

EVOLUTION OF WOMEN'S TRAUMA-INTEGRATED SERVICES AT THE SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION

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*In this article a historical overview of the evolution of the Women's Trauma Integrated Services model at the Substance Abuse and Mental Health Services Administration (SAMHSA) is presented. Milestones in women's services policy development at SAMHSA (1992–1998) and in trauma treatment development for four different trauma populations (1960–1998) are discussed. SAMHSA's 5-year Women, Co-Occurring Disorders and Violence Study (1998–2003) is described, and the rationales for a number of basic decisions about the study design are presented. New knowledge application initiatives and plans at SAMHSA to further develop the Women's Trauma Integrated Services Model are outlined. © 2005 Wiley Periodicals, Inc.**

The Substance Abuse and Mental Health Services Administration (SAMHSA) is part of the Public Health Service in the Department of Health and Human Services. It was established on October 1, 1992 under Public Law 102–321. This legislation created three centers within SAMHSA: the Center for Mental Health Services (CMHS), the

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The views presented here reflect only those of the author and not her institution of employment.

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Center for Substance Abuse Treatment (CSAT), and the Center for Substance Abuse Prevention (CSAP). The Substance Abuse and Mental Health Services Administration's centers are charged with improving services for the prevention and treatment of substance abuse and mental illness as well as the promotion of mental health.

The enabling legislation and subsequent reauthorizations have included a strong set of requirements for a SAMHSA-wide focus on women's services. These requirements established an organizational framework from which arose the 1998–2003 Women, Co-Occurring Disorders and Violence Study (WCDVS). The word "violence" in the study's title refers to either physical or sexual abuse. The aim of this article is to present a historical overview of the evolution of trauma-integrated mental health and substance abuse services, and the development and implementation of these services in the WCDVS.

Two groups of milestones served as important determinants in the creation of the WCDVS study: milestones in the development of SAMHSA's Women and Co-Occurring Disorders and Trauma Agenda, which facilitated the decision to launch the WCDVS; and milestones in the development of violence and trauma treatment, which provided a conceptual basis for the trauma programs implemented within the WCDVS.

MILESTONES IN THE DEVELOPMENT OF WOMEN AND CO-OCCURRING DISORDERS AND TRAUMA AGENDA

In the mid-1990s, there were a number of developments in the women's services arena that put pressure on SAMHSA to prioritize the development of services for co-occurring disorders and trauma in women's mental health and substance abuse services. These developments are described below.

Congressional and Executive Branch Actions for the Substance Abuse and Mental Health Services Administration

Congressional and executive branch actions established the starting point for new women's cross-center initiatives. The Substance Abuse and Mental Health Services Administration's 1992 enabling legislation required an Associate Director for Women's Services in the Office of the Administrator of SAMHSA and a Women's Coordinating Committee comprised of representatives from SAMHSA's three centers. SAMHSA's director required integrative, collaborative, and coordinated activities with respect to women's services and the Women's Coordinating Committee worked together on women's services across the three centers for the first time.

The Center for Substance Abuse Prevention, followed by the Center for Substance Abuse Treatment and the Center for Mental Health Services, supported studies on the development of women's services to treat substance abuse or mental health disorders. These studies demonstrated that a very large percentage of women with mental health problems or substance abuse problems suffered from histories of physical and sexual abuse. Recommendations to SAMHSA from these studies stressed the need to develop and/or integrate trauma services into traditional treatment models (Human Resource Association, 1995; CSAT, 1994). Consequently, the Women's Coordinating Committee selected the treatment of women with co-occurring mental health and substance abuse disorders and trauma as the basis for collaboration among the three centers.

