

Taking Charge

A Pilot Curriculum of Self-Defense and Personal Safety Training for Female Veterans With PTSD Because of Military Sexual Trauma

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The authors describe an overview of the pilot project Taking Charge, a 36-hour comprehensive behavioral intervention involving psychoeducation, personal safety, and self-defense training for 12 female veterans with posttraumatic stress disorder (PTSD) from military sexual trauma. Self-defense training can incorporate the benefits of repeated exposure while teaching proactive cognitive and behavioral responses to the feared stimuli, and thus facilitate emotional and physical rescripting of and mastery over the trauma. Results up to 6 months follow-up indicate significant reductions in behavioral avoidance, PTSD hyperarousal, and depression, with significant increases in interpersonal, activity, and self-defense self-efficacy. The authors propose that this therapeutic self-defense curriculum provides an enhanced exposure therapy paradigm that may be a potent therapeutic tool in the treatment of PTSD.

Keywords: *posttraumatic stress disorder; women veterans; personal safety; self-defense*

Women and Posttraumatic Stress Disorder (PTSD)

Feeling safe and knowing how to protect oneself in the event of a sexual or physical assault are concerns shared by most women in our society today, including those in the armed forces. The prevalence of sexual harassment, sexual assault, and physical violence against women in the armed forces is

Authors' Note: We express our appreciation to the VA Puget Sound Health Care System Mental Illness Research Education and Clinical Center (MIRECC) for funding this study. We also appreciate the staff and patients of the Women's Trauma Recovery Program, the Addiction Treatment

high with reports ranging from 43% to 63% (Fontana & Rosenheck, 1998; Sadler, Booth, Nielson, & Doebbeling, 2000). Among female patients treated at Veteran's Administration (VA) facilities, 90% reported experiencing frequent harassment during their tours of duty (Murdoch & Nichol, 1995), and as many as 37% reported being raped during their tour (Hankin et al., 1999; Murdoch & Nichol, 1995).

A common long-term result of a life-threatening traumatic event is posttraumatic stress disorder (PTSD). This is particularly true when disclosure of the event is actively discouraged or even punished (see Fontana & Rosenheck, 1998), as is often the case in military settings. Among female veterans, distress associated with sexual trauma has been found to be nearly 4 times more influential than duty-related distress in the eventual development of PTSD (Fontana & Rosenheck, 1998; see also Wolfe et al., 1998). Thus, PTSD stemming from military sexual trauma is perhaps one of the most pressing mental health concerns facing female veterans today.

PTSD symptoms include reexperiencing of upsetting traumatic events, avoidance of cues that are reminders of the traumatic events, emotional numbing, and physiological hyperarousal (American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, 4th ed., 1994). Pervasive fears of sustaining another attack may markedly restrict such women's everyday activities and functioning and thus severely impinge on their quality of life (Herman, 1992). PTSD may, therefore, markedly affect an individual's access to activities outside the home such as treatment, work, recreation, involvement in community activities, and the pursuit of educational or retraining opportunities.

Personal Safety and/or Self-Defense (PS/SD) Training as Treatment for PTSD in Women

A growing body of empirical research indicates that personal safety and/or self-defense (PS/SD) training effectively empowers women to cope with the threat of physical and sexual violence by providing a strong sense of mastery and personal control over their own safety and well-being (Ozer & Bandura, 1990; Weitlauf, Cervone, Smith, & Wright, 2001; Weitlauf, Smith, & Cervone, 2000). This "empowerment effect" appears to result in greater

Clinic, the Mental Health Clinic, and the Medical Media Center of the Seattle Division, VA Puget Sound Health Care System, for their cooperation and assistance with this pilot project. We also wish to thank self-defense instructors Carol and Boyd Gittens for their assistance with this program, Julie Weitlauf for her valuable contributions, Lisa Garrison for her expert clerical support, and Brenda Veland for her dedication to capturing the program on video. Correspondence concerning this article should be sent to Wendy S. David, VA Puget Sound Health Care System, (116-MHC) 1660 S. Columbian Way, Seattle, WA 98108; e-mail: wendy.david@med.va.gov.

personal freedom, evidenced by an increased willingness to participate in community activities (Ozer & Bandura, 1990) and has been found to extend to other vulnerable populations, such as women and men with visual disabilities (David, Kollmar, & McCall, 1998; Pava, Bateman, Appleton, & Glascock, 1991).

