The Connecticut Women's Consortium

Trauma Matters

Fall 2023

A quarterly publication dedicated to the dissemination of information on trauma and best-practices in trauma-informed care

INSIDE THIS ISSUE:

A Journey Like No Other: Trauma and Vulnerabilities Faced by Immigrants (page 1-2)

Featured Resource: Truth and Repair by Judith Herman (page 2)

CCADV: Intimate Partner Violence and Pregnancy-Associated Deaths in Connecticut (page 2-3)

Ask the Experts: An Interview with Krystal Rich, MSW (page 3-5)

From Adverse to Positive Childhood Experiences: Understanding Trauma and Resilience (page 5-6)

Who's Been Reading Trauma Matters? (page 7)

Editor:
Alana Valdez, MA

Editorial Board:
- Colette Anderson, LCSW, CWC
- Steve Bistran, MA
- Carl Bordeaux, CPRP, CARC
- Kimberly Karanda, PhD, LCSW, DMHAS
- Eileen M. Russo, MA, LADC
- Tammy Sneed, DCF

A PDF version of this publication with a full list of references and resources is available for download at our website: www.womensconsortium.org

A Journey Like No Other: Trauma and Vulnerabilities Faced by Immigrants

by The Connecticut Institute for Refugees and Immigrants (CIRI)

Transit to the United States presents many dangers for migrants seeking safety and freedom. At the Connecticut Institute for Refugees and Immigrants (CIRI), we assist asylum applicants who have traveled from continent to continent, over land and water to seek asylum at the US border.

The journey of irregular immigration is not a safe one. Criminal organizations including gangs and cartels prey on migrants, knowing that they are particularly vulnerable. Migrants are at high risk for victimization including robbery, assault, and kidnapping. They face assault and extortion from local law enforcement and detention by immigration authorities as they travel to the United States. Fatigue from traveling long distances without food, water and shelter may result in injury or death. Dehydration, hunger, deprivation, and hypothermia are all risks. Boats sink in dark waters, cars crash on isolated roads, and trains crush those who attempt to ride closer to the Mexican American border. Those who cannot keep up are left behind.

At the border to the United States, additional risks exist. Over this summer, the government of Texas installed a floating wall on the river separating Mexico and the United States, which has resulted in an ongoing legal battle with the federal government. Migrants are caught in barbed wire and fencing or injured by falling from the walls and fences set along the border. Human smugglers may become human traffickers, forcing their "customers" into conditions of labor or commercial exploitation. Cartels make a hefty profit off of kidnapping migrants and holding them for ransom.

Immigrants who do not seek admission or parole, but present themselves to immigration as asylum seekers, are placed in detention centers that are often overcrowded and under resourced. Family members are separated. Children entering with a caretaker may be sent to a facility run by the Office of Refugee Resettlement, the organization responsible for caring for unaccompanied minors, while the grandparent or adult sibling who accompanied them to the United States is rapidly deported. Even when migrants are allowed to stay in the United States to pursue asylum, they may be detained in jail or prison until their cases are heard, which may take months or even years. Migrants released from custody are generally not permitted to work and are required to report to ICE (Immigration and Customs Enforcement) for months or years while they await the filing of their case with immigration court.

The U.S. immigration system requires the re-traumatization of survivors of persecution, torture, domestic violence, trafficking, and other crimes, who must recount their multiple traumatic experiences as they engage in the legal process. Although individuals who have survived these events may be able to apply for asylum, specialized visas, or other relief because of their victimization, the preparation of the application and its adjudication require the applicants to write or speak the details of these experiences to the US government. Often, the case details are reviewed multiple times over the course of processes that last years. Despite the impact of trauma on memory, an applicant is required to accurately remember dates, times, and sequences of events. A failure to do so can result in a negative credibility finding, denial of an application, accusations of immigration fraud, and deportation.

Once in the U.S., migrants seeking a legal status find themselves, once again, in vulnerable situations. They may have past negative experiences with the police and their governments that have shattered faith in law enforcement and public entities. They may believe or be led to believe that if they go to law enforcement for help, they will be arrested or deported back to the dangerous conditions they fled. This can become yet another tool of exploitation.