Knowledge Development and Synthesis

The Substance Abuse and Mental Health Services Administration's knowledge development and synthesis on women, co-occurring disorders, and violence occurred between 1995 and 1997. This knowledge synthesis activity documented the high numbers of women affected by abuse, and revealed that co-occurring disorders were typically included in the overall traumatic syndrome. However, data supplied no compelling evidence for the direction of cause and effect (see Huntington, Moses, & Veysey, this issue). The work also documented the lack of provider training on the interrelationship of co-occurring disorders, violence, and trauma (Ridgely, Goldman, & Willenbring, 1990). The failure of mental health and substance abuse agencies to routinely screen, assess, and treat these disorders was, in turn, linked to the lack of appropriate training (Zweben & Clark, 1994).

The Center for Substance Abuse Treatment and the Center for Substance Abuse Prevention received Congressional appropriations to design and develop treatment and prevention programs for women who abused substances. First, CSAP and then CSAT funded programs in residential settings for women who abused substances and were either pregnant or already mothers. Commitment to women's needs guided the development and implementation of this new gender-specific programming (Finkelstein, Kennedy, Thomas, & Kearns, 1997). The Center for Substance Abuse Prevention also developed preventive interventions for women and their children, and funded Pregnant and Parenting Women with Infants (PPWI) grants.

In 1993 CSAP also contracted for a 3-year National Women's Resource Center (NWRC) for SAMHSA, supported through contributions from all three SAMHSA centers, the Office of Women's Services, and the Health Resources and Services Administration's Bureau for Maternal and Child Health (National Women's Resource Center, 1995). A Technical Expert Group (TEG) on violence was formed by each center to represent its interests and perspectives. The TEG on violence for CMHS produced a report on "Women, Violence and Mental Health" that framed some of the parameters of the emerging trauma-integrated services paradigm (National Women's Resource Center, 1995). Each of the three TEGs played a major role in synthesizing knowledge about violence and its consequences for SAMHSA's prevention and treatment programs. Their findings were instrumental in the development of the final NWRC report titled *Violence and Women across the Life Cycle* (Mathematica Policy Research et al., 1996).

The Center for Mental Health Services, while authorized to do women's services, did not have a prior history of congressional appropriations to support studies on women. To begin to map this territory, in 1994 CMHS sponsored a national conference, "Dare to Vision," to explore violence and trauma in women's lives. About one third of the participants at this conference were consumers with histories of violence. Together with policy makers, administrators, researchers, direct care personnel, and related advocacy groups, they generated recommendations for numerous follow-up action steps (Human Resource Association, 1995).

The Dare to Vision Conference galvanized the field to action on women and violence as no other single event had done. The first action step generated by the conference was to reduce the use of seclusion and restraint by mental hospital staff. Seclusion (shutting the patient in a room by herself, often stripped of clothing) and restraint (using four-point physical restraints to tie the patient down) has the potential to recreate the circumstances of the original physical and sexual abuse, unleashing the

same emotional responses that occurred at the time of the original victimization. The consumers who spoke about these experiences termed them *revictimization*.

Consumer Empowerment

In the late 1990s, consumer empowerment through SAMHSA was based on the values and beliefs generated through earlier consumer advocacy for a defined role and voice. This advocacy had its genesis in the early days of feminist speak-outs in the 1970s (Helpguide, 2004). At that time, attention was focused on the crimes against women, including rape, domestic violence, incest, and child battering. Women viewed these acts as a violent assertion of power by men over women. Women, in response, worked to develop new policies and practices to curb the use of this power by men, and to provide new resources for women to exercise their own power (Houghton Mifflin, 2004).

Women in settings where violence and trauma were addressed began to talk with each other about the fact that depression and substance abuse were present as very significant issues in their lives subsequent to their experience of trauma. They developed personal networks of women with similar issues to share knowledge about and experiences with physical and sexual abuse, and to frame priorities based on their recognition of their own need for trauma treatment. These consumers wanted to play a central role with SAMHSA in developing any new trauma treatment models to ensure that depression and substance abuse were addressed. "Nothing about us without us" was used by consumers as a call for more consumer choice in the design and implementation of new trauma treatment models to replace what had been treatment-as-usual in hospitals and community agencies (Chamberlin, 1995).

