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ARTICLE

TRAUMA-INFORMED OR TRAUMA-DENIED: PRINCIPLES AND IMPLEMENTATION OF TRAUMA-INFORMED SERVICES FOR WOMEN

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In this article, we attempt to bridge the gap between practice (service delivery) and philosophy (trauma theory, empowerment, and relational theory). Specifically, we identify 10 principles that define trauma-informed service, discuss the need for this type of service, and give some characteristics of trauma-informed services in eight different human service areas. The areas include outreach and engagement, screening and assessment, resource coordination and advocacy, crisis intervention, mental health and substance abuse services, trauma-specific services, parenting support, and healthcare. We draw upon the experiences of the nine sites involved in the Substance Abuse and Mental Health Service

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Administration's (SAMHSA) 5-year grant project, Women, Co-occurring Disorders and Violence Study (WCDVS), and include the recommendation that consumers be integrated into the design and evaluation of services. © *2005 Wiley Periodicals, Inc.*

Trauma-informed services are those in which service delivery is influenced by an understanding of the impact of interpersonal violence and victimization on an individual's life and development. To provide trauma-informed services, all staff of an organization, from the receptionist to the direct care workers to the board of directors, must understand how violence impacts the lives of the people being served, so that every interaction is consistent with the recovery process and reduces the possibility of retraumatization. The absence of this understanding about the impact of trauma on a woman's life is, as the title of this article suggests, the equivalent of denying the existence and significance of trauma in women's lives.

We build on the work of Maxine Harris and Roger Fallot (2001) and the trauma committee of the Women, Co-occurring Disorders and Violence Study (WCDVS), which was funded by the Substance Abuse and Mental Health Services Administration (SAMHSA). The trauma committee was comprised of representatives from nine study sites across the US. These representatives developed and studied the effectiveness of integrated services for women who struggle with mental health, substance abuse, and trauma issues. Integrated services encompass these core areas: outreach and engagement, screening and assessment, resource coordination and advocacy, crisis intervention, mental health and substance abuse services, trauma-specific services, parenting support, and healthcare.

Developing new approaches to mental health and substance abuse services requires significant preliminary conceptual and practical work. The WCDVS sites made two important initial steps in this study. First, they arrived at a consensus understanding of the key principles of trauma-informed services and outlined, at both the systems and services levels, several specific ways that mental health and substance abuse service providers could begin to utilize this approach. Second, the project demonstrated the feasibility of implementing core elements of a trauma-informed service model. For example, administrators and providers participated in educational programs designed to enhance knowledge about the impact of trauma and trauma recovery. Agencies and programs reviewed ways in which their usual services might trigger trauma-related responses and made corresponding modifications. Providers were crosstrained in the relationships between trauma, mental health, and substance abuse problems.

For some organizations, adopting a trauma-informed philosophy will require a paradigm shift. To achieve a trauma-informed service setting, the administration of the organization must make a commitment to integrate knowledge about violence and abuse into the service delivery practices of the organization. Service delivery practices can then be guided by the principles outlined herein, and all policies and practices can be reviewed to ensure that they are safe, engaging, and relevant to trauma survivors (Harris & Fallot, 2001).

THE NEED FOR TRAUMA-INFORMED SERVICES

Trauma survivors are the majority of clients in human service systems (Browne & Finkelhor, 1986; Finkelhor, 1986; Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995;

Najavits, Weiss, & Shaw, 1997; Neumann, 1994; Polusny & Follette, 1995). Since providers have no way of distinguishing survivors from nonsurvivors, best practices are those that treat all women as if they might be trauma survivors, relying on procedures that are most likely to be growth-promoting and least likely to be retraumatizing. In this article, we emphasize interpersonal trauma, that is, childhood physical or sexual abuse, and adult experience of domestic violence, other physical or sexual assault, or rape. The term *survivor* refers to a woman who has experienced one or more of these traumas.

