SECTION ONE:
UNDERSTANDING RECOVERY
AND RESILIENCY:
THEORY

Towards an Ecological Understanding of Resilience in Trauma Survivors: Implications for Theory, Research, and Practice

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SUMMARY. The ecological perspective of community psychology offers needed understanding of diverse sources and expressions of resilience among trauma survivors. Investigations by community psychologists into the nature of wellness-enhancing interventions and empowering social

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change can inform trauma-focused interventions at individual, community, and societal levels. Here, works by selected community psychologists are reviewed. The ecological view of trauma, recovery, and resilience guiding work at the Victims of Violence (VOV) Program, the range and reach of VOV's clinical and community interventions, and elements of its trauma recovery and resiliency research project illustrate the implications and relevance of these works. Five premises of an ecological understanding of resilience in trauma survivors are discussed. doi:10.1300/J146v14n01_02   *[Article copies available for a fee from The Haworth Document Delivery Service: 1-800-HAWORTH. E-mail address: <docdelivery@haworthpress.com> Website: <http://www.HaworthPress.com>* © 2007 by The Haworth Press, Inc. All rights reserved.]*

The field of community psychology, and particularly what Kelly (1968, 1986) and Trickett (1984, 1997) have called the "ecological analogy" of community psychology, have much to offer those of us who are seeking to understand and promote resilient responses to human suffering. In its emphasis on the interdependence of individuals and communities, its focus on the prevention of harm and promotion of wellness, and its interest in the empowering possibilities of ecologically informed intervention, community psychology has generated theoretical frameworks and research paradigms relevant to the study of psychological resilience in trauma survivors (Harvey, 1996; Norris & Thompson, 1995).

This article begins with a brief summary of the range and scope of traumatic events that human beings suffer worldwide and an equally brief review of research documenting the psychological price paid by many exposed to these events. These literatures serve as preludes to more recent developments in the traumatic stress studies field, including its growing interest in sources and expressions of resilience in trauma survivors. The history and tenets of community psychology, and works by selected community psychologists, are reviewed in terms of their contributions to the understanding of resilience and the design of interventions to foster resilience in both individuals and their communities. The ecological view of psychological trauma, recovery, and resilience guiding the work of the Victims of Violence (VOV) Program, the

range and reach of VOV's clinical and community interventions, and elements of its trauma recovery and resiliency research project are offered as case illustrations of these contributions.

THE EPIDEMIOLOGY OF HUMAN SUFFERING

A fair reading of the epidemiological literature of the past 30 years would confirm that huge numbers of individuals in this country and around the world have suffered, or will at some point in their lives suffer, violence, abuse, atrocity, and catastrophe. These experiences are not randomly distributed. Gender, age, income, race, class, and cultural context have a great deal to do with who is at greatest risk of different types of violence. In the United States, as in most other countries, for example, an alarming number of women and children live at substantial risk of physical and sexual violence within their own homes and most intimate relationships (Tjadeen & Thoennes, 1998, 2000). There is by now considerable evidence that abuse in childhood sets the stage for future abuse (Follette, Polusny, Bechtle, & Naugle, 1996) and that violence against women and children has become a public health problem of pandemic proportions (United Nations, 2003).

In the United States, men are more likely to become victims of violence at the hands of strangers (Tjaden & Thoennes, 1998). Around the world, in countries and cultures afflicted by civil strife and international warfare, men are also more likely to encounter the horrors of war as armed combatants. Women and children, the very old and the very young, endure the many other hardships of war (Goldstein, 2001; Graca Machel/United Nations, 1996), becoming "collateral damage" as battle fields invade civilian populations and noncombatant men, women, and children are forced to flee war-torn homelands for uncertain status as refugees. Increasing numbers of children have been witness to genocide, commandeered into armed conflicts as "child soldiers," and forced to recruit and even execute other children (Garbarino, Kostelny, & Dubrow, 1991; Mendelsohn & Straker, 1998; Myers-Walls, 2003). In the context of war, women and girls are subject to repeated rape and treated as "trophies" of war by conquering soldiers and occupying forces. Among them are those who, having been violated by enemy combatants, are ostracized by their communities and abandoned by their families (Gingerich & Leaning, 2004; McKay, 1999).

Apart from these atrocities are a host of natural and manmade disasters affecting entire communities. Earthquakes, floods, and hurricanes annually combine with incidents of school and community violence, industrial catastrophes, and acts of terror and revenge to ensure that here at home and on a worldwide stage, human suffering is broad in scope, diverse in nature.

