# DAWN Drugs and Alcohol Women Network:
# Promoting a Gender Responsive Approach to Addiction

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# Forewords

In 2010, the Department for Anti-drug Policy of the Government of Italy requested the assistance of UNICRI to establish a network of professionals to advocate for gender responsive policies and practices among policy makers and professionals. These professionals would also become focal points for supporting the amelioration of working practices in the prevention, treatment and recovery from addiction, and to more effectively meet the needs of women at risk or already using drugs.

With its long-standing expertise in research on vulnerable population and special groups, gender based violence and the social consequences of addiction, UNICRI would bring a rich expertise to the development of this programme, as well as mobilize and engage its worldwide expert network.

Almost two years later, thanks to the close collaboration between the International Relations Office of the Department for Anti-drug Policy of Italy and UNICRI, Project DAWN – Drugs and Alcohol Women Network – has grown to become a well recognized reference centre for professionals and policy makers in Italy and in countries of the Mediterranean Basin. It has established a solid and energetic network of professionals.

In close relationship with the UNODC and the WHO, Project DAWN has contributed to the adoption of instruments and tools to assist the international community in the establishment of gender responsive prevention treatment and recovery programmes, such as guidelines, training modules and web-based platforms for distance learning.

This book represents one of the tools originating from this project. It is a collection of essays, case studies, working experiences and good practices implemented at various levels, in different countries. It also contains essays on gender responsive services, the nature of the services they should offer, and how they should be structured to respond to the needs of women. This book aims to contribute to a reflection on the progress we have made in the implementation of the "gender mainstreaming approach" set forth in the Beijing Declaration and in the implementation of the good practices in this field. It examines the gender responsive approach and the place and the role of women in the post 2015 development era.

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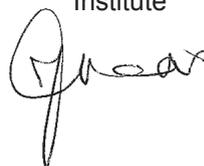
# Understanding and applying gender differences in recovery

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## Introduction

Over the past thirty years, our knowledge of women's addictions has increased dramatically, and we have added significantly to our understanding of the treatment needs of women who are addicted to alcohol and other drugs.

Historically, substance abuse treatment developed as a single-focused intervention, based on the needs of addicted men. Counselors focused only on the addiction and assumed that other issues would either resolve themselves through recovery or would be dealt with by another helping professional at a later time.

However, research shows that a vast majority of addicted women have suffered violence and other forms of abuse, and a history of being abused drastically increases the likelihood that a woman will abuse alcohol and other drugs. One of the most important developments in health care over the past several decades is the recognition that a history of serious traumatic experiences plays an often-unrecognized role in a woman's physical and mental health problems (Felitti, Anda, Nordenberg, Williamson, Spitz, Edwards, Koss, & Marks, 1998; Messina & Grella, 2006).

In one of the first studies on addicted women and trauma, 74 percent of the addicted women reported sexual abuse, 52 percent reported physical abuse, and 72 percent reported emotional abuse. "Moreover, the addicted women were found to have been abused sexually, physically, and emotionally by more perpetrators, more frequently, and for longer periods of time than their non addicted counterparts. The addicted women also reported more incidents of incest and rape" (Covington & Kohen, 1984, p. 42). More recent studies confirm that the majority of substance-abusing women have experienced sexual and/or physical abuse (Kendall-Tackett, 2005; Ouimette et al., 2000).

## Gender-responsive services

The research also demonstrates that addiction treatment services for women (and girls) need to be based on a holistic and woman-centered approach that acknowledges their psychosocial needs (Grella, 1999; Grella, Joshi, & Hser, 2000; Orwin, Francisco, & Bernichon, 2001). This author defines gender-responsive, woman-centered

treatment as the creation of an environment – through site selection, staff selection, program development, and program content and materials – that reflects an understanding of the realities of women's and girls' lives and that addresses and responds to their challenges and strengths.

## The issue of gender

Awareness of gender issues must be part of the clinical perspective. The keys to developing effective services for women are understanding and acknowledging the effects of living as a female in a male-based society. In most of the world today, the male gender is dominant, and its influence is so pervasive that it often is unseen. One result is that programs and policies called "gender neutral" are actually male based. For example, program administrators may take a traditional program designed for men, change the word "he" to "she," and call the result a "program for women."

Research suggests that social and environmental factors (including gender socialization, gender roles, and gender inequality) account for many of the behavioral differences between women and men. Gender differences are neither innate nor unchangeable; they are ascribed by society and relate to expected social roles, so it is important to acknowledge some of the dynamics in a gendered society.

Differences also exist between women based on a number of factors (such as race and socioeconomic status), and these can influence a helping professional's views of gender-appropriate roles and behaviors. Regardless of their differences, all women are expected to incorporate the gender-based norms, values, and behaviors of the dominant culture into their lives. As Kaschak (1992) states.

The most centrally meaningful principle on our culture's mattering map is gender, which intersects with other culturally and personally meaningful categories such as race, class, ethnicity, and sexual orientation. Within all of these categories, people attribute different meanings to femaleness and maleness.

## Gender responsive principles

In a research-based report for the National Institute of Corrections, which states the guiding principles for working with women, gender is the first principle. A multidisciplinary review of the literature and research on women's lives in the areas of substance abuse, trauma, health, education and training, mental health, and employment was conducted as part of this project. The following principles are applicable to any setting that serves women (Bloom, Owen, & Covington, 2003):

● Gender: Acknowledge that gender makes a difference.
● Environment: Create an environment based on safety, respect, and dignity.
● Relationships: Develop policies, practices, and programs that are relational and promote healthy connections to children, family, significant others, and the community.
● Services: Address substance abuse, trauma, and mental health issues through comprehensive, integrated, and culturally relevant services.
● Socioeconomic status: Provide women with opportunities to improve their socioeconomic conditions.
● Community: Establish a system of comprehensive and collaborative community services.

