Welcome
Linda Rosen: Good afternoon. On behalf of the Office of Juvenile Justice and Delinquency Prevention, I would like to welcome you to today’s Webinar entitled Girls at Risk: A Trauma-Informed Approach. My name is Linda Rosen and I am a Program Manager for the Innovation and Research Division at OJJDP. We are delighted you have joined us for today’s Webinar. It is one of several Webinars that OJJDP will be hosting to discuss trauma-informed care in various settings.

Linda Rosen: Today’s Webinar will feature Dr. Stephanie Covington as our presenter. She will explore the specifics of a trauma-informed approach. It is our that some of the information shared with you today will resonate and assist you to continue the work of gender-appropriate trauma-informed services for young women.

Linda Rosen: We will begin our Webinar in just a few minutes. At this time, I would like to introduce our moderator, Dr. Angie Wolf of the National Girls Institute. Angie?

Angie Wolf: Good afternoon, and good morning to some of you. My name is Angie Wolf and I am the Director of the National Girls Institute (NGI). I will be serving as your moderator today, assuming the sound goes okay. And I will start by just giving you a brief overview of the work that NGI does. NGI is a cooperative agreement with the Office of Juvenile Justice and Delinquency Prevention. The goals of the National Girls Institute are to advance the understanding and application of promising and evidence-based prevention, intervention, treatment, and aftercare programs, and deploy information on services for at-risk and juvenile justice involved girls. We accomplish this mission through a broad range of activities, to provide very in-depth, on-site technical assistance and training to (unclear) that requests it. I would encourage you to check out our Web site where we have – there is a little button you can push that will get you links to our technical assistance request form, and you can do that on the Web. We also are a hub of information and dissemination of that information. We collaborate with researchers and program developers across the country to provide work – to do work with girls. We have a partnership with federal, state, and local agencies. We work on policy development and other functions. Our intention is to be a hub of information and training for girls, for folks that work with girls in the field.
Angie Wolf: This is the first of several Webinars that will be coming out this year. We will announce the others shortly, but we will have one at some time in early August on gender-responsive behavioral models for girls. That will be our next one.

Angie Wolf: And I am really excited today that we are kicking off our Webinar series with the work of Dr. Stephanie Covington. Stephanie with her photo and bio, as well as mine, can be found in the Handouts pod on your dashboard. Stephanie is a nationally-recognized clinician, author, and organizational consultant in the area of girls and women. She is recognized for her pioneering work in the area of women’s issues. She specializes in the development and implementation of gender-responsive services in both the public and private sectors. She has published extensively, including six manualized treatment programs. She is based out of La Jolla, California, where she is Co-Director of both the Institute for Relational Development and the Center for Gender and Justice. And we are very privileged that Stephanie is going to be kicking off our Webinar series. Thank you.

Adobe Platform Information

Callie Long: Good afternoon, everyone. My name is Callie Long and I am with OJJDP’s National Training and Technical Assistance Center. As your host, I would like to take a couple of minutes to discuss a few features of Adobe Connect, which will help you maximize your opportunity to participate in today’s Webinar.

Callie Long: To view the bios and photos of the presentation panel, please access the Word documents which are available now in the upper right quadrant of your Webinar dashboard. The PowerPoint and handouts are also located there for you to access. To send a chat message to me, your host, a panelist, or another attendee, click the menu icon in the upper-right corner of the Chat pod. Choose Start Chat With, then choose Host, Presenters, or specific attendees. Type your message into the Chat box and hit Enter or click the message bubble icon to send.

Help Us Count!

Callie Long: For those of you participating in today’s Webinar as a group, please take a minute and help us count. Go to the Chat window and type in the name of the person registered and the total number of additional people in the room with you today. This will help us with our final count. Again, if you are viewing with a larger group, please type in the name of the person registered and the number of additional people joining you today.

Callie Long: There will be several opportunities for Q & A throughout the presentation. As questions arise, please send them to me to share with the panelists. During that time, we will take every opportunity to address some of the questions you have posed during the presentation.

Callie Long: At the conclusion of today’s Webinar, you will be provided with a link to take a 5-minute online survey about today’s presentation. We appreciate your feedback regarding this Webinar. You will be able to access an evaluation link on the last slide of the PowerPoint. For those of you participating as a group, when you return to your office, please enter the link on the last slide into your Web browser to share your feedback.
Callie Long: Finally, this event will be archived on OJJDP’s Online University at www.nttac.org in approximately 3 weeks. Again, thank you for joining us today. I will turn it back over to Angie.

Webinar Objectives

Angie Wolf: Great. Thank you, Callie. Here are our learning objectives for today’s Webinar. Our intentions are to give you information on defining the terms trauma-informed care and gender-responsiveness, to discuss the process of trauma, and provide specific examples of effective interventions for girls.

Angie Wolf: And, again, a thank you to Dr. Covington. I will now turn the Webinar over to her.

What About the Girls?

Stephanie Covington: Thank you, Angie. Welcome, everybody. I am looking forward to our time together today as we begin to talk about girls and what we know about girls, particularly girls with criminal justice involvement. And to just begin, the way I thought about our time together is I am going to be giving you some basic information first about girls, and we will be talking specifically about trauma, and then, as Angie mentioned, talking about some specific interventions.

The Numbers

Stephanie Covington: When we begin to think about the girls, I think it is also important for us to look at the numbers, the number of girls who actually come into contact with the juvenile justice system. And we can see that it is close to 350,000 girls in 2010, and even though boys’ arrest rate and girls’ arrest rates have gone down, the arrest rate for girls certainly has not gone down as substantially as that for boys.

Who Are the Girls?

Stephanie Covington: And so when we talk about and think about the girls in the juvenile justice system, I am sure that many of you know that girls are low risk but with high need. And we can see some of those needs really when we begin to look at their profile. So many of the girls come from families who are struggling with poverty, substance abuse, violence. The girls themselves very often have low rates of serious and violent crime, and we will talk a little bit more about that in a bit. But they do have a higher risk for status offenses, those offenses that would not be a crime if committed by an adult. Many girls also run away from home in order to survive abuse, and we know that if a girl is on the streets, there is high risk – in order for her to survive – high risk of prostitution and/or drug abuse. Girls also that come into the system very often have high rates of physical and sexual abuse, and a high incidence of substance abuse. So that profile actually begins to tell us about some of their needs.

Pattern of Offenses

Stephanie Covington: Again, when we look at the pattern of the offenses, we see differences between boys and girls. Again, for girls, higher rates of technical offenses and less violent crimes.
Trauma and Abuse
Stephanie Covington: But there are two constant themes when we talk about girls at risk, and the theme really that we see over and over again is the whole experience of trauma and abuse in their lives.

Two Core Concepts
Stephanie Covington: So we are going to be talking about two core concepts here, gender-responsive and trauma-informed.

Gender-Responsive Strategies
Stephanie Covington: A number of years ago, the National Institute of Corrections contracted with Drs. Barbara Bloom, Barbara Owen, and myself to begin to develop some guiding principles for female offenders, and these principles have relevance for working with girls also.

Guiding Principles for Gender-Responsive Services
Stephanie Covington: There are basically six guiding principles here in order to be gender-responsive, and the first one is gender. You have to acknowledge that gender make a difference. If you are working in an agency, a program, or a juvenile justice system that believes that it does not make any difference whether you are treating boys or girls, it means that there is a good chance you will not get good services for girls. So gender makes a difference.

Stephanie Covington: The issue of environment and an environment based on safety, respect, and dignity. And, of course, we know this is particularly challenging in custodial settings or in settings that were set up more with an attitude of punishment rather than an attitude of helping create change.

Stephanie Covington: Relationships. Policies, practices, and programs need to be relational and really promote healthy connections to the women who have children, to their family members, people they are in a relationship with.