THE PSYCHOLOGICAL AFTERMATH OF TRAUMA

Over the course of these same 30 years, researchers and clinicians have drawn convincing links between the extreme events to which human beings are exposed and the symptoms of psychological distress and characterological impairment that can follow such exposure (Ballenger et al., 2004; Bedard, Greif, & Buckley, 2004; Herman, 1992).

That a significant number of men and women in combat suffer immediate, delayed, and ongoing symptoms of PTSD is by now well-established (Figley, 1978; Gallers, Foy, Donahoe, & Goldfarb, 1988; Schnurr, Lunney, Sengupta, & Waelde, 2003). Equally well-documented is the psychological harmfulness of criminal victimization (Kilpatrick, Saunders, Veronen, Best, & Von, 1987), rape (Burgess & Holmstrom, 1974; Koss, 1993), child abuse and incest (Briere & Elliot, 2003; Herman, 1981), disaster (Barron, 2004; Norris, Friedman, & Watson, 2002a, 2000b), and exposure to prolonged and recurrent trauma (Herman, 1992), including the extreme violations of political violence, terrorism, and torture (Goldfield, Mollica, Pesavento, & Farone, 1988; Resnick, Galea, Kilpatrick, & Vlahov, 2004; Turner, 2004) and trafficking and prostitution (Farley et al., 2003). In toll, this research has yielded significant advances in the understanding of PTSD and other posttraumatic disorders, including what Judith Herman (1992) has called "complex PTSD," and led to a rethinking of diagnostic labels, a reexamination of the etiology of emotional disorders, and a search for effective, trauma-focused treatments (Foa, Keane, & Friedman, 2000; Weiss, Saraceno, Saxena, & van Ommeren, 2003).

NEW DIRECTIONS IN TRAUMA RESEARCH

An Interest in Untreated Survivors

Community studies of populations exposed either to natural disasters or to violence of human design suggest that individuals differ considerably in their vulnerability to symptom development and the extent to

which their early onset symptoms persist (McFarlane & de Yehuda, 1996; Norris, 1992; Norris et al., 2002a). Those who do become symptomatic differ in the nature, duration, and intensity of their symptoms, their interpretations of their experience, and the avenues they pursue to secure symptom relief. These differences reflect a complex interplay of many influences, including: the nature and chronicity of the events to which they have been exposed; demographic factors such as age, race, class, and gender; neurobiological mediators of hardiness and vulnerability; the influence and stability of relevant social, cultural, and political contexts; and any number of ecological factors that support or impede access to natural support, comforting beliefs, and trauma-informed clinical care (Green, Wilson, & Lindy, 1985; Harvey, 1996; Hernandez, 2002; McFarlane & de Yehuda, 1996).

In the face of these findings, it is important that future research not only document the range and extremity of traumatic exposure among untreated survivors, but also determine who within these populations is and is not at risk of symptom development (Yehuda, 2004). Equally important is the development of public health strategies to support positive coping and extend solace and support to those individuals and groups who are unlikely to receive professional care.

An Interest in Multicultural Influences and the Role of Context

A full understanding of the resilience that trauma survivors may bring to the challenge of trauma recovery requires that clinicians and researchers attend to the influence of cultural and contextual mediators of traumatic response (Hernandez, 2002; Tummala-Narra, 2001 and both articles in this volume). While symptoms of PTSD have been found among trauma survivors of both genders, all ages, and diverse racial, ethnic, and cultural groups, it is also true that particular events (e.g., incest, rape, or spousal abuse) and symptoms (e.g., dissociation, somatic complaints, ataques nervios) may have quite different meanings in different cultural contexts (Radan, this volume). Cultural and community values exert profound influence over a victim's willingness to disclose (or not) a particular incident of violation or abuse (Haeri, this volume), for example, and cultural interpretations of the events to which they have been exposed shape survivors' own understandings of these events (Tummala-Narra, "Conceptualizing trauma," this volume). Finally, cultural groups may differ considerably in their definitions of what is and is not resilient (Hobfoll, Jackson, Hobfoll, Pierce, & Young, 2002).

