Restorative Integral Support (RIS) for Post-Trauma Wellness

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Introduction

Research reveals a relationship between the accumulation of adversity and serious subsequent adult mental health, substance abuse and other health risk behaviors, health, and social problems (Felitti et al, 1998). Yet, a fragmented service system poses a challenge for people experiencing complex and co-occurring problems, calling for an integrated response (Larkin, 2010). Furthermore, service providers increasingly appreciate the potentially traumatic nature of homelessness, domestic violence, and other disasters faced by those served, and there is also a focus on addressing trauma that may co-occur with substance abuse and mental health problems (Chung, Domino, & Morrissey, 2009; Kim, Ford, Howard, & Bradford, 2010; Najavits, 2009). Simultaneously, a call for "recovery-oriented" systems of care has emerged from movements demonstrating that people can recover from substance abuse and mental health challenges (Bledsoe, Lukens, Onken, Bellamy, & Cardillo-Geller, 2008; Sheedy & Whitter, 2009). Agency leaders are faced with bringing together a variety of evidence-supported interventions (ESI) within the context of local needs and resources in order to provide comprehensive and recovery-oriented services for disadvantaged groups experiencing multiple problems, including adversity and trauma (Larkin, Beckos, & Shields, in press; Larkin, Felitti, & Anda, in press).

In response, the Center for Post-Trauma Wellness offers Restorative Integral Support (RIS), a model that integrates an understanding of adversity and trauma with social science research and practice knowledge of resilience and recovery to inform programs that take trauma into account. RIS is a flexible model that focuses attention on the way in which leadership, service systems, and culture work together. RIS provides a map to guide program directors and helping professionals in bringing together locally available ESIs, as well as emerging practices consistent with practitioner skills and client values, within the context of intentionally developed social networks and recovery-oriented systems of care. RIS mobilizes resilience and recovery through a comprehensive, whole person approach to support healing and transformation of people's lives on a larger scale (Larkin, Beckos, & Shields, in press; Larkin & Records, 2007). This brief article presents an overview of the RIS model and trauma-specific interventions that can be incorporated within RIS.

Restorative Integral Support (RIS): Implementation

Helping professionals and social service agencies often serve vulnerable and high risk populations experiencing multiple problems. The RIS model carefully attends to client characteristics and needs, recognizing the important contributions of social relationships and responsive systems for a comprehensive approach to helping the whole person. In fact, extensive research from the medical field connects present-day health and social problems back to earlier adversity. "Adverse childhood experiences" (ACEs) are categories of risk that are strongly associated with later life mental health and health risk behaviors, including substance abuse (Felitti et al, 1998). RIS implementation begins by bringing the role of earlier adversity into awareness in order to prevent and address ACEs and their consequences.

Adversity, Trauma, Resilience, and Recovery

The "adverse childhood experiences" (ACE) Study is a large, epidemiologically sound study carried out through a partnership between Kaiser Permanente and the Centers for Disease Control (CDC). Beginning in 1994, two waves of data collection resulted in a total sample of 17, 337 adults (Dube, Anda, Felitti, Chapman, Williamson, & Giles, 2001). ACE categories include emotional, physical, and sexual abuse, domestic violence, living with substance abusing, mentally ill, or suicidal household members, growing up with a household member who has been incarcerated, loss of a parent, and emotional or physical neglect. The number of "yes" responses to each of the categories are added to create an ACE Score ranging from 0-10. ACE Score is powerfully associated with later life health risks such as alcoholism and other drug abuse, smoking, major depression, suicide attempts, sexually transmitted diseases, physical inactivity, obesity, and poor self-rated health (Anda et al, 1999; Anda et al, 2002; Dube et al, 2001; Dube, Anda, Felitti, Edwards, & Croft, 2002; Felitti et al, 1998). As ACE Scores increase, the likelihood of liver disease, lung disease, heart disease, multiple types of cancer, and risk for broken bones also increases (Dong, Anda, Dube, Giles, & Felitti, 2003; Dong, Dube, Giles, Felitti, & Anda, 2004; Dong et al, 2004; Feliitti et al, 1998). ACEs are connected to impaired job functioning (Anda et al, 2004), homelessness (Burt, 2001; Herman, Susser, Struening, & Link, 1997; Larkin & Park, 2009; Larkin & Records, 2007), and criminal justice involvement (Messina & Grella, 2006).