Stephanie Covington: Then when we look at services and supervision, we want our substance abuse, trauma, and mental health services to be comprehensive, integrated, and culturally relevant, and we know how challenging that is. And then supervision needs to be appropriate.

Stephanie Covington: Socioeconomic status. Certainly, we need to provide women and girls with opportunities to improve their socioeconomic conditions. And this is a huge issue, and the economic issues for women and girls in this country have only gotten more dramatic over time, and we still see that women and girls who are employed are earning less than a man doing the same job or a male doing the same job. And so the socioeconomic conditions of girls need to be considered.

Stephanie Covington: And then in our communities, establishing a system of comprehensive and collaborative community services. And, again, particularly challenging at this time where there have been so many cutbacks and people are expected to do more and more with fewer and fewer resources.
Stephanie Covington: So we have those general principles that come out of the National Institute of Corrections.

**Gender-Responsive Services**

Stephanie Covington: Here is the definition that my colleague, Barbara Bloom, and I developed in order to try to help people understand what it meant to be gender-responsive. Because, for many people, they talk and say, “Oh yes, we are gender-specific, we have a program for girls,” and that began to mean different things in different places. For some places, it meant that maybe they ran a girls’ group, maybe, but often they would run the girls’ group and give the girls exactly the same material they gave the boys. So we wanted people to understand that being gender-responsive is a much more comprehensive concept.

Stephanie Covington: In this definition it talks about creating an environment through site selection, where you actually place the program and what the physical environment looks like. Staff selection, who do you actually hire to work with the girls?

Stephanie Covington: Then we think about program development, and often programs are not developed. What really happens is that – here is not an uncommon scenario. Someone hears there is money, they write a grant, they get the money, they say to someone, “Okay, now you are going to direct this girls’ program.” You have 30, maybe 60 days at the most before you have to start seeing girls. You get a staff together. The staff says, “Oh, what are we going to do with the girls?” And you create a schedule, and often that is on the schedule is actually things that the staff likes to do without thinking about, “What is it the girls really need?” And then when staff leaves, the program changes. So thinking about program development. Then thinking about the content and the material that we actually use with girls.

Stephanie Covington: All of these things need to reflect an understanding of the realities of the lives of both women and girls, but also address and respond to their strengths and their challenges. So it is a very holistic way of thinking about all the elements that need to be considered in our programming. So it is not just picking up a curriculum and you introduce it and say, “Well, now we are gender-responsive.” Well, maybe yes, maybe no. A lot of it also has to do with that environment, and it also has to do with staff attitudes.

**What is a Gender-Responsive Approach?**

Stephanie Covington: So when we think about a gender-responsive approach, it is less about looking at the differences between males and females, but it is more about taking the research, taking what do we know about girls and women and using that to guide what we do. It is stepping back and saying, “Okay, what do we know? What do we know about their lives? What does some of the research show us in terms of what kind of interventions are going to be effective? How do women grow and change? How do girls develop their sense of self?” Those are the things we want to consider when we talk about being gender-responsive.

Stephanie Covington: So one of the ways to do that really is we are using the lens of girls’ lives, we are looking through the lens of girls’ lives and thinking about the world in which they live,
and we see what is reflected back to us, and hopefully then we develop our programming accordingly.

Trauma History Among Criminal Justice-Involved Girls

Stephanie Covington: Certainly, one of the things, when you look at girls’ lives and you look at the world they live in, is trauma. For girls who are involved in the juvenile justice system, what we see are these very high rates of trauma exposure. They actually have higher rates of exposure to trauma than girls who are not in the system. And once a girl has a trauma history, this is highly associated with alcohol and drug use, high-risk sexual behaviors, sex work, physical and mental disorders. All of these things become challenges that often are the result of having a trauma history. And then, in addition to that, if she is in a custodial setting, that, in and of itself, may actually be a re-traumatizing experience. So while we bring her into a system that often is not safe.

Standard Operational Practices

Stephanie Covington: Some of the things we can think about, if you think about standard operational practices in custodial settings, what happens to a girl when she is handcuffed, what happens when we restrain her, when we put her in isolation, the pat and the cavity searches. All of these things that are very standard operating practices and operational practices in our custodial settings can actually traumatize a girl or it can re-traumatize her if she has already had this history.

Trauma-Informed Services

Stephanie Covington: So the language that we are using now is trauma-informed services. Thinking about if we know that we have a large number of girls that we are trying to serve, and many of them have trauma histories, then it is going to be very important that all of our services become trauma-informed. And I want to differentiate between trauma-informed and trauma-specific. Trauma-informed is where you change, basically, how you are practicing. You are changing how you do business. Trauma-specific means you are actually doing a trauma intervention and providing some kind of service or treatment for trauma. So when we talk about becoming trauma-informed, this would be an agency or program that has an understanding of trauma, they avoid any kind of triggering of trauma reactions, and they make adjustments in the organization so those who are trauma survivors can actually benefit from the service they are trying to provide.

Core Principles of Trauma-Informed Care

Stephanie Covington: There are five core principles of trauma-informed care. When people look at these they say, “Oh, we are doing this, this is easy.” Well, actually it is more complicated than one might think. The five core principles are: safety, physical and emotional safety, trustworthiness, choice, collaboration, and empowerment.

Stephanie Covington: Think about, okay, safety. Well, it is safety, as I said, both physical and emotional, and while that might seem something like, oh yes, your girls are safe, often for a trauma survivor they are not feeling safe. They are not feeling safe because of the yelling, the noises that they hear.
Stephanie Covington: Trustworthiness. Sometimes for a program, even starting a group on time. Can I trust that if someone says I am in the 2:00 group, my 2:00 group is going to start on time? Can I trust that what my counselor, my clinician says to me is really going to happen?

Stephanie Covington: What about choice? What kind of choices are we actually giving girls? So often in even traditional substance abuse treatment, what we say to people who come into treatment if they question what we are suggesting is, “Oh, no, your best thinking got you here. Just do what I am telling you to do.” So often we do not allow choice in our interventions.

Stephanie Covington: Collaboration. Think about it. Do girls have a sense we are collaborating with them as we are planning to help her make change in her life? Or are we basically trying to tell her what to do?

Stephanie Covington: Empowerment. We really want our girls to feel empowered. Often a program will say we use an empowerment model, but, in fact, all the choices are taken away, there is no sense of collaboration, and girls actually do not have a sense of getting in touch with their own personal power.

**Becoming Trauma-Informed Creates a Culture Shift**

Stephanie Covington: So becoming trauma-informed really creates a culture shift. And let me give you my best example of becoming trauma-informed, and it is actually my dentist. So here is a dentist who realized, “Hmm, maybe I or maybe my staff, we should understand more about trauma.” So here is how she practices dentistry today. There are TV screens up in the ceiling so while you are in the chair you can put on headphones and watch television or listen to music. Everybody coming into her practice is told, “If you are ever uncomfortable sitting in the dental chair, you can get up and walk around.” Think about that. Most of us feel when you sit in the dental chair, you cannot leave until you are given permission. They have you do a breathing exercise before they put a heavy plate on your chest. Because they understand that there are many triggers, there are triggers of sight, sound, smell in the environment that when the trauma survivor experiences it, it often pushes them back in time so they are flooded by the feelings of the traumatic event. And the dental office is filled with triggers. There is the chair you sit down in and you are tipped back. Someone leans over you, someone is working in your mouth, a heavy plate on your chest. Many, many trauma triggers.

Stephanie Covington: So my belief is if a dentist can become trauma-informed, that tells us how important it is for anyone working with girls in any kind of custodial setting or any community based program. Basically, we actually believe that anyone who works with people – doctors, nurses, correctional officers, counselors, child protective services – anyone working with people needs to become trauma-informed today.