An Interest in Resilience

Within the larger body of untreated trauma survivors, and indeed among survivors who do access professional care, are large numbers of individuals who do not develop complete or persistent PTSD despite their experience (Norris et al., 2002a; Yehuda, 2004) and an indeterminate number who seem not only to survive but even to thrive (Tedeschi & Calhoun, 1995; Wild & Pavio, 2003). These groups have created an interest in identifying origins and indices of risk and resilience in trauma survivors (Harvey, 1996; McFarlane & de Yehuda, 1996) and in what has been labeled "positive" or "adversarial" growth posttrauma (Tedeschi & Calhoun, 1995; Linley & Joseph, 2004).

With few exceptions (e.g., Wild & Pavio, 2003), the "resilience" literature and the "positive" or "adversarial" growth literature seldom cross-reference one another. Implied in both, however, is a consensus that resilience is evident when a given event has little or no deleterious impact, presumably because the individual is able to mobilize internal resources that existed pre-trauma, while positive or adversarial growth is manifest post-trauma in a higher level of functioning that has been wrested from a struggle to overcome the devastation of trauma. These distinctions blur, however, as investigators cite as evidence of resilience the ability of some survivors to transform their experience post-trauma (Grossman, Cook, Kepkep, & Koenen, 1999; Higgins, 1994) and as studies of positive or adversarial growth confirm the relevance of attributes that clearly existed pre-trauma (Linley & Joseph, 2004). While both constructs could benefit from further clarification, it seems likely that some degree of resilience pre-trauma is requisite for posttraumatic growth, and that posttraumatic growth is itself a sign of resilience.

Recently, Bonanno (2004) has questioned the approach that trauma researchers have taken to the study of psychological resilience, suggesting that their immersion in the struggles of trauma survivors who clearly require clinical care have led them to view resilience ". . . either as a pathological state or as something seen only in rare and exceptionally healthy individuals" (p. 20). Locating his critique in the spirit of Seligman's and Csikszentmihalyi's (2003) call for a "positive psychology," he suggests that resilience is common, not rare; that individuals pursue multiple pathways to resilience; and that future research must identify the full range of outcomes people suffer and achieve posttrauma.

In fairness, it is important to note that, with few exceptions, most trauma researchers would agree that it is typically a minority (though

often a sizeable minority) of survivors who develop severe and long-lasting symptoms (Ballenger et al., 2004). Indeed, according to Yehuda (2004), "The normal path is recovery, which is facilitated by a supportive environment" (p. 35). Needed is knowledge about how to create and sustain such environments.

Like many authors, Bonanno (2004) seems to regard resilience as an all-or-none phenomenon (i.e., one is either resilient or not resilient, affected or not affected). How then do we classify the incest survivor who in the daytime performs exceedingly well at a challenging job where she enjoys amicable relationships with her colleagues, but at night may be afraid to sleep because of recurrent nightmares in which she relives the many horrors of her childhood? She functions well during the work-week, but is isolated, anxious, and lonely on the weekends. Is she resilient? Is she impaired? Is it possible she might be both? Clinical practice and recent research suggest that resilience is a multidimensional phenomenon and that she is indeed both complexly traumatized and resilient (Lynch, Keasler, Reaves, Channer, & Bukowski, this volume). Similarly, how are we to classify the illegal immigrant who makes it out of a war-torn homeland, across dangerous borders and into the United States where s/he is able to secure employment and send money home, but is beset by symptoms of depression, anxiety, and PTSD? Research with war refugees (Peddle, this volume; Radan, this volume) suggests that this person, too, is both resilient and distressed, and that resilience co-occurs with even severe distress.

When resilience is defined as multidimensional (Harvey, 1996), it becomes possible to see trauma survivors as simultaneously suffering and surviving, and to suggest that both trauma recovery and the process of posttraumatic growth require the survivor to somehow access his or her resilient capacities. The need now is to augment research on the psychopathology of trauma with investigations into developmental and contextual mediators of resilient response and the nature of interventions able to foster resilience in traumatized individuals and their communities.

THE CONTRIBUTIONS OF COMMUNITY PSYCHOLOGY

Complementing these relatively recent inquiries into the nature and nurture of resilience in trauma survivors is a long-standing interest among community psychologists in the promotion of wellness, the in-

fluence of context on psychological functioning, and the empowering possibilities of ecologically informed intervention at individual, community, and societal levels.