The effects of trauma can be seen in both problems directly related to trauma and problems that initially appear to be unrelated (Allen, 1995; Courtois, 1988; Harris & Fallot, 2001; Herman, 1992; McCann & Pearlman, 1990). Studies show that 60 to 75% of women in treatment for alcohol and other drug problems have experienced partner violence during their lifetimes (El-Bassel, Gilbert, Schilling, & Wada, 2000). Women with drug problems have also experienced more rapes and more different types of rape than have women without drug problems, and the duration of the rape experience tends to be longer (Kilpatrick, Acierno, Resnick, Saunders, & Best, 1997). Those with mental health, substance abuse, and interpersonal violence problems also have a myriad of other life burdens and problems (see, for example, Brown, Huba, & Melchior, 1995). These include homelessness, HIV-positive status (Cohen et al., 2000), difficulties with employment, family problems, and so forth. They have higher levels of health problems (Liebshutz, Mulvey, & Samet, 1997) and use more health services than those with only one set of problems (Brown, Recupero, & Stout, 1995; Liebshutz et al., 1997). Relationships among substance use, emotional problems, violence, and trauma are often complex and multidetermined (Clay, Olsheski, & Clay, 2000; Wilsnack, Vogeltanz, Klassen, & Harris, 1997). Workers who are crosstrained are better able to sort out and understand the interrelationship between trauma, mental health issues, and substance abuse.

Trauma symptoms arising from past violence and the absence of a safe environment create obstacles to services, treatment, and recovery for survivors (Saakvitne, Gamble, Pearlman, & Lev, 2000). Strategies that survivors develop for self-protection, combined with the posttraumatic stress symptoms of hyperarousal or avoidance, make a survivor's entrance into a service setting seem fraught with danger. Unacknowledged or untreated trauma and related symptoms interfere with seeking help for health, mental health, and substance abuse problems; hamper engagement in treatment; and make relapse more likely (Brown, 2000; Brown et al., 1995; Janikowski & Glover, 1994; Melchoir, Huba, Brown, & Slaughter, 1999).

Many common procedures and practices in service settings retrigger trauma reactions and are experienced as emotionally unsafe and disempowering for survivors of trauma (Harris & Fallot, 2001) Service systems that do not subscribe to principles of trauma-informed treatment or understand the pervasive long-term impact of trauma may inadvertently create an invalidating environment. As a result, they may fail to reach many women and experience higher dropout rates than necessary.

METHODS

The overall nine-site study has been described in detail elsewhere in this issue (Huntington et al., 2005). Sites included primary substance abuse treatment, mental health, and violence-against-women settings with many modalities and approaches. Particular sites focused on homelessness, criminal justice, and other societal issues.

Data were gathered from site-level and cross-site evaluations, two semistructured questionnaires developed for this project, and workgroup reports and activities. A modified Delphi process (Linstone & Turoff, 2002) with four steps was used to identify and reach agreement on principles. First, the cross-site trauma workgroup (composed of representatives from each site plus some project consultants) generated initial definitions and criteria for trauma-informed practice, discussing examples from different core services.

Second, a semistructured questionnaire was constructed and administered in all nine sites. This questionnaire asked about how the site defined and was operationalizing trauma-informed services, the steps it had gone through to do this, and examples in the eight core service areas. The questionnaire was completed by the person most knowledgeable about this work at each site. This individual usually consulted with others and with program records and process evaluation reports. Four questionnaires were completed either electronically or on paper, and five were administered in telephone interviews that were then summarized and approved by the interviewee. From these, a subgroup developed more detailed definitions of trauma-informed at two levels—in terms of the relationship between staff members and program participants, and within the larger organization.

Third, these definitions were then shared with workgroup members and slightly modified to reflect additional examples and perspectives based on the workgroup members' experience. Finally, workgroup members took each of the eight core services and discussed the application of the principles within each area, with examples from different sites. The authors were all members of this workgroup and have synthesized this article from all of these sources of information.

THE 10 PRINCIPLES OF TRAUMA-INFORMED SERVICES

Many, perhaps all, of these principles are well understood by those who focus especially on working with trauma survivors, but they do not represent common practices in service settings. Some might say that they simply represent high-quality, empowering practice and are not specific to the treatment of trauma, and to some degree we agree. Implementing them will certainly benefit all women (in fact, all people) seeking assistance, but they are absolutely essential for trauma survivors who may not be able to participate or benefit from services without them. Although there is a substantial literature on working clinically with survivors, with the exception of Harris & Fallot (2001), examples have not been available in the literature that demonstrate how to operationalize trauma-informed principles in various types of services. Moreover, the sites contributing their experiences to the formulation of these principles and their application represent a diverse array of program types—in terms of modality (residential and nonresidential treatment programs of various intensities), setting (mental health, substance abuse, violence against women, and crisis services), and location (urban, suburban, and semirural). Thus, examples representing a wide range of experiences contributed to the formulations in this article.