By the mid-1990s, SAMHSA-funded service providers, administrators, and researchers had heard and acted on consumer pleas to direct resources to design comprehensive treatment of the traumatic syndrome. Many from these consumer groups also began to press for a new approach and philosophy about treatment and recovery that addressed co-occurring disorders and trauma from the perspective of the women who lived through these experiences. Their collective voice was instrumental in moving SAMHSA toward this goal.

As all three of SAMHSA's centers urged SAMHSA to develop and implement women's trauma services, questions arose about how this new initiative should be designed. What were the violence and trauma treatment antecedents from which lessons could be drawn? How could these lessons best be put into practice to help women suffering from co-occurring disorders and histories of abuse? How could consumer empowerment be tapped to achieve the goal of consumer integration in the proposed WCDVS?

MILESTONES IN THE DEVELOPMENT OF VIOLENCE AND TRAUMA TREATMENT

In 1980 the World Federation of Mental Health (WFMH) sponsored a Scientific Committee on the Mental Health Needs of Victims of Violence. Its broad charter included a charge to determine whether the range of victim responses to personal violence (including domestic violence, civil violence, captivity, and war-related violence) supported the concept of a generic posttraumatic response to violence. Representatives of government agencies and international and national associations, as well as scholars

and activists from many countries were represented on the committee (WFMH, 1980). They distilled, from a broad range of human experiences of personal violence, a more generic view of the basic psychological and physiological responses to violence.

The WFMH committee identified the common and predictable physical, psychological, emotional, and spiritual effects of personal violence in different trauma populations. This work drew attention to several constant themes across trauma groups: the impacts of violence, the process of working through these impacts, strategies to facilitate this process, and the definition and nature of healing.

The critical challenges raised by traumatic events are disempowerment and disconnection from others:

Traumatic events call into question basic human relationships. They breach the attachment of the family, friendship, love, and community. They shatter the construction of self that is formed and sustained in relation to others. They undermine the belief systems that give meaning to human experience. They violate the victim's faith in natural or divine order and cast the victim into a state of existential crisis. (Herman, 1992, p. 51)

Studies of various trauma populations have provided partial insight into the process of recovery that addresses the challenge of moving from victim to survivor, as the following illustrates:

... the process of recovering from traumatic events is the transformation from being a victim to being a survivor. Victims and survivors are similar in that they both experienced a traumatic event. But while the victim has been immobilized and discouraged by the event, the survivor has overcome the traumatic memories and become mobile. The survivor draws upon coping with the catastrophic event as a source of strength, while the victim remains immobilized." (Figley, 1985, p. 399)

The first population to be discussed includes survivors of captivity and war-related violence and trauma, primarily Holocaust survivors. The second population is veterans, primarily Vietnam veterans. (In the 20th century, the study of trauma in various populations began in World War I as the study of shell shock, continued in World War II as the study of combat neurosis, and emerged in the 1970s and 1980s as the study of the traumatic syndrome which merged into the study of posttraumatic stress disorder [PTSD]). The third population is victims of crime. The fourth population is women with histories of physical and sexual abuse and co-occurring disorders. These populations differ in important ways, yet there are constant themes across each of the four groups.

Survivors of Captivity and War-Related Violence and Trauma: Emergence of the Traumatic Stress Syndrome Paradigm

At the National Institute of Mental Health (NIMH) in the 1960s, a number of early notes, papers, and case studies reported specific examples of erosion in health and emotional well being in concentration camp survivors over time, as they established new lives following the Holocaust (Krystal & Niederland, 1968). Daily violence was a fact of life for concentration camp survivors during their confinement. In the readjust-

ments following their release from confinement, it was noted that for many survivors, physical health problems proliferated, depression and numbing or apathy were widely prevalent, and suicides were on the rise. Segal and colleagues documented these aftereffects in a monograph that also laid out recommendations for further investigation. (Segal, Hunter, & Segal, 1974). The aftereffects of confinement in camps for concentration camp survivors became known as the *concentration camp syndrome* (Eitinger, 1980). An NIMH study group was formed to analyze these findings and provide some generalized conclusions regarding the connection between violence and physical and mental health.