The trauma experienced by most undocumented immigrants negatively impacts their wellbeing. Much is due to negative experiences throughout their life and journey. Trauma is an ongoing emotional response often caused by experiencing a distressing event. Living through a traumatic event negatively impacts the brain and can harm a person's sense of safety, sense of self, and ability to regulate emotions and navigate relationships. Long after the traumatic event occurs, people with trauma can often feel embarrassment, helplessness, powerlessness, and intense fear.

There are three main types of trauma - Acute, Chronic, and Complex

- Acute trauma results from a single incident.
- Chronic trauma is repeated and prolonged such as domestic violence or abuse.
- Complex trauma is exposure to multiple traumatic events of an invasive, interpersonal nature.

Unfortunately, refugees and many immigrants often endure Complex Trauma as they experience trauma in their country of origin, trauma during their journey to the United States, and commonly, additional trauma while working through many barriers acclimating to this new country. Studies show there is an overall prevalence of major depressive disorder (MDD) and/or post-traumatic stress disorder (PTSD) diagnoses in approximately 35% of refugees and asylum seekers.

Access to culturally trained trauma-informed human service workers is essential, especially for newly arrived refugees and immigrants to the United States. While starting the journey of healing from trauma and navigating the myriad challenges faced in a new country, collaboration with a human services professional is vital. Human service workers, including case managers, clinicians, and others who offer supportive, nonjudgmental, empathetic case management, help alleviate stress, confusion, and embarrassment. In turn, individuals are more empowered and confident to reach self sufficiency.

In addition to having access to holistic human services, psychotherapy has proven to also be highly effective for trauma.

Specific treatment modalities include:

- Cognitive Behavioral Therapy (CBT) focuses on recognizing problematic thinking patterns and working to change them which then helps change behavior patterns.
- Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), designed for children/teens and their trusted adults, works to improve a range of trauma-related outcomes in minors.
- Eye Movement Desensitization and Reprocessing Therapy (EMDR) is different than most talk therapy approaches as a person will do eye movements or tapping while focusing on an image related to the trauma.
- Narrative Exposure Therapy uses the power of storytelling to help heal from past experiences.
- Art Therapy uses different forms of art mediums to help interpret, express, and resolve emotions and thoughts. Two common forms of art therapy are Trauma-Focused Music & Imagery and Reflective Writing.

It is commonplace for migrants to have experienced multiple traumatic events in their lifetime. Although some individuals come to or remain in the United States because they are drawn here by positive factors like economic and educational opportunities, others have fled to the United States because they no longer feel safe in their country of birth or residency. Political instability, high crime rates, drought and famine, natural disasters, and armed conflict are some of the factors driving immigration to the United States. Many individuals and families journey to the United States after experiencing violent crime, natural disaster, abuse, harassment, persecution and/or torture to seek safety.

The Connecticut Institute for Refugees and Immigrants (CIRI) empowers refugees and immigrants in the state of Connecticut. We envision Connecticut as a place where immigrants may fully participate in our culturally-diverse communities, where low-income families may have access to affordable immigration services and be reunited with family, where survivors of crime and persecution may have the resources needed to become self-supporting and healed and where ethnic diversity is valued as a cultural and economic strength by all. We strive to help immigrants move beyond the traumatic experiences lived by providing the tools, resources and services to support them. To learn more about CIRI's work and service, please visit www.cirict.org.

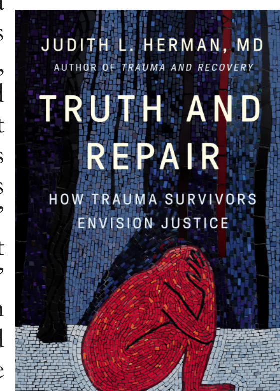
Shanika Rucker, Clinical Director
Leonela Cruz-Ahuatl, Director of Project Rescue
Caroline Sennett, Director of Immigration Legal Services