Community Psychology: A Brief History

The field of community psychology was formally "birthed" at Swampscott (MA) in 1965 when 39 participants gathered to consider the future of psychology in the then-growing community mental health movement. Those in attendance questioned the mental health field's preoccupation with individual psychopathology, its bias towards person-centered analysis and intervention, and its neglect of environmental variables (Caplan & Nelson, 1973). Determined that psychology had a role to play in addressing and ameliorating such social ills as poverty, racism, oppression, and discrimination, participants in the Swampscott Conference went on to generate new conceptual frameworks, engage in social action and social action research with oppressed and marginalized community groups, and promote individual, community, and social change by means of multi-level, competency-oriented interventions (Heller & Monahan, 1977).

Since Swampscott, community psychologists have brought to bear on the field's continuing development the tenets of liberation psychology (Watts & Serrano-Garcia, 2003), the overarching goal of social justice (Fondacaro & Weinberg, 2002; Prilletiensky, 2001), and the premises of feminist theory and research (Bond & Mulvey, 2000; Koss & Harvey, 1991; Riger, 2001). They have also generated theoretical frameworks and research paradigms for examining the reciprocal influences of persons and contexts. Particularly relevant to the understanding of resilience is the ecological perspective guiding these inquiries (Harvey, 1996; Kelly, 1968; Norris & Thompson, 1995; Trickett, Kelly, & Vincent, 1985).

The Ecological Perspective of Community Psychology

Community psychologists share with field biologists the premise that organisms live (i.e., survive, thrive, or decline) in interdependence with their environments. The ecological analogy incorporates a "resource perspective," assuming that human communities, like other living environments, evolve adaptively and can be described in terms of their development, preservation, and exchange of community resources (Hobfoll & Lilly, 1993; Kelly, 1986). These resources include the peo-

ple who comprise a community's membership and the qualities they bring to bear on community development; the formal and informal settings that define community membership and both nurture and proscribe competencies, values, and beliefs vital to community life; and the events that mark, celebrate, and sometimes challenge a community's identity vis a vis the larger world (Koss & Harvey, 1991). Healthy and health-promoting community ecosystems are characterized by an abundance and diversity of these resources and by multiple opportunities to participate in and influence community life (Heller & Monahan, 1977).

An implication of the ecological perspective is that resilience is transactional in nature, evident in qualities that are nurtured, shaped, and activated by a host of person-environment interactions. Resilience is the result not only of biologically given traits, but also of people's embeddedness in complex and dynamic social contexts, contexts that are themselves more or less vulnerable to harm, more or less amenable to change, and apt focal points for intervention. Moreover, within these contexts, individuals are not simply the passive recipients of contextual forces; rather they are "agentic, capable of negotiating and influencing, as well as being influenced by context" (Riger, 2001, p. 75).

Pathways to wellness: Guidelines for health-promoting preventive intervention. The engagement of persons and contexts creates possibilities for enhancing both individual and community wellness. Studying these engagements, community psychologist Emory Cowen (1994) has identified five "pathways to wellness" and corresponding opportunities for wellness-promoting interventions throughout the lifespan and at multiple ecological levels. The pathway he calls "forming wholesome early attachments," for example, is salient early in childhood and recognizes the importance of early, family-focused interventions to nurture positive parent-child attachments. A second pathway, "acquiring age- and ability-appropriate competencies," gains importance later when intervention programs in settings relevant to developing youth can offer compensatory wellness-support to children who have not received adequate care and nurturance earlier in life. "Exposure to settings that favor wellness outcomes," pathway three, highlights the need to create a variety of social milieus in which diverse individuals and groups can develop a sense of belongingness, relatedness, and self-esteem. "Having the empowering sense of being in control of one's fate," pathway four, and "coping effectively with stress," pathway five, are relevant to wellness outcomes across groups and developmental stages. However, empowering interventions may be particularly vital to the well-being of oppressed, disadvantaged, and marginalized groups, while interven-

tions to promote positive coping may be crucial in the face of stress and adversity.

For Cowen (1994), these pathways constitute "mutually enhancing elements in an elaborate system" (p. 159). Interventions to foster positive attachments in early childhood support the child's acquisition of age-appropriate competencies later in childhood, and access to settings that promote competence, agency, and empowerment will play an important role in preparing individuals to cope with stress and adversity.