The following 10 principles, developed by consensus, reflect the values and practices that define a trauma-informed service organization. We contend that when a service organization is trauma-informed, its services will be more accessible to and effective for survivors. Each of these principles reflects a component of creating a

service setting that is respectful, welcoming, safe, and helpful to survivors, taking into account their unique needs and the obstacles they face as they seek services and aid.

Principle 1. Trauma-Informed Services Recognize the Impact of Violence and Victimization on Development and Coping Strategies

When a trauma-informed program recognizes the long-term and pervasive impact of interpersonal violence and childhood abuse, the experiences of survivors are validated and the difficulties they face in seeking services are recognized. This validation and recognition increase the survivor's sense of safety and hope. Interpersonal violence and childhood abuse are not just isolated events in women's lives. Trauma has a broad impact, affecting a woman's identity, relationships, expectations of herself and others, ability to regulate her emotions, and view of the world (McCann & Pearlman, 1990). Many behaviors that are now the focus of treatment were developed originally as ways of coping with and adapting to traumatic events (Harris, 1998). Trauma-informed staff understands the effects of traumatic life events on individual development, the common coping strategies and adaptations used by trauma survivors, and effective treatment approaches and tools.

Principle 2. Trauma-Informed Services Identify Recovery From Trauma as a Primary Goal

Trauma-informed programs offer either specialized services that directly address recovery from past trauma (trauma-specific services) or integrate a woman's care with an agency that does provide those services. Because the issues interact so significantly, it is essential that treatment for trauma and co-occurring disorders be integrated rather than sequential or parallel (Detrick & Stiepock, 1992; Drake, Mercer-McFadden, Mueller, McHugo, & Bond, 1998; Durrell, Lechtenberg, Corse, & Frances, 1993; Kofoed, Kania, Walsh, & Atkinson, 1986; Minkoff & Drake, 1991).

Principle 3. Trauma-Informed Services Employ an Empowerment Model

Ideally, a primary goal of any service provision for survivors is to facilitate the client's ability to take charge of her life, specifically, to have conscious choice and control over her actions. An empowerment model incorporates those elements of a helping relationship that can increase the client's power in personal, interpersonal, and political spheres (Gutierrez, Parsons, & Cox, 1998). The empowerment model is essential to recovery from the overwhelming fear and helplessness that is the legacy of victimization. The following premises underlie this model:

1. There is a partnership between the woman seeking services and the helper in which both participants are valued for the knowledge base they bring to the problem.
2. The goals of the work are mutual and established collaboratively.
3. A woman's issues are understood as created or influenced by the sociopolitical context, and the impact of her cultural context is considered.

4. The program facilitates the formation of a forum where women can relate to each other in a mutually supportive way.
5. The woman feels her experience and choices are validated. The work builds on her existing strengths so that her sense of inner strength is increased.
6. The experience of collaboration provides both the woman and the helper with increased knowledge of self and others, increased self-worth, and increased competence and comfort in taking action on personal goals (Miller & Stiver, 1997).
7. The ultimate goal of the empowerment model is to expand a woman's resources and support network such that the woman becomes less and less reliant on professional services. This model supports women becoming more engaged with others and moving beyond their own healing to, for example, becoming an advocate for other survivors.

Principle 4. Trauma-Informed Services Strive to Maximize a Woman's Choices and Control Over Her Recovery

Despite the great need and vulnerability experienced by many survivors, the ultimate goal is to work collaboratively with the survivor to increase her access to conscious choice, more options, and a sense of control over important life decisions. It is only through this personal experience of choice and control that a woman reclaims her right to direct her own life and pursue her personal goals and dreams. A staff philosophy of maximizing the woman's choices and control over the treatment process takes her further away from her experience as a powerless, overwhelmed victim. If a staff person feels a woman is making a poor choice, he or she will try to understand the survivor's choice. In this process of clarification, additional information may help the staff person and the woman reach a more mutual, collaborative goal.