Featured Resource: Truth and Repair by Judith Herman

By Eileen M. Russo

In Dr. Herman's book, "Trauma and Recovery: The Aftermath of Violence — From Domestic Abuse to Political Terror" (1992, 1997), she reminds us of the historical amnesia our culture possesses concerning trauma. Herman also outlines 3 phases of trauma recovery: safety, remembrance and mourning, and reconnection. In her latest book, "Truth and Repair: How Trauma Survivors Envision Justice" (2023), Herman states, "In recent years, I have begun to contemplate a fourth and final stage, and that is justice. If trauma is genuinely a social problem, and indeed it is, then recovery cannot be merely a private, individual matter." (p. 3)

In "Truth and Repair," Herman interviews survivors and draws upon their experiences to describe justice and healing as phases of acknowledgment, apology, accountability, restitution, rehabilitation, and prevention. The book explores how social supports can perpetuate continued abuse and violence: victim blaming, a legal system that is lengthy, confusing, and expensive, and institutions that reinforce messages such as "this is a family matter" or "you cannot break your vows." This implies then that justice and healing must be addressed publicly by not only holding victimizers accountable but also by holding the social environment accountable. Ideas for achieving this goal are woven throughout the book and powerfully concluded in the final chapter titled "The Longest Revolution."



Additional Resources:

The Survivor's Agenda: https://survivorsagenda.org/agenda

Office of Victim Services: https://jud.ct.gov/crimevictim

Eileen Russo, MA, LADC, is a licensed addiction counselor, a certified clinical supervisor, and an advanced certified alcohol and drug counselor (substance use and co-occurring disorders) who has worked in the addiction and mental health field for the past 37 years. Ms. Russo also holds credentials as a relapse prevention specialist and a compassion fatigue educator. For the past 17 years, she has served as a trainer/consultant with the CT Women's Consortium, DMHAS, private agencies, and several states beyond Connecticut.

CCADV: Intimate Partner Violence and Pregnancy-Associated Deaths in Connecticut

By Devon Rayment, MA

In April 2023, the Connecticut Coalition Against Domestic Violence (CCADV) released a report entitled Intimate Partner Violence and Pregnancy-Associated Deaths in Connecticut. This report, prepared by Partners in Social Research, LLC and made possible by a grant from the U.S. Department of Health and Human Services Office on Women's Health, examined 102 cases of pregnancy-associated deaths in the state of Connecticut from 2015-2021. The cases were reviewed to explore perinatal IPV among these Connecticut residents whose deaths occurred during pregnancy or within one year after the end of pregnancy during the postpartum period. This examination of IPV service data from CCADV's 18 member organizations, in conjunction with the Connecticut Maternal Mortality Review Committee (CT MMRC) case narratives, found an increased risk for death faced by pregnant and postpartum birthing persons when experiencing or having experienced intimate partner violence (IPV) during their lifetime.

Findings from the report indicate that 33 of the 102 cases of pregnancy-associated deaths in Connecticut from 2015-2021 experienced IPV during their pregnancy within one year postpartum; a higher rate than was previously thought. Accident, homicide, and suicide were the most common manners of death among those Connecticut residents who experienced perinatal IPV. Demographic risk factors such as race, ethnicity, social well-being, employment, marital status, and education were also examined in the report. Research has shown that IPV has a significant impact on an individual's physical and mental health. The percentage of birthing persons with substance use disorders, mental health conditions, or adverse childhood experiences (ACEs) was greater among those with lifetime IPV than among those who had never experienced IPV and therefore at greater risk during the perinatal period.

In addition to the investigation of the individual factors contributing to these pregnancy-associated deaths, this report examined the role of the healthcare system in Connecticut as it relates to IPV screening and referrals to services for those birthing persons who disclose IPV. The American College of Obstetricians and Gynecologists (ACOG) recommends universal screening for IPV at periodic intervals during an individual's pregnancy and postpartum period. There are a variety of screening tools available to providers, as well as training to support providers in implementation of IPV screening in their practices. Universal screening relies on the implementation of proper screening techniques by providers and accuracy of self-reported data from patients. Intimate Partner Violence is often underreported for a variety of reasons—safety concerns, emotional and mental abuse, fear, coercion, finances, and a lack of understanding of resources available for support. The National Coalition Against Domestic Violence (NCADV) defines intimate partner violence as "the willful intimidation, physical assault, battery, sexual assault, and/or other abusive behavior as part of a systematic pattern of power and control perpetrated by one intimate partner against another. It includes physical violence, sexual violence, psychological violence, and emotional abuse." According to NCADV, of the cases that are reported, one in four women and one in nine men experience intimate partner violence in their lifetime.