Understanding adversity and trauma

In addition to ACEs, other types of events can contribute to emotional and physical injury among both children and adults. Examples include neighborhood violence, living in a war zone, and natural disasters. The Substance Abuse and Mental Health Administration (SAMHSA) describes trauma:

> Traumatic experiences can be dehumanizing, shocking or terrifying, singular or multiple compounding events over time, and often include betrayal of a trusted person or institution and a loss of safety. Trauma can result from experiences of violence. Trauma includes physical, sexual and institutional abuse, neglect, intergenerational trauma, and disasters that induce powerlessness, fear, recurrent hopelessness, and a constant state of alert. Healing is possible (SAMHSA National Center for Trauma-Informed Care: http://www.samhsa.gov/nctic/).

RIS clarifies the distinction between adversity and trauma and explains the impact on development. Wilber (1995, 2000) points out that development takes place within a cultural and systemic context, which is visually depicted through the Integral concept of the quadrants. Figure 1 maps the upper quadrants to the individual and lower quadrants to the collective; the right hand quadrants represent observable aspects of the individual and collective ("IT" & "ITS"), and the left hand quadrants are subjective ("I") and inter-subjective ("WE") aspects of each. ACEs and adverse adult experiences tend to take place within observable systemic and environmental interactions, mapped to the lower right quadrant. The other quadrants reflect different dimensions of the adversity, including whether or not the adverse event is also a trauma (Larkin & Records, 2007).

Figure 1. Adversity and trauma

Developmental processes & developmental capacity strengths & skills emotions trauma experience	I	IT Health risk behaviors physical health neurodevelopment self care behaviors
Cultural values shared meanings social supports	WE	ITS ACEs adverse adult experiences domestic violence

community resources natural disasters
service access

The meanings people make of adverse interactions are influenced by lower left culture and upper left individual perception. Numerous developmental processes are also taking place within the interior (upper left) of the individual. One's developmental capacity is a resource as are lower left social supports and lower right access to services. An adverse event has the potential to derail development, but this can also be counteracted by cultural and systemic supports. Trauma is an upper left subjective assessment indicating that an adverse event is experienced as overwhelming (Larkin & Records, 2007). Thus, it is perceived as being beyond one's capacity and resources to manage the adversity (see also Lazarus & Folkman, 1984; Kabat-Zinn, 1990). Felitti and colleagues (1998) suggest that people may attempt to manage overwhelm and anxiety associated with ACEs by adopting health risk behaviors, such as substance abuse or overeating, that offer temporary relief. From a quadrant perspective, these observable behaviors are mapped to the upper right quadrant. The observable neuro-developmental impact of early adversity is also mapped to the upper right quadrant (Larkin & Records, 2007).

Thus, adversity co-arises with a variety of inner and outer resources, with trauma emerging as an "all-quadrant" experience. RIS facilitates recovery by mobilizing resources oriented toward each of the quadrants to enhance resilience and fortify development to resume healthy processes. This comprehensive, whole person response is designed to promote healing (Larkin & Records, 2007; Larkin, Beckos, & Shields, in press).

The role of community in resilience and recovery

Recognizing that high ACE Scores are characteristic of the most disadvantaged population groups, RIS takes ACEs into account in order to restore health and well-being. Social scientists have explored personal and social characteristics that help people overcome adversity. Real-world application of this knowledge to prevent costly consequences among high ACE Score groups is valuable to society as a whole (Larkin, Felitti, & Anda, in press). Communities can enhance protective factors to help people manage adversity, overcome obstacles, and create a worthwhile and meaningful life. Opportunities for skill development and relationships that offer hope and a sense of expectation can all help to fortify individual resilience (Fraser, Richman, & Galinsky, 1999; Goldstein & Brooks, 2005; Henderson, 2003; Smith & Carlson, 1997). The combination of community

resources and individual strengths have the potential to counter mental health and health problems (Davidson, O'Connell, Tondora, Lawless, & Evans, 2005). A recovery process takes place through peer and other social supports to facilitate a developmental healing process (Gardner, Lehman, Brown, & Brooks, 2000; Starnino, 2009).