Principle 5. Trauma-Informed Services Are Based in a Relational Collaboration

This principle recognizes that interpersonal trauma needs to be healed in a context in which the interpersonal relationships are the opposite of traumatizing. Saakvitne and colleagues (2000) define a therapeutic relationship as one that offers respect, information, connection, and hope (a RICH relationship). This type of relationship helps develop safety and trust, the essential building blocks of healing human connections. Safe relationships are consistent, predictable, nonviolent, nonshaming, and nonblaming.

Staff must be aware of the inherent power imbalance in the helper-helped relationship and do their best to flatten the hierarchy. Interpersonal violence involves a perpetrator and a victim. The trauma of this "power over" experience for the victim is best healed in a very different type of relationship, one that is collaborative and empowering (Miller & Stiver, 1997).

When the helper asks the woman to do something, a woman can easily feel she must do what is suggested to get help. This instinctive compliance may be especially characteristic of survivors who had to repeatedly conform to an abusive authority, or who experienced abuse as the price they had to pay to get attention or care. To reduce that pressure to conform, the woman's right to direct the treatment must be made explicit. It must be stated that she has the right to refuse to answer a question, refuse

treatment, or request an alternative treatment. Ideally, within the limits of the organization, she may also be able to request a different staff person and modify her services.

Principle 6. Trauma-Informed Services Create an Atmosphere That Is Respectful of Survivors' Need for Safety, Respect, and Acceptance

Human service agencies need to work with the women they serve to modify staff approaches, programs, procedures, and, in some cases, the physical setting to create a place perceived as safe and welcoming for survivors. A welcoming environment includes sufficient space for comfort and privacy, absence of exposure to violent or sexual material (e.g., staff should screen the magazines in the waiting area), and sufficient staffing to monitor the behavior of others that may be perceived as intrusive or harassing.

A feeling of safety is also enhanced when the provider and all staff at the agency adhere to the confidentiality policy, give clear information, are consistent and predictable, and give the woman as much control and choice over her experience as possible, including her right to set limits and modify the process. Clear boundaries and well-defined roles are essential to providing a safe environment for survivors.

Principle 7. Trauma-Informed Services Emphasize Women's Strengths, Highlighting Adaptations Over Symptoms and Resilience Over Pathology

Too often, programs focus so intently on problems that they miss the many strengths a person brings to the human service setting (Brown & Worth, 2000). The medical model highlights pathology and inadvertently gives the impression that there is something wrong with a person rather than that something wrong was done to that person. On the other hand, defining a person entirely as a victim of a situation brings another problematic identity. The term *survivor* was coined to counteract the sense of powerlessness that *victim* implies.

Trauma-informed practice recognizes symptoms as originating from adaptations to the traumatic event(s) or context (Allen, 1995; Saakvitne, Gamble, Pearlman, & Lev, 2000). Validating resilience is important even when past adaptations and ways of coping are now causing problems. Understanding a symptom as an adaptation reduces the client's guilt and shame, increases her self-esteem, and provides a guideline for developing new skills and resources to allow new and better adaptations to the current situation.

Another commonly missed strength is the person's capacity to serve in valued social roles. Someone may have many problems and yet function well as a mother, employee, neighborhood organizer, and so on. Emphasizing in the recovery process the skills associated with her social roles increases the woman's perception of her own resources and feelings of hope.

Principle 8: The Goal of Trauma-Informed Services Is to Minimize the Possibilities of Retraumatization

This principle rests on the premise that service providers recognize and understand the potential for retraumatization for women in treatment. When one understands

the abuse of power inherent in all victimization, it becomes clear that the power differential between the person seeking help and the person offering it will be threatening to a woman who experienced abuse at the hands of those whom she depended on in childhood. Once service providers understand the potential for retraumatization and the survivor's fear (and sometimes expectations) of it, then it is possible to work explicitly to protect against it.

Too often, well-meaning individuals participate in a system that retraumatizes survivors of childhood abuse and interpersonal violence. Invasive or insensitive procedures may trigger trauma-related symptoms. Staff actions may inadvertently parallel interpersonal dynamics that recall and exacerbate trauma responses. For example, aggressive, confrontational group techniques intended to break down denial in someone who is abusing substances can trigger memories of childhood abuse. Many abused children develop ways to shut down emotionally or dissociate in an attempt to survive abuse. The harder the aggressive therapy group tries to break through, the more the trauma survivor protects herself from the assault by shutting down. She may then have to endure criticism for her "resistance to treatment," possibly re-creating the experience of being blamed for the abuse as a child.