**A Culture Shift: Scope of Change in a Distressed System**

Stephanie Covington: It is the shift in thinking about these core values that begins to tell us how to do our work. How do we embed these core values into our system of service? And it means all aspects of the program activities. Again, it is not just using your curriculum. It means administrators, supervisors, people who work in the kitchen, someone who is driving a van,
anyone who is coming in contact with the girls needs to change how they are walking, how they are talking, how they are thinking so that there is a whole new routine about how the environment of this program is evolving. So it changes our understanding and it changes our practice.

**A Culture Shift: Changes in Understanding and Practice**

Stephanie Covington: We think differently, and as we begin to think differently and more thoughtfully, then we begin to act differently. So often, one of the things I say when I am doing a presentation, and I am going to suggest this to all of you. At some point, maybe next week, I would like you to decide to role play a teenage girl coming to your program for the first time, and just imagine what it is like. If you are in the community, what is it like to come into the waiting room to talk to the receptionist? If you are in a custodial setting, what do you think it feels like the first time a girl walks in there? And begin to role play someone coming there for the first time, and think about, “What could be changed to make this place feel safer? What could be changed that might make this place a better place for girls?”

**Questions?**

Stephanie Covington: So I am wondering if there are any questions at this time from the things that I have covered this morning?

Angie Wolf: Yes, Dr. Covington. I believe we have a few questions. A couple of folks want you to elaborate a little bit on the association of trauma and some of the other factors, alcohol, substance use, prostitution.

Stephanie Covington: Sure, and we are going to talk about that in a minute, but let me say that we know that for trauma survivors, for girls, if we look at girls who are prostituting, they are usually very high rates of trauma in their lives. If you look at girls who are struggling with substance abuse, they are usually high rates of trauma. So when we begin to look at many of these sub-issues that we think about and we sort of trace them back, we will often see a trauma history. And what that tells us is we need to be, when we are doing our interventions, we need to be prepared to work on this intervention on multiple levels. And let me take substance abuse as an example. So the old fashioned, traditional substance abuse treatment was we talked about it as a single focused intervention. We just deal with substance abuse here. But today we know, if you are working with substance abusers, you also need to be working on trauma. You need to be working on both. And we will see some more about this in the next part of the presentation. Any other questions?

Angie Wolf: Yes, we have a few others, and I am going to take the liberty of asking a question myself. What are the rates of experiencing trauma for boys compared to girls?

Stephanie Covington: The rates for boys and girls, and one of the things you have to realize, we do believe that male childhood sexual abuse is underreported. But the rates that are being used from the data we know is that one out of every five girls in her childhood is sexually abused, and that is compared to one out of every eight or nine boys. So in childhood we see very similar rates, in some ways, we think physical abuse is somewhat similar. And after we talk a little bit
more about trauma, I am going to talk about the gender differences over the lifespan so we can begin to see some of those differences between males and females.

Angie Wolf: And the last question for this section, I will go back to one of the slides that you mentioned earlier on in your presentation around creating a gender-responsive environment, and you listed several ways: staff selection, site selection, programming. If an organization or a facility were going to just really do some system change, is there a place that is better to start in that process? Is there something you would prioritize or allocate resources to first?

Stephanie Covington: Well, the first thing I would do is the thing that is usually the simplest to do, and that is the physical plant in terms of cleanliness, paint, art on the walls, some of those things. Usually those things are the quickest things to do. The harder things to do are to think about how staff interact with each other and how they interact with the girls, and that becomes more complicated, but it is really stepping back and taking a look. There is also a process that Roger Fallot and I have been doing in Connecticut with mental health and substance abuse providers on becoming trauma-informed and gender-responsive, and we have some questions for people to answer in order to self-assess where they are on those five core principles. And if people are interested in that, I could also send that to you and you could add it to the Handout pod later.

Angie Wolf: Great, thank you.

Stephanie Covington: Would you like me to go back to the PowerPoint now?

(silence)

**Process of Trauma**

Stephanie Covington: Okay. So here is a Process of Trauma chart, which I think will help probably answer the question better that the person asked earlier, to think about how all these things are interconnected. So first we see the traumatic event, and one of the things about trauma, it is an event but trauma is an event and a response to event. It is both things that create trauma. And the event is one where someone feels very threatened and it overwhelms her ability to cope both physically and psychologically. So there is a physical impact as well as the psychological impact. Now, her response then, initially, if it is an adult it is intense fear, helplessness, or horror. But for a child, it is disorganized or agitated behavior. So we know that many of the girls who come into juvenile justice have that disorganized and agitated behavior.

Stephanie Covington: We see the immediate response to trauma, and this is where we hear about the fight, flight, freeze response, and this is where there is also a numbing, a physical numbing, a psychological numbing, the hyper-vigilance, always scanning the environment. And you end up with someone with a sensitized nervous system and changes in the brain, and we believe that the brain changes become chronic if there are multiple instances of childhood sexual abuse.

Stephanie Covington: Then there is the current stressor. This could be the trigger I mentioned before, the sight, sound, smell in the environment. It could be life events. It could be the
experience of living on the streets. It could be the experience of living the drug life. It could be the experience of being arrested.

Stephanie Covington: And now you have someone in a painful emotional state and we have three basic categories of responses. We have the Retreat responses, the isolation, the dissociation which is a mind/body split, depression, and anxiety, what we might consider the mental health responses. Then we have the Harm To Self, the substance abuse, the eating disorders, the deliberate self-harm, and the suicidal actions. And then Harm To Others, we have the aggression, the violence, and rages.

Stephanie Covington: And when we see this, we see some differences in terms of males and females. For females, there is more of the middle box and the left-hand box, and for males, there is more of the middle box and the right-hand box. That does not mean that girls are never aggressive and violent, but compared to boys, they are less so. So when we look at this, we can begin to see that if we are working with a girl with a substance abuse problem, we have to also consider any kind of trauma she might have experienced in her life.

Stephanie Covington: You know, traumatic events can come from any kind of – all kinds of ways. It is physical abuse, it is sexual abuse, it is emotional abuse, it is witnessing violence as in growing up in a home with domestic violence, it can be automobile accidents, plane crashes, frightening medical procedures, all kinds of things. And both males and females are at equal risk for all these various forms, except for the interpersonal violence. Interpersonal violence is where we see greater risk for girls and women.

**The Adverse Childhood Experiences (ACE) Study**

Stephanie Covington: Now, the ACE Study, the Adverse Childhood Experiences Study, can really help us understand these interconnections. So what I would like you each to do is to make a note on a piece of paper, if you would make two columns. Okay? Make two columns numbered from 1 to 10, and we will use those for answering some questions here. Now, the ACE Study was a collaboration between the Centers for Disease Control and Kaiser Permanente here in San Diego. It was the biggest healthcare study ever done, and we had 17,000 adult people who participated in this. I am sure many of you have heard about this but I think it is important to emphasize it. They asked people 10 questions and I am going to ask you these 10 questions, and I am going to ask you to, in your list of 10 things, to answer them twice. Once for yourself and once for a typical girl you work with, a girl who is a client of yours, a girl that you work to serve, and answer the way you think she would answer, but I'd also like you to answer them for yourself. And these are all about events before age 18.

**ACE Study**

Stephanie Covington: The first question. Did you experience recurrent and severe emotional abuse? So if you would answer yes or no for yourself, and yes or no for a typical girl you work with.

Stephanie Covington: The second question is recurrent and severe physical abuse. Again, answering twice, once for yourself and once for the typical girl you work with.
Stephanie Covington: Contact sexual abuse? Again, answering twice.

Stephanie Covington: Emotional neglect?