Knowledge about the effects of violence under confinement gained from the study of Holocaust survivors was enriched through study of the experiences of veterans of World War I, World War II, and the Korean War, as well as survivors of captivity in Japanese prisoner-of-war camps and survivors of Chinese thought reform camps. Distilling common themes from these experiences, Lifton (1996) provided a description of the process of individual change toward healing:

Confrontation is the first of three steps toward significant personal change . . .

Having encountered the experience of falling apart, they could engage in a process of reordering or examining various aspects of self and world . . . and they could finally achieve a special sense of renewal in which sensitivity to threat could combine with playfulness, erotic freedom, and deepened general awareness. (Lifton, 1996, p. 392)

Psychosocial educational empowerment groups were employed as an intervention strategy for Holocaust survivors in a unique manner (Danieli, 1993). In the Group Project for Concentration Camp Survivors, the goal for these group members was not to feel better, but to get better. Getting better, for this group, involved continuous and consistent unraveling of the survivor's posttrauma feelings and attitudes while they pursued liberation and self-actualization.

The groups that were formed for this purpose were composed of individuals and any surviving family members. Within these groups, the members began to talk about their memories and experiences. Survivors were asked to develop a multigenerational family tree that depicted the history of their family. The development of this family tree helped to reestablish the individual's shattered sense of history and place. It also served to elicit traumatic memories to begin the work of recovery. It proved to be an innovative and rewarding therapeutic approach.

Vietnam Veterans: Evolution of Traumatic Syndrome Into the Diagnosis of Posttraumatic Stress Disorder

The behavior of Vietnam veterans after they came home from the war was first brought to public awareness through the media. Notably aberrant behavior and explosive acts of hostility by individuals were widely reported. Clinicians were challenged and intrigued by the seeming puzzle their behavior posed—home from the war, but still fighting the war (Lifton, 1993). A handful of therapists who were committed to care for Vietnam veterans built on Lifton's traumatic stress syndrome concepts in powerful new ways. "Unhealed wounds" was a phrase used to describe traumatic stress; it became an apt

description of the damage and injury rendered by violence in a guerilla war fought in an environment that did not appear to follow known codes and rules of war (Shay, 2002).

In 1980 the American Psychiatric Association formed a committee to study and recommend a formal psychiatric diagnosis for these traumatic syndrome conditions. Their recommendation in the *DSM-III* was for a diagnosis of posttraumatic stress disorder (American Psychiatric Association, 1980). The appearance of this new diagnostic category for trauma caused by violence, developed by key individuals who had been studying trauma, provided legitimization of the wounds of trauma and established a basis for third-party reimbursement of trauma treatment. Posttraumatic stress disorder is a generic diagnosis regarding the aftereffects following various types of trauma. It provided a lens through which some of trauma's main psychological and physical aftereffects could be identified and studied more precisely.

Psychosocial educational empowerment groups first emerged as "rap groups" in local settings. By the mid-1970s, hundreds of rap groups had been organized. Political pressure on the Veteran's Administration (VA) from hundreds of veteran's groups resulted in a new legal mandate for Operation Outreach, based upon a self-help, peer-counseling model of care. Under this program, the VA implemented readjustment counseling for Vietnam veterans. These counseling sessions were held at community locations such as Vet Centers or "storefront" programs:

Vet Centers . . . discovered and refined a new paradigm for delivery of services for victims and survivors of traumatic stress. A uniquely constructed mix of services, a treatment model emphasizing growth-enhancing potential of traumatic events, staffs which include both peers and professionals, a specialized governmental structure within a governmental department, and strong community and political support were viewed as critical ingredients. (Blank, 1993, p. 916)

