

Working with Substance Abusing Mothers: A Trauma-Informed, Gender-Responsive Approach

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The Source

A Publication of the

National Abandoned Infants Assistance Resource Center

Berkeley, CA (Volume 16, No.1, 2007)

Prevalence

According to the National Center on Addiction and Substance Abuse (2006), in 2003, six million women (ages 12 and older) were alcohol abusers or alcohol dependent. That same year, 2.6 million women were abusing or dependent upon illicit drugs. Addiction is a complex and challenging social and health problem that affects millions of women and girls every day. However, addiction in women's lives can no longer be discussed without acknowledging the violence in their lives. A history of being abused drastically increases the likelihood that a woman will abuse alcohol and other drugs. In one of the first studies on addicted women and trauma, 74% of the addicted women reported sexual abuse, 52% reported physical abuse, and 72% reported emotional abuse (Covington & Kohen, 1984). "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. (Ouimette et al., 2000).

The Link Between Trauma and Substance Abuse

Women are strongly attuned to connections and relationships. Because healthy connections are crucial for women, their psychological problems can be linked to disconnection or violation (Miller, 1976). Women frequently begin to use substances in ways that initially seem to make or maintain connections, in attempts to feel connected, energized, or loved when these feelings are otherwise missing in their lives. They may begin to use alcohol or other drugs to alter themselves to fit the available relationships

-- typically, in order to please their male partners. They change themselves to maintain the relationships.

Women also use substances to numb the pain of non-mutual, non-empathic, and violent relationships. They may turn to substances to provide what their actual relationships are not providing, such as energy, a sense of power, emotional and physical comfort, and relief from confusion. Addicted women often are paired with men who disappoint them by failing to provide emotional and financial support (including support for their children) and who wind up in jail. These women take solace from their disappointment through drug use.

When a woman is disconnected from others (in non-mutual relationships) or involved in abusive or other traumatic relationships, she experiences a “depressive spiral” that includes diminished vitality, disempowerment, confusion, diminished self-worth, and a turning away from relationships (Covington & Surrey, 2000). All these are fertile ground for addiction and relapse and must be addressed in treatment. Therefore, it is critically important to integrate trauma theory when developing substance abuse services for women.

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. The response is one of overwhelming fear, helplessness, or horror. PTSD is one type of disorder that results from trauma.

The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV TR) lists the following symptoms of PTSD (American Psychiatric Association, 2000, p. 427-429):

- Re-experiencing the event through nightmares and flashbacks
- Avoidance of stimuli associated with the event (for example, if a woman was assaulted by a blonde man, she may fear and want to avoid men with blonde hair)
- Estrangement (the inability to be emotionally close to anyone)
- Numbing of general responsiveness (feeling nothing most of the time)
- Hypervigilance (constantly scanning one’s environment for danger, whether physical or emotional)
- Exaggerated startle response (a tendency to jump at loud noises or unexpected touch)

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 examined 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 et al.,1997).

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 in their childhood from family members and people known to them. However, as males age, they are more likely to be harmed from enemies or strangers, whereas women are more likely to be harmed by their lovers or partners (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 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 or is a stranger.

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.

Impact of Substance Abuse and Trauma on Mothering

Over the years, evidence indicates that maternal substance abuse is a major contributing factor to child maltreatment. Addicted mothers are less often able to provide adequate shelter, care, and economic stability for their children. Further, the impaired judgment and emotional instability associated with substance abuse contribute to the risk of child abuse. Although estimates of the prevalence of substance abuse problems among parents (the majority are mothers) who have contact with the child welfare system vary, the range is from half to 80% (Grella et al., 2006).

What is less well understood is the impact of trauma on a woman's capacity to mother. The *wounded mother* is often the *blamed mother*. For many of these women, mothering means struggling to parent your child while at the same time struggling to recover. A history of past trauma can affect how a woman experiences parenting and how effective she is as a parent. There are several major parenting issues for trauma survivors:

- Feelings of shame, guilt, and inadequacy can interfere with parenting.
- Interaction with a child can trigger a mother's traumatic past.
- The mothers are at risk of becoming overprotective of their children.
- At the other extreme, they may be neglectful in order to avoid being "triggered" by their children.
- Addicted mothers may have been inadequately nurtured themselves.

Addiction programs for women who have children should include education in parenting and child development and interventions that address relationships with and reunification with their children.

Many addicted women are more motivated to enter treatment and become abstinent when they become pregnant. (Hankin, McGaul, & Heussner., 2000). This often is an opportune time to intervene with them. However, the challenge is for the woman to remain clean and sober after giving birth.

Becoming Trauma-Informed

As the understanding of and appreciation for 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 and 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

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. It is important to note that these three stages are interdependent and usually do not occur in a linear fashion.

Stage 1 - Safety

Stage 1 - safety -, focuses on caring for oneself in the present. On 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 self-soothing techniques, rather than drugs, to alleviate anxiety and depression. Self-soothing can include activities such as reading, walking, music, meditation, and bubble baths.

Understanding the impact of trauma is particularly important for women who have had criminal justice involvement. Unfortunately, standard practices – such as searches, seclusions, 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 also 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 characteristics of the criminal justice system can be further traumatizing.