Stephanie Covington: Physical neglect? Again, answering twice.

Stephanie Covington: And then, again, thinking about before age 18, did you grow up in a household where both biological parents were not present? It could have been an out-of-home placement, foster care, or it could have been a situation where there was a divorce or a separation and you never saw the other parent. And so if you could think about that, and answer again twice, once for yourself and then again once for a typical girl you work with.

Stephanie Covington: Next question. Was your mother being treated violently? Think about that for yourself, answering twice.

Stephanie Covington: Did you grow up in a household with an alcoholic or drug-using person? That is question number 8.

Stephanie Covington: Question 9. Did you grow up in a household with a mentally ill, chronically depressed, or a family member who was attempting suicide?

Stephanie Covington: And then question 10. Did you have a family member who was imprisoned?

Stephanie Covington: So after you have answered all of these 10 questions, what I would like you to do is to score this, and how you score this is you count one point for each yes answer. So you will have a score between zero and 10 for yourself, and you will have a score between zero and 10 for a typical girl that you work with.

Stephanie Covington: Now, I am going to tell you the results of this. Now, I am going to assume when you look at the girls you work with, I am going to guess that probably close to 100 percent of the girls you work with have a score of over 4; 4 seemed to be a major demarcation or change point in this research project. And I am also going to suggest that I think many of you will have a score of 4 or more. So let us look at what they learned from this.

Stephanie Covington: They found that looking at people’s lives 30, 40, 50 years later, that people who had a score of 4 or more yeses on those questions about before age 18 were the people who were struggling with smoking, alcoholism, the injection of illegal drugs, and obesity. So years later, those experiences in childhood were having an impact on physical health.

**Higher ACE Score Chronic Health Conditions**

Stephanie Covington: Then they went back and they looked at chronic health conditions: heart disease, autoimmune diseases, lung cancer, pulmonary disease, liver disease, all of these things listed here. And they found that the people who were being served and using healthcare for chronic health conditions were the people who had scores of 4 or more in this study. So you can begin to see the impact of these early traumatic childhood events and how they impact people later in their lives.
Stephanie Covington: When people had a high score, many of them were given 1 hour with a mental health professional. It does not sound like much, does it? Given everything they had experienced in their lives. But they had 1 hour and this is how each interview started. It started with, “I see that you have...” whatever they checked off. “Tell me how this has affected you later in your life.” They found that that 1 hour made a huge difference to people. People talked about that, finally, someone had asked the question. One man said, “I have never talked about this since I was age 5 when I tried to tell my mother.” A 78 year old woman said, “No one has ever asked me so I thought I would take this secret to my death.”

Stephanie Covington: We are afraid often of asking questions because we think people are going to have a meltdown. The people at Kaiser were afraid of this study. The staff did not want it. They said people are going to decompensate, you cannot ask these questions, we do not have enough mental health services. So there was a group of people on the staff where a pager was always carried 24 hours a day for 3 years in case any of the 17,000 people needed to call. If you guessed – think about guessing how many people you think called. The reality is they had no calls. No one was so distressed by the questions that they needed an emergency kind of assistance. The people who were most distressed were the staff. Staff were very concerned about what was going to happen. Not the people who were asked the questions.

Adverse Childhood Experiences Five-State Study 2010
Stephanie Covington: So that study was done in San Diego, it was a fairly skewed population in terms of its affluence, etc. So they took these same questions to five different states a couple of years ago. They did Arkansas, Louisiana, New Mexico, Tennessee, and Washington, and they did 26,000 adults here, and this was a much more comprehensive slice of the American population.

ACE Scores and Impact
Stephanie Covington: And what did they find? They found exactly the same results. They found that people who had high scores, 4 or more on those 10 questions, were the people who were experiencing more chronic depression, had more suicide attempts, had more mental health problems, more addiction, and were at greater risk of being victimized by rape or domestic violence.

Adverse Childhood Experiences Underlie Suicide Attempts
Stephanie Covington: Also, the suicide, look at this slide. If a child has an ACE score of 4 or more, they are 10 times more likely to attempt suicide than a child with an ACE score of zero.

Adverse Childhood Experiences
Stephanie Covington: So what we begin to see, as someone asked earlier about how are these things connected, you have adverse childhood experiences that disrupt the neural development of a person and they end up with social, emotional, and cognitive impairments, areas in life they struggle. They often adopt health-risk behaviors. You have disease, disability, and social problems, and early death. For people with high scores, 20 years, 2 decades of lost longevity of life.
Women in Prison, Childhood Traumatic Events, Largest Effect – Mental Health

Stephanie Covington: They have also taken this study and looked at women in the prison system. Now, one of the things we know about women in our criminal justice system is that so many of the women were the girls in the juvenile justice system. And we know that many of the girls who are in the juvenile system today are at great risk of being in the adult system tomorrow. So, again, they used those 10 questions, they asked women in prison, and the women that had the high scores were the ones who had more physical health problems. But they found the greatest effect was on mental health. The women with the higher scores were on more medication, needed more treatment, had attempted more suicide.

Stephanie Covington: And look at this statistic. If a woman had a score of 7 or more yes answers on that 10 questions that I gave you, there was a 980 percent greater risk of having mental health problems. So here is the connection between trauma and mental health. So we see all of these connections and results from traumatic experiences.

ACE Study

Stephanie Covington: I also want to share with you another study done on the ACE Study. This is from Walla Walla, Washington, from a high school. These kids are on probation, they are in a high school. The principal has been the principal and done this work for many, many years. The school operates in a very structured way. If you misbehave, if you break one of the school rules, and there is a consequence. So it is a very structured, rather standardized way of working with kids at risk.

Stephanie Covington: So the principal hears about the ACE Study and he hears about becoming trauma-informed, and he thinks, “Hmm, I wonder if any of this is going to be relevant for the kids we work with.” So a boy acts out in the classroom, he swears at the teacher, he goes to the principal’s office, and this time the principal says, “Wow, I am wondering if you are okay.” And the kid says, “Oh, yeah.” And he says, “Well, you know what the rules are here, so something must be going on. And I am wondering, thinking about your anger, how angry are you on a scale of 1 to 10?” The kids says, “I am an 8,” and the principal says, “Boy, you must really be angry. I am wondering what is going on in your life?” And the young man says, “Oh, it is just like every other day. My dad was drunk and beat me up this morning before I came to school.” The principal said, “Wow, that would be enough to make you angry.” The student then said to him, “I guess I should go back in and apologize to the teacher.”

Stephanie Covington: Now, over the several years that this young man has been in the probation high school, he has never offered to apologize. So the principal is really taken aback by the difference, so he decides they are going to do things differently in their high school. They are going to use and think about the ACE Study in terms of the boys and girls they work with, but also thinking about becoming trauma-informed, so they start a new way of responding.

Washington High School

Stephanie Covington: And here are the statistics from Washington High School from 2009 to 2010, doing business as usual. They had 798 suspensions, 50 expulsions, and 600 written referrals. After they incorporated the new approach, they had 135 suspensions, 30 expulsions, and 320 written referrals. This is an example of becoming trauma-informed and changing how
you do business. They did not put in any types of trauma treatment, but they changed how they operated, how they talked to these people, the kids, and what they did. The boys and girls did not change. The staff changed. And this is essentially what we are talking about.

**Adverse Childhood Experiences**

Stephanie Covington: Here is another piece of information about adverse childhood experiences, and looking at teenage sexual behavior and teenage pregnancy. And you will see, looking at intercourse by age 15, as the ACE scores go up, sexual activity goes up, teen pregnancy goes up, and teen paternity goes up.

Stephanie Covington: This looks at the ACE score and the likelihood of having over 50 partners. Again, as the ACE score goes up, the number of sexual partners goes up.