Key elements in this therapeutic model involved gradated revisiting and revivification of the traumatic events, followed by some amount of psychological working through of veterans' reactions:

. . . the treatment model is an uncovering and working through model . . . that contains challenges for growth and development . . . Counseling emphasizes the impact, recovery, and growth potential aspects of traumatic stress, rather than the disease aspects. (Blank, 1993, p. 916)

Crime Victims: Posttraumatic Stress Disorder as a Consequence of Civilian and Domestic Crimes

In 1982, under President Ronald Reagan, the first President's Task Force on Victims of Crime was established (President's Task Force on Victims of Crime, 1982). The task force's leaders, who are widely credited for moving the work of the task force toward proposing and encouraging the enactment of legislation for crime victims, stimulated a new generation of study and resource development for improving the well-being of victims of crime. Prior to that time, the impacts of crime on its victims had received little or no policy or program attention.

From the outset, it was understood that one of the most debilitating and long lasting consequences of criminal victimization, above and beyond physical disability,

were the psychological and emotional impacts and scars. The task force convened hearings in major cities in the United States during which crime victims gave testimony, and the central thrust of their testimony concerned the mental health impacts that they suffered. The task force concluded that the treatment of psychological injury was as important as the binding of a wound or the setting of a broken bone. They believed that crime victims faced fears and pressures that could develop into serious and prolonged emotional disturbances. The final report of the task force noted: "The application to crime victims of post-traumatic stress syndrome, articulated in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, is an important first step. Much remains to be done." (President's Task Force on Victims of Crime, 1982, p. 106)

This final report included recommendations on a broad variety of fronts, including mental health services.

In 1984 the Victims of Crime Act was passed in Congress (Victims of Crime Act, 1984). As soon as the act became law, the Office on Victims was established at the Department of Justice. The Crime Victims Compensation Fund was created through this legislation, from which crime victims could seek reimbursement for lost wages, physical injury treatment, and mental health counseling treatment (both for victims of crimes and their family members). The legislation also provided funds earmarked for community programs for serving victims of rape, domestic violence, etc., which offered many different types of group interventions. These were peer-based groups that sought many of the same goals as the Vietnam veterans' rap groups. Their primary goal was to empower and enable crime victims to identify and seek appropriate mental health and related social services, and to help them see these services as a legitimate and essential right.

Violence and Trauma Impacts on Women: A Focus on Gender

During earlier studies of various populations of victims/survivors, gender had not been a factor in defining the problem, recruiting the population to be studied, or developing treatment approaches. The focus had been on men, because men composed a large percentage of the study populations (e.g., veterans and captives). Small numbers of women were also represented in these groups, but the operative assumption was that these findings were applicable for any person, man or woman, who had experienced any type of trauma.

In the 1970s, one of the first explicit mental health studies on gender examined the rates of depression in women. This study revealed that women had higher rates of depression than men, by almost 2 to 1. In addition, there were higher rates of depression among women who had suffered loss, violence, and abuse (Guttentag, Salasin, & Belle, 1980). Furthermore, the women with depression were more likely than women without depression to be mothers of small children serving as single heads of households and living in poverty.

Changes in federal government priorities for social service programs followed the 1980 presidential election. In the mental health arena, many programs were canceled, and there was a major restructuring of remaining programs. The Community Mental Health Center program at the National Institute of Mental Health was shut down, and this drying up of dollars and formal services produced a vacuum on many services fronts, including co-occurring disorders and trauma, in states and communities. The

National Rape Research Center at NIMH was also closed down. These changes heralded a period of inactivity at the federal level for women's services throughout the 1980s.

In the mid-1990s, the Women's Services Office at SAMHSA established an agenda of priorities following extensive consultation with major constituencies. This agenda built on the priorities last established through the President's Commission on Mental Health in 1978 (President's Commission on Mental Health, 1978). The priorities included: (a) co-occurring disorders and histories of physical and sexual abuse, (b) role issues in mothering and/or care taking, and (c) the inclusion of women in the criminal justice system in the continuum of women to be served. SAMHSA's three centers began a collaboration to discuss and develop a women's project that would become the WCDVS.