In light of these findings, we wondered whether a therapeutic self-defense curriculum might function as an enhanced exposure therapy paradigm for women veterans who were sexually traumatized and who had PTSD. Such training could provide an effective form of behavioral therapy by offering the benefits of repeated exposure to simulated assault scenarios while teaching proactive cognitive and behavioral responses to feared stimuli. To find out whether female veterans with assault-related PTSD would be interested in this type of intervention, we conducted an interest survey in our clinic (David, Cotton, Simpson, & Weitlauf, 2004) and found that the majority feared future assault (76%), believed that these fears limited their activities (78%), and believed that PS/SD training would increase their sense of safety and security (85%). These positive results led us to develop Taking Charge (TC), a therapeutic self-defense program, and this article provides an overview of the results of an open-trial pilot evaluation of one TC cohort.

Method

Participants

Twelve patients enrolled in the TC pilot group, and 10 participated in the research evaluating the group. One research participant left town after completing the class and chose not to continue with any of the remaining research. The participants were medically cleared by a staff physician, and each was determined to be physically and psychiatrically stable (e.g., not currently suicidal, psychotic, using substances, pregnant, or involved in domestic violence situations). They were also screened for cardiac, orthopedic, and medication complications that would mean group participation was contraindicated. Each was actively engaged in outpatient mental health treatment at the VA. All carried chart diagnoses of PTSD and scored in the PTSD positive range on the PTSD Checklist–Civilian version (PCL-C; Weathers, Litz, Herman, Huska, & Keane, 1993) of 38 or greater (see below for details on the scale; see Dobie et al., 2002 for information on cut scores for female veterans).

The mean age of the 10 research participants was 48.3 years of age (range 28 to 62). Seven of them were non-Hispanic White with the remaining women identifying themselves as Native American (1) or Other (2). Most of

the participants were living in their own homes (9), and one stated that she was homeless and staying with family members. More than one half the women reported being divorced (6), two were married, one has never been married, and one did not respond to this question. One woman was working part-time, five were receiving a VA pension, one was on another form of subsidy, one was a student, one was unemployed, and one chose not to respond. Six women reported having attended some college, three were college graduates, and one reported postgraduate studies. Income ranges were as follows: three less than U.S. \$20,001 per year, three between \$20,001 and \$30,000, three more than \$30,001, and one not responding to the question. Four of the 10 reported prior self-defense training.

Procedures

The participants in this open pilot study completed a paper-and-pencil packet of measures 5 times: (a) 1 month prior to the onset of the group (Baseline 1, B1), (b) immediately before the group began (B2), (c) at the conclusion of the final group session (Posttest 1, P1), (d) 3 months after the final session (P2), and (e) 6 months after the final session (P3). All participants provided informed consent, and all study procedures were reviewed and approved by the University of Washington Internal Review Board and the VA Puget Sound Research and Development Committee.

Materials

A demographic questionnaire consisted of nine items covering age, ethnicity, living situation, marital status, number of children, employment status, education, and annual household income.

Portions of Ozer and Bandura's (1990) Self-Defense Scale were used to assess changes in self-efficacy on a variety of indices. All items were rated on 10-point Likert-type scales. Four items assessed risk perception (thinking patterns in Ozer & Bandura, 1990), including beliefs about the likelihood of assault, ability to discern risky situations, level of fear of assault, and the frequency of thoughts and worries about assault or personal safety. We were concerned about changes on each particular item and, therefore, did not sum them. The Interpersonal Self-Efficacy subscale consists of responses to eight short vignettes regarding how confident participants are that they can handle a variety of potentially dangerous interpersonal situations (e.g., feeling threatened by someone in an elevator). The Activities Self-Efficacy subscale consists of 17 items representing various community activities (e.g., going hiking, attending a movie alone) and asks participants to rate how certain they are that they could engage in each activity. The Self-Defense Self-Efficacy

subscale consists of 12 brief scenarios describing potential attacks by either strangers or known individuals and asks participants to rate how certain they are they could use up to 12 different physical self-defense strategies to counter each type of attack for a total of 70 ratings. The internal consistency of all the subscales was found to be strong in the original sample.