Because a high ACE Score assessment indicates an historical shortage of protective resources, RIS emphasizes the intentional development of the community to counteract earlier adversity. Thus, RIS enhances the notion of "trauma-informed care" by specifically taking into account the developmental impact of ACEs in addition to adult adversity, distinguishing between adversity and trauma, and intentionally working with the community to mobilize resilience and recovery. Within a compassionate and recovery-promoting culture, ACE and trauma screening screening can help people explore their own resiliency and supports in recovery.

Within the RIS model, attitude and behaviors of agency leaders and all staff members play key roles in a comprehensive approach. Agency leaders set a tone and example for healthy behaviors, supporting self care by staff members who provide relationship-building and role modeling for clients (Larkin, 2006; Larkin, Beckos, & Shields, in press). RIS inclusion of self-care is bolstered by literature focusing on its importance among helping professionals (Brenner & Homonoff, 2004; Christopher, Christopher, Dunnagan, & Schure, 2006) as well as prevention of vicarious traumatization (Badger, Royse, & Craig, 2008). In fact, research shows that health behaviors can be contagious through social networks (Christakis & Fowler, 2007). Furthermore, therapeutic community is a well-researched intervention that mobilizes social networks, with adaptations to other populations and settings, in which staff and recovering community members all contribute to a culture of recovery. Program graduations lead to those further along in recovery taking greater responsibility and mentoring newcomers (NIDA, 2002). Employing this research, RIS implementation intentionally develops social networks. An important early step engages staff members in the articulation of values and principles that underly programs, which strengthens the culture of recovery as programs operate cohesively to carry out the mission. Staff embodying these values provide relationship-building and role modeling for those served, setting a tone for the culture in which a therapeutic community can emerge (Larkin, Beckos, & Shields, in press).

Recovery movements can compliment and support professionally delivered "evidence-supported interventions" (ESIs) while promoting

empowerment through human relationships (Carpenter, 2002; Starnino, 2009). In fact, there is a call to integrate recovery-oriented systems of care within ESIs (Bledsoe et al, 2008). The Substance Abuse and Mental Health Services Administration (SAMHSA) is focused on the design of "recovery-oriented systems of care" (Sheedy & Whitter, 2009). Thus, RIS guides agency leaders and helping professionals to examine and shape policies, procedures, and systems to streamline care in a way that facilitates the development of healthy social networks. For example, programs can be set up to include stages and graduations, with peer mentoring of newer participants (Larkin, Beckos, & Shields, in press). RIS then incorporates ESIs and emerging trauma interventions within the context of culture and systems supporting recovery (see Figure 2).

Figure 2. RIS incorporation of trauma interventions

ESIs or emerging practices processing feelings or shifting subjective experience

Body-oriented practices
Behaviorally oriented ESIs

I IT

WE ITS

Culture of recovery
Healthy social networks
therapeutic community
peer supports

recovery-oriented systems of care
policies and procedures
service access
(linkages or service integration)

Trauma Treatment

Evidence-supported interventions (ESIs)

Grounded in research on resilience, therapeutic community, and service systems, RIS carefully develops the context within which ESIs can be incorporated. It is also important to note that the National Institutes of Health (NIH, 2008) has set forth a more integrative view of evidence-based behavioral practice as an ongoing decision-making process that combines knowledge of best practices with client values, practitioner skills, and local resources. ESIs can also be combined to help people experiencing multiple problems. For example, an

individually-oriented ESI for trauma could be offered along with peer group and family treatments, within the context of a therapeutic community and recovery-oriented systems. RIS is a flexible model that supports this process, guiding the incorporation of locally-available best practices that are consistent with practitioner skills and client preferences.

