PDP Communiqué

Training beyond Policy and Regulations: Assisting with Trauma and Stress

Eugene J. Monaco, Executive Director and Public Service Professor, Professional Development Program

The different ways in which trauma, complex stressors, and issues of wellness affect victims concern those who deal with the consequences. It drives their need to better understand how to more effectively deal with issues of trauma and stress. We focus this issue of the Communiqué on training and evidence-based practices that assist workers as they interact with their clients who may be confronted with problems resulting from trauma and stress.

Trauma and stress can have significant life-changing consequences on behavior, relationships at home or in the workplace, and our overall ability to cope with life events. Children subjected to primary or even secondary trauma can be particularly affected in their cognitive processes, physical health, behavior, and social functioning. This may lead to further social-behavioral issues and criminal conduct, adding additional stress to already overworked social service, juvenile justice, and criminal justice systems.

Therefore, it's imperative for those who deal with the by-products of trauma and wellness to better understand its consequences and to be well informed about emerging evidence-based practices in the field of trauma management. As an illustration, I'd like to note the way in which the Substance Abuse and Mental Health Services Administration (SAMHSA) publishes up-to-date information for the public and professionals on its National Registry of Evidence-based Programs and Practices (www.nrepp.samhsa.gov), which covers 342 interventions available for implementation. For those social workers, counselors, health care workers, teachers, and trainers who have had little or no formal training on dealing with the impact of trauma, from domestic violence, sexual abuse, rape, substance abuse, mental health issues, suicide, or child abuse, this SAMHSA information can be vital. It serves to promote an increased capacity to both recognize these complex issues and produce more positive outcomes for trauma victims.
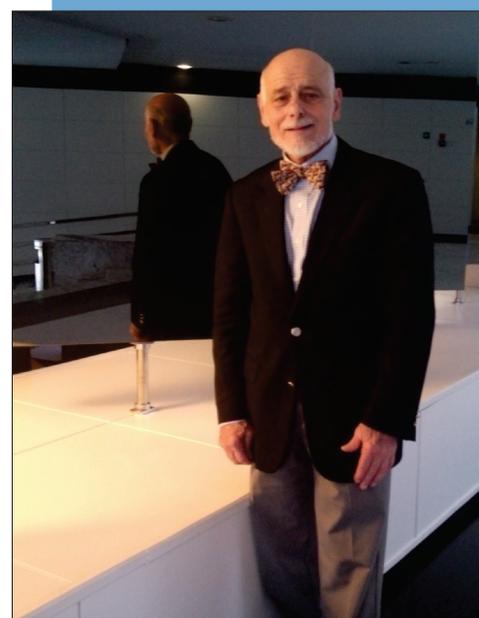
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VOLUME 34, SPRING 2015

Individuals with Adverse Childhood Experiences (ACEs) have higher instances of:

- ⊘ **Recurrent and severe physical abuse**
- ⊘ **Recurrent and severe emotional abuse**
- ⊘ **Sexual abuse**
- ⊘ **Growing up in a household with:**
  - ◆ Alcohol or drug user
  - ◆ Member being imprisoned
  - ◆ Mentally ill, chronically depressed, or institutionalized member
  - ◆ Separation/Divorce
  - ◆ Mother being treated violently
  - ◆ Both biological parents absent
  - ◆ Emotional or physical abuse

severe and persistent emotional problems,

adult disease and disability,

health risk behaviors,

serious social problems,

higher health care costs, and

shorter life expectancy.

15 times more likely to attempt suicide

3 times more likely to experience depression

2 times more likely to develop chronic obstructive pulmonary disease

As many as **66%** of people in treatment for drug abuse reported ACEs.

4 times more likely to become an alcoholic

2.5 times more likely to smoke

4 times more likely to inject drugs

30% will later abuse their own children.

3 times more likely to have serious job problems

2 times more likely to have a serious financial problem

3 times more likely to use antidepressant medication

4 times more likely to develop a sexually transmitted disease

2 decades shorter life expectancy for those who reported six or more ACEs, compared to those who reported none

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Over the past several years, wellness-and-trauma-informed practice has become of great interest to those in the field of training workers in the human and social service areas. For instance, in December 2013, the New York State Office of Children and Family Services (NYSOCFS) published a white paper, *Promoting the Well-Being of Children, Youth and Families in Child Welfare*. This white paper offered a tiered framework for promoting healthy development and well-being, increasing the focus on child well-being.

At PDP, we have discovered that workers who attend our training require additional assistance beyond the knowledge of policy and regulations in the social service system; they also need current practice knowledge, tools, and information that will enable them to recognize and deal with clients who have experienced a trauma-related primary or secondary incident. We have directly seen the way in which today's social service workers' jobs have become more demanding and complex. In addition to training that assists in implementing policy and regulations, workers now require additional information and training in well-being and trauma, which can greatly assist them in carrying out their varied job duties and responsibilities.

