Weaving the Vision:
Research-to-Practice Strategies for Women's Recovery

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There is an urgent need to address standards of care and best practices regarding women-specific treatment for substance abuse, trauma-related disorders, and women's co-occurring problems. In our field today, many programs claim to be women-centered, yet they continue to use outdated treatment approaches uninformed by an understanding of the relational nature of women's identity development, the unique onset and patterns of women's substance use and abuse, and the effects of trauma and its links to addiction and recovery. An expanding body of research and clinical experience substantiates the superior efficacy of women-specific, culturally responsive substance abuse treatment services, and as a result, "best practices" have been developed and published (CSAT, in development; Najavits, 2002b; Young & Gardner, 2002; CSAT, 2001; Krestan, 2000; Covington, 1999; Covington & Surry, 1997; CSAT, 1994; CSAT, 1993). However, despite significant pioneering efforts (e.g., the launch of NIDA *Science & Practice Perspectives* in 2002, and the first "Weaving the Vision: Research-to-Practice Strategies for the Provision of Quality Women's Substance Abuse Recovery Services" conference in 2003, see sidebar on page 58), the dissemination, application, testing, and refinement of such practices continue to lag behind the research.

The "Weaving the Vision" conference represents an extension of knowledge dissemination that we hope will continue.

In pursuit of science

In recent years, application of research findings into interventions for drug-dependent persons has stimulated extensive discussion of drug treatment organizations' readiness for change, methods for effective technology transfer, and recommendations to support adoption of evidence-based practices into community treatment centers (Glasgow, Lichtenstein & Marcus 2003; Marinelli-Casey, Domier, & Rawson 2002; Backer, David, & Soucy 1995). The last two decades have brought about huge advancements in knowledge about women and drug use, resulting in the definition of new models and dissemination of "best practice" models, elements of which have been increasingly diffused throughout currently existing gender-specific drug treatment services (CSAT in development; CSAT, 1993). Table 1 (page 58) notes some examples of practice change as a result of the infusion of this gender-specific knowledge development, the first two of which are described in this article.

Gender-responsive treatment: Relational theory

Gender-responsive treatment is a new, integrated approach to women's alcohol and drug treatment based on theory, research, and clinical experience. This approach creates an environment through site selection, staff selection, program development, and content reflective of an understanding of the realities of women's lives and responsive to the issues of the clients (Covington, 2002).

Theoretical framework. Gender-responsive treatment is informed by the "Self-in-Relation" theory developed by theorists and clinicians at the Stone Center at

Table 1. Examples of Gender-specific Knowledge Development and Practice Change

AREA OF KNOWLEDGE DEVELOPMENT	PRACTICE CHANGE
Significance of relationships (relational theory)	Communication with family and significant others encouraged; post-admission non-communication policies now seen as punitive. Use of manualized curricula (e.g., Covington, 1999)
Trauma	Acknowledgement of need for safety, acceptability/utility of psychotropic medications, integrated treatment for co-occurring disorders. Use of manualized curricula (e.g., Covington, 2003; Najavits, 2002b)
Parenting	Children accompany mothers into treatment. Use of manualized curricula (e.g., Nurturing Parenting, 2004)
Substance-exposed children's health	Interdisciplinary pediatric intervention programs; child welfare/drug abuse treatment collaborations (Young & Gardner, 2002)
Brief intervention	Motivational and educational interventions across treatment and primary care settings (Miller & Rollnick, 2002; Armstrong et al., 2001)

MARIN SERVICES FOR WOMEN SPONSORS PIONEERING RESEARCH-TO-PRACTICE CONFERENCE

In September 2003, Marin Services for Women, with major funding from the Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment and the Charles and Helen Schwab Foundation, sponsored a first-of-its-kind conference to help move the field forward into increasingly evidence-based practice. The conference "Weaving the Vision: Research-to-Practice Strategies for the Provision of Quality Women's Substance Abuse Recovery Services" brought together more than 300 participants including researchers in women and substance abuse, providers, policymakers, consumers, and funders to participate in this unique day of music, visual art, oral history, meditation, and didactic instruction. Conference goals included:

- Expansion of knowledge and synthesis and dissemination efforts to facilitate transfer of knowledge into practice for women-specific treatment services;
- Discussion of development, testing, and application of standards of care and best practice guidelines to ensure accessible, superior quality substance abuse treatment services for women.