Based on the CT MMRC case narratives reviewed, this report finds inconsistencies in screening for IPV across healthcare visits, both during routine visits to the OBGYN and visits to the Emergency Departments at hospitals across the state. According to this report, these inconsistencies indicate a pattern of missed opportunities for healthcare providers to intervene in the lives of their patients who are experiencing IPV during the perinatal period. The report findings suggest the need for more qualitative research on screening and referral protocols used by healthcare providers in Connecticut. In addition, more research is needed on screener readiness to provide screenings to birthing persons and the ability to accept a disclosure of IPV and refer the patient for support and services. Finally, the report also recommends strengthening pathways to care by increasing connections between health providers, mental health agencies, community providers and IPV service organizations in order to better meet the needs of birthing persons across the state who are experiencing IPV.

Scan the QR code to read CCADV's full report on IPV and pregnancy-related deaths

Ask the Experts: An Interview with Krystal Rich, MSW, Director of the Connecticut Children's Alliance

By Tammy Sneed

Krystal Rich is the Executive Director of the Connecticut Children's Alliance (CCA), a non-profit organization dedicated to preventing and ending child abuse in Connecticut. Krystal oversees the Child Advocacy Centers and Multidisciplinary Teams: facilities and teams responsible for providing specialized and personal care to child victims and families.

TAMMY SNEED: Can you talk to me today about your role as the Executive Director for the Connecticut Children's Alliance? What is CCA's mission?

KRYSTAL RICH: Absolutely. CCA's mission is to end and prevent child abuse in Connecticut. Our agency started off in 2009, solely as the coalition for Child Advocacy Centers and Multidisciplinary Teams in the state. As the coalition, we're responsible for providing support through training, education, different funding opportunities, and monitoring and supporting quality assurance for our centers and teams. Through that process and working with our teams and centers to intervene in child abuse, we really saw the need to start focusing on prevention. In 2017, we also took on another program to further our mission called Prevent Child Abuse Connecticut, which is a chapter of Prevent Child Abuse America, and the goal of that organization is to focus on the prevention of child abuse long before it occurs. On a

day-to-day basis, it's working a lot with our partners and making sure that we're all on the same page. Connecticut is a small state, but there's still a lot going on in different areas, so we try to support our CACs and their staff as much as possible and work on the state level with our different stakeholders to look at different policies, see how we can increase collaboration, and identify training needs and different resources. Every day is a little bit different, but it usually mostly focuses on the collaborative approach with our partners.

TAMMY: You and I work a lot together and I always appreciate your work, your efforts, and how you support the state and our kids. Let's dive into the work. Can you talk a little bit about what a Multidisciplinary Team is (MDT) and a Child Advocacy Center (CAC)?

KRYSTAL: The Child Advocacy Center model is an innovative approach to addressing child abuse cases. It's designed to provide this child-centered, coordinated response. Just to give a little context to you—I think it's always important to start off with the history of the model—the CAC model was developed in the late 1980s as a response to some of the challenges that were faced by child abuse victims and the professionals working on those cases. Before this model was in existence, child abuse investigations were often disjointed and very traumatic for the victims, involving sometimes multiple interviews in various settings.

At the time, it was not unheard of for a child to be interviewed upwards of 15 different times in 15 different locations by people who truthfully didn't have the training or skill set to be interviewing kids. Because of all of this, again in the late 1980s, there was a man by the name of Bud Cramer, who at the time was a District Attorney in Huntsville, Alabama, and he was trying a lot of these child abuse cases. One day, he had a child abuse victim who was going to be taking the stand in court and he was prepping her. As he was going through the questions that he was going to be asking, the child looked directly at him and said, "I don't want to do this anymore. Why don't you people talk to each other?" He paused and he really thought about that. There were many conversations that happened from that point, but what he ended up developing is what we know today as the CAC model.