## Common themes in the lives of addicted women

Several years ago the United Nations developed a monograph on the treatment of drug-addicted women around the world. At a meeting of experts held in Vienna, it became clear that many of the issues that addicted women struggle with are universal:

● Treatment issues.
● Systemic issues.
● Shame and stigma.
● Physical and sexual abuse.
● Relationship issues.
● Fear of losing children.
● Fear of losing a partner.
● Needing a partner's permission to obtain treatment.
● Lack of services for women.
● Lack of understanding of women's treatment.
● Long waiting lists.
● Lack of childcare services.
● Lack of financial resources.
● Lack of clean and sober housing.
● Poorly coordinated services.

It is important to note that helping professionals around the world report an association between addiction and all forms of interpersonal violence (physical, sexual, and emotional) in women's lives (United Nations Office on Drugs and Crime, 2004).

# A model for women's recovery: women's integrated treatment

The recurring theme of the interrelationship between substance abuse and trauma in women's lives indicates the need for a multi-focused approach to services. One treatment model, developed by the author, is called "Women's Integrated Treatment" (WIT). The WIT model is based on 1) the definition of and principles for gender-responsive services (previously discussed), 2) a theoretical foundation (discussed below), and 3) multi-dimensional therapeutic interventions. Several studies (e.g., Covington, Burke, Keaton, & Norcott, 2008; SANDAG, 2007), including two experimental, randomized, control-group studies (Messina, Calhoun, & Warda, 2012; Messina, Grella, Cartier, & Torres, 2010) show positive results for the WIT model. These results are discussed in a later section.

## Theoretical foundations

In order to develop gender-responsive services and treatment for women, it is essential to begin with a theoretical framework. This is the knowledge base on which programs are developed. The three fundamental theories underlying the WIT model are: relational-cultural theory, addiction theory, and trauma theory.

## Relational-cultural theory

A link between understanding women's addiction and creating effective treatment programs for women is understanding the unique characteristics of women's psychological development and needs. Theories that focus on female development, such as "Relational-Cultural Theory" (Jordan, 1991) posit that the primary motivation for women throughout life is the establishment of a strong sense of connection with others. Relational-Cultural Theory (RCT) developed from an increased understanding of gender differences and, specifically, from an understanding of the different ways in which women and men develop psychologically. According to this theory, females develop a sense of self and self-worth when their actions arise out of, and lead back into, connections with others. Connection, not separation, is the guiding principle of growth for women and girls. RCT describes the outcomes of growth-fostering relationships, as well as the impact of disconnections. Disconnections happen at the sociocultural level, as well as the personal level, through racism, sexism, heterosexism, and classism. The issues of dominance and privilege are two aspects of Relational-Cultural Theory (Jordan & Hartling, 2002).

## Addiction theory

In recent years, health professionals in many disciplines have revised their concepts of all diseases and have created a holistic view of health that acknowledges the physical, emotional, psychological, and spiritual aspects of disease. In a truly holistic model, the environmental and sociopolitical aspects of disease are also included. The WIT model uses a holistic model of addiction (which is essentially a systems perspective) to understand every aspect – physical, emotional, and spiritual – of the woman's self as well as the environmental and sociopolitical aspects of her life, in order to understand her addiction. An addicted woman typically is not using alcohol or other drugs in isolation, so her relationships with her family members and other loved ones, local community, and society are taken into account. For example, even though a woman may have a strong genetic predisposition to addiction, it is important to understand that she may have grown up in an environment in which addiction and drug dealing are commonplace (Covington, 2007).

Although the addiction treatment field considers addiction a "chronic, progressive disease," its treatment methods are more closely aligned to those of the acute care medical model than the chronic-disease model of care (White, Boyle, & Loveland, 2002). An alternative to the acute-care model for treating disease is "behavioral health recovery management" (BHRM). This concept grew out of and shares much in common with "disease management" approaches to other chronic health problems; it focuses on quality-of-life outcomes as defined by the individual and family. It also offers a broader range of services earlier and extends treatment well beyond traditional (medical) services. The more holistic BHRM model extends the current continuum of care for addiction by including: 1) pretreatment (recovery-priming) services; 2) recovery mentoring through primary treatment; and 3) sustained, post-treatment, recovery-support services (Boyle, White, Corrigan, & Loveland, 2005).

An integration of BHRM and the holistic health model of addiction is the most effective theoretical framework for developing treatment services for women because it is based on a multidimensional framework. It allows clinicians to treat addiction as the

primary problem while also addressing the complexity of issues that women bring to treatment: genetic predispositions, histories of abuse, health consequences, shame, isolation, or a combination of these. When addiction has been a core part of multiple aspects of a woman's life, the treatment process requires a holistic, multidimensional approach.

## Trauma theory

Violence against women is so pervasive that the United Nations has addressed and defined violence against women as "any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivations of liberty, whether occurring in public or private life" (United Nations General Assembly, 1993).

The third theory integrated into the WIT model is based on the principles of trauma-informed services (Harris & Fallot, 2001) and the "Three-Stage Model of Trauma Recovery" developed by Dr. Judith Herman (1997).

# Understanding trauma

Trauma is not limited to suffering violence; it includes witnessing violence as well as stigmatization because of gender, race, poverty, incarceration, or sexual orientation. The terms violence, trauma, abuse, and post-traumatic stress disorder (PTSD) often are used interchangeably. One way to clarify these terms is to think of trauma as a response to violence or some other overwhelmingly negative experience (e.g., abuse). Trauma is both an event and a particular response to an event. PTSD is one type of anxiety disorder that results from trauma.

