Women's Integrated Treatment (WIT): Helping Women Recover and Beyond Trauma
Covington, S. S., Burke, C., Keaton, S., & Norcott, C. (2008)

Description of intervention	Helping Women Recovery (HWR) is a curriculum designed to treat women with histories of addiction and trauma in various settings. Sessions of HWR are based in four modules: self, relationships, sexuality, and spirituality; areas that have been identified as relapse triggers that are crucial to growth and healing. A combination of psychoeducational, cognitive-behavioral, expressive arts, and relational approaches are employed in sessions. Beyond Trauma (BT) is a trauma-specific curriculum following HWR that highlights the areas of violence, abuse and trauma, the impact of trauma, and healing from trauma. Major emphasis is placed on coping skills, especially emotional wellness development. Beyond Trauma also aims to help women in their expression and experience of feelings of grief, loss, fear, shame, and anger.
What was the intervention designed to do?	The Women's Integrated Treatment (WIT), involves two gender-responsive curricula (*Helping Women Recover, HWR* and *Beyond Trauma, BT*) integrating trauma and substance abuse treatments.
Underlying conceptual or theoretical model(s)	*Helping Women Recover* and *Beyond Trauma* are grounded in the theories of addiction, trauma, and women's psychological development.
Rationale for developing the intervention	Substance abuse treatments were originally designed for men and women were expected to fit into those models. They were highly confrontational and did not look at addiction through the lens of women's experience. In addition, substance abuse treatments did not address trauma. Yet, the majority of women in substance abuse treatment are trauma survivors. It became clear that existing substance abuse treatment modalities were not responsive to women, hence the need to develop gender responsive and trauma specific interventions in order ensure that women had access to good substance abuse treatment.
Who is the intervention designed to help?	Women experiencing substance abuse who have histories of trauma (participants do not have to have histories of IPV, however).
What are the eligibility criteria for the intervention study?	○ History of substance abuse ○ History of trauma is not required to participate ○ At least 18 years of age
Rationale for specific inclusion/exclusion criteria	Women's Integrated Treatment is not promoted as a treatment for trauma survivors, but the program provides a lot of information and resource that is relevant for survivors of trauma, including for participants who have friends or family that are trauma survivors. Over the course of the program, as participants have more access to information about what trauma and abuse

	look like, they tend to identify themselves as survivors. In Covington et al. (2008), all women originally came to KIVA for substance abuse treatment. Women are not required to share traumatic experiences in order to participate in the intervention. However, during intake, the staff found that over 90% of participants were also trauma survivors.
Study Design	• One group, non-randomized, pre-posttest design • Standardized assessment and program intake forms were administered at several points: (1) intake; (2) completion of the first 45 days (i.e. stabilization period prior to beginning HWR); (3) completion of HWR; (4) completion of BT; and (5) exit
Outcome variables and Measures	• Sociodemographic characteristics: 1) San Diego County Alcohol and Drug Data System (SDCADDS); 2) AIDS/Hepatitis Assessment (AIDS/HEP) • Trauma: Trauma Symptom Checklist (TSC-40; Elliott & Briere 1990) • Depression: Beck Depression Inventory (BDI; Beck et al. 1961) • Criminal activity and current drug use: Addiction Severity Index for females (ASI-F; SAMHSA 1999) • Client satisfaction: The Client Satisfaction Questionnaire (CSQ)
Level of scientific rigor	Randomized: No Appropriate outcome measures: Yes Active Control Group: No Effect size: Not reported
What adaptations were made specifically for IPV survivors?	Though every location implements WIT differently, It is always emphasized that the group is a safe place. The group also forms agreements concerning confidentiality. The groups discuss what IPV looks like in a relationship, about women's experiences of IPV, and about the need for safety planning. Within the curriculum, there is no formal assessment for safety and risk but special attention is paid to dealing with safety issues within the facilitator guide.
Considerations and/or adaptations related to culture and identity	A newer version of the program has both English and Spanish workbooks. Attention to cultural differences is not explicitly addressed within the curriculum, but the curriculum is written broadly enough to allow facilitators to make it as culturally relevant as possible depending on who is in the group. Over the years, diverse groups of women have gone through and completed the program and there has never been a case of an individual not being able to complete the curriculum because of cultural issues.

