An Ecological Approach to Services for Women Survivors of Psychological Trauma and Comorbid Substance Use Disorders

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ABSTRACT

Women who have experienced interpersonal trauma often experience co-occurring addictive and psychiatric disorders. Psychiatric disorders that are sequelae of psychological trauma and frequently comorbid with anxiety disorders include anxiety disorders such as posttraumatic stress disorder, and mood, dissociative, somatoform, eating, and personality disorders. The combination of these factors, if left untreated, can lead to an array of problems such as homelessness, involvement with the justice system, further traumatic experiences, educational deficits, financial difficulties, unemployment, family breakdown, and isolation. These problems effectively create a vicious cycle or chronic entrapment for the trauma survivor wherein she is continually exposed to increasing levels of adversity and traumatic experiences. Attempts to address the unique issues associated with women with co-occurring disorders and histories of psychological trauma have been made recently both on a micro and macro systems level. On a macro level, these attempts include the development and implementation of services for survivors that take into account gender, culture, trauma-informed & trauma-specific services, along with integration of mental health, substance abuse. On a micro level, attempts are made to study and assess the individual needs of this population, including both large scale studies such as the Women, Co-Occurring Disorders, and Violence study and the Homeless Families study. Moreover, this population's opinions and voices increasingly have been involved in the delivery of services by welcoming their roles as consumers/survivors and people in recovery. This paper will provide a qualitative and quantitative literature review of the macro and micro level efforts to provide effective services to women survivors of psychological trauma who have co-occurring disorders.

Services for women survivors of psychological trauma who have co-occurring disorders need to be comprehensive, integrated, and focused on the unique roles of women and based on an approach that values a relational perspective (SAMHSA, 2004; Covington, 2007). On a micro level special attention needs to be given to the sequence of services provided, i.e., meeting basic human needs such as food, shelter, and clothing; the establishment of safety; and management of current/chronic exposure to traumatic events. On a macro level having a basic understanding of the interaction between developmental trauma and current stressors is paramount to creating and implementing services that are effective and sustainable.

INTRODUCTION

In the general U. S. population, 61 percent of men and 51 of women have been exposed to some type of trauma (Kessler, Sonnega, Bromet, & Hughes, 1995). Of those exposed, 5 percent of men and 10 percent of women meet criteria for PTSD (Kessler et al., 1995). Eighty percent of women presenting for addictions treatment report lifetime histories of either sexual or physical assault, or both (Cohen & Hien, 2006). Other researchers estimate a range of 30 percent to 90 percent of women receiving substance abuse treatment reporting histories of abuse (Finkelstein & Markoff, 2004; Haller & Miles, 2004; Marcenko, Kemp, & Larson, 2000). A national study of homeless women who were raising children found that 94% reported having experienced at least one type of psychological trauma, and more than two-third (69%) reported traumatic experiences both in childhood and adulthood (Sacks, in review). Up until recently, treatment programs for mental health and substance use disorders were separate entities. However, it is becoming increasingly clear the interrelationship between trauma, mental health and substance abuse and the need to integrate these services.

Women with histories of chronic abuse beginning at an early age are more likely to develop complex PTSD - a syndrome that includes psychiatric disorders such as depression, somatization, dissociation, eating disorders, personality disorders, and comorbid substance use disorders. In tandem, these individuals also have difficulty managing affect, regulating impulses, maintaining healthy relationships, and developing a strong identity. A number of researchers are exploring and identifying links between early trauma exposure and impact on development. Early and chronic trauma exposure