The symptoms of PTSD fall into four categories:

● Intrusive symptoms: flashbacks, nightmares, and intense or prolonged distress.
● Avoidance symptoms: isolation and disconnection from others; avoiding people, places, and situations that are triggers or reminders.
● Negative emotions and thoughts: blaming, excessive negativity, fear, anger, shame, and diminished interests.
● Arousal and reactivity: angry outbursts, reckless and dangerous behavior, hypervigilance, difficulty sleeping, and an increased startle response (American Psychiatric Association, 2013).

There are two types of PTSD: simple and complex. Complex PTSD usually results from multiple incidents of abuse and violence (such as childhood sexual abuse and domestic violence). A single traumatic incident in adulthood (such as a flood or accident) may result in simple PTSD.

A review of studies that examine the combined effects of post-traumatic stress disorder and substance abuse found more co-morbid mental disorders, medical problems, psychological symptoms, in-patient admissions, interpersonal problems, lower levels of functioning, poor compliance with aftercare and motivation for treatment, and other significant life problems (such as homelessness, HIV, domestic violence, and loss

of custody of children) in women with both disorders than in women with PTSD or substance abuse alone (Najavits, Weiss, & Shaw, 1997).

## Gender differences

There is a difference between women and men in terms of their risk for physical and sexual abuse. Both female and male children are at relatively equal risk from family members and people known to them. However, as males age, they are more likely to be harmed by enemies or strangers, whereas women are more likely to be harmed by their lovers or partners (Covington, 2003, 2008; Kendall-Tackett, 2005).

In adolescence, boys are at risk if they are gay, young men of color, or gang members. Their risk is from people who dislike or hate them. For a young woman, the risk is in her relationships, from the person(s) to whom she is saying, "I love you." For an adult man, the risk for abuse comes from being in combat or being a victim of crime. His risk is from "the enemy" or from a stranger. For an adult woman, the primary risk is again in her relationship with the person to whom she says, "I love you." Clinically, we think that this may account for the increase in mental health problems for women. In short, it is more confusing and distressing to have the person who is supposed to love and care for you do harm to you than it is to be harmed by someone who dislikes you, is defined as an enemy or is a stranger.

Figure 1 and 2 from the Bureau of Justice Statistics indicate some of these gender differences.
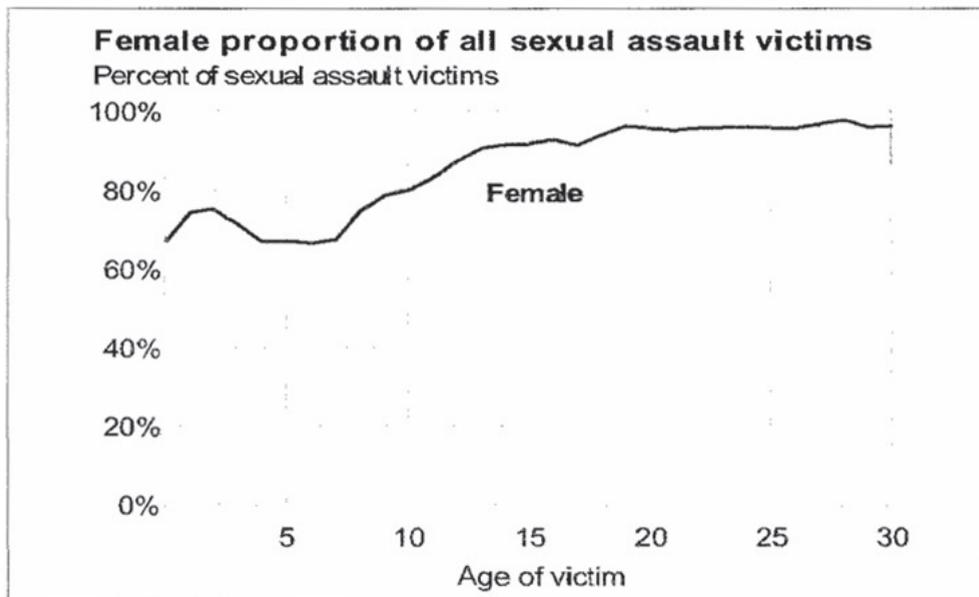


**Figure 1** Source: Bureau of Justice Statistics. (2000). Sexual assault of young children as reported to law enforcement: Victim, incident, and offender characteristics. Washington, DC: U.S. Department of Justice.
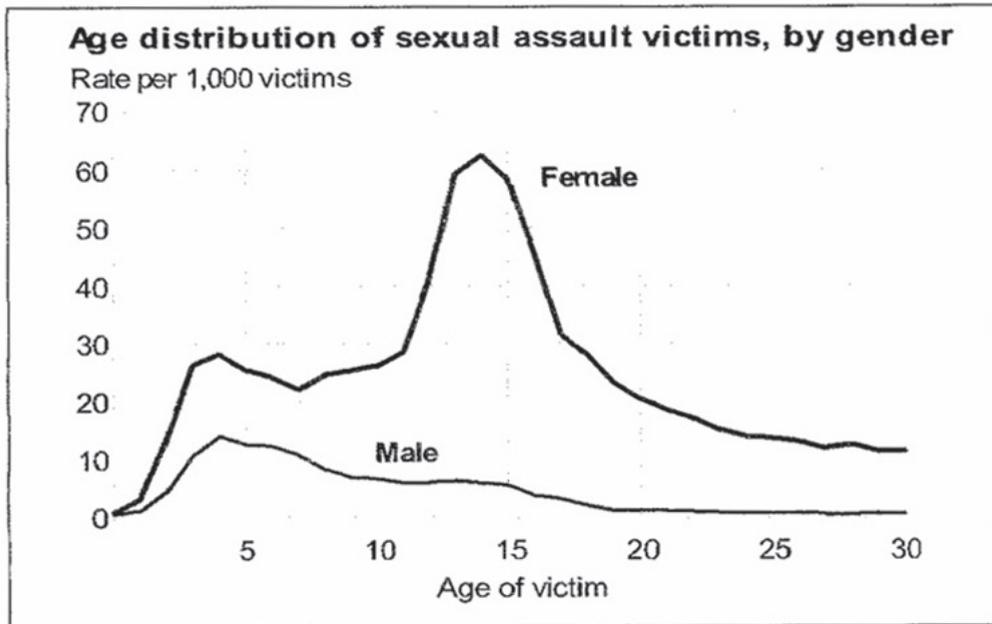
**Figure 2** Source: Bureau of Justice Statistics. (2000). Sexual assault of young children as reported to law enforcement: Victim, incident, and offender characteristics. Washington, DC: U.S. Department of Justice.

