Why Gender Matters in Trauma Services: An Interview with Stephanie Covington, PhD, LCSW

By Martha Gilmore, PhD, CGP, FAGPA, Annual Meeting Committee Co-Chair

Editor's Note: Stephanie S. Covington, PhD, LCSW, is a nationally recognized clinician, author, organizational consultant, and lecturer. She is a pioneer in the field of women's issues, addiction, and recovery. She has developed an innovative, gender-responsive, and trauma-informed approach that results in effective services in public, private, and institutional settings. Dr. Covington will be presenting the Special Institute: Why Gender Matters: Creating Trauma Services for Women and Men *at AGPA's 2015 Annual Meeting in San Francisco, California.*

MG: Your Special Institute is focused on the provision of trauma services, with a particular emphasis on being responsive to the needs of both men and women with co-occurring disorders. How did you become interested in this?

SC: In the early 1980s, I worked extensively with women who had addictive disorders, and it became very clear that for many of them there was a connection between their alcohol/drug use and their trauma histories. Then I noticed that at addiction conferences no one was talking much about women or about trauma. I thought we needed to think more about the types of services that would be effective for women. Historically, services for addictive disorders have been designed by men for men, and mental health services for women have also been designed by men. Women are often left out of the picture when designing service systems. Putting their needs into focus became my passion. I actually hadn't thought about corrections until the end of the 80s when I had an opportunity to spend a few days in a prison. This changed my life and the way I saw the world, as well as how I saw my work.

MG: How do you define trauma and trauma-informed treatment?

SC: Trauma is any kind of external event that overwhelms someone's capacity to cope. It takes many forms. It is experienced differently by different people with different histories. I also use the diagnostic criteria of the DSM to guide my assessment.

I've worked with Maxine Harris, PhD, and Roger Fallot, PhD, who coined the term trauma-informed services many years ago. Their work focuses on five core values that are required for a program or agency to be trauma-informed. These are safety, trustworthiness, choice, collaboration, and empowerment, and they can mean something different for women and men. We also talk about those five core values in terms of staff in agency and institutional settings. My experience is that many people working in the human services field feel overwhelmed, so these values become important for staff, as well as clients.

MG: Could you say a little more about choice and collaboration?

SC: Let's use substance abuse treatment as an example. Think about choice. If I am a woman going to a treatment program, it would not be unusual for me to be told, "This is what you are going to do." If I responded, "I don't know if this is going to work for me," I might get the response, "We know that your best thinking got you here, so just do what we're telling you to do." There is no sense of choice, no sense of treatment being a collaboration. Rather, it's "these are our policies;"

"this is our program;" "this is what you have to do in order to complete the program." It's not collaborative treatment.

MG: Do you feel that the word "trauma" is being overused in our current climate?
SC: The word is sometimes overused to some degree, and when you overuse something you trivialize it. Using addiction as an example: As a society we ignored addiction for decades. Then there was the recovery movement at the end of the 80s, and everybody was addicted to something. It took a while to swing back into a more middle ground. Likewise with trauma, there was a lot of denial and an inability to see it or talk about it; now everything is traumatic; everybody's traumatized, and it's become a throwaway term. "I had such a traumatic day at the office." Really? Stressful yes; traumatic, probably not. We haven't come to the middle ground yet, and I think that is a reaction to having it be an unmentionable for so long.

MG: Another focus of your presentation is on being gender-responsive. How does that relate to being culturally responsive?
SC: Think of gender as being a culture as well. The culture of women and the culture of men are quite different. Our socialization processes are different; our messages are different. Those differences often get brushed aside in therapeutic interventions, and people become what I call gender-neutral, which I don't think exists. When we ignore these differences (whether male, female, transgender—I don't think we can use a binary model any more), we become very male focused because that's the dominant framework in our society; so gender-neutral is really male. Both men and women do much better when they're separated in terms of group process, particularly doing trauma work. They do better in terms of their ability to disclose and feel comfortable and safe.

MG: Some theorists have used a stage model of trauma group therapy, where you start with a homogeneous group and eventually move to a more heterogeneous group and a mix of genders. What do you think about using this stage model?
SC: When I think about stages, I think about Judith Herman's work, *Trauma and Recovery*, which was a seminal book in helping many of us to think about trauma both clinically and socially. She describes three stages. Stage one is the safety stage, very much focused in the present tense, the here-and-now. Stage one addresses such issues as how to cope, how to get safe with others and safe with self. She uses a homogeneous group, including the dimension of gender, for stage one. For some people, particularly if they are self-harming, the safety stage takes years to work through.

The second stage is remembrance and mourning, which involves telling the story and doing more specific trauma work, moving from the present into the past. Again Herman talks about conducting homogenous groups for stage two.

The third stage involves moving into the future; that's where she talks about reconnection and relationships. This is seen as a more psychodynamic type of group and is ideally heterogeneous for gender, as well as other qualities. Most people require several years of therapy before they are ready for a stage three trauma group, so it is not available to most people, especially those in agency or institutional settings. Those people may never be in a co-ed group.

The healing process actually has this flow to it, even though it's not as neat and tidy as it sounds. These stages work well for us as clinicians in terms of thinking about the treatment and healing process, but no one's life fits into these boxes. It looks great on a PowerPoint or in the chart in the book, but the recovery process is often more blended that this.

MG: How do your trauma groups work?
SC: They have three basic themes. One is psycho-educational; helping members learn about trauma and abuse. There's usually so much denial in traumatized people that they often don't realize that what they've experienced is abuse or trauma. The second theme involves understanding the typical responses to trauma. When people begin to learn this it helps them to begin to understand their lives better. They begin to realize the interconnection between their experiences and some of their current challenges. The third theme involves developing coping skills by learning a variety of ways to comfort and self-soothe. This includes things that are simple and pragmatic that they can do on their own, not just in the therapy situation. This approach is actually pretty simple. I've learned over the years from training people that sometimes clinicians are afraid of working with trauma. Yet when they see that there are relatively simple things that can be done, they're much more willing to broach trauma issues with their clients.