The power of social contexts. Community psychologist Rudolf Moos (2002, 2003) and his colleagues have spent decades studying the ways in which individuals and social contexts influence one another and what attributes of social context might underlie the beneficial effects of intervention. These attributes, he suggests, can be categorized into three broad dimensions that have salience across multiple settings: (a) Relationship dimensions include such attributes as participants' support of one another and the degree of spontaneity and open expression among them; (b) Personal growth and goal orientation dimensions include the extent to which the context provides opportunities for personal growth; and (c) system maintenance and change dimensions include qualities such as clarity of purpose and responsiveness to change. Moos' (2003) research further suggests that intervention programs function as transient social contexts and can be assessed on these same dimensions. Supportive relationships and group cohesion among intervention participants, reasonably high expectations for personal growth, clear goals, and a moderate degree of structure are associated with positive intervention outcomes, for example. However, while the more enduring contexts of family, school, workplace, and established community setting exert both powerful and relatively long-lasting impacts on individual health and well-being, even highly effective interventions will have short-lived influence without post-intervention support from familiar social and cultural contexts (Moos, 2002, 2003).

The literature of community psychology is replete with investigations into the attributes of effective intervention programs (see, e.g., Durlak & Wells, 1997; Harvey, 1985; Paster, 1980). Invariably, these studies confirm that: (a) the beneficial influence of interventions depends heavily on their knowledge of and responsiveness to contextual influences, and (b) the durability of an intervention's influence depends on if and how its effects are incorporated into the life and culture of more enduring social contexts. At the level of individually-focused interventions, mutual self-help groups have proven effective vehicles for providing on-going support to participants in time-limited clinical inter-

ventions (Moos, 2003). In a similar vein, stage-specific group treatment may offer to trauma survivors an "ecological bridge" to new and safer community (Mendelsohn, Zachary, & Harney, this volume). At the level of local community, sound knowledge of existing resources and the "match" achieved between intervention resources and a target community's resource needs are essential to intervention success (Sandler, 2001). Equally important is a collaborative relationship with community members who can help to sustain the beneficial effects of intervention (Paster, 1980). The empowerment model of community crisis response (Harvey, Mondesir, & Aldrich, this volume), for example, is one that seeks to augment the resources of traumatized communities and to link the short-term goal of timely, collaborative trauma-focused response with the longer term goal of community capacity-building.

The influence and nuances of cultural mediators. An ecological perspective includes the supposition that culture matters and that attentiveness to nuances of culture, race, and ethnicity is essential to the design of health-promoting interventions. Community psychologist Ed Trickett (1996) refers to a "diversity of contexts" in recognition of the many and varied cultural contexts within which individuals develop and are socialized, and to "contexts of diversity" in recognition of the fact that broad generalizations about race, class, and culture are not helpful. Instead, phenomena such as ethnic identity are "potentially fluid, negotiated in the differing settings of importance, and intimately connected to the complex interdependence of cultural history, current circumstance and future aspiration" (Trickett, 1996, p. 218).

In applying an ecological perspective to the understanding of resilience in diverse cultural contexts, Tummala-Narra ("Conceptualizing trauma," this volume) notes that prevailing views of resilience are generally shaped by middleclass and Western values of individual autonomy and achievement, values that may not resonate across cultures and may not reflect culturally salient views of positive response to adversity. Hobfoll et al. (2002) suggest that across cultural contexts, expressions of agency and mastery may rely on different loci of control (i.e., the self in many Western cultures, the family or the community in others). Interventions to foster resilience in non-mainstream cultural contexts must be alert to these differences.

Developing ecologically relevant and effective interventions requires attention not only to differences *between* but also to differences *within* racial, cultural, and ethnic groups, and consideration of the ways in which these differences are expressed, highlighted, concealed, and negotiated in various social contexts (Kelly, 1986; Trickett, 1996; Tummala-Narra, "Con-

ceptualizing trauma," this volume). Other factors influencing the efficacy of interventions in specific cultural contexts include the meaning of an intervention to participants, its relevance and appropriateness to participants and settings, the cultural validity of its underlying constructs, and cultural and contextual factors affecting the durability of its impact over time (Trickett, 1997).

Transforming social environments. Contextual forces can impede as well as foster individual and community well-being. Because social problems are often deeply embedded in relatively intransigent social environments and long-standing cultural practices, community psychologist Kenneth Maton (2000) emphasizes the importance of intervention programs that have as their goal the transformation of social environments. He identifies four dimensions of social environments that are amenable to change and four corresponding intervention goals: (a) capacity-building to reform the instrumental attributes of a social environment (e.g., core activities, problem-solving capacities, leadership); (b) group empowerment to restructure social environments and alter power relationships and resource distribution among social groups; (c) relational community building to develop new relational norms for social environments and ensure an array of opportunities to a diverse citizenry; and (d) culture-challenge to address aspects of prevailing cultural norms that contribute to the persistence of social problems.