The Aggression Questionnaire (Buss & Perry, 1992) consists of 29 items that assess how characteristic it is for the individual to engage in physical aggression, verbal aggression, and to feel anger and hostility. Each item is rated on a 5-point Likert-type scale (0 = *extremely uncharacteristic of me*, 4 = *extremely characteristic of me*). Subscale reliabilities are acceptable, with Cronbach's alpha ranging from .62 to .78.

The PCL-C (Weathers et al., 1993) is a 17-item questionnaire that covers all of the *DSM-IV* PTSD diagnostic criteria. Participants are asked to indicate how much each symptom has bothered them in the past month (1 = *not at all*, 5 = *extremely*). The internal consistency of the scale has been found to be quite good (Cronbach's alpha = .97).

The Beck Depression Inventory (BDI; Beck, Steer, & Garbin, 1988) is a widely used 21-item measure with good psychometric properties that was used to assess current depressive symptoms.

The General Self-Efficacy Scale (Schwarzer & Jerusalem, 1995) is a 10-item scale assessing self-perception regarding ability to manage challenging general types of circumstances. Each item is rated on a 4-point Likert-type scale (1 = *not at all true*, 4 = *exactly true*).

Intervention Curriculum

Taking Charge (TC) is a 12-week (36-hour) structured group intervention designed to provide women with sexual assault histories training on assertiveness, boundary setting, prevention skills, and physical techniques designed to resist assault. Each 3-hour group session was divided into three parts: (a) 1 hour of psychoeducation on facts about sexual assault and role-play practice exercises on assertive communication and boundary setting, (b) 1 hour of physical self-defense training with two self-defense specialists, (c) 1 hour of group debriefing. Three experienced female psychologists were present throughout each session, and the two martial artists (one female, one male) were present for the first 2 hours of each group session.

Data Analysis Strategy

Within-subject paired *t* tests were used to ascertain whether there were significant differences between either of the baseline assessments and the three posttest follow-ups. Because we felt the risk of inflated Type I error

(false positives) was preferable to that of Type II (false negatives), we did not adjust our alpha levels to account for multiple tests. However, because these pilot data are based on a small number of participants ($n = 8$ from baseline to posttest, $n = 8$ from baseline to 3-month follow-up, and $n = 7$ from baseline to 6-month follow-up) and multiple uncontrolled tests were performed, the reader is cautioned not to overinterpret the findings.

Results

The paired t tests yielded no significant differences between Baselines 1 and 2. However, there was a trend for symptoms to be heightened at Baseline 2, so the more-conservative Baseline 1 was used in the following analyses.

Risk Perception

The women's perception of the general risk of assault did not change throughout the class and all follow-up points (see Table 1 for all means and standard deviations). However, the women did endorse feeling less fearful about being assaulted at the immediate posttest, $t(7) = 3.6, p = .008$. This finding did not persist through the 3- and 6-month follow-ups. The women also believed they were better able to discern risky versus safe situations, and this improvement remained significant through the 3-month follow-up; baseline to posttest, $t(7) = 4.4, p = .003$; baseline to 3-month follow-up, $t(6) = 2.6, p = .038$.

Psychiatric Indicators

Overall PTSD severity was not significantly reduced at posttest; however, there were significant reductions from baseline to the 3-month, $t(7) = 3.4, p = .012$, and 6-month follow-ups, $t(6) = 3.0, p = .024$ (see Table 1). To discern whether there were particular changes in any of the three PTSD symptom clusters, we disaggregated the PCL-C and separately examined reexperiencing symptoms, avoidance symptoms, and hyperarousal symptoms. Re-experiencing symptoms showed no significant changes from baseline to any of the follow-up points; however, the Avoidance subscale showed significant reductions from baseline to the 3-month, $t(7) = 4.9, p = .002$, and 6-month follow-ups, $t(6) = 4.4, p = .004$, as did the Hyperarousal subscale; baseline to 3-month follow-up, $t(7) = 2.8, p = .027$; baseline to 6-month follow-up, $t(6) = 3.7, p = .010$. In addition, we found significant decreases in depression on the BDI between baseline and all three of the follow-up points; baseline to posttest, $t(7) = 3.1, p = .017$; baseline to 3-month follow-up, $t(7) = 5.1, p =$