MG: How do you handle telling the stories of trauma in group?
SC: Telling the story of one's trauma has to be done on the person's own timeline. We tell clients they don't have to actually talk about the trauma unless they want to, and it's amazing how many people will join a trauma group if they know they don't have to talk about the event. The reality is that most people get to a place where they feel safe enough to share their story. For a lot of women what really seems to facilitate that is an exercise where they make a collage about the impact of trauma on their life. Telling the story is an individual preference; some people will go through a group process and share some things, but really want to do a lot of the work individually. Others feel like they shared enough and won't want to go back there again. I believe in honoring a person's preferences. I really believe we have our own timeline and our own process.

MG: How do you manage when group members get triggered by other group members?
SC: This is so important to discuss in the group. Triggering is going to happen in a person's life so it's important to have coping techniques and skills to use both in the group and outside of the group. When someone in the group feels the need to constantly repeat details, it's good to have some containment around that. That repetition can be used defensively which is not always useful and might trigger others or themselves; often that person is also the one that is not showing any affect. I might say to them privately at the end of a group meeting, "I notice that you've told us this story in detail several times now, so I wonder what it would be like when we meet again if you don't talk about this and just sit and see what comes up for you in terms of feelings."

MG: What do you think of individual versus group treatment?
SC: It's not an either/or situation. When I had my private practice, a lot of my work was individual work. In my writing, I've focused on group interventions because so many agencies and treatment programs run groups. The value of group is that trauma survivors often feel very alone, and being in a group where they see other people having the same issues and struggles is helpful.

MG: In my training, I was taught that people had to be clean and sober for at least one year before they could begin to work on underlying issues. In my work with trauma survivors, the issues of substance abuse and addiction run concurrent with the trauma therapy and can't really be separated. What are your thoughts on the staging of treatment of addiction and trauma?

SC: The mantra in the addiction field historically was that you had to be clean and sober for a year before you could do trauma work, but many people never got the year, and they never had any opportunity to do anything with their trauma. But the two are linked. Substance use is a self-soothing strategy, which at first effectively manages difficult feelings until it becomes a bigger problem as an established dependency or addiction. You have to be able to treat the addiction and the trauma at the same time and not have these artificial rules. This doesn't mean that you allow someone to come to treatment drunk, but postponing the treatment of trauma for a year denies clients an important opportunity for healing. Instead, we have to make sure enough is in place in order for the client to sustain recovery from addiction while doing the trauma work.

MG: Can you talk about the kind of support and self-care the staff need in order to do this work?
SC: The difficulty at work is not with the people we serve; it's with the structure of the workplace. Some therapists bring their own unresolved trauma histories with them to this difficult, stressful, and painful work. Roger Fallot and I do a lot of work with mental-health and substance-abuse state agencies in the process of becoming gender-responsive and trauma-informed. We see how the different executive directors' personalities and philosophies impact their agencies. So in one agency, the director sees someone out on a walk and praises them for their self-care, while in another, the response might be more critical or negative.

Self-care is actually pretty simple, it's just that many of us struggle to do it consistently. It means eating healthy food; getting enough rest and exercise; going to a funny movie and/or being able to focus on things that bring you joy to help you offset the effects of such stressful work. There has to be some kind of balance in our work and in our personal lives, but it's often very difficult to achieve.

MG: How does this apply to therapists who are in a private practice?
SC: We have to plan our day. Your schedule is everything when you're in a private practice, and you have to schedule some time for self-nurturing. I don't think people easily do this. I suggest 30-second vacations for people in private and public settings—30 seconds in the morning and in the afternoon. During these 30-second vacations, you can 1) focus on your breathing; 2) look at something beautiful; or 3) smile at another human being.

MG: Tell us about the experiential work planned for your Special Institute.
SC: Most of my training is experientially focused. I would never do a one-day training without experiential work. Studies on adult learning show that adults learn better through experience. When clinicians can do the exercise and have the experience, it becomes more embodied and more natural for them to decide to use it or not with clients.

MG: What can you tell us about gender-specific addiction treatment?
SC: There is longitudinal data to support what we've seen clinically. A just-published article (Evans, Li, Pierce, & Hser, 2013) on a 10-year study of women-only substance abuse groups versus mixed group shows that those in the women-only groups were able to better maintain their sobriety and have less involvement with corrections and mental health services.

Recently, there's a lot more interest in how to be gender-responsive with men. People are very intrigued by this idea because even though we've always had treatment designed for men, it has not addressed male socialization or gender differences. One of the things we've done in helping men recover is to talk about "man rules." When asked what they were told about being a man growing

up, they respond: “Don't show your feelings;” “Do things on your own;” “Be strong;” “Don’t ask for help.”

MG: How are you finding the work with people that don't identify so much in the binary of male or female?

SC: With a transgender population, we work with whatever ways they identify themselves. They may not want to be in a group, but for those who do, they’re in the group as they're living their life. That often becomes an issue with the group about acceptance and difference and you use that clinically. Someone who wants to have no identity in terms of gender is a challenge if you’re running groups. I don't have an easy solution for that one. It will be interesting to see what participants at the AGPA Annual Meeting have to say about that and what kind of solutions they have developed.

Reference:

Evans, E., Li, L., Pierce, J. & Hser, Y. (2013). Explaining long-term, outcomes among drug dependent mothers treated in women-only versus mixed-gender programs. *Journal of Substance Abuse Treatment,* 45(3), 293-301.