SAMHSA provides a National Registry of Evidence-based programs and practices: http://www.nrepp.samhsa.gov/ as well as a guide to websites outlining ESIs: http://www.samhsa.gov/ebpWebGuide/index.asp. Awareness of high ACE Score backgrounds among those served points to the helpfulness of including trauma interventions within RIS. RIS also provides the "trauma-informed" care context within which ESIs addressing any number of problems, including mental health and substance abuse problems that may be consequences of trauma, could be incorporated. Depending upon available resources, it may be possible to bring ESIs on-site through investments in continuing education for agency providers or agreements with other organizations. Since practitioner skills and resources will differ in various areas, RIS models will look different in diverse areas while facilitating access to unique individually-oriented interventions (Larkin, Beckos, & Shields, in press).

The following ESIs for trauma have been identified through evidence-based practice websites provided by SAMHSA and could be explored for local accessibility and appropriateness for inclusion within RIS implementation (http://www.nrepp.samhsa.gov/ and http://www.samhsa.gov/ebpWebGuide/index.asp. Cognitive-behavioral exposure therapy (CBET) and Eye Movement Desensitization and Reprocessing (EMDR) are two well-known ESIs for trauma. Trauma-informed substance abuse and mental health interventions include: A Woman's Path to Recovery, the Boston Consortium Model, Seeking Safety, Trauma Affect Regulation: Guide for Education & Therapy (TARGET), and the Trauma Recovery & Empowerment Model (TREM). The Sanctuary Model is an example of an organizationally-oriented ESI for trauma. Helping Women Recover and Beyond Trauma are criminal justice programs.

Research has also been conducted on trauma interventions specifically developed to help children and adolescents. Child-Parent Psychotherapy (CPP), Trauma-focused cognitive-behavioral therapy (TF-CBT), and Structured psychotherapy for adolescents responding to chronic stress (SPARCS) are examples identified through evidence-based practice websites provided by SAMHSA. Interventions for youth in schools and child/family agencies have also been developed. Examples include Real Life Heroes and Cognitive-

behavioral intervention for trauma in schools (CBITS). SITCAP-ART is a trauma intervention program for adjudicated and high risk youth. Youth-serving agencies could consider the appropriateness of including one or more of these ESIs when implementing RIS (please see http://www.nrepp.samhsa.gov/ and http://www.samhsa.gov/ebpWebGuide/index.asp). This involves exploring how to make these interventions accessible to those served within the agency.

Emerging practices

The RIS model facilitates research to practice, through the inclusion of ESIs, and practice-based research on emerging practices. Both ESIs and emerging practices would need to be evaluated for effectiveness within the local context. New interventions often emerge based on theory, basic science, or adaptations of existing approaches, and then practitioners seek partnerships with researchers.

Acu-point tapping techniques (Lane, 2009; Feinstein, 2011) such as Thought Field Therapy (TFT) (Bray, 2006; Callahan, 2000; Pignotti, 2007) and the Emotional Freedom Technique (EFT) (Craig, 2008; Flint, Lammers, & Mitnick, 2006) are grounded in neuroscience research and Eastern knowledge of energy meridians (Feinstein, 2011; Perry, 1999; Porges, 2001, 2007, 2007a; Sahar, Shalev, & Porges, 2001; van der Kolk, 2003, 2004, 2007). Recent pilot studies indicate that EFT may be a promising trauma treatment (Church, 2009; Church, Geronilla, & Dinter, 2009).

Practitioners of Somatic Experiencing (SE), developed by Levine (1997), draw on neuroscience and polyvagal theory to explain this body-oriented approach (Perry, 1999; Porges, 2001, 2007, 2007a; Sahar, Shalev, & Porges, 2001; van der Kolk, 2003, 2004, 2007). SE, which does not require any recounting of events to facilitate nervous system release of trauma held in the body, has been found to reduce consequences of trauma while fostering resilience among Indian tsunami survivors (Parker, Doctor, & Selvam, 2008) and social service providers who survived a natural disaster (Leitch, Vanslyke, & Allen, 2009).