Herman (1997) 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 (1997) 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.

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.

Stage 3 - Reconnection

This stage focuses on developing a new self and creating a new future. Stage 3 groups traditionally are unstructured and heterogeneous. This phase of trauma recovery corresponds to the ongoing recovery phase of addiction treatment. For some women, this work can occur only after several years of recovery.

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.

Creating Programs for Women and Girls

When developing addiction treatment for women and girls, research demonstrates that services need to be provided in a holistic and woman-centered approach. Gender-responsive/woman-centered services can be defined 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 holistic model of treatment works 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 we take into account her relationships with her family members and other loved ones, her local community, and society. The link between understanding women’s addiction and creating effective treatment programs for women lies in understanding the unique characteristics of women’s psychological development and needs.

In addition, a woman’s relationship with her children and her identity as a mother often are major clinical issues. Treatment needs to address the critical issue of parenting and connections to children. There needs to be a full range of services for children, either in the program or by referral to a collaborating agency. Women who have not adequately cared for their children or who are perceived as neglecting their children carry a tremendous amount of guilt. Further, their children often need therapeutic services designed for children with addicted mothers, in addition to adequate care.

In developing gender-responsive services, one important ingredient is the curriculum/material used. The following are three manualized curricula that are designed for working with women and girls. They are theoretically-based and trauma-informed, each with a facilitator’s guide and a participant’s workbook. They use cognitive-behavioral, relational, and expressive arts techniques.

Helping Women Recover: A Program for Treating Addiction

The three theories of addiction, trauma, and women’s psychological development create the foundation of the 17-session program. The four modules focus on the issues of: Self, Relationship, Sexuality, and Spirituality (Covington, 1999).

Voices: A Program of Self-Discovery and Empowerment for Girls

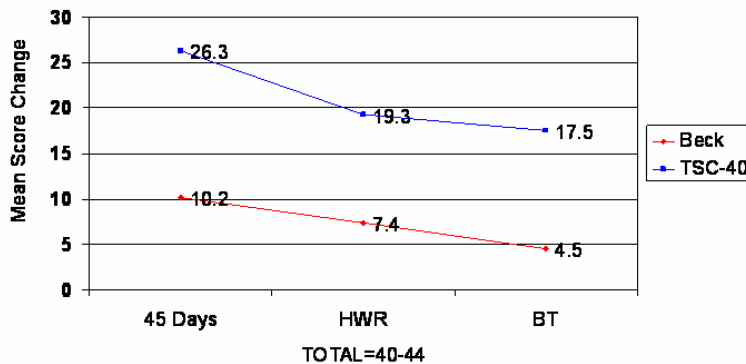
This is the girl’s version of *Helping Women Recover*. There are 18 sessions with four modules: Self, Connecting with Others, Healthy Living, and .The Journey Ahead. The foundation of this program material is based on the three theories mentioned above, with the addition of resiliency theory and attachment theory (Covington, 2004).

Beyond Trauma: A Healing Journey for Women

This 11-session program focuses on three areas: teaching women what trauma and abuse are; helping them to understand typical reactions; and developing coping skills. The foundation of this material is the work of Judith Herman and several other trauma theorists (Covington, 2003).

A study of *Helping Women Recover* and *Beyond Trauma*, with women in a residential program with their children, demonstrated a decrease in depression (using Beck’s Inventory) and trauma symptoms (using the Trauma Symptom – 40 Scale) (Miller, 1976).

Client Assessment Scores Improve after Completion of HWR and BT



Source: KIVA Program records – BDI & TSC Assessment,
August 31, 2004 – October 13, 2006
Keaton, Curtis, and Burke (2006) SANDAG

The study also found improvements in the women’s perceptions in terms of mothering. These women felt less guilty as mothers and were more comfortable in asking for help with parenting skills. They also believed more strongly that understanding their own childhoods helped them to be better parents and that their children were safe in their care.

Client’s Parenting Self-Perception

	Change
My child is safe with me.	↑
Understanding my own childhood helps me be a better mother	↑
I feel guilty as a mother.	↓
I feel comfortable asking for help from others with my parenting skills.	↑

N=44

Conclusion

The following are suggestions of what we each can do as we work with women and their families:

- *Create gender-responsive services.*
As we look through the lens of women’s lives, the issues reflected back to us are a guide to our work. These issues (e.g., substance abuse, trauma, poverty, mental illness, HIV/AIDS, homelessness, etc.) indicate where our focus needs to be.
- *Invest in women.*
We can learn from developing countries. They have found that investing money in women’s lives is the best way to support families.
- *Become trauma-informed.*
Learn about the impact of violence on women and children. Then adjust and modify our services to reflect this understanding.

- *Reflect on our attitudes and beliefs about mothers.*

Mother-blaming has been part of women's experience for generations. Society needs to look at the expectations placed on women who are struggling with multiple issues and assess their "level of burden" (Brown et al., 1995) before we judge them. Many of those who are struggling to parent are women who may not have been mothered themselves.

NOTE: This article is adapted from *Women and Addiction: A Gender-Responsive Approach* (Covington, 2007) which is part of the Hazelden Clinical Innovator's Series. There is a manual for clinicians with an accompanying DVD and CEU credits.

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