This issue of the Communiqué focuses on trauma and well-being from a scholarly, practical, and professional perspective. The article by Heather Larkin Holloway, Associate Professor at UAlbany's School of Social Welfare, addresses research-to-practice interventions in post-trauma wellness. She also stresses the importance of training in these areas for workers to raise their awareness surrounding the issues of post-trauma wellness. In addition, the piece by Brenda Seckerson, University at Albany Employee Assistance Program (EAP) Coordinator, speaks to the holistic dimensions of wellness.

Through the writing of these qualified and experienced professionals, I hope to provide our readers with insight to better understand the dynamics of trauma and well-being. *PDP*

Say **"What happened to you?"** *instead of* **"What did you do?"**

Resources: www.recognizetrauma.org/statistics.php, www.childhelp.org/child-abuse-statistics/

Restorative Integral Support (RIS) for Post-Trauma Wellness

Heather Larkin Holloway

Heather Larkin Holloway

This brief article presents the Restorative Integral Support (RIS) model and addresses training implications for agency leaders and providers of service to clients.

Research reveals a relationship between accumulated adversity and serious health risks, health, and social problems. Agency leaders are faced with bringing together a variety of best practices to respond to client needs within the context of local resources to provide comprehensive and recovery-oriented services for people experiencing multiple problems, including adversity and trauma.

Restorative Integral Support (RIS) integrates an understanding of adversity and trauma with knowledge of resilience and recovery to inform programs. RIS is a flexible model that brings attention to the way in which leadership, service systems, and culture work together. It is a map linking locally available evidence-based and emerging practices consistent with practitioner skills and client values, within an intentionally developed restorative context.

RIS implementation begins by raising awareness of adverse childhood experiences (ACE) and the consequences of accumulated adversity. Individual development takes place within a cultural and systemic context—presented via the integral concept of the quadrants (Figure 1). The top two quadrants represent the individual and the lower quadrants represent the community. While right hand quadrants depict observable aspects of the individual and community, left quadrants represent subjective and inter-subjective dimensions. Adverse experiences are typically observable interactions, mapped to the lower right quadrant. Each quadrant represents a perspective on adversity, including whether or not the adverse events are subjectively traumatic.

The meanings people make of adverse interactions are of course influenced by culture (lower left) and subjective experience (upper left). Resources include lower right service access, lower left social supports, upper left developmental capacity, and upper right coping or self-care behaviors. ACE researchers suggest that people may adopt health risk behaviors (mapped to the upper right), such as substance abuse or overeating, to manage overwhelming feelings (upper left) associated with accumulated adversity and trauma. The observable neuro-developmental impact of early adversity is also mapped to the upper right quadrant.

It becomes clear that adversity co-arises with a range of inner and outer resources. Trauma is an "all-quadrant" affair. Providers can apply RIS to mobilize resources in each quadrant perspective to strengthen resilience, restore developmental processes, and facilitate recovery from the consequences of adversity and trauma.

Agency leaders, providers, and all staff members play roles in creating restorative communities. Leadership sets an example and the cultural tone of programs. A holistic intervention perspective includes support for self-care by the staff members providing role modeling and relationship-building for clients. When using RIS, it becomes clear that policies and system design are also interventions that influence healthy community development. Examining and re-shaping lower right quadrant systems, procedures, and policies can streamline care and facilitate a culture of recovery. It is within this restorative, ACE/trauma-informed context that evidence-supported interventions (ESIs) and emerging practices can be integrated for an enhanced service impact (see Figure 2).

Figure 2			
	• ESIs or emerging practices • Processing feelings or shifting subjective experience **I**		• Body-oriented practices • Behaviorally oriented ESIs **It**
RIS incorporation of trauma interventions		**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)

Depending upon available resources, it may be possible to bring evidence-supported interventions on-site through investments in continuing education and training for agency providers or agreements with other organizations. Since practitioner skills and resources will differ in various areas, RIS models can look different and handle diversity.

Figure 1			
	• Developmental processes & capacity • Strengths & skills • Emotions • Trauma experience **I**		• Health risk behaviors • Physical health • Neurodevelopment • Self-care behaviors **It**
Adversity and trauma		**We**	**Its**
	• Cultural values • Shared meanings • Social supports • Community resources		• ACEs • Adverse adult experiences • Domestic violence • Natural disasters • Service access

The Dimensions of Wellness

Brenda Seckerson, MA, CEAP
University at Albany
Employee Assistance Program (EAP) Coordinator

Brenda Seckerson

Over the years we've come to realize that when we talk about "wellness" we need to consider more than just our physical health. Overall well-being has several dimensions, and we are best served by looking at it from a holistic perspective. What are the dimensions of wellness?