Another example of retraumatization reported by participants at the study sites is that psychiatric inpatient staff trying to help stabilize a patient may say, "Don't bring up old trauma, you're already overwhelmed." Substance abuse program staff and some Alcoholics Anonymous (AA) groups may embrace the philosophy that talking about past victimization is a distraction from recovery or even a voice of self-pity. These ideas and attitudes may very closely re-enact the survivor's experience of being told to keep quiet about the abuse. They may also imply that she exaggerated or even caused the trauma, or can make it worse by revealing it.

Survivors need to have their experiences heard and validated. Making connections between their past experiences and their current situation is crucial. This does not mean pushing them to uncover memories when they are already overwhelmed. It does mean understanding the impact of trauma, how current problems relate to past trauma, and the need to provide women with concrete information about an integrated model of recovery (Harris, 1998).

Principle 9. Trauma-Informed Services Strive to Be Culturally Competent and to Understand Each Woman in the Context of Her Life Experiences and Cultural Background

As mentioned under Principle 3, treatment providers must be able to understand a woman's cultural context. Cultural competency includes having the knowledge and skills to work within the client's culture, understanding how one's own cultural background and the program influence transactions with the client (Fong & Furuto, 2001). Understanding the influence of someone's culture is essential to making an effective therapeutic connection and being part of a woman's recovery. The meaning one gives violence and trauma can vary by culture. Healing takes place within a woman's cultural context and support network, and different cultural groups may have unique resources that support healing. Cultural competence does not require that every service provider have detailed knowledge of every culture, but rather that he or she recognize the importance of cultural context. It is often helpful to ask questions, be open to being educated, and try to understand the woman's experience and responses through the lens of her cultural context.

Cultural context is not the only difference among women that is important. Sexual orientation, religion, age, economic class, disability status, race/ethnicity, and other characteristics all interact to create more or less stigma associated with violence, trauma, co-occurring disorders and treatment, different patterns of relationships, varying barriers to healing, and different resources with which to work.

Principle 10. Trauma-Informed Agencies Solicit Consumer Input and Involve Consumers in Designing and Evaluating Services

Women should be involved in designing treatment services and be part of an ongoing evaluation of those services (Prescott, 2001). They can be on an advisory board that reviews program design, serve as paid consumer specialists, or participate in focus groups and/or in regular feedback forums about how to respond to program evaluations and improve services.

CONSUMER/SURVIVOR/RECOVERING PERSON INTEGRATION

Of the 10 principles, the last one is the least well-represented in the literature. Yet it is through this true integration of consumers that the many of the other principles are realized. Therefore, we decided to elaborate on the rationale for this principle.

When an organization integrates consumers in designing, and evaluating services, it not only creates a better program, but also provides an empowering growth experience for the consumers involved. While consumers in some systems have been integrated into the service delivery systems (e.g., rape crisis centers developed by survivors; substance abuse centers developed by recovering individuals), consumers who experience the combined effects of substance abuse, mental illness, and violence have not had input into the services that are supposed to serve them (Carmen & Rieker, 1989).

Consumer input was an essential and required part of the WCDVS. The first input women offered was that they were not satisfied with the title *consumer*. Some women preferred *survivor* and some preferred to be called *recovering women*. An empowerment approach suggests that women have the right to name themselves, and that diversity is strength. Therefore, in the context of the WCDVS, women named themselves *Consumer/Survivor/Recovering* (C/S/Rs).

A trauma-informed human services system would be one in which the C/S/R women are integrated and actively involved at all levels of developing, delivering, and evaluating services. The C/S/R group's integration includes developing ways to collect their feedback about services and incorporating that feedback into service planning; including peer-run services as part of the service package; and hiring C/S/R women for multiple roles within the service delivery system (e.g., as resource advocates, counselors, group facilitators, evaluators, or administrators). "Nothing about us without us," the underlying philosophy of the mental health movement, applies also to women who have experienced substance abuse and trauma.