has the potential to affect an individual's ability to regulate affect, process information, and sustain healthy relationships (Ford, Courtois, Steele, van der Hart, & Nijenhuis, 2005; Ford & Russo, 2006; van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005). As a result, the ability to interact effectively with one's immediate and extended environment is seriously compromised. A study conducted by Johnson, Palmieri, Jackson & Hobfoll (D. M. Johnson, Palmieri, Jackson, & Hobfoll, 2007) with abused women suffering from PTSD living in the inner city found that symptoms of PTSD interfered with the ability to create and maintain access to necessary resources. Without access to psychosocial and material resources to cope with stressors lead to an increased vulnerability to future stressors. Such deficits and the inability to access resources have severe consequences leading the survivor to continuous exposure to increasing levels of adversity and traumatic experiences. It is not surprising then that women with trauma and comorbid psychiatric and substance use disorders (SUD) represent a subpopulation with severe symptoms and one that is most difficult to treat (Heckman, Hutchins, Thom, & Russell, 2004; Hien, Cohen, & Campbell, 2005; Stewart, Conrod, Pihl, & Dongier, 1999).

SOCIAL IMPACT AND SEQUELAE OF PSYCHOLOGICAL TRAUMA

In addition to psychological and physical problems associated with trauma exposure and substance abuse, other contextual factors play a role in an individual's exposure to stressors and ability to cope with these stressors. Social status is one such factor. Kubiak's (Kubiak, 2005) social location theory states that each of us possesses identities within our society (e.g., race, socioeconomic class, gender, age, residential status, legal status). The greater the number of oppressed identities that one possesses

will impact the degree of exposure to trauma and stress. Similarly, Hill, Ross & Angel (Hill, Ross, & Angel, 2005) propose that people who live in a neighborhood that is plagued with high crime, gang violence, abandoned buildings, drugs, teen pregnancy, high unemployment rate, unfunded schools, housing shortage and unresponsive police are at higher risk to develop a neighborhood disorder. Individuals exposed to this disorder experience a breakdown of social order which is found to significantly increase their psychological distress. When treating individuals it is critical to take into account these factors that impact daily functioning and recovery. If we look to the criminal justice system we can see that the majority of incarcerated women are more vulnerable to experience oppressed identities and neighborhood disorder. Women offenders are primary caregivers who are poor and minority with limited education and job skills, and long histories of psychological trauma exposure (Department of Justice, 1999)

Moreover, societal values are transmitted to the individual through interpersonal relationships and interaction with systems. According to Kubiak (Kubiak, 2005) this is done in an aggressive manner through interpersonal violence and systemic discrimination such as racism and sexism. For many psychological trauma survivors exposed to chronic abuse and violence the messages that they construe early on is that they are the cause of their difficult circumstances and that they are to blame. Although this is rarely the objective truth, such forms of victim blaming constitute a form of emotional abuse that exacerbate the effects of physical or sexual violence or abuse (Teicher, Samson, Polcari, & McGreenery, 2006) as well as contributing to a sense of guilt and shame that further burden the traumatized individual (Augenbraun, in review). Developmentally, with

limited cognitive resources and limited social support, a child is not able to accurately make sense of their predicament (Cook et al., 2005).

In a qualitative study (Romero-Daza, Weeks, & Singer, 2003), thirty five in-depth interviews were conducted with female sex workers and drug users with high incidence of ongoing traumatic events from childhood to the present. Women described in detail their traumatic life experiences, lack of support and heavy use of illegal substances. The level of isolation, loss and abandonment was palpable in their stories. At the micro level system, women reported that they did not count on any immediate helpful connections. At the macro level system, women reported that they did not find any support. In order to survive, they became sex workers, by doing so they were able to meet their and their family's basic needs, as well as, their addiction and at times their partner's addiction. They were also more vulnerable to experience more traumatic events and reenactments. Thus, the interaction of contextual factors such as social location status, transmission of values, along with other lifetime experiences and forms of stress contribute to a "cumulative adversity effect" on the individual compounding a survivor's sense of isolation and hopelessness (Kubiak, 2005).