Figure 1 shows that a significant number of males are sexually abused as children. From ages one to ten, approximately 35 percent to 20 percent of victims are male and 65 percent to 80 percent are female. However, in adult life, victims of sexual abuse are almost 100 percent female.

Figure 2 indicates that the age of greatest risk for males is age five; for females it is age fourteen.

Of course, different women have different responses to violence and abuse. Some may respond without trauma because they have coping skills that are effective for a specific event. Sometimes trauma occurs but is not recognized immediately, because the violent event is perceived as normal. Many women who used to be considered "treatment failures" because they relapsed are now recognized as trauma survivors who returned to alcohol or other drugs in order to medicate the pain of trauma. By integrating trauma treatment with addiction treatment, we reduce the risk of trauma-based relapse.

# Becoming trauma-informed

As the understanding of traumatic experiences increases among clinicians, mental health theories and practices are changing. It is important for service providers to understand trauma theory as a conceptual framework for clinical practice and to provide trauma-informed services for their clients. According to Harris & Fallot (2001),

trauma-informed services do the following:

● Take the trauma into account.
● Avoid triggering trauma reactions or retraumatizing the woman.
● Adjust the behavior of counselors and staff members to support the woman's coping capacity.
● Allow survivors to manage their trauma symptoms successfully so that they are able to access, retain, and benefit from the services.

There are five core values that treatment services need to incorporate in order to be trauma informed (Fallot & Harris, 2008):

● Safety: Ensuring physical and emotional safety.
● Trustworthiness: Maximizing trustworthiness, making tasks clear, and maintaining appropriate boundaries.
● Choice: Prioritizing client choice and control.
● Collaboration: Maximizing collaboration and sharing power with clients.
● Empowerment: Prioritizing client empowerment and skill building.

These five core values need to be in place for staff members as well as clients. It is not realistic to expect that they can be incorporated for clients but not experienced by the staff as well.

For treatment providers who want to include or expand trauma services, the following model provides a description of how to integrate trauma-informed services and trauma treatment into addiction treatment programs.

## A three-stage model for trauma recovery

In Trauma and Recovery, psychiatrist Judith Herman (1997) defines trauma as a disease of disconnection. She presents a three-stage model for trauma recovery: 1) safety, 2) remembrance and mourning, and 3) reconnection. These three stages are interdependent and usually do not occur in a linear fashion.

### Stage 1: safety

The first stage focuses on caring for oneself in the present. Upon entering addiction treatment, a woman typically is in Stage 1 and her primary need is safety. "Survivors feel unsafe in their bodies. Their emotions and their thinking feel out of control. Often, they also feel unsafe in relation to other people" (Herman, 1997, p. 160).

If we want to assist women in changing their lives, we must create a safe environment in which the healing process can begin to take place. Counselors can help women to feel safe by ensuring as much as possible that there are appropriate boundaries between the clients and all the helping professionals (that is, the environment is free of physical, emotional, and sexual harassment and abuse). Although it may be possible for a clinician to guarantee absolute safety only in a private-practice setting, participants in treatment programs need to know that the environment is likely to be safe for them. Counselors also should assess each woman's risk of domestic violence and,

if needed, provide resources to a woman so that she can get help. These resources include telephone numbers for the local domestic violence hotline and the local women's shelter.

Many chemically dependent trauma survivors use drugs to medicate their anxiety or depression because they know no better ways to comfort themselves. Counselors can teach women to feel safe internally by teaching them to use grounding exercises or self-soothing techniques, rather than drugs, to alleviate anxiety and depression. Many grounding exercises are based on use of the breath and other forms of mindfulness. Self-soothing can include activities such as reading, walking, music, and bubble baths.

Herman emphasizes that a trauma survivor who is working on safety issues needs to be in a woman-only recovery group (including the facilitator). Until they are in Stage 3 (reconnection), women may not want to talk about sensitive issues in groups that include men. Herman cites Twelve Step groups as the type appropriate for Stage 1 (safety) recovery because of their focus on present-tense issues of self-care in a supportive, structured environment. This safety stage focuses on issues that are congruent with the issues of beginning recovery. However, it is also important to note that some trauma survivors do not feel safe in co-ed Twelve Step groups when there are men who aggressively pursue them.

### Stage 2: remembrance and mourning

A woman who is stabilized in her addiction treatment may be ready to begin Stage-2 trauma work. Stage 2, remembrance and mourning, focuses on trauma that occurred in the past. For example, in a survivors' group, participants tell their stories of trauma and mourn their old selves, which the trauma destroyed. During this phase, women often begin to acknowledge the incredible amount of loss in their lives. Although the risk of relapse can be high during this phase of work, the risk can be minimized through anticipation, planning, and the development of self-soothing mechanisms.