Speakers included Lula Beatty, PhD, from the National Institute on Drug Abuse, Stephanie Covington, PhD, LCSW, Marty Jessup, PhD, RN, and Lisa Najavits, PhD. Additional information about the conference is available on the web at www.marinservicesforwomen.org.

Marin Services for Women (MSW), in Marin County, California, is a nonprofit agency providing women-centered addiction services including residential, intensive outpatient, outpatient, continuing care, and transitional and long-term clean and sober housing. A provider of services for over 25 years, MSW has developed an empowerment-based treatment approach rooted in shared core values of mutual support, respect, compassion, and accountability. The program supports women in developing an internalized sense of authority that informs recovery in the safety and structure of the milieu. MSW is a long-term contractor with the California Department of Alcohol and Drug Programs, California Department of Social Services, CalWorks, Marin County Child Protective Services, and the Marin County Probation Department. MSW's funding matrix includes private insurance contracts and corporate, foundation, and individual philanthropy.

Wellesley College. The Stone Center model, which was built on the early work of Jean Baker Miller (1976), proposes that women's psychological development differs in fundamental ways from the traditional model of development derived from men's experience. The Stone Center "Self-in-Relation" model describes the attributes of relationships that foster growth and healthy development and are fundamental to women's psychological well-being. The relational model also asserts that psychological problems or so-called "pathologies" can be traced to disconnections or violations within relationships, arising at personal/familial levels as well as at the socio-cultural level. Regarding women's addiction, relational theory is extremely useful in conceptualizing the contexts and meanings of substance abuse in women's lives and particularly helpful in suggesting new treatment models.

Addiction and relationships. From the perspective of the relational model, women often use drugs in order to make or keep connections to other persons in their lives. Addicted women also describe their addictions as relationships, e.g. "Alcohol was my true love" or "Food was my source of comfort." The task in helping a woman to recover is to help her transfer her attachments to addictive "relationships" (with substances, people, or both) to sources of growth-fostering connections, such as her therapist, her mutual-help group, or members of her recovery group.

Addiction and trauma. Another source of relational disconnection contributing to the development of addiction and relapse in women is interpersonal violence, which drastically increases the likelihood that a woman will abuse alcohol and other drugs. In a 1982 landmark study of 34 addicted women and a matched sample of 34 non-addicted women, 74 percent of the addicted women reported sexual abuse, 52 percent reported physical abuse, and 72 percent reported emotional abuse. The addicted women had been sexually, physically, and emotionally abused by more perpetrators more frequently and

for longer periods of time than their non-addicted counterparts (Covington & Kohen, 1984).

The connection between addiction and interpersonal violence is complex and multifaceted. There are also gender differences in terms of abuse. "While both male and female children are at risk for abuse, females continue to be at risk for interpersonal violence in their adolescence and adult lives. The risk for males to be abused in their teenage and adult relationships is far less than for females" (Covington & Surrey, 1997, p. 341). Consequently, treatment of substance-abusing women must take into account the likelihood that most clients will have suffered abuse. Many women formerly considered "treatment failures" because they relapsed may now be understood as trauma survivors who returned to alcohol or other drugs in order to medicate the pain of trauma. Our increased understanding of the role of trauma in addicted women's lives offers new treatment possibilities for substance-abusing trauma survivors. By integrating trauma treatment with addiction treatment, there is less risk of trauma-based relapse.

Program models. *Helping Women Recover: A Program for Treating Addiction* (with a special edition for the criminal justice system) and *Beyond Trauma: A Healing Journey for Women* are two curricula based on the "Self-in-Relation" theoretical model (Covington 2003; Covington 1999). Both curricula include exercises designed to help women explore their relationship with alcohol and other drugs, develop connections with other women in the recovery group, understand their relationships with important people in their lives, and facilitate the therapeutic alliance with the treatment counselor. *Helping Women Recover* is a program curriculum for creating gender-responsive addiction treatment that includes the topic of trauma. The Facilitator's Guide, a step-by-step manual (containing the theory, structure, and content for conducting groups), corresponds to the participant's workbook. The program's four modules —

self, relationships, sexuality, and spirituality — reflect the areas that women say are the areas of greatest change in recovery and the potential triggers for relapse (Covington, 1994).