Interventions to pursue these goals can be initiated at multiple ecological levels. At the individual level, for example, culture challenge may involve asking individuals to rethink familiar understandings and abandon long-standing biases. At the community level, it may require activism to create new community settings or to reform existing ones, and at the societal level, participation in movements for social reform and social justice. Each of Maton's (2000) goals has relevance to the design of interventions to support the resilient capacities of trauma survivors and their communities. Each is represented, too, in the clinical, community, and research activities of the Victims of Violence Program.

THE VICTIMS OF VIOLENCE PROGRAM

The Victims of Violence Program (VOV) is an adult outpatient trauma clinic located in a multi-site urban public health system that serves a diverse client population, including large numbers of economically disenfranchised citizens and growing numbers of immigrants and political refugees from Africa, Asia, Latin America, Haiti, and the Mid-

dle East. Initiated in 1984 with start-up funds from local city government, VOV was established as a training program of the hospital's academically affiliated Department of Psychiatry in 1985. Since then, its mission in the hospital, in the network of health care services in which it is located, and in the larger community has been to develop comprehensive mental health services for crime victims and crime victimized communities

Services and Service Components of the VOV

VOV's services include crisis intervention and response, psychological assessment and longer-term clinical care, and a wide array of groups. Clinical care at VOV is guided by an ecological view of psychological trauma (Harvey, 1996; Yassen & Harvey, 1998) and a "stages by dimensions" understanding of trauma recovery (Lebowitz, Harvey, & Herman, 1992; Mendelsohn et al., this volume). This framework emphasizes the importance of attending to lives in context and the need for clinical care with trauma survivors to focus, first, on securing and maintaining personal safety and, then, on forming new, more empowered relationships with others.

Since its inception, VOV has secured grant funding[1] to create and sustain new resources for communities and community settings afflicted by violence. VOV's Community Crisis Response Team (CCRT), initiated in 1988, translates an ecological view of psychological trauma (Harvey, 1996) into a protocol for timely intervention in diverse contexts (Harvey et al., this volume). Its Victim Advocacy and Support Team (VAST), initiated in 2000, brings the lessons of grass roots activism to bear on clinical care and clinical training (Gomez & Yassen, this volume), and its more recently initiated Center for Homicide Bereavement (CHB) integrates clinical and community care for individuals and families bereaved by homicide.

An Ecological View of Psychological Trauma, Trauma Recovery, and Resilience

VOV's varied services and program components reflect the organizing influence of an ecological view of psychological trauma and trauma recovery (Harvey, 1996). Drawing directly upon the ecological perspective of community psychology, this framework proposes that individual differences in traumatic response (and, indeed, in risk of traumatic exposure) are the result of complex interactions among per-

son, event, and environmental factors. Interdependent and reciprocal interactions among these factors set the stage for more or less resilient and agentic responses to traumatic exposure, help to determine the quality and availability of informal sources of social support and underlie both access to and comfort with professional care.

The ecological model includes a definition of trauma recovery that is hallmarked by achievements in eight domains of psychological functioning (Harvey, 1996; also see Liang, Tummala-Narra, Bradley & Harvey, this volume). Resilience is understood to be a multidimensional phenomenon. A survivor may be seriously impaired in one or more domains typically impacted by trauma and yet evince remarkable strengths in others. Resilience is also conceptualized as an active process by which individual survivors are able to access strengths in some domains in order to secure recovery in others. An important goal of psychotherapy with trauma survivors is to recognize and help the survivor mobilize his or her resilient capacities.

Recognizing that most trauma survivors will not turn to psychotherapy (or any other highly specialized form of professional care), the ecological framework also acknowledges the importance of environmental interventions to foster wellness and enhance resilience among untreated trauma survivors and their communities. At VOV, environmental interventions towards these ends include not only the CCRT, VAST, and the CHB, but also year-round staff involvement in anti-violence coalitions, public education campaigns, and human rights activism.

Ecologically Informed Intervention and Research at the VOV

The ecological framework provides theoretical foundation for clinical care, community intervention, and research at VOV.