## The trauma informed environment

In women's treatment programs, sensitivity to trauma-related issues is critical for a healing environment. A calm atmosphere that respects privacy and maximizes the choices a woman can make will promote healing. Staff members should be trained to recognize the effects of trauma, and clients should have a clear understanding of the rules and policies of the program. A trauma-informed environment includes:

● Attention to boundaries – between staff members and participants, among participants, and among participants and visitors. For example, clients should be given permission to say "no" to hugs. Hugging may be an expression of positive emotion for some women, but for those who have been traumatized it could represent an undesired intrusion into their personal spaces.
● Language that communicates the values of empowerment and recovery. Punitive approaches, shaming techniques, and intrusive monitoring are not appropriate.
● Staff members who adopt the "do no harm" credo to avoid damaging interactions. Conflict is dealt with through negotiation.

## Women in the criminal justice system

Understanding the impact of trauma is particularly important when working with women in the criminal justice system. Unfortunately, standard management practices – such as searches, seclusion, and restraint – may traumatize or retraumatize many females. Experiences in the criminal justice system can trigger memories of earlier abuse. It can be retraumatizing when a survivor of sexual abuse has a body search or must shower with male correctional officers nearby. It can be retraumatizing when a battered woman is yelled at or cursed at by a staff person. Incarceration can be traumatizing in itself, and the racism and class discrimination that are characteristic of the criminal justice system can be further traumatizing.

# The link between trauma, substance abuse and other health issues

The following chart helps to explain the process of trauma and its interrelationship with substance abuse and other disorders. Trauma begins with an event or experience that overwhelms a woman's normal coping mechanisms. Victims have physical and psychological reactions in response to traumatic events – defined as normal reactions to an abnormal or extreme situation. This creates a painful emotional state and subsequent behaviors. The behaviors can be placed into three categories: retreat, harm to self, and harm to others. Women are more likely to retreat or be harmful to self, while men are more likely to harm self and/or others (Covington, 2003).

## The Process of Trauma

| Traumatic Event |
|---|
| Overwhelms the physical and psychological coping mechanisms |

↓

| Response to Trauma |
|---|
| Fight or flight, Freeze, Altered state of consciousness, Body sensations, Numbing, Hyper-vigilance, Hyper-arousal |

↓

| Sensitized Nervous System Changes in Brain |
|---|

↓

| Current Stressors |
|---|
| Reminders of trauma, Life events, Lifestyle |

↓

| Painful Emotional State |
|---|

↓ ↓ ↓

| Retreat | Harmful Behavior to Self | Harmful Behavior to Others |
|---|---|---|
| Isolation Dissociation Depression Anxiety | Substance abuse Eating disorders Deliberate self-harm Suicidal actions | Aggression Violence Rages |

**Figure 3** Source: Beyond Trauma: A Healing Journey for Women, by Stephanie S. Covington. Copyright © 2003 by Stephanie S. Covington.

As noted earlier, one of the most important developments in health care since the 1980s is the recognition that serious traumatic experiences often play an unrecognized role in a woman's physical and mental health problems. For many women, a co-occurring disorder is trauma related. The Adverse Childhood Experiences Study (Felitti et al., 1998; Felitti & Anda, 2010) shows a strong link between childhood trauma and adult physical and mental health problems. Ten types of childhood traumatic events were assessed (emotional abuse and neglect, physical neglect, physical abuse, sexual abuse, family violence, family alcoholism, parental separation/divorce, incarcerated family member, and out-of-home placement). A score of four or more increased the risk of both mental and physical health problems in adult lives. This study was a model for research done on women in the criminal justice system. For women who scored seven or more, the risk of a mental health problem was increased by 980 percent (Messina & Grella, 2006).

Addicted women are more likely to experience the following co-occurring disorders: depression, dissociation, post-traumatic stress disorder, other anxiety disorders, eating disorders, and personality disorders. Mood disorders and anxiety disorders are the most common. Women are commonly diagnosed as having "borderline personality

disorder" (BPD) more often than men are. Many of the descriptors of BPD can be viewed differently when one considers a history of childhood and adult abuse. The American Psychiatric Association is considering adding the diagnosis of "complex PTSD" in the next edition of the DSM (Herman, 1997).

# The process of recovery for women

Over the years, the definition of recovery has shifted from a focus on what is removed or eliminated from a woman's life (i.e., alcohol, drugs, cigarettes, criminal activity, depression, hospitalizations) to what has been added to her life. Recovery is a process through which severe problems with alcohol and other drugs, as well as co-occurring disorders, are resolved and there is a development of physical, emotional, spiritual, and relational health.

# The spirals of addiction, recovery, and trauma

We can envision the process of addiction as a downward spiral and the process of recovery as an upward spiral, as is illustrated in Figure 4. The line that goes through the middle of the spiral represents the addiction, which is ever-present in the woman's life. The downward spiral (constriction) shows how addiction pulls her into ever-tightening circles as she becomes completely focused on the drug of choice and it becomes the organizing principal in her life. Using alcohol or other drugs, protecting her supply, hiding her addiction from others, and cultivating her love hate relationship with her drug begin to dominate her world.
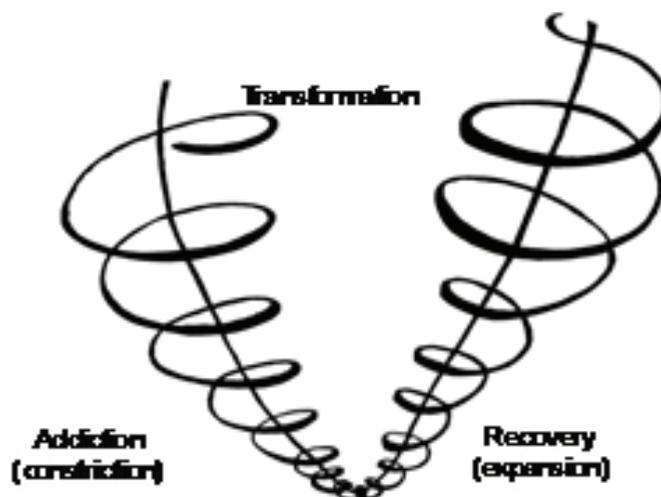


**Figure 4** Source: Helping Women Recover: A Program for Treating Addiction, by Stephanie S. Covington. Copyright © 1999, 2008 by Stephanie S. Covington.