Beyond Trauma: A Healing Journey for Women is an integrated program that thematically makes the connection between substance abuse and trauma throughout its eleven sessions. The psycho-educational component teaches women what trauma is, its process, and its impact on thoughts, feelings, behavior, and relationships. Its major emphasis is on development of coping skills. The *Beyond Trauma* program materials include a facilitator's manual, participant's workbook, and three videos. The program is based on the principles of relational theory and uses cognitive-behavioral techniques (CBT) and expressive arts. For more information on Dr. Covington's work, see: www.CenterForGenderAndJustice.org and www.StephanieCovington.com.

Processing trauma: *Seeking Safety*

Seeking Safety is a present-focused coping skills approach designed to simultaneously treat PTSD and substance use disorder (SUD) (Najavits, 2002b). Developed over 10 years with research support from the National Institute on Drug Abuse, *Seeking Safety* was first described in 1996 (Najavits, Weiss, & Liese, 1996), and since then has evolved not only from a focus on women to both genders, but also from group modality to individual, and from outpatient to diverse settings. Feedback in clinical programs also shows high acceptability in both genders, as well as in the clinicians treating them (B. Burchfield, personal communication, November 17, 2002; V. Brown, personal communication, April 18, 2001; C. Smith, personal communication, February 16, 2000). Developed for use in early recovery from both disorders, *Seeking Safety* also has been widely applied to individuals who do not formally meet criteria for PTSD or SUD (e.g., clients with a trauma history). *Seeking Safety* does not require clients to delve into the past, although it can be combined with trauma-processing methods.

At the local level, where collaboration between researchers and comunity-based treatment programs is desired, relationships may be initiated by modest projects that would serve the interests of both researchers and programs.

Empirical evidence. *Seeking Safety* was the first treatment for the dual diagnosis of PTSD/substance abuse with published outcome results, and at this point has been studied more than any other approach (Najavits, 2002a). Seven outcome studies have been completed thus far on a variety of samples, all evidencing positive results: outpatient women in group modality (Najavits, Weiss, Shaw, & Muenz, 1998), women in prison in group modality (Zlotnick, Najavits, & Rohsenow, 2003), low-income mostly minority women, in individual format (Hien, Cohen, Litt, Miele, & Capstick, in press), adolescent girls, in individual format (Najavits, Gallop, & Weiss, under review), outpatient men traumatized as children, in individual format (Najavits, Schmitz, Gotthardt, & Weiss, in press), women in a community mental health setting, in group format (Holdcraft & Comtois, 2002), and men and women veterans, in group format (Cook, Walser, Kane, Ruzek, & Woody, in press). Other studies of *Seeking Safety* are currently underway, with larger samples and control or comparison conditions. For a more detailed description of the completed studies, see the *Seeking Safety* Web site, www.seekingsafety.org.

Treatment Principles of *Seeking Safety*. The treatment is based on five key concepts: *(1) Safety as the priority of treatment.* The title *"Seeking Safety"* expresses its basic philosophy: when a person has both substance abuse and PTSD, there is an urgent clinical need to establish safety. Safety is a broad term that includes discontinuing substance use, reducing self-harm behavior, ending dangerous relationships (such as domestic violence), and gaining control over symp-