Stephanie Covington: This is a study using the ACE questions, those same 10 questions used by Crittendon, which is a program for girls in various locations across the country. And looking at the number of girls that was in this study, there were over 900. How many had an ACE score of over 4? How many had an ACE score of over 5? Those who were young mothers, who were teenage mothers, again how many had a score of 4 and 5? How about those that were mothers who were also in the juvenile justice system that were being served by Crittendon? Again, looking at their scores, and those who were mothers and in child welfare. So, again, we begin to see all these interconnections when we begin to think about traumatic events in the lives of girls.

**Questions?**

Stephanie Covington: So any questions about some of the things I have discussed in this segment of our program?

Angie Wolf: Yes, we have a few. How do you make the intake of the females into the juvenile justice system more trauma-informed?

Stephanie Covington: That is a big question. It depends on where you are doing your intake. One, I would think about how – we need to have people in the juvenile justice system who have been trained to become trauma-informed, which has to do again with body language, attitude, verbal language. You need to think about the room and the space in which you are doing the intake. Again, they are different in all different kinds of places. There are not a lot, by the way, in the juvenile justice system who have become trauma-informed, but those who have thought a lot about privacy, about how long to have girls sitting on benches being cuffed. I mean there are just so many things we could think about. You just have to step back, really, and look at the space, the physical space, and listen to how people talk, and think about, “What could we do differently here?” Every place I have ever been could make changes, and all of them are sort of dependent on the situation.

Angie Wolf: We have got a question here on how the questions were derived for the ACE Study, that original list that you proposed.
Stephanie Covington: This original study was done by two physicians, Vince Felitti and Bob Anda, and I do not know how – it was a number of years ago, actually. The study is getting much more play and interest now. When the original study was done, it was probably 8 or 10 years ago. And I think, initially, Dr. Felitti was actually working in a program on weight management at Kaiser, and what he was trying to figure out was why people could not keep the weight off. And he decided it was something in the past, and these questions were created. But other than that, I do not know the history of them.

Angie Wolf: Thank you. We have one more here from someone who is interested in talking about how they hire new staff, and what kinds of questions you could ask to ascertain whether that potential employee is open to trauma-informed care or is going to make a good candidate for trauma-informed training.

Stephanie Covington: Okay, a couple of questions. Let us first start on the gender side. Here are two questions I suggest when you are working to hire people who are going to work with girls. One of the questions I ask people, “In the last 3 years, tell me about a book you have read or a movie you have seen in which you have learned something about girls.” And if people have not been learning anything, they are really not interested in this population. The other question I ask is, “Look over the course of your life and tell me about a woman who has had a positive influence on your life, and tell me how you honor her today.” Now, you are listening for the tone of voice. It is okay for somebody to say, “Gee, it is my grandmother and when I think about it, I am not doing anything to honor her today.” But that is very different than a response that says, “I do not let women impact me.” Well, think about that. So you want to think about the gender piece. But the trauma piece, I would ask, “Have you had any training in trauma? What is your understanding? Do you think that trauma has any implications for the work that we are doing here with girls?” I would ask some questions about what their understanding is. And, again, often when we are asking questions we are not expecting people to give you the right answers informationally, but we are looking for tone of voice, we are looking for body language, we are looking for attitude. For someone who says, “Look, they have done something bad and that is the issue here,” well, this is someone who is going to have a hard time incorporating what we know about trauma into their work. Okay, thanks.

Stephanie Covington: So let us see if this looks like some of the girls you work with. Well, this slide is an interactive slide that is not working. What we are supposed to be having here are these all intersecting circles. There would be one that is substance abuse, one that is homelessness, one that is mental health, one that is trauma. But for some reason it is not working that way. So imagine it is this girl with all these multiple issues in her life, and what I wanted to share with you in terms of this image is this concept of level of burden.

Level of Burden

Stephanie Covington: This is a concept that a colleague of mine, Vivian Brown, developed when developing a program for women. But I think it works very well with girls also. We do a lot of assessments, and one of the things that I think in doing our assessments – what are we really looking for here? And what she talked about in working with women with multiple issues is to determine what level of burden they are carrying. She talked about the use of alcohol and other drugs, homelessness, mental health problems, health, HIV/AIDS, cognitive impairment, history of abuse. And she found that staff treated women differently when in staff meetings they said,
“You know, Jane is carrying a level of burden of 6. Mary has a level of burden of 5.” Staff treated the women differently and the women began to think about themselves differently in terms of level of burden. And child protective services who are trying to reunite mothers and children also began to think differently. And I think we want to think about this with the girls. Many of the girls that we are working with and trying to serve carry a level of burden that really should be, at best, the burdens of adulthood, not of childhood. But they are carrying multiple problem conditions and often we are expecting rapid change when, in fact, again these are hard life experiences to be managing as a young person.

Trauma

Stephanie Covington: We have been talking about trauma and talked a little bit about being gender-responsive, but I would also like to talk about the differences in trauma between males and females, and to expand on a question that someone had earlier. Where we see the differences between males and females is when we look over the lifespan. So, for example, if we go into childhood, both boys and girls are at risk for physical and sexual abuse as children. As I said earlier, the studies show there is more childhood sexual abuse among females. We also know male childhood sexual abuse is underreported. So let us just say boys and girls in childhood are at risk for physical and sexual abuse, and the greatest risk comes from people they know, from their family members and other people they know. Even though families continue to say to their kids, “Be careful of strangers,” etc., in some families it would be more important to say, “Be careful of Uncle Bob.”

Stephanie Covington: Where we see the gender differences now, as I said, was lifespan, so let us move into adolescence. For a young man, his risk for abuse increases if he is a gay young man or a young man of color, and his risk comes from people who dislike him, such as the police, his peers. If he is a gang member, his risk comes from the oppositional gang, from someone who dislikes him. But compare that to the girl who, in her teenage years, her greatest risk for harm comes from her relationships, essentially from the person to whom she is saying, “I love you.” And we have seen the statistics on physical abuse in dating relationships escalate over the past 10 years. The old number was one out of every five girls in a dating relationship is being physically abused. The newer statistics say one out of every three girls in a dating relationship.

Stephanie Covington: So then we move into adult life. For a man, if he serves in our military, his greatest risk for harm comes from the enemy. If he lives in our communities, his greatest risk for harm is being the victim of a crime committed by a stranger. If you look at a woman’s life, if she serves in the military, her greatest risk for harm comes from the men she is serving with. And if she lives in our communities, her greatest risk for harm actually comes from her relationships, from the person to whom she is saying, “I love you.” So when we work with females, we very often are working with someone who was harmed by someone they knew in their childhood, harmed by someone they knew when they were in a relationship as an adolescent, and then harmed again in their adult lives by someone they were in a relationship with. That is a very unusual circumstance for men and very unusual. So it is important to consider these gender differences.

Stephanie Covington: While all violence is abhorrent, we think that because of the abuse that happens in a relationship for women and this kind of enduring violence is why there are more mental health problems connected to trauma experienced by females than by males.
Sexual Assault Graph
Stephanie Covington: There are a couple of graphs here. This is from the Bureau of Justice Statistics looking at the proportion of all sexual assault victims. You will see in childhood, this is the female line percentage up here and the balance would be the males. But you will notice, as life goes on, it becomes almost 100 percent female. Age of greatest risk for boys, 5, and for girls, 14. So, again, on these slides you can see that there are definitely gender differences.

