in Children (www.tlcinstitute.org). *What Color is Your Hurt?* (preschool children); *I Feel Better Now!* (ages 6-12) and *Trauma Intervention Kit*; are guides for the helper working with children in groups. A new manual, *Adults and Parents in Trauma,* recognizes the need for parental involvement and offers specific therapeutic interventions to facilitate healing.

Submitted by:
Richard Stillson, PhD

Gambling Problems Cause Trauma for Children and Families

Imagine a child living in a home where there are endless fights about money, inconsistent or absent parents, or abusive behavior. Maybe there is no food in the house; or it was just discovered that the college fund, or the 401K is "missing"; maybe the foreclosure sign has just been planted on the front lawn, or the police have come to the home to arrest a parent. These are just the "visible" traumas that can occur in a family where there is a problem or pathological gambler. The prevalence rate of gambling problems in the US is about 5%, which includes a range from "problem" gambler to the DSM IV's definition of "probable pathological gambler" (NGISC, 1997). One in twenty Connecticut adults will experience a gambling problem within this range at some time in their lives. It is estimated that each problem gambler impacts a minimum of eight other people. About 38% of problem gamblers in Connecticut have children under the age of 18 living at home (CCPG, 2006).

Trauma, at its root, is about loss; loss of self, loss of safety, loss of normalcy. The experience of "a pervasive sense of loss encompassing physical and existential aspects of their lives, including loss of: their parent(s), trust, security, sense of home and material goods" was the most notable finding in a qualitative study of children's experience of living with a parent with a gambling problem (Darbyshire, et. al, 2001). As one 13-year-old put it: "She doesn't care about anybody else except herself. And she won't stop it. She knows she can get rid of it, but she just won't, she likes it too much. She likes it better than she likes us."

Problem gambling is easy to hide and often misunderstood. The dramatic expansion of legalized gambling opportunities in the US has far outpaced the public's understanding and appreciation that gambling is a risky behavior on par with alcohol and other drugs. The number of casinos, lottery outlets and games compared to 30 years ago has been estimated at a 2500% increase. Young people, their parents, and the educators and other helping professionals who serve them, are all disadvantaged by this lack of awareness. Gambling problems frequently co-exist with other risky and addictive behaviors such as alcohol, substance abuse, eating disorders, and other compulsive behaviors. This "co-morbidity" further drives the gambling issues into the background and can be the reason there are continuing concerns with the client even though there appears to be progress on the presenting issues. Another frequent scenario where gambling is a possible factor is when clients in recovery "transfer" their addiction or compulsive behavior to gambling. In all these situations the gambling problems remain undetected and unresolved, and the children continue to experience the trauma caused by them.

Counselors and therapists, while comfortable exploring a plethora of behaviors and attitudes with their clients, typically do not consider personal finances or money management within the realm of the therapeutic relationship. Along with the possibility of "co-morbid" behaviors, these are "red flag" areas which, if explored, could provide the helping professional with valuable insight. To assist helping professionals identify gambling as an underlying issue, there are several brief assessments available on gambling. A "yes" answer to one or more of these questions indicates the need for more thorough screening and/or referral to a gambling certified counselor, which would result in a more effective and comprehensive treatment plan for the client and significant loved ones. The state sponsored Problem Gambling Services (PGS) and Bettor Choice Programs (BCP) offer consultation and case management to referring professionals. Most important for the family, PGS and BCP provide comprehensive services to children and family members of the gambler to assist in recovery from the trauma caused by problem gambling.

Submitted by:
Mary Lou Costanzo, NCPG, LCSW
Susan D. McLaughlin, M.P.A., CPP-R
DMHAS Problem Gambling Services

For a copy of the brief screening tools, or for more information, contact Mary Lou Costanzo, Clinical Director, at DMHAS Problem Gambling Services, 860-344-2244, or visit our new website, www.gamhope.org

Getting into Trauma Matters

- You can access an electronic version of the "*Trauma Matters*" Newsletter at www.traumamatters.org; www.dmhas.state.ct.us; or www.womensconsortium.org
- Do you want to be placed on our mailing list or is there an event or topic you would like covered in this newsletter? Please call "*Trauma Matters*" editor Carol Huckaby at 203.498.4184, x25 or e-mail her at chuckaby@womensconsortium.org.

CHILDREN'S TRAUMA SERVICES RESOURCE GUIDE

Klingberg Family Centers – Traumatic Stress Institute (TSI) ensures that a trauma informed treatment is used for treatment of children. TSI has been instituted at all levels of Klingberg programs and provides consultation to other agencies implementing trauma-informed treatment principles. Office locations in New Britain and Hartford.

370 Linwood Street, New Britain, CT 06052
Contact: Mark H. Johnson
markj@klingberg.org
Phone: (860) 224-9113

Wheeler Clinic, Inc. – Program services for children focus on developing strengths through a family-focused, community-based approach to treatment, special education and prevention and wellness programs. Services are offered in Bristol, Hartford, New Britain and Plainville.

91 Northwest Drive, Plainville, CT 06062
www.wheelerclinic.org
Phone: 1-800-793-3588

Clifford Beers Clinic - Child and Family Trauma Center – A community-based clinical center of excellence for the treatment of childhood trauma.

95 Edward Street, New Haven, CT 06511
Contact: Alice M. Forrester
aforrester@cliffordbeers.org
Phone: (203) 772-1270 Ext. 214

Yale Child Study Center – National center for children exposed to violence. The Childhood Violent Trauma Center – A trauma-focused clinic, evaluates and treats children and families who have been exposed to a violent, criminal or other potentially traumatic event.

230 South Frontage Road, New Haven, CT 06520-7900
Contact: Steven Marans steven.marans@yale.edu
Phone: (203) 785-7047

Website Resources:
Child Trauma Institute www.childtrauma.com
NCTSN The National Child Traumatic Stress Network
NCTSN.org
211 Connecticut at www.211CT.org

Nonprofit Organization
U.S. Postage Paid
New Haven, CT
Permit No. 118