Just as Alcoholics Anonymous suggests "one alcoholic talking to another" helps with recovery, so too does one trauma survivor talking to another. The C/S/R women can share experiences, strengths, and hope with other women and serve as role models, encouraging growth and reducing the possibility of relapse. Making the transition from someone receiving services to someone actively involved in designing and evaluating

services is a process of growth and learning. Like the concept of sponsorship in AA, a C/S/R mentor can help another woman through this transition. As women begin to value themselves, they are better able to advocate for themselves and for others like them. Another principle of the AA program is "in order to stay clean/sober you have to give away what you have been given so freely." Integration of the C/S/R women gives them the opportunity to give back by helping others, which has a further benefit of enhancing self-esteem.

Once a woman understands how her life experiences have affected her and accepts herself as she is, she begins to move forward and become excited about the future. Becoming accepted as a contributing member of a workforce can be an important healing experience for a C/S/R woman. Transforming her from powerless to powerful, she gains self-respect, as well as respect throughout the community. The C/S/R group's integration allows women's voices to be heard, increases their self-esteem, and transforms their feelings of isolation and shame into feelings of being valued and respected for their life experience and the contributions they can make.

Developing a consumer-centered and trauma-informed organization requires commitment from those at the top of the power hierarchy. "Behavior change is not just about changing client's behavior, but our own—the services, the systems, the institutions and organizations" (Brown & Worth, 2000). Leaders set the tone for the entire organization by valuing diversity, teamwork and collaboration, as well as supporting a larger focus on transformation and on learning. Organizational values that support trauma-informed work include: having equal regard for the value of consumer and professional staff, believing that "together we are more powerful than either one alone"; eliciting from staff in all roles innovations and input about the program; and maintaining the perspective that change is positive and that we can always find better ways to intervene.

As with all change, the C/S/R group's integration requires some supports to be effective. Professional staff may need training in the benefits of the C/S/R group's involvement. The C/S/R women may need training in advocacy and in other skills necessary to do their jobs well. Policy changes may be needed as well. For example, hiring policies may need to be changed to reflect the principle of equating the value of life experience with professional education. These system changes are needed to produce relevant, effective services consistent with the values of respecting the potential in all people.

APPLICATIONS OF TRAUMA-INFORMED SERVICES: SPECIFIC SUGGESTIONS FOR SPECIFIC GOALS

One of the strengths of the WCDVS was the diversity of sites involved. What follows are examples of application strategies for the 10 principles, organized according to different tasks, settings, or programs. This implementation section gives only a sampling of strategies to operationalize the principles in actual service settings.

Outreach and Engagement

Outreach and engagement activities seek to identify people who may benefit from the services an organization offers, to make contact with potential consumers, to provide information about available services, to develop an initial relationship with these

potential consumers, and to assist potential consumers in engaging in appropriate and needed services. Trauma-informed outreach workers can prioritize consumer safety by explicitly seeking permission to speak with the woman, by asking the woman about the amount and kind of privacy she prefers for initial conversations, and by following the woman's lead in determining the appropriate extent of her self-disclosure. Many programs have found that including consumers as outreach workers helps them to meet these goals.

Screening and Assessment

Recognizing the centrality of trauma in women's lives, we recommend that all consumers applying for mental health or substance abuse services, and perhaps other services as well, be screened for a history of abuse and current safety from violence. Conducting screening as well as more in-depth assessment in a trauma-informed manner involves:

1. Understanding that women may be uncomfortable answering questions because of distrust of others in general or of service providers in particular, a history of having their boundaries violated or fear that the information could be used against them.
2. Making certain that the interviewer has the need to know the information being requested and the right to ask the woman certain questions given the woman's stated goal.
3. Balancing the usefulness of information for the consumer against the use of the consumer's time and the emotional impact of the questions when designing intake forms and training intake workers.
4. Clearly communicating the consumer's right not to answer any question.
5. Clearly communicating reasons for asking questions that are not apparently related to the problem for which the woman is seeking service.

Resource Coordination and Advocacy

Resource coordination and advocacy is a trauma-informed term for what has traditionally been called *case management.* Trauma-informed service plans include safety plans, advance directives for times of crisis, and trauma-specific services. Trauma-informed services should empower women as experts on their own lives and encourage them to set their own goals and make their own decisions. The service provider helps women to recognize and make use of their strengths, emphasizes skill building, and engages them in problem-solving.