When a woman is in this downward phase of constriction, the counselor's task is to break through her denial. The woman must come to a point of transition, in which she shifts her perceptions in two ways. She must shift from believing "I am in control" to admitting, "I am not in control." She must stop believing "I am not an addict" and admit, "I am an addict." Both shifts can feel humiliating. The UN has noted that many societies have a double standard that attributes far more shame to a woman who has an addiction than to a man who does (United Nations Office on Drugs and Crime, 2004). The effects of alcohol on pregnancy (fetal alcohol spectrum disorder) contribute to the stigmatization of addicted women. Even when not pregnant or parenting, a substance-abusing woman is characterized as a "fallen woman" or a "slut," which adds to the stigma of seeking help for her addiction. Although society may stigmatize a male addict as a "bum," it rarely attacks his sexuality or his competence as a parent. We must understand that a woman who enters treatment may come with a heavy burden of shame. She does not need to be shamed further; rather, she needs to be offered the hope that she can heal.

The upward spiral of recovery (expansion) still revolves around the drug but in ever-widening circles, as the addiction loosens its grip and the woman's world expands away from it. Her world grows to include new, healthy activities; new, healthy relationships; an expanded self-concept; and richer sexual and spiritual lives.

Notice that the process is not merely one of turning around and ascending the same spiral but one of profound change, so that the woman ascends a different spiral. When women speak of recovery, they speak of a fundamental transformation: "I'm not the same person. I'm different than I was."

Because so many addicted women have been traumatized, it is important to consider the process of trauma and recovery. The same concept of a spiral can be used, because trauma also constricts and limits a woman's life. The traumatic events in her life often become a central issue for her (as represented by the line through the middle of the downward spiral). Again, there is a turning point at the bottom of the spiral. The upward spiral can also represent the process of healing from trauma. For many women it is a concurrent process of recovery (from addiction) and healing (from trauma). As a woman becomes more aware of how trauma has affected her life, she experiences less constriction and limitation. With new behaviors and coping skills, there is greater opportunity for growth and expansion. If the woman has experienced trauma, it is still a thread in the tapestry of her life but it is no longer the core.

Using the spiral example, we can expand our definition of recovery for women. Recovery means growth and expansion, it means having the inner self (thoughts, feelings, beliefs, and values) consistent with the outer self (behaviors and relationships). This means that there is cohesion, congruence, and consistency in the woman's life. What she is thinking and feeling are now congruent with what she is doing. In essence, helping a woman to recover is about helping her to build integrity in her life and, ultimately, to experience profound, transformational change.

# Seven gender-responsive, trauma-informed curricula

In developing gender-responsive services, the curriculum or material used is crucial to the success of the treatment. The following are descriptions of seven manualized curricula that the author has designed for working with women and girls. They are theoretically based and trauma informed. Each includes a facilitator's guide and a participant's workbook. Each uses cognitive-behavioral, relational, mindfulness, and expressive arts techniques. These materials not only help to provide services but also can be used to educate staff members[81].

## Helping Women Recover: a program for treating addiction

This evidence-based resource provides a comprehensive, seventeen-session curriculum that includes the information and tools that counselors, mental health professionals, and program administrators need to implement an effective program for women's recovery in varied settings. *Helping Women Recover* is organized in four modules that address key areas that women in treatment identify as triggers for relapse: self, relationships, sexuality, and spirituality. The content addresses the issues of self-esteem, sexism, family of origin, relationships, domestic violence, and trauma. The curriculum is built on the integration of theories of women's psychological development, trauma, and addiction.

A step-by-step guide for facilitating each session is provided. It includes lectures, activities, and discussions, as well as timing and notes for the facilitator. A participant's workbook, *A Woman's Journal*, is filled with self-tests, checklists, and exercises to enable each participant to create a personalized guide to recovery. The Helping Women Recover program can be implemented by a staff with a range of training and experience (Covington, 2008).

*Helping Women Recover* is widely used in addiction treatment programs, mental health clinics, eating disorder programs, and domestic violence services. There is a special edition for women in the criminal justice system. It provides specific information about women in correctional settings to staff members in such programs.

## Beyond Trauma: A Healing Journey for Women

*Beyond Trauma: A Healing Journey for Women* also is designed for practitioners to use in any setting (outpatient, residential, therapeutic community, criminal justice, or private practice) to assist women in understanding trauma, its impact, and ways of coping. It includes a facilitator's guide, a workbook for women, facilitator training DVDs, and a client DVD.

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[81] More information on the curricula described in this chapter and other gender-responsive and trauma-informed materials for women can be found on two websites: www.stephaniecovington.com and www.centerforgenderand-justice.org

The curriculum's eleven sessions cover topics such as the connections between violence, abuse and trauma; reactions to trauma; grounding skills; the mind-body connection; and healthy relationships. It draws on psychoeducational, cognitive-behavioral, expressive arts, mindfulness, and relational-therapeutic approaches to support a strengths-based framework responsive to women's gender-specific needs for healing and support. The *Beyond Trauma curriculum* can be used alone or in addition to the *Helping Women Recover curriculum*. It can expand and deepen the trauma work in the *Helping Women Recover curriculum*.