He brought together all the various disciplines that have any investigative purpose or service component that work with child abuse cases to form a Multidisciplinary Team and the Child Advocacy Center model. It was really a pioneering concept at the time. Today, there are upwards of 1,000 CACs across the United States.

Part of the CAC, as you mentioned earlier, is the MDT. A lot of people get confused about what the differences are. The way I like to frame it is, I call it the Child Advocacy Center model, which has two components: there's the Child Advocacy Center itself, and the Multidisciplinary Team. The MDTs, Multidisciplinary Teams, are comprised of professionals from all different fields, including law enforcement, Child Protective Services, medical, mental health, prosecution, and advocacy: anybody you can possibly think of that really plays a role in a child abuse investigation and response. The MDT collaborates to investigate and provide appropriate services in response to child abuse victims and their families. They bring together their different expertise and make sure that there are no gaps in the response. As I mentioned, prior, everyone kind of worked in a silo. Investigators did their thing. Service providers did their thing. The Multidisciplinary Team brings everyone together to make sure that they're talking about the case, the child, and the family's needs all at the same time.

Every Multidisciplinary Team is connected to a Child Advocacy Center. The Child Advocacy Center itself is a child-friendly facility designed to create comfort and a non-threatening environment for child abuse victims. It is meant to, again, streamline that process by centralizing those services that are needed for a child abuse investigation in one place whenever possible. All our CACs have specialized interviewers that are trained in what we call the Child First model, and that model teaches people how to talk to kids in a non-leading way. When they're interviewed, they're interviewed in a safe space where there's a camera system and the investigative partners can watch this camera system to make sure that the questions that they need for their investigation are being asked. This way, that child doesn't have to go through an interview with each of those different people. At the CAC there are also services around long-term advocacy, specialized medical services, mental health services, and services for non-offending caregivers as well. That's the entire CAC model, but it really is the CAC, that actual facility and the staff that works there, and then all the multidisciplinary partners coming together.

TAMMY: Now, how many MDTs and CACs do we have in our state?

KRYSTAL: We have 17 Multidisciplinary Teams and ten Child Advocacy Centers. We have eight Child Advocacy Centers in the state that work with one Multidisciplinary Team and two of our Child Advocacy Centers work with several Multidisciplinary Teams.

TAMMY: We know that these kids and the non-offending families have experienced significant trauma. How do the CACs and MDTs support these children and families?

KRYSTAL: When the child and family initially come to the CAC, there is a lot of information and education provided to the caregivers around different services that are available for the child as well as different services that are available for them and other family members within the home. No child leaves the Child Advocacy Center—leaves this process—without us ensuring that there are appropriate referrals for the child, and then for the family members if needed. Those referrals could be mental health, so we certainly make sure that there are trauma-informed, evidence-based mental health services available.

It may also be basic needs: if we want people to thrive and do well, we need to make sure that their basic needs are met. Sometimes it's a matter of supporting a family to get secure housing or identifying if there's food insecurity or transportation issues. We will do that as well and make sure that they have that in addition to mental health support. One of the things that's really key in this is making sure we're addressing the needs of the whole family. We know kids do so much better and are so much more successful when their families are also doing well, especially their caregivers.

TAMMY: That's wonderful. Love that motto. On average how many cases are we seeing in the state of Connecticut on an annual basis?

KRYSTAL: We have seen an increase over the years—I think a lot of that has to do with just awareness, of the better way to handle these cases—but on average over the last several years, you see anywhere from 1,800 to 2,000 unique cases and that's cases of sexual abuse, physical abuse, trafficking, and exposure to violence.

TAMMY: Wow, that's a significant number. I think about the workers that are working with these kids and families that are hearing and seeing these stories daily, helping the families through horrific things; it must be difficult for them as well. How do the CACs and the MDTs address vicarious trauma, or secondary trauma, to the workers that are doing this work?