Key Elements (Staff and Clients)
Stephanie Covington: Now, when we take all this information and then the question is, “What are the key elements here?” And the interesting thing is that the staff needs to know certain things, but also the girls that we serve need to know certain things, the girls that are our clients. Staff and girls need to know what trauma is and what abuse is. You cannot assume that because she has experienced abuse, she actually knows she has been abused. She may not know that she has been traumatized. Understanding typical responses, finding out what usually happens to people. And then developing coping skills. Again, this is important both for the staff to learn these things and for the girls to learn these things.

Stephanie Covington: Now, earlier you also remember I had you answer those 10 ACE questions for yourself, and I made the comment that I think for a lot of you, you may have a score over 4, which means you also – not only do you need to learn these three things because you are working with the girls you work with, but it is also really important for you to develop coping skills for yourself and have an opportunity to do some healing for yourself.

Effects of Abuse on Girls
Stephanie Covington: When we look at the effect of abuse on girls, particularly sexual abuse, it has a profound impact on girls in terms of how they see themselves, their risk for teen pregnancy. When girls are being physically or sexually abused in the family, there is risk of running away. Girls often use alcohol or other drugs as a way to numb the pain, to numb themselves psychologically, numb themselves physically. It impacts academics, how well they do in school, as well as self-harm. The number of girls that are cutting and burning themselves, the majority of those – I am not going to say 100 percent, but very close to that – you will find that there is abuse in her history.

Triggers
Stephanie Covington: Now, one of the things that can be really useful when working with girls, when we think about what we want to be assessing for, is this whole understanding about triggers. Remember I said a trigger is a sight, a sound, a smell. Something in the environment that can trigger the girl so she is pushed back in time, flooded by the feelings that she had when the abuse was happening. And so it is really important when we are working with women and girls to be able to find out – what are the things that trigger her? It is important for her to understand what the triggers are, and it is different for different people.
**Trigger Examples**

Stephanie Covington: Sometimes if she is in some kind of residential or custodial setting, they do bed checks at night with a flashlight. That could be a trigger. Feeling frightened of the dark. Hearing people yelling. Being touched by anyone, even if it was done in a non-threatening way. Feeling lonely, not being... Triggers can come from anywhere, so we want to be asking girls, “What are those things that happen, the sights, the sounds that make you feel uncomfortable? Then how might you or others notice when you have been triggered you feel unsafe or upset? What usually happens just before you lose control?”

**Warning Signs of Triggers**

Stephanie Covington: And there are usually warning signs from people who have been triggered and before this escalates. When someone has a panic attack, that shortness of breath, tightness in the chest, the heart pounding, bouncing legs, eating more, clenching their teeth, restless, agitated, pacing. Usually there are individual warning signs for each person.

**Self-Calming Strategies**

Stephanie Covington: Then we want to ask, “What are the things that help you to calm down when you start to get upset? What are the calming strategies, what are the things you can use to self-soothe?”

Stephanie Covington: And, again, you will see there is a whole variety of different kinds of things. Taking a time out. Taking a walk. Listening to music. Punching a pillow. Hugging a stuffed animal. Taking a shower. There is a whole range of different kinds of self-calming strategies. But as you look at these lists you will see, particularly for girls who are in custodial settings, the list becomes very limited. You cannot just choose to take a walk. You cannot just choose when you are going to take a shower. A lot of those decisions are taken away. And so that is why, particularly working with girls and women who are in custodial settings, we teach a lot of breathing exercises because it is something she can do anytime, regardless of what the structure of the day, and no one knows what she is doing. So using breath becomes a very powerful self-calming strategy for a girl who is in a custodial setting.

**Women’s Integrated Treatment (WIT)**

Stephanie Covington: So the model I use, this is really the model for all my work, it is called Women’s Integrated Treatment. You will notice the acronym is WIT, and what that really means is that you have got to hold onto your sense of humor. If you lose your sense of humor – the work is difficult and it is very easy to get overwhelmed. And this model is based on the definition and guiding principles I gave you. I believe our work needs a theoretical foundation. And then the interventions and strategies that we actually use with the girls need to come from our theory and they need to be multi-dimensional. So there are all different kinds of ways of working with girls in terms of techniques.

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

Stephanie Covington: The Voices Program, which is the girls program that I have written, we are going to talk about some of those interventions, some of those exercises and things in a little
What About the Girls?

Stephanie Covington: So what do we know about the girls? What are some of the things we need to think about?

Reality of Girls’ Lives

Stephanie Covington: Well, there is the reality of girls’ lives, so I want to comment on a couple of these. It is really important to think about what are the lives of girls today in this time period.

Socialization and Identity

Stephanie Covington: We have talked about for years that girls, as they move into adolescence, stop “being” and start “seeming.” And they develop their identity through connection with others, and often girls give up their sense of self in order to be more datable and more attractive to boys.

Culture and Class

Stephanie Covington: We know that culture and class have a significant impact on girls, and when we think of girls losing their voice, that can look different across different ethnic groups and races. And girls get very mixed messages according to their culture.

Sexuality

Stephanie Covington: Sexuality, we know that the majority of girls are sexually active. Also, the majority of girls who are sexually active, it was involuntary. I would not necessarily call it rape, but she had sex when she did not want to because saying no was not effective. We also know that the majority, not the majority, 25 percent of sexually active ninth grade girls use alcohol and drugs with intercourse. And, in fact, many girls, their first sexual experience is with their first alcohol and drug experience, and the drug is given to them by the person that wants to have sex with them. We know that four out of every 10 young women are pregnant before the age of 20. And teenage sex today often means girls servicing boys, it is not particularly focused on pleasure for her or in the context of a relationship.

Stephanie Covington: This just shows some ads. This was an ad in New York City, obviously selling jeans, maybe not selling sex, but this is the world of girls.

Stephanie Covington: A *Rolling Stone* cover, they are in a very highly sexualized environment.
Violence and Aggression

Stephanie Covington: If we look at aggression and violence, if you look at the statistics, what you would say is girls are becoming more violent. That is what the numbers show on some level. Lyn Mikel Brown has developed this concept of horizontal hostility. She said, “Girls are angry today. But it is not safe to be angry at your teacher or your parent or your boyfriend, so they get angry at each other. And so the hostility moves horizontally.”

Girls Are Not More Violent

Stephanie Covington: Now, OJJDP did a study a few years ago that says, in fact, girls are not more violent. That we have changed our arrest laws and our changes in law enforcement policy have had an impact on the arrest rate. That there has always been the same percentage of girls who have been violent for years. But we have redefined violence. So today if a girl hits another girl with a backpack on a high school campus, the police will be called. If that happened 20 years ago, they would go to the police [sic]. So we have to be very cautious about the numbers here.

Girls’ Mental Health Needs

Stephanie Covington: We know that girls’ mental health needs, that girls, as I said before, are coping with these incredibly serious issues and their family and those burdens. And that also increases mental health problems. And if we look at girls in custodial settings and we see the high suicide attempts, again we can also relate that back to the ACE Study.

Addressing the “Whole Girl”

Stephanie Covington: So I think when we are working with girls, we want to address the whole girl, all of the physical, the sexual, the relationships, the emotional, intellectual, and spiritual – all of these various domains. So we are going to be talking about Voices and talking about some of the exercises that I use with girls.

Questions?

Stephanie Covington: Any questions about what I have talked about during this segment?

Angie Wolf: Yes, Dr. Covington, we have a few. We have received a number of questions around between-girl differences, like the experience of trauma with lesbian girls specifically. Can you talk a little bit about that?

Stephanie Covington: Well, for years there has been this myth that girls and women become lesbians because they have been abused by males. So I do not know if that is the direction the person was going in, but what you have to realize is there are many heterosexual girls and women who have been abused by males. So, yes, we see high rates of abuse in girls’ lives, whether they are straight or whether they are gay. We also see very high rates of abuse in our transgender population. So you work with them around the trauma they have experienced. But I would be very cautious about using cause and effect, if that is what was underneath the question.
Angie Wolf: Thank you. We are also receiving questions on specific program elements that might mitigate the effects of trauma, including meditation and mindfulness components in programming, as well as increasing (inaudible/ faint voice) components.