	The authors are also currently developing a version of *Beyond Violence* (a similar program) for transgender men who have transitioned but are living in female prisons as men.
Considerations and/or adaptations related to experiencing multiple types of trauma (individual and collective)	There are no specific adaptations for women experiencing multiple types of trauma given that the curriculum addresses trauma more broadly.
What is the mode of delivery?	In-person

What were the key findings?	• Less substance use ($p \leq .05$)
	  ○ Almost all (99%) of the KIVA clients who successfully completed the program reported remaining drug and alcohol free, as well as conviction-free, during the program.
	• Less depression ($p \leq .05$)
	  ○ Decrease in the mean score from 45 days (10.2, SD = 9.4) to the end of HWR (7.4, SD = 8.2); t (43)=2.380. The score continued to improve after participating in BT (4.5, SD = 6.4); t (22)=4.246.
	• Fewer trauma symptoms (including anxiety, sleep disturbances, and dissociation, $p \leq .05$)
	  ○ Average score on TSC-40 decreased significantly from 26.3 (SD = 20.4) at 45 days to a mean score of 19.3 (SD = 19.2) after completion of HWR; t (40)=2.908, $p < .01$. The scores continued to decrease to a mean of 17.5 (SD = 21.0) after completion of BT.
	  ○ Mean subscale depression score was 6.1 (SD = 4.6) at the 45-day point and 4.3 (SD = 4.7) after completion of HWR; t (40)=2.806, $p < .01$. Scores dropped to 3.8 (SD = 4.7) after completion of BT.
	  ○ Mean subscale score of sleep disturbances was 6.3 (SD = 5.4) at the 45-day point and 4.3 (SD = 4.7) after HWR; t (40)=3.057, $p < .01$. Scores dropped to 3.8 (SD = 4.5) after completion of BT.
	  ○ Anxiety was significantly lower at 4.2 (SD = 5.4) than it was at 45 days (5.8, SD = 5.4) at the completion of BT.
	  ○ Dissociation was also significantly decreased, from a mean score of 4.8 (SD = 4.4) at 45 days to a mean score of 3.4 (SD = 4.1).
	• Fifty-four women completed the exit satisfaction questionnaire. Ninety-two percent rated their experiences at KIVA as being either “very positive” or “positive,” and all the clients said they would definitely (94%) or probably (6%) recommend KIVA to other women they know who have similar issues.

Author's reflection on study results/ findings	Changes made in the intervention reflect both what has been learned over time within the field and what has been shown to be efficacious and effective within the group. For example, "settling practices" are used before the start of every group. Whereas early on those practices would be pre-selected, it was discovered that some activities (such as sitting still with music playing) were triggering to some in the group. Currently, the program offers different settling processes depending on people's preferences and needs. It is also important to consistently use similar techniques throughout the course of the program to establish new neural pathways (the newer versions of the program are also informed by neuroscience).
Implementation challenges and strategies for addressing those challenges	Not provided
What, if any, professional qualifications are required to deliver the intervention?	Does not require a clinician to deliver the intervention
What training is required to use this model?	1. Facilitator guides are written in such a way that someone who is experienced in leading groups can teach themselves the intervention. However, training is always available in various parts of the country and many implementing agencies have on-site training. 2. The personal qualifications of a facilitator outweigh their educational qualifications. Qualities such as being responsible, dependable, empathic, compassionate, and interested in the issues of women and girls are key. In the California prison system where *Beyond Violence* (similar program) is used, women with harsher sentences have been trained to be facilitators. These women have limited education but are extremely capable as facilitators due to their experiences and ability to connect with their group members. 3. The best way for staff to be trained is for the staff to go through and complete the material as group participants. In many cases, staff members will have experienced some of the same challenges themselves and may be triggered by the material covered in a particular session.
In what settings can the intervention be delivered?	Residential treatment setting, substance abuse treatment programs, juvenile justice programs, schools, outpatient sexual assault programs, DV shelters
Ongoing research regarding this	Newer versions of BT have been released that have extended the program from 11 to 12 sessions. An abbreviated 6-session version also exists. In

intervention	addition, there is an adaptation of the program that is designed for adolescent and teenage girls (*Voices*) that can be implemented in a variety of settings such as treatment programs, juvenile justice programs, and schools.
Author's recommendations and reflections	It is easier to implement WIT in agencies or institutions where there is organizational support and minimal organizational trauma or disruption. There is no "best" setting in which to implement the program. However, the program is most successful in places where the facilitator is enthusiastic about the material and wants to facilitate, the agency is supportive, there is an adequate space for the group, and the situation/environment is maintained and positive. It is important that all interventions have periodic updates. When you use outdated materials, participants do not respond the same way over time and the program becomes less effective. You have to let people know that you have a sense of their lives. It is also important to develop more integrated approaches. In HWR, the focus is on substance abuse and trauma is a subtheme and in BT, the focus is on trauma and substance abuse is the subtheme. However, we really need to approach these experiences in a more much more holistic, comprehensive, and integrated way because they are so connected in women's lives. It is not effective to address them separately and while integration is important it is still a struggle.
Citations – article of intervention	Covington, S. S., Burke, C., Keaton, S., & Norcott, C. (2008). Evaluation of a trauma-informed and gender-responsive intervention for women in drug treatment. *Journal of Psychoactive Drugs*, *40*(5), 387-398. DOI: 10.1080/02791072.2008.10400666
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