



Circle of Strength

Magellan Healthcare, Wyoming's Care Management Entity

Balancing work and family can be tough for caregivers of children with behavioral health disabilities

Source: *National Wraparound Initiative, www.nwi.pdx.edu*

Children and teens with behavioral health disabilities may have symptoms that make it harder for them to participate in school and other activities. These symptoms may include feelings such as anxiety or depression, as well as behaviors such as aggression or noncompliance with authority figures. Children and teens with behavioral health disabilities may require a great deal of support from their parents or other caregivers, who are often responsible for coordinating specialized educational, healthcare, and other services as well as responding to crises. Holding a paid job may provide these caregivers with many resources to support their children, including income, reliable health insurance, social support, and a sense of meaning and balance for the caregiver. However, caregivers may find it challenging to balance the responsibilities of caring for a child or teen with behavioral health disabilities and the responsibilities of holding a paid job outside the home. For example, caregivers may need to reduce their work hours or need to miss a day of work if their child experiences a crisis or needs intensive treatment. In a recent NIDILRR-funded study, researchers asked people caring for children and teens with behavioral health disabilities about their employment experiences. They wanted to find out what factors were related to the amount of time that the caregivers spent in paid employment. They also wanted to find out what factors were related to caregivers needing to miss work to attend to their children's behavioral health needs.

Researchers at the Rehabilitation Research and Training Center for Pathways to Positive Futures looked at data from the Longitudinal Child and Family Outcome Study, a study of families of children and teens receiving behavioral health treatment in service systems supported by the Substance Abuse and Mental Health Services Administration between 2004 and 2011. The data were collected from interviews with caregivers of children ages 6–17 who reported engaging in paid work within the last 6 months. During the interviews, the caregivers answered questions about their employment experience during the previous 6 months, including the following:

- how many months they had been employed,
- how many hours per week they had worked and
- the total number of workdays they had missed due to their children's behavioral health needs.

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The caregivers also answered questions about the level of strain they experienced as a result of caregiving, including “objective” strain (how much their family encountered problems such as financial challenges, a lack of free time, or disrupted relationships as a result of the child’s behavioral health disability) and “subjective” strain (how often they experienced feelings of sadness, guilt, worry, anger, resentment or embarrassment related to their child’s behavioral health disability). Finally, the caregivers answered questions about the severity of their child’s behavioral health symptoms, and provided demographic information about their gender, age, race/ethnicity and how many children they had living in their home.

The researchers found that the caregivers reported being employed for an average of 5.2 months out of the previous 6 months and working nearly full-time at about 35 hours per week, on average. The caregivers reported missing about one workday per month on average because of their children’s behavioral health needs. The caregivers whose children had more severe behavioral health symptoms missed more workdays than the caregivers of children with less severe symptoms.

When the researchers looked at the link between caregiver strain and employment, the researchers found that:

1. Regardless of the children’s symptom severity, the caregivers reporting more objective strain worked fewer hours per week than the caregivers reporting less objective strain. However, caregivers reporting more subjective strain, particularly feelings of anger, resentment or embarrassment, worked more hours per week than those reporting less subjective strain.
2. Regardless of the children’s symptom severity, the caregivers reporting more objective strain missed more workdays than the caregivers reporting less objective strain. Again, the opposite pattern was seen with subjective strain: the caregivers reporting more anger, resentment, and embarrassment related to their children’s disability reported missing fewer workdays than the caregivers reporting less of these feelings.
3. In addition, caregivers who were white, male or who had fewer children living in their homes worked more hours per week than the caregivers who were African American or other races, female, or who had more children. The caregivers who were African American or Hispanic reported missing more workdays due to their child’s disability than the caregivers who were white.