KRYSTAL: That's a great question. This trauma really can take a toll on the well-being of our partners. I don't think we even always recognize the things that people are dealing with on a day-to-day. Looking at that number 1,800 to 2,000 cases, that's a lot of trauma that people are seeing.

I do want to acknowledge before I give these examples that there's a lot more to do here as a state and as a country to support our partners, although we, over the years, have put much more of a focus on it. Certainly, [we provide] training and education. There is a focus on making sure that our partners are trained on what vicarious trauma is and secondary trauma is and what it can look like. A lot of times depending on what discipline you come from—from the social work side of things, we're taught that on a regular basis—but not all our disciplines receive that kind of training. We try to make sure that [education] is provided to them from their lens and a lot of that is around how to develop healthy coping skills, how to acknowledge it's completely normal to have this response when you see trauma, how to see, too, when you're closing it off and trying to kind of ignore it, but that it's still having this impact on you physically or mentally.

I would say that MDT setup is inherent to providing some of that support; I don't think any of us really realized how important it was. All our Multidisciplinary Teams meet, although they are constantly working together, at least monthly to look at all of their cases. Prior to COVID, they used to always meet in person, and now they're slowly starting to do that [again]. I don't think any of us realized how significant that was.

The debriefing before and after a case review and just being around the partners that you work with that have become friends: I think that collaborative approach and that teamwork helps a bit with the vicarious trauma. A lot of our teams—and they do it in different ways—will have debriefing sessions or have opportunities to debrief cases that are really tough to make sure that people have the support that they need. The other piece too is a recognition of, an appreciation of, what our partners are doing on a regular basis, which is something that we try to do. It's not work that always gets talked about because it's a hard topic to talk about, but whenever possible, it's important to recognize the tough work that they're doing.

TAMMY: In thinking about this work and where we are as a state, if you had the perfect opportunity to be able to implement your wish list for the work of the CACs and MDTs, what are some of the gaps or some of the things you would want to implement to strengthen this process and support the staff that is doing the work and to support the children and families that unfortunately are going through some really traumatic experiences?

KRYSTAL: So, there's a very long wish list, but I will for time's sake focus on two sections that I think about often. One would certainly be more resources for all aspects of the MDT process. We know now, especially during this period after experiencing a pandemic, we are in desperate need still of more mental health services, more supportive services, and basic needs for our families and kids. There are wait lists, but they are extremely long. We know in these cases that the earlier we intervene, the less likely there's going to be long-term effects into adulthood, so it's really critical that we have access to these resources in a timely fashion.

I often think about how if you're a child who discloses that you've been abused—which is going to be one of the worst things, possibly, that happens in your lifetime—and you're told to hold on to that and wait three weeks for therapy or for support, that's not fair. We shouldn't be asking our kids for that. So, [we need] a focus on more resources. That will help our partners: it takes a toll on our partners when they can't provide the kids and the families with the services that they need on a regular basis. And I know that it takes a toll on our service providers who are looking at their wait list, only wishing that they could get these kids and families in sooner.

The other piece we really need to look at is fair and equitable wages for all our partners. This is tough work and if you look at some of the salaries and hourly wages for some of the folks that are within the MDT process, it's not sustainable. Our workers who are working with this trauma should not have to have multiple jobs just to make a living. So, when I talk about resources, it's important that we look at them from both of those angles. The other thing that I would say is with this work that's critical is more of a focus on prevention and making sure that when we're looking at intervention, we're also looking at prevention.

By prevention, I don't just mean trainings and talk about red flags and identifying abuse, but I really mean addressing those basic needs. We know that if families have affordable housing, stable jobs, and stable, high-quality affordable childcare, all those things lead to better outcomes for families. I would love it if we would have more of those conversations on the state and national levels about how to integrate both prevention and intervention together.

TAMMY: Krystal, this has been so helpful in learning from you about CACs and MDTs and the importance of working with our children and families, the realization that we need more in Connecticut to support them because we don't want kids and families to be on wait lists, the importance to make sure we're taking care of our staff from everything from dealing and supporting them with vicarious trauma to looking at wages and making sure people have that opportunity to be together.