Clinical assessment and clinical care. Clinical intervention at VOV begins with an assessment that attends not only to signs and symptoms of distress but also to attitudes and values prevailing in the larger society and in the client's cultural context and home community. It asks the clinician to inquire not only about the behavior of family members and friends, but also about the actions of medical, mental health and social service providers, criminal justice personnel, and religious and community figures. One goal of this assessment is insight into the ways in which clients' location in complex ecological networks shapes their experience of and adaptive (and/or maladaptive) coping with trauma. Another is that assessment set the stage for care that will foster safer

connections with others and new, more empowered action in the world outside of therapy.

Community intervention, social advocacy, and social action. Within VOV the aims of community-wide interventions are guided by respect for ecological context. The goals of community intervention are to address the community's vulnerability and promote community healing, not by replacing or overwhelming but rather by augmenting and enhancing existing community resources. These aims infuse all VOV services but are perhaps most clearly recognized in the outreach, consultation, and intervention strategies of the CCRT and in VAST's integration of individual and social advocacy practices. Both programs are described in depth in articles included in this volume (Harvey et al.; Gomez & Yassen).

Ecologically-informed research on resilience in trauma survivors. The ecological model suggests that full understanding of psychological trauma, recovery, and resilience requires research with both treated and untreated survivors and the delineation of factors relevant to recovery in both populations. Research at VOV, therefore, incorporates attention to the experience of trauma survivors from diverse contexts and at various points in the recovery process, as well as inquiry into the cross-cultural applicability of constructs and assessment tools developed in the context of our Trauma Recovery and Resiliency Research Project. Within this project, the multidimensional definition of trauma recovery and resilience (Harvey, 1996) has been operationalized in the form of two assessment tools: the Multidimensional Trauma Recovery and Resiliency scale (the MTRR-99) and companion interview, the MTRR-I.[2] These measures can aid clinicians in their search for a nuanced understanding of the strengths that trauma survivors bring with them to psychotherapy (Lynch et al., this volume; Tummala-Narra, "Trauma and resilience," this volume), and can be used with treated and nontreated survivors in studies of resilience in racially, culturally, and linguistically diverse survivors (Bradley & Davino, this volume; Daigneault, Cyr, & Tourigny, this volume; Radan, this volume;).

DISCUSSION

The literature of community psychology, the contributions of the community psychologists whose work has been reviewed here, and the now twenty-year history of VOV highlight the relevance of ecological theory to the understanding of resilience in trauma survivors and the sa-

lience of ecological considerations in the design and conduct of interventions to nurture and mobilize the resilient capacities of trauma survivors and their communities.

An Ecological View of Resilience in Trauma Survivors: Five Premises

Five premises, each with corresponding implications for ecologically informed intervention and each supported by the theory and practice of community psychology, offer a new and deeper understanding of psychological resilience in trauma survivors. Each has been instrumental in shaping theory, practice, research, and training at the VOV.

- Resilience is best understood as both transactional and contextual, arising from the reciprocal engagement of persons and contexts. Persons and contexts, individuals and communities, groups and societies, survivors and ecosystems are appropriate focal points for interventions to foster resilience among those at risk.
- Resilience is also a multidimensional phenomenon, expressed in relative degrees across multiple domains of psychological functioning. Expressions of resilience can co-exist with symptoms of even severe psychopathology. A goal of clinical intervention is to help the survivor mobilize his/her resilient capacities. A goal of social and community intervention is to develop social contexts that can foster wellness and sustain multiple modes of resilience among those at risk and those who have already suffered harm.
- Whether initiated at individual, community, or societal level, interventions to promote and sustain resilience must enhance the relationship between person and context. Communities characterized by a wide diversity of resources and multiple opportunities for community members to influence community life are ideal contexts for persons to become resilient. Contributing to the development of such contexts is or ought to be an explicit goal of social and community interventions to promote resilient functioning.
- Attention to cultural context and nuance is an important determinant of intervention efficacy; culture challenge may be an important component of meaningful intervention.
- Finally, even highly effective interventions will rely for lasting impact on their becoming embedded in and familiar to more enduring social settings and community contexts. Attention to the possibili-

ties for ensuring lasting impact and enduring change are important features of intervention design and conduct.