The Substance Abuse and Mental Health Services Administration's (SAMHSA) Eight Dimensions of Wellness (www.promoteacceptance.samhsa.gov/10by10/dimensions.aspx) outlines the areas to consider when focusing on what we need to experience a sense of wellness.

- **Emotional:** Coping effectively with life and creating satisfying relationships
- **Environmental:** Good health by occupying pleasant, stimulating environments that support well-being
- **Financial:** Satisfaction with current and future financial situations
- **Intellectual:** Recognizing creative abilities and finding ways to expand knowledge and skills
- **Occupational:** Personal satisfaction and enrichment derived from one's work
- **Physical:** Recognizing the need for physical activity, healthy foods, and sleep
- **Social:** Developing a sense of connection, belonging, and a well-developed support system
- **Spiritual:** Expanding our sense of purpose and meaning of life

The National Wellness Institute (NWI), a non-profit organization whose mission is to promote global wellness, defines wellness as *an active process through which people become aware of, and make choices toward, a more successful existence* (www.nationalwellness.org/?page=Six_Dimensions). NWI uses a Six Dimensions of Wellness model developed by Dr. Bill Hettler, co-founder of the organization. This model highlights the emotional, intellectual, occupational, physical, social, and spiritual features of well-being.

When thinking of wellness from this multi-dimensional approach, it is important for each of us to periodically take stock of which areas might need some enhancement in order to support our well-being. It is important to be mindful that different dimensions will stand out as needing more attention than others during certain periods of our lives. Reflecting on these dimensions from time

What is Child Traumatic Stress?

"Child Traumatic Stress occurs when children or adolescents are exposed to traumatic events or traumatic situations that overwhelm their ability to cope" (The National Child Traumatic Stress Network, 2015).

Trauma can be physical and/or psychological; it can result from being victimized, by witnessing violence, by going through a painful or terrifying situation, or by experiencing loss. The National Child Traumatic Stress Network (NCTSN) specifies 13 types of traumatic experiences that can lead to child traumatic stress, at www.nctsnet.org/trauma-types. Those traumatic experiences include:

- **Community Violence:** whether as a victim, witness, or even as the perpetrator
- **Domestic Violence:** witnessing physical, sexual, and/or emotional abuse between partners
- **Medical Trauma:** experiencing a serious illnesses or enduring invasive medical procedures
- **Natural Disasters:** living through a tornado, hurricane, earthquake, etc.
- **Abuse:** physical or sexual abuse or sexual exploitation
- **Grief:** the loss of someone important to the child, whether unexpected or anticipated
- **Child Traumatic Stress:** can result from one event or multiple traumatic experiences.

Without knowing a youth's entire history, it is impossible to know if he or she is experiencing Child Traumatic Stress. In order to lessen the likelihood of re-traumatizing the youth, it is important to interact with all youth and families in a trauma-informed way. Being trauma-informed includes maximizing that child's sense of safety, supporting the positive and stable relationships in the child's life, and managing your own stress so it doesn't impact your interactions with the youth or lead to Secondary Traumatic Stress.

Working with youth experiencing Child Traumatic Stress is hard, emotional work that can lead to Secondary Traumatic Stress in those people trying to help. Secondary Traumatic Stress (also referred to as Compassion Fatigue, Vicarious Trauma, and Burnout) is caused by indirect exposure to traumatic material, such as repeatedly hearing stories about traumatic events. The effects of Secondary Traumatic Stress can compromise a worker's ability to be of service to the very people he or she is attempting to help (NCTSN, www.nctsn.org/resources/topics/secondary-traumatic-stress). *PDP*

Evidence-supported trauma interventions are easily identified through websites provided by SAMHSA and could be considered for inclusion within RIS implementation (www.nrepp.samhsa.gov/ and www.samhsa.gov/ebpWebGuide/index.asp). It is also important to note that new interventions often emerge based on theory, basic science, or adaptations of existing approaches—practitioners using these interventions frequently seek partnerships with researchers to build an evidence-base.

Recent pilot studies suggest that the Emotional Freedom Technique (EFT) may be a promising trauma treatment. Somatic experiencing, a technique that does not require recounting events to facilitate nervous system release of trauma held in the body, has been found to reduce trauma consequences and strengthen resilience. Mindfulness meditation helps with stress reactivity, anxiety, and depression. Integrative Restoration (iREST), a deeply relaxing meditative body-oriented practice designed to release negative emotions and calm the nervous system, is a promising adjunctive PTSD treatment. Providers have also found many of these emerging practices helpful for their own self-care.