## Healing trauma: strategies for abused women

This five-session intervention is designed for women who have been abused. There is introductory material on trauma for the facilitator and then detailed instructions (specific lesson plans) for the group sessions. The session topics include: the process of trauma, power and abuse, grounding and self-soothing, and healthy relationships. There is a strong emphasis on grounding skills.

*Healing Trauma* is an adaptation of Beyond Trauma (see description above). It is particularly designed for settings that require a shorter intervention, such as short-term addiction treatment, domestic violence agencies, sexual assault services, and jails.

The materials – a facilitator's guide and participant's workbook – are on a CD-Rom for ease of duplication (with the workbook in Spanish and English). They focus on the three core elements that staff members and clients need to know: an understanding of what trauma is, the process of trauma, and its effects on both the inner self (thoughts, feelings, beliefs, and values) and the outer self (behavior and relationships).

## Voices: a program of self-discovery and empowerment for girls

*Voices* was created to address the unique needs of adolescent girls and young women. It encourages them to seek and celebrate their "true selves" by providing a safe space, encouragement, structure, and the support they need to embrace their journeys of self-discovery. The program includes modules on self, connecting with others, healthy living, and the journey ahead, which can be delivered in eighteen group sessions. Each session has an opening section, a teaching on a topic, an interactive element (e.g., discussion of issues, questions), an experiential component (activities to try out new skills and learning), and a closing section to facilitate reflection. The program's theoretical foundations include theories of gendered psychological development, attachment, resilience, addiction, and trauma. Trauma is addressed in the program both explicitly and implicitly though attention to self-esteem, connections with others, body image, emotional wellness, good decision-making, and so on.

*Voices* is used in many settings (e.g., outpatient and residential substance abuse treatment, schools, juvenile justice, and private practice). It includes a facilitator's guide and a participant's workbook. The participant's workbook utilizes an evidence-based process called Interactive Journaling®. In the context of girls' lives, structured journaling provides an outlet for creativity, personal expression, exploration, and application of new concepts and skills.

## A Woman's Way through the Twelve Steps

*A Woman's Way through the Twelve Steps* includes the original self-help book based on interviews with recovering women about their experiences and understanding of the Twelve Steps, plus a facilitators' guide; a participants' workbook; an app; and a DVD for clients, family members, and facilitators who want to learn how women and girls can utilize the Twelve Steps in a safe, nurturing way. (The self-help book and the workbook are available in English and Spanish.)

When offered as a thirteen-session program, *A Woman's Way through the Twelve Steps* includes an opening session followed by one session for each of the twelve steps of Alcoholics Anonymous. It uses interactive activities to help women understand the principles or themes in each of the steps. Staff members who participate in the *A Woman's Way* training groups are able to develop a deeper understanding of the basic tools for living embedded in the steps.

## Beyond Violence: A Prevention Program for Criminal Justice-Involved Women

*Beyond Violence: A Prevention Program for Criminal Justice-Involved Women* was developed for women who commit violent or aggressive crimes. The curriculum consists of twenty sessions (two hours per session), and the program materials include a facilitator's guide, a participant's workbook, and a DVD. The focus is on the violence or aggression that the women have experienced as well as on what they have perpetrated. The interactive activities are based on cognitive-behavioral, relational, and experiential therapeutic approaches.

*Beyond Violence* uses a social-ecological model (Dahlberg & Krug, 2002) to contextualize and explain violence. This model considers the complex interplay between the individual, relationship, community, and societal factors that put people at risk for experiencing and/or perpetuating violence. Applying a gender lens to the social-ecological model results in a program that is specific to women's life experiences.

This is the first researched-based curriculum on this topic; it is suitable for use in domestic-violence agencies and community corrections as well as in institutional settings.

## Beyond Anger and Violence: A Prevention Program for Women

This curriculum was developed for women who are struggling with the issues of anger and violence in their lives but are not involved in the criminal justice system. It is an adaptation of the Beyond Violence program and uses the social-ecological model to contextualize violence. It also incorporates information on gender differences in the expression and acceptability of anger. The focus is on both the anger and aggression that women feel and the aggression or violence they have experienced. The curriculum is designed for use in a variety of community-based settings, such anger management programs, substance abuse treatment, domestic violence programs, VA hospitals, and other mental health settings.

## Research on the curricula

One study of the "Women's Integrated Treatment" (WIT) model using Helping Women Recover and Beyond Trauma, with women in a residential program with their children, demonstrated a decrease in depression (using Beck's Depression Inventory) and trauma symptoms (using the Trauma Symptom Checklist – 40 scale) (Covington et al., 2008; SANDAG, 2007). The first forty-five days in treatment were used as an orientation phase. The decrease in symptomatology from admission to day 45 indicates the importance and potential impact of the treatment environment itself. The women then participated in the seventeen-session Helping Women Recover (HWR) program, followed by the Beyond Trauma (BT) program. There was a significant decrease in both depression and trauma symptoms at the completion of HWR (p<.05). There was further improvement (p<.05) when the women participated in the BT groups that followed HWR.