Training in mindfulness helps minimize both physiological and psychological signs related to stress (Ditto, Eclache, & Goldman, 2006; Grossman, Niemann, Schmidt, &Walach, 2004; Marcus et al., 2003; Ortner, Kilner, & Zelazo, 2007). Mindfulness meditation supports recovery from Depression (Teasdale et al, 2000), aids relief from anxiety disorders (Kabat-Zinn et al, 1992), and reduces stress reactivity among people recovering from substance dependence (Garland, Gaylord, Boettinger, and Howard, 2010).

A pilot study carried out with soldiers at Walter Reed Army Medical Center (WRAMC) suggests that Integrative Restoration (iREST), a meditative and deep relaxation practice designed to release negative emotions and calm the nervous system, may be a promising component of PTSD treatment (Money, Fritts, Miller, Gore, & Engel, 2008). Imagery rescripting is another emerging practice that focuses on helping trauma survivors to realize safety and self-efficacy by modifying intrusive imagery related to past trauma (Blakley, 2009).

Emerging practices also include the adaptation of ESIs by agency providers who may not have a graduate or professional education. When ESIs are inaccessible to disadvantaged population groups, such as homeless people, agency providers sometimes seek professional consultation or training in order to offer psycho-education or support that draws on the ESI. Examples might include use of cognitive-behavioral skills, motivational strategies, or EFT support around client self care.

RIS Research and Evaluation

Consistent with the NIH EBBP (2008) process, RIS implementation involves the integration of research knowledge with practitioner skills, and local cultural values and resources. RIS also embraces "Service Outcomes Action Research" (SOAR) (Duffee, 2010), employing this as an Integral team-based research process to evaluate the efficacy of ESIs in the local setting and bring emerging practices to research by revealing data through multiple methodologies (Larkin, Beckos, & Martin, 2012; Thomas, 2004). By creating partnerships with Universities or other research institutes, agencies can develop a data-informed practice process (DIPP) (Duffee, 2010) that leads to the integration of research and practice (Larkin, Beckos, & Martin, 2012). Within RIS, reflection on continuously generated data is balanced with practice as an art that involves consideration of identified ethical principles (Garner, 2011). Decision-making about practices and program development are made within this context. Through this integration of research and practice, RIS implementation develops knowledge of comprehensive, whole person services to support recovery from adversity and trauma (Larkin, Beckos, & Martin, 2012). By expanding research partnerships across professions, including economists, next steps could involve assessing societal cost-savings associated with the reduction of health and social problems that are often consequences of trauma (Larkin, Felitti, & Anda, in press; Larkin, Beckos, & Shields, in press).

Conclusion

This brief paper serves as an overview and resource on trauma interventions for helping professionals. "Restorative Integral Support" (RIS) offers a framework that includes and transcends current approaches to helping people work through adversity and trauma. Consistent with an evidence-based behavioral practice process (EBBP) presented by the National Institutes of Health (NIH, 2008), the RIS model orients helping professionals to incorporate locally available evidence-supported interventions (ESIs) and emerging practices for trauma, building upon practitioner skills while taking client culture and values into account. Leadership, policies, and recovery-oriented systems can work together to create a therapeutic community within which ESIs and emerging practices can be brought together for a comprehensive, whole person approach that takes client characteristics into account. Trauma treatments include evidence-supported interventions (ESIs) as well as emerging practices. Depending on practitioner skills and interests as well as client needs and local cultural values and resources, helping professionals may choose to pursue continuing education in trauma treatment or develop relationships with other local providers offering these types of services. The RIS model facilitates research to practice, through the inclusion of ESIs, and practice-based research on emerging practices. Both ESIs and emerging practices would need to be evaluated for effectiveness within the local context. RIS focuses on the important task of effectively meeting client needs, and then offering a framework that can guide evaluation for effectiveness.

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