I always think about some of those professions that are very reluctant to get that kind of help but if you're all in that same room, like you said, it kind of just naturally happens. They're not isolated. I also appreciate you talking about the pandemic and its impact. We definitely saw that impact and need now to really take a look at what we have in areas that we need to enhance. Your work is amazing. I love that you have that prevention work now under Connecticut Children's Alliance, so that's wonderful as well. Is there anything else you'd like to say before we wrap up this afternoon?

KRYSTAL: I really appreciate you having me here. I'm just so appreciative every day that I get to work with this collaborative group of individuals who care about this work. It's really an honor to be in this role.

Scan the QR Code to listen to this interview on our podcast

From Adverse to Positive Childhood Experiences: Understanding Trauma and Resilience

Dr. Vincent Felitti, head of the Kaiser Permanente Department of Preventative Medicine in San Diego in the 1980s, was determined to find out why 50% of patients dropped out of his obesity clinic despite losing weight. After a series of interviews with patients who had dropped out, he discovered that most had been sexually abused as children; these findings suggested to him that patients might be using obesity as a coping mechanism to deal with past trauma or to avoid unwanted sexual attention. In 1995, he partnered with Dr. Robert Anda at the Centers for Disease Control and Prevention (CDC) to develop and conduct the first Adverse Childhood Experience (ACEs) survey. From this survey of 17,000 Kaiser Permanente patients, we now know that three types of ACEs—physical abuse, sexual abuse, and emotional abuse—are extremely common and directly correlate with negative mental and physical health outcomes in adulthood. The more ACEs a person experiences, the higher their ACE score: a higher score increases the likelihood of experiencing worse health outcomes.

While the Kaiser-CDC study was ground-

breaking, it had limitations. Its respondents were at a socioeconomic advantage—primarily white, middle- or upper-middle class, insured, college-educated, and employed—inherently preventing the assessment and understanding of diverse traumas. The initial questions focused predominately on experiences within the home and failed to account for external traumas like gender and sexuality-based discrimination, bullying, witnessing violence, or being in foster care.

Multiple studies have been developed since the Kaiser-CDC study to address limitations and broaden the scope of ACEs research. In 2012, the Philadelphia ACE Project conducted an Expanded ACE Study, utilizing survey questions that reflect the home and community experiences specific to living in an urban environment, specifically in Philadelphia. This study found that seven in ten of 1,784 adults surveyed had experienced one ACE and 40% had experienced four or more of the expanded community-related ACEs. Beginning in 2019, researchers in Texas began exploring how ACEs specific to gender and sexual minorities—homophobia, exposure to violence against LGBTQ+ people, and social pressure towards heteronormativity—impact adult mental health. Adults exposed to SGM-ACEs were found to have higher rates of depression and anxiety symptoms.

The environmental factors that inform ACEs vary drastically, rendering it nearly impossible to develop a survey that captures the nuance of all possible traumatic childhood experiences. The World Health Organization has developed an International Questionnaire (ACE-IQ), intended to be applicable worldwide: critics say the survey is still too limited to accurately represent the experience of people in 195 different countries.

Recently, the public health discourse has shifted from simply identifying ACEs to exploring how to prevent them and promote positive childhood experiences (PCEs). PCEs have been shown to build resiliency in children who have experienced ACEs and offset the negative health effects of trauma. Counter to an ACEs score, Pinetree Institute provides a survey delivering a "resilience score", quantifying PCEs. Questions about PCEs were added to the CDC's 2021 Youth Risk Behavior Surveillance System (YRBSS) surveys, assessing the presence of supportive adults in a child's life, their parental structure and communication with their parents, healthy friendships, school safety, and community engagement.

Further surveys are necessary to understand ACEs caused by unique circumstances, like exposure to police violence, the impact of the COVID-19 pandemic, and immigration trauma. Additionally, more research is needed to address the impact of ACEs among specific subgroups like Native American and Hispanic and Latinx populations. Despite these blind spots, ACE studies have invariably highlighted the importance of social welfare programs in preventing childhood trauma. The CDC offers technical packages to support municipal and state policy changes such as a federal minimum wage increase, accessible healthcare, federal nutrition packages, and paid family leave to provide resources to lessen the risk of ACEs within the home.