During this same time, focus groups were sponsored by SAMHSA to help to determine the views of researchers, administrators, providers, and consumers about the most important goals for the WCDVS. Focal themes emerged from these groups for the implementation of WCDVS: only women would be included; women's voices and stories would serve as the base for planning new services; trauma and co-occurring services would be delivered in an integrated manner; trauma-specific services would be delivered in a trauma-informed manner; and consumers would be integrated into every aspect of WCDVS implementation, from planning through evaluation and knowledge application. The first priority to be addressed by SAMHSA was the development of trauma-integrated services and the evaluation of their effectiveness.

SAMHSA'S WCDVS STUDY

The primary goal of WCDVSI was the generation and application of empirical knowledge about the development and implementation of a trauma-integrated services model within the public mental health and substance abuse systems, and evaluation of the effectiveness of this model. The target population, women 18 and older, had to be diagnosed with co-occurring mental health and substance abuse disorders and histories of physical and/or sexual abuse. The total number of women included in the study at baseline was 2,729. A WCDVS cross-site interview questionnaire was developed to record measures of client symptomatology at baseline, during the course of treatment, and after the close of the integrated trauma services interventions.

The WCDVS study had two phases. Phase I (which lasted for 2 years) involved the design of a new trauma services system of integrated care, selection of the most promising trauma and service interventions for use in this new system, and development of the cross-site questionnaire protocol to use in tracking study participant's responses. Phase II (which lasted for 3 years) involved the full implementation of the integrated trauma services intervention model designed in Phase I, and evaluation of client progress using a pre- and posttreatment and comparison group design in which the cross-site questionnaire was administered at baseline, 3, 6, 9, and 12 months. SAMHSA funds earmarked for the WCDVS supported 14 sites in Phase I, and 9 of these sites competed successfully for funding in Phase II.

Decisions about the framework and design of the WCDVS generated intense interest in the larger mental health, substance abuse, and trauma services communities. These communities asked "Why women only?"; "Why consumer integration?"; "Why services integration?"; "Why PTSD and complex PTSD?"; "Why trauma-informed and trauma-specific interventions?" The rationale for these decisions is summarized below.

Why Women Only?

During the 1980s and early 1990s, researchers found that gender analyses were not conducted in most analyses of data from intervention studies with both sexes (Mowbray, Oyserman, Lutz, & Purnell, 1996; Test & Berlin, 1981). This identified lack of gender analyses provided momentum for advocacy groups, researchers, administrators, caregivers, and others to demand studies on trauma that reported results by gender, or trauma studies conducted on women only.

The decision to include women only was made not to minimize the fact that many men are also victims of physical and sexual abuse, but to map this terrain more fully for women. In fact, many of the sites involved in this study did establish trauma intervention groups for the male partners of the women in this study because the women themselves lobbied for it (Fallot, 1999). Because of the sheer numbers of women who experienced co-occurring disorders and histories of physical and sexual abuse, and their increasing willingness to give voice to these experiences, selecting women only as the study population seemed a natural and timely response to SAMHSA's quest to learn about women.

Why Consumer Integration?

The consumer integration goal led to an overall plan for the representation of consumer voice in decision-making at all levels of the WCDVS. The consumer integration process was launched during the first couple of WCDVS meetings. At the outset of this process, the consumers renamed themselves *consumers of mental health services, survivors of physical and sexual abuse, and recovering from substance and drug abuse (C/S/Rs)*.

These women participated in multiple forums within the study, and did so in vital roles new to women's services research and development (Mockus et al., this issue). Their roles were defined for each phase of the study, and C/S/R women established meeting and training schedules for themselves that became a routine part of the study. Some C/S/R women became paid staff members for the site project; others had their fees and expenses reimbursed by the sites. Many of them played active roles in the Steering Committee's subcommittees. A helpful publication was developed by the WCDVS Coordinating Center on consumer integration (Prescott, 2001).