According to Relational Cultural Theory (RCT), isolation is the antithesis to psychological growth for the female. Theorists such as Siegel (Siegel, 2001) and Yehuda and McEwen (Yehuda & McEwen, 2004) propose that people are emotionally and socially "hard-wired." Given this premise, RCT bases its principles on the idea that humans grow in connection with each other (Walker & Rosen, 2004). Relational theory as developed by the Stone Center (Jordan, Kaplan, Miller, Stiver, & Surrey, 1991) states that women grow in connection with others and that the individual women derives her

sense of self through and by her relationships. Psychological growth for the female occurs through mutually empathic and mutually empowering relationships that allow her to attend to others, understand others, be understood by others, and thereby participate in the growth of other individuals. Relationships, then, are seen as central to a female's psychological well-being. In a relational model the implication for therapy is the establishment of a mutually empathic, mutually empowering relationship. The primary tool used for healing in this model is the relationship. While it is difficult to operationalize all the discrete factors that contribute to building a mutually empowering, mutually empathic relationship, the most salient features of this model are the concepts of mutuality, mutual empathy, mutual empowerment, and the use of countertransference related to connection and disconnection (Jordan et al., 1991; Jordan & Surrey, 1986). It is necessary that treatment models take into account the establishment of healthy relationships and the fostering of connections for women. Doing so will prove critical to the recovery process. Taking into account relational factors aims to counteract what Covington (2007) refers to as the "condemned isolation" that so many survivors of trauma suffering with comorbid SUDs and other disorders experience. The impact of such isolation is illustrated in extreme acting out behavior that gets women involved in the criminal justice system and can be more aptly viewed as a "resistance for survival."

Similar to RCT, McFarlane and van der Kolk (McFarlane & van der Kolk, 1996) indicate that "the central issue in disaster management is the provision and restoration of social support." (p.24). During times of societal crisis' such as wars, entire communities tend to become more cohesive to protect each other from the enemy and to ensure that their group would have the possibility of survival. In order to overcome such adversity

and remain emotionally undisturbed, communities depend on the supportive environment provided by the society at large (McFarlane & van der Kolk, 1996). However, other types of societal crisis such as the "war on drugs" and/or "community violence" seem to lack societal support because these types of problems become chronic and seem somewhat intractable. This lack of societal support contributes to the development of PTSD at an individual and community level. If the adversities persevere and the society continues unresponsive, the complex forms of posttraumatic psychosocial and behavioral problems may develop on an epidemic basis. Once communities and its members are unable to support and provide for one another, reenactment at individual and community levels continues to occur leading towards further trauma development and further pain. Therefore, the experience of psychological trauma not only impacts the individual and immediate group members, but can expand to whole communities and societies at large.

VICIOUS CYCLE OR CHRONIC ENTRAPMENT

Specific factors that contribute to a women's chronic entrapment in trauma and addiction include: limited financial resources, unemployment due to lack of education, high incidence of childhood sexual and physical abuse, lengthy histories of domestic violence as adults, substance abuse, and legal involvement. Within the criminal justice system alone the change in the number of women offenders has drastically increased over the last several decades. Specifically, the number of women in jails and prisons has tripled while the number of men has doubled. Although the percentage of serious violent crimes has steadily decreased since 1993, the percentage of drug offenses has risen at the greatest rate since 1999 (Department of Justice, 1999). Covington (Covington, 2007) notes that these increases may be attributed to changes in the legal system where harder

sanctions are imposed related to drug charges. Moreover, Covington and Bloom (Covington & Bloom, 2007) suggest that this emphasis on law breaking as an individual pathology skirts the issue underlying complex social problems.

The majority of women in prison today are there due to drug related offenses, as well as, domestic violence. Three million women are arrested each year and one million are held in custody. Women comprise approximately 16 percent of the nation's incarcerated correctional population. Often these women are mothers and primary caregivers for approximately 1.3 million minor children. As a result, children are being cared for by other family members and, depending upon the time served, some children are transferred over to the foster care system (Department of Justice, 1999). The break-up of the family serves as an example of trauma reenactment in that the mother has suffered a loss and the disruption of parental bonds during sensitive development periods and is not without its consequences. Children of incarcerated parents are significantly affected in three areas: parent/child separation, enduring traumatic stress, and inadequate quality of care (Johnston, 1995). This trauma-reenactment also serves as one pathway for the intergenerational transmission of trauma and abuse.