Stephanie Covington: Yes. I think when we are working with trauma survivors using mindfulness techniques, using meditation, guided imagery, there are a lot of different kinds of things that we do. And one of the key pieces here when you are working with a trauma survivor, you want to offer her the opportunity of closing her eyes or lowering her eyelids or finding a focal point. Sometimes people are afraid to do guided imagery or some of the meditation work because people do not want to close their eyes. Well, they do not have to close their eyes. The closing of the eyes is really there to block out the stimulation of the room in which she is sitting. So, yes, using the concepts about both relaxation exercises and mindfulness are good things to incorporate.

Angie Wolf: We can see how the trauma-informed approach would benefit girls in programming and facilities, but can you talk a little bit about the staff and how the staff respond to having this new set of skills to interact with girls?

Stephanie Covington: Staff respond with a whole range of responses. At some end of the continuum you are going to have people that are really excited to get the information and it make sense to them and they want to learn more. At the other end of the continuum, you are going to have people say, “You are just trying to explain away her behavior,” or, “You are not making her responsible,” or whatever the drill is. Right? So you will have a range. What I have seen over time, when programs become more trauma-informed, there often is turnover in staff. People who do not like the concept of either gender-responsiveness or becoming trauma-informed are people who decide they want to leave because they do not want to do this kind of work. So you will have a range of responses. I wish I could say everybody wanted to do this, but they do not.

Angie Wolf: Okay, great. We have got one more question about Voices. What is the age range of (overlapping comments)...?

Stephanie Covington: The age range is 12 to 18, I wrote it for 12 to 18, but I would not put 12 year olds and 18 year olds in the same group. You can have 12 and 13 year olds, maybe 14, and then 17 and 18 year olds. We have also used the program with young women 18 to 21 or 22 very effectively. So it really depends on your group, but I like grouping the girls more in terms of age cohort groups with some similarity of age.

Angie Wolf: Okay. And do you have a best practices way that you would ask or incorporate receiving trauma, specific information on a girl’s experience with trauma on an intake form?

Stephanie Covington: You mean in terms of how you ask the questions at intake?

Angie Wolf: Yes.

Stephanie Covington: How would you ask girls about her history? Sure. There are a variety of different ways of asking questions. Some people actually use the 10 ACE questions as part of their assessment. And you can get the actual questions, not exactly how they are on the
PowerPoint because they are very condensed. Some people ask questions about things like, “Has anyone ever hurt you? Has anyone ever touched you in a way that made you uncomfortable?” So there are ranges of ways to ask the questions. And you have to understand that when you ask the questions, you may get the correct response at that intake, or she may not want to tell you right now, and sometimes when she has been in the program for a while and feels safer, then she will share the information. So we never assume that the information we got at intake has all the details or all the information. So should we go back to our slides?

(silence)

Voices

Stephanie Covington: Okay. So let us look at Voices in our remaining time, so I will go quickly. We have four modules and there are exercises in each one of these modules where I showed you the theory before. And in each session there is an opening – a way to open the group, and it is important how you close the group, there is a teaching point that is interactive with issues and questions, and there are experiential exercises.

Module A: Self

Stephanie Covington: So here is our Self module, and in this we have five sessions. And, basically, what I really want the girls to begin to do here is to begin to answer the question, “Who am I?” Now, there are 27 activities so obviously I am not going to share them all, but I picked out a few.

Who Am I?

Stephanie Covington: Girls in their adolescence, that is their developmental task is developing a sense of self, so there are a variety of different ways that we look at this. Talking about “Who am I,” and having them find words to describe themselves from who they are on the inside. And, to me, the inner self is our thoughts, feelings, values, and beliefs. Our outer self is behavior and relationships. And what I think is important for girls is to have a sense of who they are on the inside and have that connected and congruent with what we see on the outside, which is behavior and relationships. So they have some language to begin to think about how they would describe themselves, and they have in their workbook a lot of words for possibilities to pick. So that is one of their exercises.

Five Senses Activity

Stephanie Covington: We do the Five Senses Activity in the beginning of the program as a way to teach a grounding or self-soothing exercise. And because we know we are working with girls where many of them are trauma survivors, but we do not say in a procession, “Since you are all trauma survivors.” What we say is we try to normalize it. Sometimes when you are in a group for the first time and you are with people you do not know and you are placed where it is unfamiliar, any of us can be really uncomfortable. So it is really important that we have ways to calm and soothe ourselves if we are feeling uncomfortable. In the Five Senses Activity you have the girls, just to themselves, in group silently, name to themselves five things they can see, four things they can touch, three things they can hear, two things they can smell, and one thing they can taste. And this is a way to ground someone into the here and now, into this present
moment. And you will find in your Handout pod a Five Senses card page where you can Xerox that page, which has multiple images like this, and do it on card stock or laminate it, and then each girl gets a card that she can carry with her with this exercise.

**Feeling Okay Chart**

Stephanie Covington: We also do the Feeling Okay Chart. Again, this idea that sometimes you are not feeling okay, and particularly if you are working with girls who are substance abusers, usually what they do when they are not feeling okay is they drink or use. So we want them to be able to fill out the chart the things they can do when they are alone during the day, things they can do during the day when they are with other people, when they are alone at night, when they are with others, things they can do to calm themselves or to self-soothe.

**My Life’s Journey**

Stephanie Covington: They do an exercise on Life’s Journey, and they do an exercise thinking about the people, events, and experiences that have brought them to be who they are today, again, working with this sense of self.

**Tree of Self Esteem**

Stephanie Covington: They do the Tree of Self Esteem. This is a collage, they cut out words and pictures that represent the messages they have been given in their lives about who they are. And up in the tree leaves, words and pictures that represent their current beliefs about who they are. We want them to see that often what is happening up here and how they feel about themselves is related to messages they received down here.

**Me: Inside and Out**

Stephanie Covington: Unfortunately, some of these slides did not turn out here. This is a slide for an exercise, Inside and Out. This slide would show this girl with nothing on her. Okay? And we are talking about how sometimes we feel some way on the inside, but we show something else on the outside. So here is a girl, she had this blank image. Right? And then she began to think about when she was feeling certain things on the inside, but what she was showing people is, “I do not care. I am in control. I am shy. I am tough, and sometimes I am popular.” So that is another exercise the girls do.

**Media Messages**

Stephanie Covington: And we also in this session talk about media messages. What are the things...? The girls work on posters, they work in groups of twos to do posters, looking at the message from the media telling them about who they are and how they should be.

Stephanie Covington: So that gives you a flavor of some of the things in the Self module.
**Module B: Connecting With Others**

Stephanie Covington: Module B is Connecting With Others. This is the one that focuses on relationships. Again, here we have seven sessions. We have 36 different activities with the girls. There are more activities than you can ever use in any session so that you never feel a loss for something to do.

Stephanie Covington: The session on communication talks about different communication styles. They do an exercise that they love doing, it is a non-verbal communication and you have the girls work in groups of two, and one of them is talking for a minute about something important to her, and the other girl shows her non-verbally that she could care less. Now, of course, they are very good at doing this. Then they switch roles, and they talk about how they felt. And then they replay it with someone sharing something important to them, and the person listening lets them know non-verbally that they really care. So we work with communication in a variety of ways.

Stephanie Covington: We talk about family, we do a family sculpture where we sculpt families and look at some of the family interactions and the roles the girls have played in their families.

Stephanie Covington: Mothers and daughters, about their relationship with their mother. It might be a birth mother, it might be an adoptive mother or foster mother, so we do that.