Empirical validation for HWR and BT was rigorously tested in two experimental studies funded by the National Institute on Drug Abuse (NIDA). Evidence from the first NIDA study shows significant improvement during parole among previously incarcerated women who were randomized to a women's integrated prison treatment program using HWR and BT sequentially, as compared to women who were randomized to a standard prison therapeutic community. Women who participated in the WIT program were significantly more likely to be participating in voluntary aftercare treatment services (25 percent versus 4 percent) and significantly less likely to be incarcerated at the time of the six-month follow-up interview (29 percent versus 48 percent), compared to women who participated in the standard treatment (Messina & Grella, 2010). Another randomized study among women participating in drug-court treatment settings found that the women in the gender-responsive treatment group (using HWR and BT) had better in-treatment performance, more positive perceptions related to their treatment experience, and trends indicating reductions in PTSD (Messina et al., 2012).

Focus-group results also indicate strong support for and high satisfaction of the curricula mentioned above from drug-court and prison participants and staff (Bond & Messina, 2007; Calhoun, Messina, Cartier, & Torres, 2010; Messina & Grella, 2008).

Research projects also have been conducted on Beyond Violence. Short-term outcomes were examined in relation to mental health symptoms of anxiety, depression, serious mental illness, and post-traumatic stress disorder, as well anger, aggression, and hostility. Short-term outcomes of the pilot of Beyond Violence demonstrated statistically significant improvements in women's mental health symptoms and reductions in anger as a result of the intervention. These results provide preliminary evidence of the success of the intervention in reducing mental health symptoms that often are common for women convicted of violent offenses, including sub-populations of women with life sentences and women meeting dual-diagnosis criteria (i.e., meeting criteria for a substance-use disorder and a mental health disorder). The research team is currently monitoring administrative data to determine if the successful short-term outcomes lead to longer-term reductions in recidivism and/or improvements in institutional behavior (Kubiak, Kim, Fedlock, & Bybee, 2012).

Based on the positive results of the piloting of Beyond Violence, a randomized control trial is underway was conducted comparing Beyond Violence to Assaultive Of-

fender Programming at a state women's prison in the general population setting. The results show that women who participated in Beyond Violence have significant changes in measures of mental health symptoms and forms of anger expression.

Women who completed the BV intervention attended 97 percent of the scheduled sessions and reported high rates of satisfaction, as well as over 90-percent agreement that their needs were met and that they benefited from the material. Overall, women found the group experience transformative, and many stressed that the group facilitated their becoming better persons; gaining accountability for the past, present, and future; and realizing self-worth (Kubiak et al., 2012).

| Training Group | Therapy Group |
| --- | --- |
| Focus is on: Learning as a group | Focus is on: Individual growth |
| Using the group for experiential learning by means of activities | Using the group to recreate family-of-origin dynamics |
| Having support from outside the group (for individual issues) | Using the group for support for individual issues |
| Sequential learning | Process |

# Learning the curricula: staff development

If a treatment program uses a specific curriculum with women, one of the best ways to train staff members, supervisors, and administrators is to have them participate in the curriculum themselves as a group (Covington, 2012). This has been done in a variety of settings, including residential, outpatient, and correctional programs. An hour or an hour-and-a half session can be conducted in a weekly staff meeting or over lunch, with a different staff member facilitating each week. For the program director, these sessions offer a team-building tool and also help to reveal staff members' strengths and challenges.

When planning to implement this process, it is important to be able to explain the differences between a therapy group and a learning (training) group.

# Providing treatment

Trauma can skew a woman's relational experiences and hinder her psychological development. Because it can affect the way a woman relates to staff members, her peers, and the therapeutic environment, it is helpful to ask, "Is this person's behavior linked to her trauma history?" However, traditional addiction and/or mental health treatment often does not deal with trauma issues in early recovery, even though it is a primary trigger for relapse among women and may be underlying their mental health disorders. Many treatment providers lack the knowledge and understanding of what is needed in order to do this work.

Here are three important things that can be done in treatment programs:

● Educate women as to what abuse and trauma are. Women often do not know that they have been abused. Nor do they have an understanding of PTSD.
● Normalize their reactions. It is important that women learn that their responses are normal, given their experiences. The DSM states that trauma responses are normal reactions to abnormal situations.
● Provide coping skills. There are grounding and self-soothing techniques (e.g., breathing exercises) that women can learn to help themselves cope with their traumatic experiences. (See Covington, Beyond Trauma: A Healing Journey for Women for specific techniques to use in individual and group therapy).

## Avoid revictimization and retraumatization

A woman who has experienced a traumatic event also experiences increased vulnerability. She may have difficulty tolerating, expressing, and/or modulating her emotions. This results in what is called "emotional dysregulation." An example of this is when she over responds to neutral cues and under responds to danger cues. Therefore, traumatized women are at increased risk of similar, repeated revictimization. "Retraumatization" refers to the psychological and/or physiological experience of being "triggered." That is, a single environmental cue related to the trauma – such as the time of year, a smell, or a sound – can trigger a full fight-or-flight response. Often, substance abuse treatment providers hesitate to provide trauma services for women in their programs because of the fear of "triggering" them. Triggers in the environment cannot be completely eliminated. Therefore, it is important to create a safe environment in which women can learn coping skills. This is the reason that the therapeutic environment is so important for women. They must feel safe.

# Conclusion

Historically, substance abuse treatment programs were designed for the needs of predominantly male clients. Over the past three decades, researchers and treatment providers have begun to identify the characteristics and components of successful treatment programs for women. A solid body of knowledge has now been developed that reflects the needs of women in treatment, and there is both a definition of and principles for the development of gender-responsive treatment. Women's exposure to violence has emerged as a critical factor in treatment. Therefore, it is imperative that substance abuse treatment services become integrated, incorporating what we have learned from

relational-cultural theory (women's psychosocial development), addiction theory, and trauma theory. Such a gender-responsive and trauma-informed program can provide the safe, nurturing, and empowering environment that women need to recover, heal, and find their inner strengths.

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