There were areas of conflict between consumers, providers, and the federal project officers for the WCDVS. Providers faced the struggle of embracing the C/S/R group as colleagues, and not just as patients. Status was the subtext for conflict about issues such as appropriate consumer training, consumer advancement within the WCDVS, and equality of all participants in each phase of the WCDVS. Issues of payment, transportation, and childcare for C/S/R women, and integration of them into the existing organizations posed many problems. Federal project officers addressed these problems through the WCDVS Steering Committee, at the individual sites, and with others associated with the project in order to achieve some consensus about many of the overall project policies and site-by-site solutions.

Why Services Integration?

The original SAMHSA plan for the WCDVS set forth the goals of both systems integration and services integration for each site. After initial efforts to structure systems integration protocols, this requirement was not maintained because of the complexity

of embarking on true systems integration within the limited study time frame (Moses, D'Ambrosio, & Reed, 2004).

Earlier findings that services integration is associated with improved consumer outcomes provided the rationale for the WCDVS requirement that mental health, substance abuse, and trauma services be developed in an integrated manner (Cocozza et al., 2000). In the WCDVS, services integration was accomplished primarily through strategies to increase communication, coordination, and advocacy. Lessons learned in this study about issues that may arise in the course of implementing services integration are available in more detail in Moses and colleagues (2004).

Why Posttraumatic Stress Disorder and Complex Posttraumatic Stress Disorder?

The PTSD symptom subscale was used as a measure for symptomatology at baseline, and at the 3-, 6-, 9-, and 12-month follow-up interviews for women included in the WCDVS, because PTSD was the designated official trauma diagnosis. Complex PTSD was not used since it is only a proposed diagnostic category and not yet an official *DSM* diagnosis. However, both were discussed and contrasted by the researchers, and although PTSD was the only diagnosis used, complex PTSD was clearly a more fitting description for a subgroup of women in the WCDVS.

The diagnosis of PTSD includes the following elements: re-experiencing the trauma—flashbacks, nightmares, intrusive memories, and exaggerated emotional and physical reactions to triggers that remind the person of the trauma; emotional numbing and avoidance—feeling detached, losing interest, and avoiding activities or places that remind the person of the trauma; increased arousal—difficulty sleeping, irritability, hypervigilance, and exaggerated startle response (Helpguide, 2004).

In contrast, the diagnosis of complex PTSD includes the following elements: severe behavioral difficulties (such as alcohol/drug abuse); difficulty in controlling intense emotions (such as anger, panic, or depression); mental difficulties such as amnesia or dissociation (including a serious condition known as dissociative identity disorder, formerly known as multiple personality disorder, which is characterized by “splitting off” parts of oneself) (Helpguide, 2004).

The differences between PTSD and complex PTSD are important in diagnosing women whose abuse began in early childhood and persisted over a long period of time. Posttraumatic stress disorder is associated with trauma as an event, while complex posttraumatic stress disorder is associated with trauma as a prolonged series of traumatic events over time. For those women who have experienced a prolonged period of abuse, complex PTSD might be selected as the probable diagnosis. The choice of diagnosis needs to be considered because the treatment of PTSD differs from the treatment of complex PTSD (van der Kolk, 2001).

Why Trauma-Informed Services and Trauma-Specific Interventions?

For the WCDVS to address trauma, two different types of services were believed to be critical to success (Harris, 1998). These services were termed trauma-informed and trauma-specific services. Trauma-informed services involve understanding, anticipating, and responding to the issues, expectations, and special needs that a person who has been traumatized may have in a particular setting or service. At a minimum,

trauma-informed services should do no harm; they must avoid retraumatizing survivors or blaming them for their efforts to manage their traumatic reactions. The WCDVS developed principles, definitions, and guidelines for trauma-informed services (see Elliott, Bjelajac, Falot, Markoff, & Reed, this issue).