Recognizing the sequelae of psychological trauma in the form of psychiatric and addictive disorders; deficits in affect regulation, information processing, and relationships; and the limited ability to gain access to psychosocial and material resources is a first step to breaking the vicious cycle or chronic entrapment of abuse. Moreover, the identification of trauma reenactment as part of the sequelae to chronic exposure to psychological trauma is also key to working with this population. Trauma reenactment occurs on a personal, institution, and societal level. In essence, trauma survivors

communicate their story to others via harmful internalizing (self harm, suicidal ideation) and/or externalizing (aggression, destruction of property, theft) behaviors (D. G. Miller, L., 1994), while larger systems distance themselves from such difficult clients by identifying with the aggressor rather than the victim (van der Kolk, 2007). The lives of women offenders exemplify the complexity of treating individuals who experience early and ongoing abuse. Thus, it is imperative that treatment interventions provide comprehensive and integrative services to work with the individual and her ecological system.

SERVICES FOR WOMEN SURVIVORS WITH CO-OCCURRING DISORDERS

Given the number of factors affecting women trauma survivors with co-occurring disorders, a treatment response would need to be wide-ranging and targeted toward a multi-level and multi-systemic approach. From an ecological perspective, intervention would need to take place on a systems level as well as on an individual level in order to be effective. Systems and services would need to be trauma-informed and interventions would include a trauma-specific component. (Fallot, in press). A trauma-informed system would possess an understanding of trauma, its impact, consequences, and pathways to healing at all levels of service within the organization. Trauma-specific services would target trauma's impact on the individual and focus on healing and recovery (Fallot, in press) Individual treatment would also need to take into account the unique roles of women in our society, along with specific aspects related to mental health and substance abuse. Ideally, a systems intervention would include the educational, religious, governmental, medical, social, and business communities. There have been a number of studies examining services to women with trauma and addiction, most notably,

the Women, Co-Occurring Disorders, and Violence study and the Homeless Families study. We will examine these studies in the context of a multi-level and multi-systemic approach to treatment and report their findings.

Women, Co-Occurring Disorders, and Violence Study (2003)

A five-year, multi-site, national study of services for women with co-occurring disorders and histories of abuse and violence was funded by SAMHSA in 1999. A total of nine sites participated in developing integrative mental health and substance abuse services. In addition, consumers of these services were invited to play an active role in helping to develop, implement, and assess such services (Moses, 2003). Four trauma-specific models and integrated substance abuse models were used. The trauma-specific models included: Seeking Safety (Najavits, Weiss, Shaw, & Muenz, 1998), Addictions and Trauma Recovery (ATRIUM; (D. Miller & Guidry, 2001), Trauma Recovery and Empowerment Model (Harris, 1998), and Triad (Fearday, Clark, & Edington, 2001). Outcomes from the national study demonstrated that interventions which address mental health, substance use, and traumatic stress problems in an integrated manner were associated with significant improvements in a wide variety of measures of psychosocial functioning and health (Morrissey et al., 2005).

In this multi-site study, researchers also compiled qualitative data regarding the initial challenges to creating trauma-informed and trauma-specific services (Moses, 2003). Creating shared understandings and shared philosophies were the two major themes that emerged during this process. The specific programmatic challenges experienced by this diverse working group included: 1) Theoretical differences regarding the etiology of substance abuse, e.g., disease model versus self-medication model, 2)

Opposition at the service level rooted in apprehension about ability to contain trauma, lack of specialized expertise, and unease related to unresolved traumatic issues on the part of staff, 3) Opposition at the administration level related to differential beliefs regarding the impact of trauma, and concerns over scarce financial and staff resources, 4) Monetary concerns connected to non billable hours for training and supervision and lack of reimbursement for trauma treatment in SUD programs with unlicensed staff, 5) Inconsistent client participation due to transportation and childcare issues, or fear linked to addressing trauma, or other priorities related to basic necessities of life, e.g., food, housing, employment, and 6) Staff turnover. Helpful practices to overcome obstacles required collaboration, open forums, education, cross-training, interagency planning and coordination.