Crisis Intervention

For women with histories of violence who may also have substance abuse and/or mental health disorders, crises often occur, especially before recovery is well-established. The goal of trauma-informed crisis intervention is to allow the woman to retain as much control as possible. The most effective way to do this is to work with the woman to plan for a crisis before it occurs, allowing her to make her wishes known regarding what will happen, what services will be accessed, and who will be involved.

Advance directives can be developed that specify what might trigger a woman to become agitated and the best strategies to help her become calm (Saakvitne et al., 2000). Physical and chemical restraints and involuntary hospitalization should be avoided whenever possible. Survivors should be told in advance of the circumstances in which restraints would be used and what choices they would have available.

Trauma-Specific Services

Services that directly address the experience of trauma include trauma assessments, psychoeducational groups about violence and its impact, services that teach safety skills and ways to manage trauma symptoms, and individual or group counseling in which trauma is a focus. Trauma-specific services should be offered in a trauma-informed setting. Such settings can provide safety from abusers and safety planning for women who are currently at risk of being abused. Ideally, these settings will have support available on a round-the-clock basis.

Women should be supported in developing good self-care and affect regulation skills before they delve deeply into their traumatic experiences or are exposed to the stories of others; however, choice and control should be left to the woman. Providers should be well-trained in dealing with trauma issues. For example, they should be familiar with current literature on psychological trauma and its treatment (Allen, 1995; Herman, 1992; McCann & Pearlman, 1990; Saakvitne et al., 2000) as well as more specific topics relevant to their settings (trauma and substance abuse, self-injury, dissociation, parenting, etc.). Ongoing supervision with a trauma-informed supervisor is critical; the work can be challenging and the issues complex. It is invaluable to have support, information, and help sorting out the strong feelings that work with survivors can elicit in the helper (Pearlman & Saakvitne, 1995; Saakvitne, Pearlman, & Staff of the Traumatic Stress Institute, 1996).

Parenting Services

One domain that is often affected by a history of violence and trauma is a woman's experience of parenting. Because guilt and shame often interfere with a parent's ability to be emotionally available and empathic with her children (Seval-Brooks & Fitgerald-Rice, 1997), a primary goal of trauma-informed services is the reduction of guilt and shame. Group formats are helpful in reducing shame and in decreasing isolation. Parents should be empowered as the best sources of information about their children and encouraged to view their own recovery as part of healing the parent-child relationship. They should be educated about the common vulnerabilities of trauma survivors, such as retraumatization being triggered by a child's age or behavior, and supported in finding ways to take care of their own feelings as well as those of their children. Parents should be helped to examine issues of trauma in the way that they were parented and to explore the ways this affects their own parenting. Experiential exercises are helpful in this process and also promote empathy between parents and children, but must be selected carefully to minimize triggering. It is also important to be sensitive to the needs of survivors who may have lost children through the child welfare system.

Trauma-informed parenting services build on parents' strengths and help parents to apply them to their own healing and that of their children. Programs might consider

providing access to developmental specialists for consultation and giving mothers parenting materials specific to being a survivor (Elliott, 2003b; Saakvitne, 2004).

Mental Health and Substance Abuse Services

Histories of trauma and violence are integrally intertwined with histories of substance abuse and/or mental health disorders among women (Clay et al., 2000; Wilsnack et al., 1997). Thus, all women with substance abuse and mental health issues should be treated in programs designed for trauma survivors, whether or not a history of trauma is disclosed, and all three issues (substance abuse, mental health, and trauma) must be addressed in an integrated way from the beginning. Use of substances and many mental health symptoms may be attempts to cope with trauma. For example, self-injury is most often a sequel of trauma and needs to be differentiated from suicidal behavior with intent to die.

Physical and emotional safety must be emphasized. Involuntary, coercive, and/or strongly confrontational approaches not only increase shame but also can be experienced as traumatizing, and disempowering. Treatment should use collaborative (non-hierarchical) models in which the woman sets the pace and goals for treatment. All procedures should emphasize strengths and tools for coping within a context of hope for the future. Traditional self-help meetings may or may not be helpful in addressing trauma. In fact, survivors may need orientation and support to feel safe in such meetings and to work the 12 steps in their lives.