Trauma-specific interventions are those designed to address the behavioral, intrapsychic, and interpersonal consequences of physical and sexual abuse. In the WCDVS, trauma-specific services varied in terms of service setting, clinical approach, content, focus, and structure. Group interventions that emphasized empowerment were the main feature of each site's trauma-specific services (Moses, Reed, Mazelis, & D'Ambrosio, 2003). The study's designers believed that the use of trauma-informed services to support the trauma-specific interventions would enhance engagement and retention in treatment, and facilitate long-term quality of life and wellness.

In Phase II of the WCDSV, a new type of trauma-specific psychosocial educational empowerment group was used. The two trauma-specific group interventions used by the majority of the sites were Trauma Recovery and Empowerment Model (TREM; Harris, 1998) and Seeking Safety (Najavits, 2001). The Trauma Recovery and Empowerment Model and Seeking Safety interventions were created prior to the implementation of the WCDVS and modified during the course of the project. The other two group interventions that were used, Addiction and Trauma Recovery Integration Model (ATRIUM; Miller & Guidry, 2001) and Triad (Clark & Fearday, 2003), were developed concurrently with Phase I of the study. By the beginning of Phase II, all of these interventions had been tailored for use in this study.

All four of these interventions were enthusiastically welcomed by the women in this study. A trauma implementation substudy was done across sites to compare these four interventions on a large number of dimensions, including: number, duration, and frequency of sessions; location of the sessions; session leaders; whether the sessions were open or closed to new participants once a group was formed and had begun to meet; after-group support; and the C/S/R women's involvement. The results of this substudy will be of great use for future research and practice (Moses et al., 2003).

The historical models of group interventions in trauma treatment have been discussed. The specific examples, such as the group interventions for Holocaust survivors (Danieli, 1993); the rap group and the VA's readjustment counseling system of care for Vietnam veterans (Blank, 1993); and the peer-based group interventions for rape, domestic violence, and victims of other crimes were instrumental in the design of the treatment approach for the WCDVS.

FUTURE POLICY AND EMPIRICAL DIRECTIONS

The Substance Abuse and Mental Health Services Administration's implementation of the recommendations in the President's New Freedom Commission on Mental Health's Final Report is the basis for transforming existing models of treatment for trauma, mental health, and substance abuse into new trauma-integrated initiatives (President's New Freedom Commission on Mental Health, 2003). The Administration has established that a "science into services" philosophy governs the sequence of steps taken from establishing evidence through scientific inquiry through further development and implementation. With the conclusion of the WCDVS, a series of implementation activities were planned. In September 2003, a new Trauma-Integrated Services Knowledge Application Initiative was funded. Through this new initiative, funds are pro-

vided to a number of key mental health constituent organizations to translate and incorporate the findings from the WCDVS into targeted materials for their audiences, and provide technical assistance to potential adopters of these findings to facilitate their application.

The Substance Abuse and Mental Health Services Administration is also exploring including trauma-integrated services into its evidence-based practices such as Assertive Community Treatment (ACT) teams. In addition, new clinical and services research will be initiated at NIMH on trauma, in accordance with the recommendation in the New Freedom report for more research on trauma. The New Freedom report identifies trauma as one of four areas that has not been studied enough, noting that:

The mental health field lacks sufficient information about dealing with trauma and its effects on different populations. Also, few treatments specifically for adult survivors of childhood abuse have been studied in randomized controlled trials. (New Freedom Commission on Mental Health Report, 2003, p. 71)

THE CHALLENGE

The real challenge is addressed to women themselves. Women speaking up about their own experiences and needs provides the basis for knowledge development, women advocating for women to tackle unmet needs initiates the action, and women insisting on advancement of their own goals and goals for their families is the basis of all of the progress reported in this article, and has served as a constant beacon to guide the way.

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