Table 1
Means and Standard Deviations of Risk-Related Cognitions ($N = 9$)

	Baseline 1	Posttest	3 Months Follow-up	6 Months Follow-up
	<i>M (SD)</i>	<i>M (SD)</i>	<i>M (SD)</i>	<i>M (SD)</i>
Risk perception				
Perceived general risk of assault	8.7 (1.6)	7.9 (1.7)	7.9 (1.3)	8.6 (1.1)
Fear of assault	8.0 (2.1)	3.7 (1.8)**	7.4 (2.4)	5.9 (2.0)
Ability to discern risk	6.3 (2.4)	3.4 (1.8)**	3.7 (1.4)*	4.9 (2.3)
Psychiatric indicators				
PTSD symptoms (PCL total)	74.9 (11.8)	57.6 (24.9)	66.6 (13.8)*	62.1 (17.4)*
PCL Reexperiencing subscale	22.2 (3.4)	17.7 (7.3)	20.9 (4.6)	20.1 (5.9)
PCL Avoidance subscale	30.5 (5.8)	23.2 (10.7)	26.7 (6.5)**	24.3 (7.6)**
PCL Hyperarousal subscale	22.2 (3.8)	16.6 (7.2)	19.0 (3.6)*	17.7 (4.6)**
Depression (BDI total)	41.9 (14.1)	19.7 (16.3)*	32.2 (12.4)	34.3 (12.8)**
Hostility and/or anger	17.7 (5.9)	12.6 (7.1)	17.0 (6.6)	17.3 (5.5)
Self-efficacy parameters				
General self-efficacy	25.1 (7.3)	30.5 (6.0)	25.9 (5.9)	26.1 (6.3)
Interpersonal self-efficacy	4.6 (2.4)	8.9 (.9)**	7.4 (1.7)**	7.2 (2.6)**
Activities self-efficacy	2.1 (2.1)	6.9 (2.2)*	4.9 (2.2)**	4.3 (1.9)**
General self-defense self-efficacy	2.4 (2.0)	8.9 (1.1)**	7.8 (2.5)**	7.1 (2.2)**

NOTE: PTSD = posttraumatic stress disorder; PTSD Checklist–Civilian version; BDI = Beck Depression Inventory.

* $p < .05$. ** $p < .01$.

.001; baseline to 6-month follow-up, $t(6) = 3.9$, $p = .008$. There were no significant changes in physical or verbal aggression or in feelings of anger and hostility on any of the comparisons between Baseline 1 and the three follow-up points.

General and Specific Self-Efficacy

We found no significant changes from baseline to any of the follow-up points on general self-efficacy (see Table 1). However, there was a significant improvement on interpersonal self-efficacy at all three follow-up points relative to baseline: baseline to posttest, $t(7) = -5.1$, $p = .001$; baseline to 3-month follow-up, $t(6) = -4.6$, $p = .004$; baseline to 6-month follow-up, $t(6) = -4.7$, $p = .003$. In addition, there were similar improvements at all of the follow-up points with regard to self-defense self-efficacy: baseline to posttest, $t(7) = -7.2$, $p = .000$; baseline to 3-month follow-up, $t(6) = -4.9$, $p = .003$; baseline to 6-month follow-up, $t(6) = -4.2$, $p = .006$; specific self-defense techniques self-efficacy: baseline to posttest, $t(6) = -9.0$, $p = .000$; baseline to 3-month follow-up, $t(6) = -8.3$, $p = .000$; baseline to 6-month follow-up, $t(6) = -9.5$,

$p = .000$; and self-efficacy for engaging in community activities; baseline to posttest, $t(7) = -3.4$, $p = .011$; baseline to 3-month follow-up, $t(6) = -5.7$, $p = .001$; baseline to 6-month follow-up, $t(6) = -3.9$, $p = .008$.