Healthcare

Healthcare settings have special challenges in serving survivors. Traditionally, it has been difficult to integrate a trauma perspective with a medical setting. Yet many survivors have major medical needs and experience medical treatment settings as triggers or unsafe situations. Receiving routine health or dental care may be difficult experiences for survivors of trauma (Saxe & Frayne, 2003). Many health examination and treatment procedures are invasive, make one feel vulnerable and exposed, and may trigger traumatic responses. A sense of control over one's own body is very important for people who have been abused in the past. Informing a woman about what is going to be done before it is done, and continuing to explain what is happening throughout the procedure can strengthen this sense of control. Many types of equipment, including lights and enclosed spaces, can be triggers for women. Providers can ask women what they can do to make the women feel safer and ask if they would like to have a support person present.

Traumatic reactions or fear of them prevents many women from seeking healthcare and may interfere with their ability to hear or remember information given during healthcare visits. Thus, it is important to review this information at several stages, and to monitor whether aspects of an exam or procedure are triggering traumatic reactions. Following an office visit, a woman may need some time to ground herself to become ready to travel home safely.

SUMMARY AND DISCUSSION

The principles of trauma-informed care described in this article apply in all service settings, although they may be articulated differently across service components.

Understanding an individual woman's entire life context, the strengths she has exhibited, and the adaptations she has made to survive the violence in her past is crucial to creating an alliance and collaborative approach to health. Seeing each woman as the expert on her own life, and giving her maximum choice and control over her recovery process is the beginning of helping her to view herself in a more empowering way. Therefore, the relationship between the provider and the survivor must be based on a collaborative rather than an expert model. Taking this principle to the systems level, survivors must be involved in a substantive way in the design, evaluation, and delivery of the services they use.

Both our focus in this article and that of the Women, Co-occurring Disorders and Violence Study is on women. Our recommendations here, however, are for both men and women seeking human services, whether they are trauma survivors or not. With a history of trauma so common and with some survivors reluctant to identify themselves as having experienced violence in their past, Harris and Fallot (2001) recommend "universal precautions" when interacting with women and men being served. That is, providers should assume that every client is a survivor of interpersonal violence and utilize the 10 principles of trauma-informed treatment. Trauma-informed practice as outlined here is a respectful way to interact that is also appreciated by people without a traumatic past.

We hope that this article will increase awareness of the importance of providing trauma-informed services, and provide guidance for those who wish to improve their service delivery in this way. Perhaps the best first step for an organization is to train all existing staff, from administrators to clerical workers, on the pervasiveness of violence and the impact the experience of violence can have on women's lives. Several excellent resources are available for training in trauma, including a trauma-informed services curriculum for nonclinicians (Elliott, 2003a), a complete trauma training curriculum (Saakvitne et al., 2000), manualized group interventions (Fearday, Clark, & Edington, 2001; Harris, 1998; Miller & Guidry, 2001; Najavits, 2001), and peer-run efforts (Institute for Health & Recovery, 2001; Triad Women's Project, 2000). Resources for program development include an overview of trauma-informed and trauma-specific services (National Center on Family Homelessness, 2003), service system design (Harris & Fallot, 2001; Fallot & Harris, 2002), and a self-assessment that reviews organizational policies and procedures in terms of their impact on trauma survivors (Institute for Health & Recovery, 2002). Input from consumers of services should be part of this review process (Brown & Worth, 2000; Prescott, 2001). Consumers, administrators, and providers can then work collaboratively to amend procedures to make them more trauma-informed. Future hiring can target individuals who are knowledgeable about trauma through either education or experience.

Working collaboratively, providers and consumers will continue to discover new ways of helping survivors achieve the quality of life to which they are entitled. Such changes in service delivery point to the next steps in developing and systematically evaluating trauma-informed models. First, these initial principles need to be further defined and operationalized in terms of specific activities and competencies. Then, these activities and competencies need operational measurements that permit consistency of program and provider evaluation across sites. Trauma-informed service implementation can then be evaluated in terms of fidelity to a formal model, following the evaluation approach that has been taken with other complex interventions such as assertive community treatment, integrated services for people with co-occurring disorders, and supported employment. Reliable comparisons of the relative effectiveness

of trauma-informed services (compared to non-trauma-informed services) rest on the development of this specificity in definition and measurement.

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