Stephanie Covington: There is a session on friendships. They do a collage on what are the qualities of a good friend. They talk about what qualities they bring to friendship.

Stephanie Covington: Then we have some pieces on dating and sexuality, and on supportive and abusive relationships.

**Is it Love?**

Stephanie Covington: So when we get into the relationships side, we also talk about love, and they do posters again. We break them into groups of threes, a poster on infatuation, a poster on sexual attraction, and a poster on love. And here I am emphasizing that love is a feeling, but more importantly, love is a behavior. And how you know someone loves you is by how they act.

**Sexual Bill of Rights**

Stephanie Covington: They do a Sexual Bill of Rights that say if you are sexual, or if you are planning to be sexual, what kinds of rights do you want to have? And the girls are very stuck with this one, and when you start giving them ideas like the right to say yes, the right to say no, the right to safety, all these things, they say to each other, “Can you imagine feeling like you have those rights?” Girls do not think about this at all.

**Connecting With Others**

Stephanie Covington: When we talk about healthy relationships, we talk about what are supportive relationships and what are the qualities in them, and what are relationships that are not supportive on the other side. And then they circle what are the qualities they have in their relationships, how they feel in their relationships.
What is Abuse?
Stephanie Covington: And we talk about abuse, emotional abuse, physical abuse, and sexual abuse, the definitions.

Effects of Abuse
Stephanie Covington: And we talk about some of the impacts, what happens when someone has been abused.

Power and Control Wheel
Stephanie Covington: And they have a copy of the Power and Control Wheel that comes out of the domestic violence world that has all of these various segments. There is the physical and sexual abuse, but there is also intimidation, emotional abuse, using isolation, minimizing, denying. And they go around and I have the girls brainstorm, describing what these look like in a relationship. So they describe what behaviors, what this would look like in a relationship. And you will see I have added in here what some of the girls do to each other, the bullying, calling names, and so forth, so we can talk about descriptive language around abuse and relationships.

Module C: Connecting With Others
Stephanie Covington: The third module is our Healthy Living module, which focuses on body, mind, and spirit. We are going to talk a little bit about bodies, but also we talk here about eating disorders, emotional wellness, use of alcohol and other drugs, and spirituality. And there are 24 activities in these four sessions.

My Body Image
Stephanie Covington: They do an exercise, the body parts they like, dislike, and feel neutral about. They also do an exercise, they have a place in their workbook where they say five thank yous to their body, what they appreciate about their body. They do a collage on the role of food and fuel and feelings, and looking at their relationship to food and food in their families.

Five Steps to Emotional Wellness
Stephanie Covington: We talk about emotional wellness, that there are steps to emotional wellness. You have to tune into your feelings and be able to name, you have to even sense that you are having a feeling, and being able to name the feeling, locate the feeling in your body, we learn how to express the feeling, and then also being able to practice containment. So there are some exercises around all these steps for emotional wellness.

Containing vs. Stuffing
Stephanie Covington: We also talk about what happens if you are feeling flooded by feelings. And when you have a really intense feeling and you just slow down and stop, and ask yourself, “Does the intensity of the feeling match the situation?” Then you also can look at what might be contributing to your intense feeling. And how old do you feel you are as you are having the feeling? Because often the intense feeling does not match the situation. It belongs to another time and place.
Weighing it Out
Stephanie Covington: Substance abuse, there are several activities. One is the cost and benefit of using alcohol, tobacco, or other drugs.

Module D: Journey Ahead
Stephanie Covington: The last module is the Journey Ahead. Two sessions here, and nine activities.

Crossroads
Stephanie Covington: Talking about crossroads, they brainstorm all the crossroads they are coming to where they have to make choices about staying in school, leaving school, staying with this boyfriend, leaving this boyfriend, whatever the choices are. Then they look at the long-term consequences of going this way, the long-term consequences of going that way, the short-term consequences.

Making Good Decisions for Me
Stephanie Covington: And we do some decision making exercises, they have some strategies for decision making and they mark where they think they are in terms of those skills. They also draw a picture of the best decision they have ever made for themselves.

Sisterhood and Support
Stephanie Covington: So this gives you an idea of a program for girls. You will notice that the trauma is in there, it is dealt with in more subtle ways and not in very overt ways, except the teaching points as to what abuse and trauma are.

Questions?
Stephanie Covington: Any questions at this point before we wrap up?

Angie Wolf: Yes, we have got a few. Can you talk a little bit about how an organization might get training to do Voices and get certified to be a Voices provider?

Stephanie Covington: Yes. Training happens in a variety of ways. There are trainings that are open at various places in the country at various times, and also organizations decide to have training brought on-site. Sometimes I do the training, but more often I have trainers who go out and do the training. We always do the training once a year in Connecticut through the Connecticut Women’s Consortium. If you go to my Web site you will see where trainings are scheduled, and if you are interested, you e-mail me and we help connect you up to a trainer.

Angie Wolf: Okay, great. Thank you. I think that is about it for the question portion.

Stephanie Covington: Okay, shall I go back and close?
Angie Wolf: (overlapping comments)...say a few things at the end. But on behalf of NGI, I want to say again thank you to Dr. Covington for this work. We are very privileged to have you be our first Webinar provider, and we are so excited and look forward to more work with you on this issue in the future.

Stephanie Covington: Thank you.

Angie Wolf: And I also want to thank NTTAC for organizing this and making this as easy as possible for all of us, and making it available for folks for the next several days. This has been quite a treat and I thank you, Michelle and Callie, for all the work that you have done.

Stephanie Covington: I have been delighted to work with you. Do I have a minute to wrap up or not?

Angie Wolf: Yes, go ahead, Stephanie.

Stephanie Covington: Okay. I just have two more slides that I want to suggest.

**Moral Challenges**

Stephanie Covington: This is one from a couple of years ago out of the *New York Times* magazine section where they talked about moral challenges. They said the moral challenge of the 19th century was slavery. The moral challenge of the 20th century was totalitarianism. But the moral challenge of our century, of the 21st century, is brutality against women and girls. And I think that is something that we all need to think about. I think it is a very profound statement.

**Women and Girls Healing**

Stephanie Covington: In closing, I want to suggest to you that I think when we work to help women and girls heal, we are working on multiple levels. You are working with a girl, you are working on the individual level, or we as women are doing our own work, we work on that individual level. But it is also a political act to help a woman and/or a girl heal, to become whole. So when you are working with these girls, I believe you are actually doing political work. And I also believe that as we help girls and women heal, we are also working on the spiritual level. What has been lost in our society is that great feminine spiritual principle, and my belief is that if we can take that great feminine spiritual principle that has been lost in our world and bring it into balance with the great masculine spiritual principle, I believe that is the only hope for our planet. So I think our work happens and I think it happens on multiple levels. And I thank you for letting me be able to do this Webinar today. Thank you.

**For More Information**

Linda Rosen: Thank you so much, Dr. Covington. On behalf of OJJDP, I would like to thank our speaker, Dr. Covington, our host, the National Training and Technical Assistance Center, and you, the participants, for joining us. I hope the ideas expressed here will assist you in providing the youth support services necessary to prevent them from exposure to additional trauma.
Linda Rosen: Please take a moment to fill out our evaluation that will pop up momentarily in order to provide us with your feedback and any ideas for future Webinars. OJJDP is always looking for new and innovative practices to deliver quality services to youth involved in the justice system. We continue to welcome your input and appreciate you sharing your ideas with us.

Linda Rosen: In addition to the NGI series of Webinars, OJJDP will be hosting a Webinar in July on Trauma-Informed Care that is focused on children in the school system. It will be on July 23, and it is part of our multi-agency collaboration with the Department of Education and...(end of audio)