Restorative Integral Support (RIS) is a model that includes and transcends current approaches to helping people resolve adversity and trauma. Key training implications are: 1)Leadership training in the RIS framework and 2) Develop leaders who create agencies that intentionally support self-care among staff—recognizing this as an aspect of intervention that includes the organizational context created by staff. A training plan framed by RIS can be a valuable resource for agencies and workers who help clients with adversity and trauma backgrounds. *PDP*

This article summarizes a longer article available at: www.posttraumawellness.net/files/9313/5941/5125/RestorativeIntegralSupportCPTW.pdf

Resource: www.posttraumawellness.net

News and Views

PDP Staff Retire

Dave Lindholm

Dave Lindholm, Senior Education Specialist, retired from PDP on October 31, 2014. Dave joined PDP in 1997 as an Education Specialist and brought with him prior experience as a trainer working at the Nebraska Department of Correctional Services and Southeast Community College in Lincoln, Nebraska. Originally a mathematics instructor, Dave began offering courses in using microcomputer applications, well-ahead of others in this area. This experience served him well at PDP. Dave was promoted to Senior Education Specialist in 1999 and spent his 17 years at PDP training thousands of people across NYS on various Microsoft and NYS proprietary applications.

In 2007, Dave received the PDP Outstanding Trainer Award. It is clear that Dave's greatest contributions extend beyond trainee numbers alone. His work to train staff who are blind or visually impaired to use assistive technologies, such as JAWS and Dragon NaturallySpeaking, was also well-recognized and praised.

During his time at PDP, Dave helped thousands of trainees learn advanced computer systems to deliver services more effectively. He also served as a coach and mentor for new PDP training staff. His last major endeavor before retirement was to assist Adult Protective Services caseworkers and related staff migrate from a desktop application to a web-based platform called ASAP.NET. Dave's many contributions to PDP and our training audience will continue to make a difference for years to come.

Lisa Futtner

Lisa Futtner, Project Staff Associate, retired from PDP on August 29, 2014 after 29 years of service. Her early work supporting establishment of NYS's Outcome-Based Child Welfare Training System included guidance and support to colleagues in the PDP Adolescent Services Resource Network. She was involved in the development of the Independent Living Core Training Program, which incorporated the first skills-based competencies component. Lisa's work on this program was followed by the implementation of the Outcome-Based Training System foundation and specialty components, particularly the child protective services response training. Lisa adeptly guided the development of Child Welfare Casework Documentation training, as well as Forensic and Child Welfare Interview training. She was instrumental in the ground-breaking changes to practice in the prevention of domestic violence. In recognition of her many career contributions, Lisa was recognized with the PDP Executive Director's Award in 2012. Her work in child welfare has left a lasting imprint on practice improvement and professional development.*PDP*

Mary Kazmierczak

Mary Kazmierczak, Principal Education Specialist, retired from PDP on December 19, 2014 after 27 years of service. Mary has managed PDP's Child Welfare Permanency Planning Project for the past 15 years and prior to this served as Regional Office Project Associate assigned to the OCFS Albany Regional Office from 1986 to 2000.

On a statewide level, Mary's influence on child welfare practice has been significant. She guided development of NYS's first Foster Parent Manual, The Supervisor's Guide to Assessing

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Practice, as well as assisted in NYS's efforts to not only establish a baseline of practice, but to also measure the impact of training on practice. She stewarded the revision of the Child Welfare/Child Protective Common Core training, the foundational program for new child welfare caseworkers. Mary also worked extensively on the development of various child welfare training and practice initiatives including:

- Family Preservation—Reunification
- Achieving Permanency Through Surrender and Termination of Parental Rights
- Engagement Skills Clinic for Child Welfare Supervisors
- The Supervisors Guide to Current Planning
- Core Essential Skills for Experienced Caseworkers
- KEYS Model of Child Welfare Supervision

With a management style that embodies a strength-based approach, Mary encouraged project staff to identify and build on their strengths, take initiative, and pursue excellence in PDP's contributions in promoting Child Welfare practice improvement throughout New York State. *PDP*

The Dimensions of Wellness

time, setting achievable goals, finding resources and support when called for, and giving ourselves permission to do what we need to do to live a healthier and more fulfilling life are the keys to creating wellness. Additionally, for those in the helping professions who are assisting others in their efforts to establish a healthier life, utilizing a "dimensions of wellness" model can provide a concrete means of educating clients and give them a clear system to draw upon to assess and enhance their own well-being. These models can become a helpful guide for all of us as we make our way down the path to a greater sense of health and well-being. *PDP*

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