The authors noted that the objective strain of caring for a child or teen with a behavioral health disability may make it difficult for caregivers to fully engage in paid employment. In particular, disruptions to family life and relationships can lead caregivers to reduce their work hours or miss work to attend to family issues. This may, in turn, increase financial challenges for the family. Even when caregivers can balance work and caring for their child, the stress of managing that balance may lead to subjective strain like feelings of anger or embarrassment. Social workers and other service providers may assist caregivers in building their social support networks so that families can respond to crises or disruptions without the caregiver needing to miss work or increasing their stress levels. In addition, service providers may wish to ensure that family support services are culturally relevant and responsive to individuals from non-white racial backgrounds.

To Learn More

The *Rehabilitation Research and Training Center on Pathways to Positive Futures* offers a range of publications, webinars and other resources for young people with mental health conditions and their families, as well as the professional and peer support personnel who work with these families. Among these resources you'll find:

- Strengthening Family Support for Young People with Mental Health Needs in the Transition to Adulthood: A Tip Sheet for Service Providers www.pathwaysrtc.pdx.edu/pdf/projPTTC-FamilySupportTipSheet.pdf

Facts about trauma

Children who have experienced trauma are at a higher risk to experience other negative situations. The Echo Training group provides other facts about trauma that may not be well known:

- » Trauma is everywhere. In the general population, 67% of us have experienced at least one Adverse Childhood Experience. In people of color, that is more likely to be 83%.
- » Once we've experienced trauma, our nervous system gets easily 'stuck on high' (hypervigilant, panicky, manic, angry, nervy) or 'stuck on low' (depressed, numb, lethargic) or oscillates between the two.
- » People who have experienced trauma as a child are statistically more likely to experience sexual assault in later life. (Loss of danger cues, inability to recognize 'unsafe' relationships, freeze response that makes them a sitting duck all increase the risk.)
- » We are paranoid, tend to catastrophize and have black and white thinking (for example, people are either friends or enemies with nothing in between). We are more sensitive to light and sound. We can also develop fear of open or crowded spaces.
- » Our bodies react to long-term stress hormones by knocking out some of our stress hormone receptors—people feel 'blah.' They often create drama or engage in risky behaviors just to feel something.

Echo Training offers a basic trauma training where participants can learn more facts about how trauma shows up in the way we think and behave. Trauma causes changes to the body and brain that are often mislabeled as *a condition* or *problem*, when they are in fact adaptive responses to ensure our survival. Find upcoming trainings on their www.echotraining.org.

Echo Training also provides the following trainings:

- Trauma-Informed Nonviolent Parenting Classes,
- Working with Childhood Trauma,
- Working with Childhood Trauma II,
- Community Resiliency Model,
- Trauma and Addiction,
- Yoga for Trauma Recovery,
- Parenting Weekend Intensive,
- Seeking Safety, and
- Trauma Responsive Play

Source: Echo Training

Families for Depression presents teen depression webinar

Families for Depression Awareness is presenting a free fall webinar series. The first several sessions will focus on teen depression. Presenter Amy Saltzman, M.D. will discuss how caring adults can encourage teens to manage stress. The program is designed for parents, caregivers, school educators and personnel, youth workers, and anyone interested in teen mental health. www.familyaware.org.

Play has become a four-letter word

Play really can be a form of learning. However, in the article, "Playtime may bolster kids' mental health," Angela Lashbrook points out that since 2001, play has been contrary to learning. She argues that play can enhance learning and improve children's behavior. Read the full article at www.theatlantic.com/health/archive/2018/08/playtime-may-boost-kids-mental-health/568186.

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Crisis Text Line

All Wyoming residents have access to a free, 24/7 text line for people in crisis. Simply text **WYO** to **741741** to be connected to a crisis counselor. This resource can be used in non life-threatening situations. If your child or someone you know is in a life-threatening situation, call 911 right away!

Contact us

Office Hours:

M – F, 9 a.m. to 5 p.m. MST.

Phone: 307-459-6162

Emergency services are available 24 hours a day.

Toll-free: 1-855-883-8740

TDD/TTY: 1-800-424-6259

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