In a follow-up report regarding the Women with Co-occurring Disorders and Violence study clinical researchers (Markoff, Reed, Fallot, Elliott, & Bjelajac, 2005) formed a trauma work group and reflecting upon their experiences identified a number of best practices for implementing trauma-informed and trauma-specific services for women with co-occurring disorders.

Initially, what this group discovered very early on in the process was that integrating traumatic stress, mental health, and substance abuse services from the perspective of provider and consumer requires creating a common language. For example, what to call the women seeking services offered up diverse responses among the group. Women receiving SUD treatment viewed themselves as in recovery, women who identified with domestic/violence sexual assault viewed themselves as survivors, and other women involved in the mental health field viewed themselves as consumers. The

name ultimately agreed upon was, consumer/survivor/recovering persons (CSRs). According to researchers the best-practices for implementing trauma-informed and trauma-specific services include: 1) Acknowledgement regarding the impact of trauma. For example, trauma affects a person's sense of self, relationships with others, ability to regulate affect, manage stress, and views of the world. Behaviors previously viewed as resistance, psychopathology, acting out, or lacking motivation are a survivor's attempt at regulating or avoiding traumatic stress responses. These responses are viewed as behaviors that were used in an attempt to cope with earlier traumatic events. 2) Create safe spaces to reduce revictimization. 3) Use of empowerment and strengths-based techniques. 4) Provide women with choices and information regarding treatment and services. 5) Facilitate mutual and healthy relational connections between women, program, and providers. 6) Aid in understanding of important differences among women. 7) Involve women into the service delivery process by eliciting feedback regarding helpful and unhelpful or triggering practices in order to enhance program services and aid in peer mentoring

Homeless Family Study

Forty-one percent of homeless women who are caring for children are several times more likely to be suffering from substance use disorders (Acierno, Resnick, Kilpatrick, Saunders, & Best, 1999) than stably housed women. Homeless women who have substance use disorders also are at very high risk (~50%) of suffering from depression or PTSD (Bassuk, Buckner, Perloff, & Bassuk, 1998). A multi-site national study of services for homeless mothers was initiated by SAMHSA in 1999 and over a four-year period more than 1500 homeless women caring for children received repeated

assessments and services designed to assist them with a variety of psychosocial needs including PTSD.

All participating homeless women and children received "trauma-informed" services as a result of staff education and training on the impact that psychological trauma can have on psychosocial functioning and parenting, and on avoiding inadvertent exacerbation of PTSD when delivering services (Sacks, in review). More than half of the study sites provided "trauma recovery interventions" (Sacks, in review) that were designed to teach strategies for managing or reducing PTSD symptoms, including ATRIUM (D. Miller & Guidry, 2001), *Stages of Healing* (Bradley, 2002), TARGET (Ford & Russo, 2006) and two different intensities (16 sessions and 10 sessions) of Trauma Recovery and Empowerment Model (TREM) (Harris, 1998). The trauma recovery models were designed and adapted to enhance trauma recovery in accordance with evidence-informed national guidelines (SAMHSA, 2004), and were adapted to meet the unique needs and circumstances of the participating homeless women and children at each site.

Results of the study (Sacks, in review) indicated that one in three women showed a substantial reduction in PTSD symptoms. One fourth of the participants had very high or moderate initial levels of PTSD symptoms and did not report more than small reductions over the eighteen-month study period, and forty percent of the participating women reported stably low levels of PTSD symptoms. Unexpectedly, the trauma recovery models were not associated with greater reductions in PTSD symptoms than the standard trauma-informed interventions. The factors that were most associated with reductions in PTSD symptoms were stable housing and employment, suggesting that

either trauma recovery or trauma-informed interventions can benefit homeless mothers if they address housing and employment as primary goals. The enhancement of self-esteem, social support, and empowerment that is the focus of the TREM, ATRIUM, and Stages of Healing models, and the emotion regulation and stress management skills that are the focus of the TARGET intervention may contribute to increased stability of housing and meaningful employment, although that hypothesis could not be tested in this study. As with the interventions in the Women, Co-Occurring Disorders, and Violence Study, the Homeless Families Study embody an integrated relational self-empowerment approach to helping underserved and highly stressed women recover from PTSD.