toms of both disorders. In *Seeking Safety,* safety is taught through *Safe Coping Skills,* a *Safe Coping Sheet,* a *Safety Plan,* and a report of safe and unsafe behaviors at each session, for example. *(2) Integrated treatment. Seeking Safety* is designed to treat PTSD and substance abuse at the same time. In *Seeking Safety,* integrated treatment includes helping clients understand the two disorders, including exploring the relationship between the two disorders in the present (e.g., using drugs to cope with trauma flashbacks), and teaching that healing from each disorder requires attention to both disorders. *(3) A focus on ideals. Seeking Safety* evokes humanistic themes to restore clients' feeling of potential for a better future. Each session is framed as a positive ideal, one that is the opposite of some pathological characteristic of PTSD and substance abuse, e.g. the topic *Honesty* combats denial, lying, and the "false self." *(4) Four content areas: cognitive, behavioral, interpersonal, and case management.* While originally designed as a cognitive-behavioral intervention, the treatment was expanded to include interpersonal and case management domains. The interpersonal domain is an area of special need because PTSD most commonly arises from traumas inflicted by others, both for women and men (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995). Interpersonal issues include how to trust others, confusion over what can be expected in relationships, and the need to avoid reenactments of abusive power. The case management component offers help obtaining referrals for problems such as housing, job counseling, HIV testing, etc. *(5) Attention to clinician processes.* It can be a challenge to provide effective therapy to clients with this dual diagnosis, who are often considered "difficult." Clinician processes emphasized in *Seeking Safety* include compassion for clients' experience, using coping skills in one's own life, giving the client control whenever possible (to counteract the loss of control inherent in both trauma and addiction), meeting the client more than halfway, and obtaining feedback about how clients view the treatment.

Seeking Safety offers a clinician guide and client handouts for use with each of the 25 topics such as *Asking for Help, Healthy Relationships, Healing from Anger, Coping with Triggers, Recovery Thinking, and Safety.* Each topic is independent of the others to allow clients to enter or leave treatment at different times, and for shorter or longer time frames. The *Seeking Safety* Web site www.seekingsafety.org provides sample sessions, articles, and other materials that can be downloaded.

Research-to-practice in action

In presenting Dr. Stephanie Covington's and Dr. Lisa Najavits's innovative treatment models, the 2003 Marin Services for Women "Weaving the Vision" conference represents an extension of knowledge dissemination that we hope will continue. In 1998, the Institute of Medicine report entitled *Bridging the Gap*

Between Practice and Research described several approaches to "closing the gap" in research, treatment, and policy activities, and included models for technology transfer, organizational change, dissemination of practice guidelines, consensus conferences, publication of evidence-based reviews, collaboration case studies, incentives models, practice-based research networks, and change initiatives that incorporate trust-building experiences (Lamb, Greenlick, & McCarty, 1998). A number of these recommendations have been subsequently carried out and have led to implementation of the NIDA Clinical Trials Network (NIDA, 2004a), Addiction Technology Transfer Centers (SAMHSA, 2004), and Practice Improvement Collaboratives throughout the United States (NIDA, 2004b).

Diffusion of research findings into community-based treatment programs can be supported by these federal initiatives. Also, at the local level, where collaboration between researchers and community-based drug treatment programs is desired, relationships may be initiated by modest projects that would serve the interests of both researchers and programs, such as a treatment outcomes study (i.e., program evaluation) to examine outcomes at the level of client and program data. Initiatives such as this would expose researchers and program staff to each other's cultures, values, and attitudes toward research. Scientist participants could include research trainees (e.g., psychologists, nurses) mentored by senior-level researchers. Programs could include any treatment setting wishing to begin collaboration with researchers at a level that would reap meaningful and useful data, but at a commitment short of the rigor and time required for a randomized clinical trial.

Such a collaboration has several goals for building mutuality and trust: 1) provision of a critical community service; 2) engagement of treatment staff in research procedures, and empowerment of staff to inform research design and analysis; 3) provision of a rich educational experience for research trainees; 4) a process for building relationships for increasingly complex research collaborations such as randomized clinical trials of drug abuse treatment interventions. Researchers and the research process also would benefit through exposure to treatment program values, perspectives, and life "in the trenches."

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Stephanie S. Covington, PhD, LCSW, *has more than 25 years of experience in the addiction field and is recognized for her pioneering work in women's services. Based in La Jolla, CA, Dr. Covington consults and has published extensively.*

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Authors' Note

The description of *Seeking Safety* was adapted, in part, from Najavits (2002b) and Najavits (in 2004).

Acknowledgments

Dr. Jessup's work on this article is supported in part by the National Institute on Drug Abuse (NIDA) and the Treatment Research Center, Department of Psychiatry, University of California, San Francisco (grant P50DA09253).

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