Discussion

Previous research has consistently demonstrated that personal safety and physical self-defense training affords many benefits to self-selected samples of women in the community. This was the first-known project investigating PS/SD training in a clinical sample and thus differed from those previously studied in several ways: (a) all of the women had significant assault histories, including military sexual trauma and met diagnostic criteria for PTSD; (b) the women were, for the most part, older than most college students; and (c) all of the women had at least some familiarity with formal, structured training in physical fighting and military combat.

As hoped, results of this pilot group indicate that PS/SD training can be a viable and feasible treatment adjunct in addressing disabling psychiatric symptoms and bolstering community involvement for female veterans engaged in PTSD treatment. Specifically, the results of the current study indicate that the research participants showed significant improvement in the following areas: They reported a heightened ability to discern risky situations, a decrease in obsessive fear and worry about assault without believing themselves to be invulnerable; an increased sense of personal safety and increased confidence in their self-defense skills, improved confidence in their ability to be assertive and to set appropriate interpersonal boundaries, decreased depression, decreased PTSD avoidance and hyperarousal symptoms, and increased willingness to participate in community activities. Furthermore, participants did not endorse negative psychological effects of training, such as increased anger or hostility.

It is particularly noteworthy that all 12 participants who began the group also completed it. The lack of attrition was surprising given the intensity of the intervention and the often-high attrition rates with other types of PTSD exposure interventions (Becker & Zayfert, 2001). Although little can be generalized about the lack of attrition from such a small sample, it is encouraging nonetheless. It is possible that providing participants with active skills designed to limit their vulnerability to future assault helped them stay in the group even when it was quite stressful. Group participants articulated that they valued the strong bonding and support they shared with each other, and it is possible that this helped to reduce attrition as well.

Personal safety and/or self-defense shares many features of traditional exposure-based behavior therapies but also has some additional features that

set it apart. Unlike traditional exposure therapies that utilize imaginal exposure and learned relaxation techniques, PS/SD incorporates strategic, active, and powerful physical responses that are practiced repeatedly in a simulated threat context. Stuhlmiller (1994) claimed that “action-based techniques can stimulate the arousal and imagery that are associated with the original trauma and that may not be easily accessible through relatively passive means” (p. 389).

Because the PS/SD intervention was highly focused on learning and practicing a new behavioral repertoire in response to trauma stimuli, it may be especially useful in targeting the avoidant symptoms of PTSD. In fact, data from this pilot cohort indicate that the hyperarousal and the avoidant symptoms clusters of PTSD were positively affected by this treatment, with participants reporting decreases in these types of symptoms through the 6-month follow-up period. Although the specific reasons for this pattern of results are as yet unclear, it is possible that PS/SD training provided the participants with the tools to better gauge actual threat, thus possibly reducing excessive hypervigilance and hyperarousal. Personal safety and/or self-defense may have also allowed participants to see that facing self-defense training scenarios similar to their assaults did not result in unmanageable anxiety, thus reducing the need to avoid the often-ubiquitous reminders of their assaults in their day-to-day lives. However, there may not have been enough iterations of exposure to the emotionally charged specific personal assault scenarios to bring about a reduction in reexperiencing symptoms.

Limitations of the Current Study

The results of the current pilot study indicate positive and lasting effects from a 36-hour curriculum in PS/SD training among female veterans receiving mental health treatment for PTSD. It is important, however, to be cognizant of the following caveats. The participants represent a small, self-selected subset of the larger population of female veterans receiving mental health care services who were carefully screened for psychological, physical, and environmental instability. These factors may limit the generalizability of the current findings, even to other female veterans with similar clinical profiles. The current study was also limited by low statistical power, lack of a control group, and an inflated risk of Type I error in that numerous statistical tests were conducted to gauge the pattern of results for this pilot cohort. The general consistency of the findings across the three post-intervention time periods does lend some credence to these data; however, it will be critical to replicate these findings with other samples and more rigorous research designs to determine whether wide-scale dissemination in the VA and general community is warranted.

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