Treatment Models

Currently, there are a number of gender specific psychoeducational models that address substance abuse, mental illness and trauma issues. (Ford & Russo, 2006; Harris, 1998; D. G. Miller, L., 1994). Many of them are holistic and integrative, trauma-informed and group-oriented, manualized models. The number of treatment sessions range from 12 to 29, time per session range from 50 to 120 minutes. Depending upon the model, treatment groups can be led by people in recovery, paraprofessionals, or clinicians. For the most part, cognitive-behavioral and relational theories have been used (SAMHSA, 2004). Some models have been adapted for use in correctional settings such as, Helping Women Recover (Covington & Bloom, 2007). Consistent with RCT this program strives to create a therapeutic milieu that emphasizes a sense of belonging (attachment), safety (containment), openness (communication), participation (involvement), and empowerment (agency).

According to Fallot and Harris (Fallot, in press), substance abuse services need to incorporate trauma informed services as well as trauma-specific services. Given the significant correlation between substance abuse problems and the experiences of trauma, providing services to address both issues seem to be the most appropriate way to deliver efficient treatment. Fallot and Harris recommend that programs understand how experiences of psychological trauma and posttraumatic stress can be manifested in many different ways, affecting a variety of life domains. For example, a person who uses illegal substance to decrease PTSD symptoms, may be also end up involved in the criminal justice system, may experience interpersonal violence, and so on.

Programs are also recommended to establish an open communication between providers and consumers to prevent any type of reenactment. The therapeutic relationship is built upon the premise that consumers are experts of their lives and therapists' role is of a collaborator/facilitator of change.

BEYOND TRAUMA-INFORMED AND TRAUMA SPECIFIC SERVICES

Harris and Fallot (Harris & Fallot, 2001) recommendations to use trauma theory to design service systems are a vital paradigm shift in the mental and substance abuse areas. Several studies have adopted the shift and report better outcomes (Markoff, Reed et al., 2005). From a micro level system, the paradigm shift is being very effective and provides safe and healthy interactions with the individual's close connections. The authors propose that, in addition to trauma theory, when designing service systems, providers need to adopt a community educator/advocator role. In doing this, unrelated and related systems are reached and welcomed to be part of a paradigm shift in which a whole society is involved in the caring and protection of each other. Mental health and

substance abuse providers cannot work in isolation, they too need to establish the connections and collaborations with other systems. From a macro level system perspective, providers will benefit from reaching out to other community organizations to become trauma-informed agencies. The repetitive interactions with multiple systems which can contain suffering and despair may prevent further re-traumatization and reenactment.

Another paradigm shift was designed to provide relational gender specific services to women using a Relational Systems Change Model (RSCM) (Markoff, Finkelstein, Kammerer, Kreiner, & Prost, 2005). This model proposes that the same Relational Cultural Theory principles utilized to establish healthy connections at an individual level (mutuality, authenticity, empathy and empowerment) can also be utilized at behavioral health services on state and local systemic levels. The RSCM includes all the systems involved in the mental and substance abuse care of women, from bottom-top to top-bottom. This included policy makers, which influence the type of treatment women would get depending on health insurance and/or state assistance, consumers, mental health providers, substance abuse providers, case managers, and shelter staff. The main purpose of working in collaboration was to provide a "trauma-informed, integrated system of care for women with co-occurring substance abuse and mental health disorders and histories of violence" (p.239). The state of Massachussets adopted the relational systems change model through the Women Embracing Life Living (WELL) Project, reporting significant gains in the delivery of services for women with multiple histories of traumatic events and problems with substance use (Markoff, Finkelstein et al., 2005).

