RESPONSE: TREATING WOMEN ON THEIR OWN TERMS

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We don't know what strategies work better or worse for eliciting sensitive information, such as a history of trauma, and this can have a major impact on the treatment process.

Christine Grella: The authors describe a very good program and it may be that the role playing is tied up with other characteristics of the program that may be efficacious. They suggest that they have seen improvement in outcomes for women in their program since they instituted the women-only treatment components. But it may be that they have very well-trained staff, it is a well-run program, that there are other program-related characteristics associated with their good outcomes, and that the role-playing component is part of it. We don't know because we don't have data. The role playing should be isolated and tested.

Lorraine Collins: I think we have to separate out how patients feel and react when they are in a therapeutic setting and what therapy enables them to do when they are back home 6 months later. A woman might really feel good and be able to role-play assertiveness or whatever in the therapy setting, but then be unable to assert herself when she has moved outside of the clinical setting. You may find that the treatment has not actually been effective. In the case of any promising treatment, followup is very important when you look at outcomes, especially in the first 3 months, when we know a lot of relapsing occurs.

William Cornely: One of the mistaken beliefs among providers is that people can enter a program and have talk therapy for 30 to 60 days and then experience some sort of event—'break through' their trauma issues. But it's a much more complex and lengthy process than that.

Grella: The authors are correct that we don't know what strategies work better or worse for eliciting sensitive information, such as a history of trauma, and that this can have a major impact on the treatment process. And they are correct in suggesting that we need empirical studies of different methods for eliciting such information.

We have looked at the issue in terms of whether traumatized women will stay in treatment and what the impact on the treatment process would be; for example, how will women's HIV risk behaviors, which can be related to trauma experience, be affected?

Collins: I support what the authors are saying about women, because that is the group where most trauma occurs. But it might be worth mentioning men also, because of what we know about risky sexual behavior and, often, trauma of young men related to sexuality issues.

There is a type of communication research that could be relevant here. For instance, the research we have suggests that people are willing to disclose certain kinds of information—such as their alcohol consumption and drug use—to computers, though they would not disclose face-to-face. You can do the intake [interview] as a warm, 'let's get to know each other' session, where you put the patient in front of a computer, let him or her respond to whatever questions you put there, and then filter the results through the warm get-together later. That would be very easy to study.

At our research institute, we have a clinical research center where all of our clients go through a computerized assessment that we call our 'core data base.' And they seem to handle it really well—men and women, alcohol and drug problems. I don't have specific information about trauma, though.

The computer programs are efficient because of the way linkages are programmed, but a particular treatment facility might find that kind of software development expensive. Once the programming is done, though, it can be used across a number of settings. It's not as though each facility would have to create a new system.

Grella: The best source of guidance would be our patients: We could design a study of individuals who have gone through treatment—perhaps through different modalities—and ask them when they would be most comfortable and how—in what format—they would be most comfortable providing this kind of sen-

sitive information. I think if we elicited those suggestions from patients, we could set up a sound design to test different approaches empirically.

Cornely: With Dr. Thomas McLellan at Treatment Research Institute, we are going to start testing a system in September: Half of the women will fill out a computerized version of the Addiction Severity Index and half will have the traditional questionnaire.

Collins: I think that's a great start. If the computerized approach works, then it would be much more efficient once the investment in hardware and software has been made.

Grella: I don't think we're going to find one single method that will work for all women, let alone all men and women. It is going to depend on lots of different variables: How recent was the trauma? How severe? I would like to see a discussion of the variability in traumatic experience and how women present it and, therefore, the impact on assessment and treatment processes. Some events might be very distal and not associated with the client's immediate needs. The next step seems to be eliciting information about the reaction, severity, centrality of the trauma for the individual in treatment.

Cornely: The level of staff training and education with trauma varies across programs. My experience has been that many treatment personnel enter into counseling without any training. That can also be detrimental. Some sort of questionnaire is needed to assess the staff's level of training and awareness of the issues of sexual abuse, incest, and the like. People can take a course or two and think they are experts, but I have seen counselors do harm. &