VOV and the Ecological Perspective of Community Psychology

In many ways, VOV is a unique intervention program located in an equally unique social context. In other respects, it can be viewed as an evolving example of ecological theory in action. From the perspective of community psychology, VOV can be viewed as follows:

An exemplar of ecologically informed intervention. VOV began life not only as a new clinical service for trauma survivors, but also as a self-conscious commitment to enhancing the victim service resources of our local community, altering the ecology of a relatively traditional psychiatric setting and changing the ecological relationship between crime victims and the larger community. In its 20-year history, the program has evolved from a small, poorly funded, and quite marginalized intervention program into an elaborate set of service, training, and research activities and into a relatively well-established community setting. The challenge now is for VOV to remain a source of innovation and itself become a context amenable to change.

A partner with and consultant to other community resources. Heeding Moos' (2003) advice that intervention programs depend for lasting impact on the support of enduring social contexts, VOV staff have maintained and further developed strong ties with the grassroots feminist organizations that nurtured us twenty-plus years ago. We have also developed strong and reciprocal relationships with victim advocacy, human rights, and anti-violence programs throughout the greater metropolitan area as well as with other psychiatric settings serving trauma survivors. We have exchanged consultation, training, and other resources with these organizations and groups and worked with them to form a collaborative network we are all able to call upon for political and social support. And in our engagement with others in the traumatic stress studies field, we have been able to benefit from and contribute to national and international dialog concerning the needs of trauma survivors and the possibilities of clinical and community intervention on their behalf.

A sponsor of capacity-building interventions and new community resources. The CCRT (Harvey et al., this volume), VAST (Gomez & Yassen, this volume), and CHB are emblematic of VOV's efforts to develop new community resources, contribute to the development of new competencies and capacities in traumatized individuals and com-

munities and to, in Cowen's (1994) language, create new and needed wellness-enhancing settings. Each of these services is located in the community, not the hospital; each is an integral component of VOV; and each is making a unique contribution to the changing ecosystems of both hospital and community.

A setting characterized by increasing diversity and attentiveness to issues of race, class, and culture. Like many feminist programs, VOV began life as an undertaking of white, middle-class professional women. Over the years, attentiveness to the limitations of a racially and culturally homogeneous organization, a value for diversity and strategic decisions in terms of staff hiring, program development, and trainee recruitment have enabled VOV to become increasingly diverse. Today, our multiracial, multicultural, and multidisciplinary staff is a much closer "match" to the population we serve. It includes men as well as women and a range of linguistic capabilities that were unimagined by us when we began. These changes have not occurred free of tensions and misunderstandings, and the work is certainly not done. However, the benefits of diversity are clear in range of services we are able to provide, the multicultural competencies we are developing, and our own growing comfort with our diversity

In sum, VOV's origins and evolution, its varied service, research, and training activities, and its engagements with health care system, local community, and larger society are indicative of the potent contributions that community psychology can make to helpful and timely trauma-focused clinical care, to culturally relevant social and community interventions, to ecologically informed research with trauma survivors from diverse social and cultural contexts, and to a new and needed understanding of the resilience that trauma survivors and traumatized communities can bring to bear on the process of trauma recovery.

CONCLUDING REMARKS

Maton (2000) describes the women's movement as illustrative of the power, possibilities, and reciprocal influences of integrated social transformation strategies. It is important to note, then, that VOV traces its origins and much of its continuing passion for social justice to the women's movement. Feminism has shaped our understandings of violence, gender, and culture, given direction to our personal, professional, and political aspirations, and supported our own resilience in the face of recurrent exposure to violence and abuse. In our partnerships with local

feminist organizations and our international ties to feminist colleagues and activists, VOV staff participate in local, national, and international campaigns for societal transformation. It is through our engagement with these that we are constantly reminded of the enormous resilience that trauma survivors are able to craft from supportive social and cultural contexts.

NOTES

1. The Community Crisis Response Team, Victim Advocacy and Support Team, and Center for Homicide Bereavement of the Victims of Violence Program are supported by federal Victim of Crime Act funds awarded by the Massachusetts Victim Witness Assistance Board. The Victim Advocacy and Support Team receives additional grant support from the Office of Victim of Crime for services to victims of domestic and international trafficking.

2. The English-language versions of the MTRR-99 and the MTRR-I are included in this volume. Spanish and French translations of the MTRR-I can be obtained from the authors of papers included in this volume: Angela Radan, PhD (Spanish), and Isabelle Daigneault (French). The Japanese translation can be obtained by contacting Dr. Kuniko Muramoto, PhD, at kunikomura@mub.biglobe.ne.jp

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