The development of trauma informed services (Fallot, in press) and the relational systems change model (Markoff, Finkelstein et al., 2005) have influenced the formation of integrative services using relational approaches. Although these types of services are in their early developmental stages, currently, there are a few studies supporting its further development. In a quantitative study, Marcenko (Marcenko et al., 2000), studied 127 African American mothers with young children and a history of substance abuse from an underprivileged community. The authors tested a developmental model that includes childhood experiences of abuse, its relationship to adult functioning and child placement. Findings suggest that the number of childhood traumas is positively correlated to substance abuse. The greater the substance dependence, the higher the risk for mothers to have their children removed from the home. The authors suggest for the welfare services to work in collaboration with substance abuse services in order to provide more comprehensive and integrating services to mothers with substance use disorders and their children. This is an example of how researchers and clinicians are more aware of the need for trauma informed services to reaching out to other type of services that are also part of an individual's ecological system. By educating other services about trauma, clinicians will facilitate the integration of fragmented ecological subsystems and systems in the lives of individuals affected by a number of traumatic events. Thus, other systems non-related to mental health and addiction services are more likely to respond in a supportive manner in order to further promote growth at a personal, familial and societal level.

Jail diversion programs are another example of the need to integrate trauma informed services and to work in collaboration with other systems. Nationwide, there are

numerous jail diversion programs, which are also building bridges between mental health and substance abuse services with the criminal justice system. The function of jail diversion programs are to facilitate referrals to mental health and/or substance abuse services to individuals who have criminal charges and have serious psychiatric disorders. Due to the significant increase of women offenders, the development of gender and trauma specific jail diversion programs for women have been established since the late 1990's (Chang, Meckel, & LaRosa, 2007). In the State of Connecticut, there are two gender specific jail diversion programs for women, which provide trauma services, substance abuse treatment using a relational cultural theory approach. Study outcomes from these two programs indicate that after six months of outpatient treatment, women reported significant improvements in substance use, employment, criminal justice, trauma symptoms, existential well-being and hopefulness (Pollard, Schuster, Lin, & Frisman, 2007). Educating important key personnel from the criminal justice system to understand women offenders' mental health needs was crucial for the success of the programs and for the continuation of services. Providing services, which integrate individuals' ecological systems, have the potential to change whole communities.

CONCLUSION

In his ecological system, Bronfrenbrenner (Paquette, 2001) proposes that a human being develops within a system of relationships formed by his/her environment. This environment contains several layers, beginning with the most basic and close to the individual such as her biological make up, immediate familial-bond/community, and expanding to her societal landscape. All of these layers interact with one another and are interdependent. At the microsystem level, a person is directly linked with her immediate

surroundings which are family members, neighbors and any other system which has direct impact on an individual's daily functioning. At the mesosystem, an individual's functioning is affected by the interactions of systems involved in her life at the present time. At the exosystem, the influence of systems involved in a person's life, will affect her treatment outcome and the relationship between the systems. At the macrosystem level, the impact is directly related to cultural norms, customs, and laws.

We are proposing a step by step ecological treatment. Women need gender specific services focused on the rebuilding of relationships starting at a microsstem level. At this level a woman can be given the opportunity to rediscover or reconnect with her own internal locus of control (Follette, in press; Gold, in press; Jackson, in press). Through the use of non-flooding, body work and experiential emotion-focused techniques (e.g., (Fisher, in press; Fosha, in press) a woman can gain control over the bioaffective consequences of traumatic stress responses (B. van der Kolk, personal communication, January 18, 2008). At the same time, guidance and modeling to build healthy relationships builds upon her ongoing personal growth (J. D. Ford, & Saltzman, W. , in press; S. Johnson, & Courtois, C. , in press).

At the macrolevel providers need to go beyond a trauma informed or even trauma recovery treatment approach to educate the communities at large, including religious, government, education, medical, and business systems about the adaptive changes that occur on a biopsychosocial basis when girls or women experience, survive, and struggle to recover from psychological trauma (J. D. Ford, in press) and addiction (Covington, 2007).

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