In September 2020, the State of Connecticut received a three-year grant from the CDC to develop an initiative—the Preventing Adverse Childhood Experiences Data to Action Initiative (PACES D2A)—to measure and prevent ACEs in Connecticut. In its first two years, the initiative created a public awareness campaign to raise awareness of the availability of Earned Income Tax Credits (EITC) for low-income families. In June 2023, an increase in the EITC was passed, raising the rate to 40% and providing $44.6 million in state tax credits to approximately 211,000 low-income residents. The initiative also intends to combine ACEs-related data across state agencies to "better understand and characterize ACEs in Connecticut communities."

In August 2022, Governor Ned Lamont signed legislation to address the availability of mental health and substance use disorder treatment for Connecticut youth. At the time of writing, there are now four children's urgent crisis centers throughout the state licensed by the Department of Children and Families (DCF). These centers are spread throughout the state and are designed to provide outpatient services and establish a connection to follow-up care for children and teens experiencing behavioral health crisis.

CHILDREN'S URGENT CRISIS CENTERS

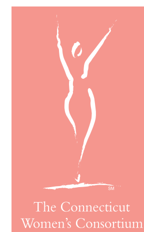
Map provided by the Southeastern Regional Action Council

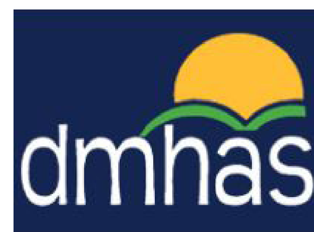
Who's Reading Trauma Matters?

Dr. Marc Potenza!

Dr. Marc Potenza browses a digital copy of Trauma Matters

Dr. Marc Potenza is a board-certified psychiatrist who specializes in addiction psychiatry. He is a Professor of Psychiatry, Child Study and Neuroscience at the Yale University School of Medicine, where he is Director of the Division on Addictions Research at Yale, the Center of Excellence in Gambling Research, the Yale Research Program on Impulsivity and Impulse Control Disorders, and the Women and Addictive Disorders Core of Women's Health Research at Yale. Dr. Potenza has received multiple national and international awards for excellence in research and clinical care and is on the editorial board of fifteen journals. He has consulted to the Substance Abuse and Mental Health Services Administration (SAMHSA), the National Institutes of Health (NIH), the American Psychiatric Association (APA) and the World Health Organization (WHO) on addiction matters.





The Connecticut Women's Consortium
2321 Whitney Avenue, Suite 401
Hamden, CT 06518
www.womensconsortium.org

References and Resources

Resources

Connecticut Institute for Refugees and Immigrants (CIRI): https://cirict.org

Intimate Partner Violence & Pregnancy-Associated Deaths in Connecticut, April 2023, CCADV: https://www.ctcadv.org/application/files/7516/8856/7531/MaternalMortalityReport4.23.pdf

State of Connecticut Office of Victim Services: https://jud.ct.gov/crimevictim

The Survivor's Agenda: https://survivorsagenda.org/agenda

References

CDC. (2023). YRBSS Overview. Centers for Disease Control and Prevention. www.cdc.gov/healthyyouth/data/yrbs/overview.htm.

Dorri, A. A., Stone, A. L., Salcido, R., Russell, S. T., & Schnarrs, P. W. (2023). Sexual and gender minority adverse childhood experiences (SGM-ACEs), perceived social support, and adult mental health. Child Abuse & Neglect, 143, 106277. https://doi.org/10.1016/j.chiabu.2023.106277

García, W. M. and U. J. (2023). Federal judge orders Texas to remove floating border barrier. Abbott immediately appeals the ruling. The Texas Tribune. https://www.texastribune.org/2023/09/06/texas-border-floating-barrier-buoys-federal-judge-ruling/

Governor Lamont And DCF Announce Opening Of Four Childrens Urgent Crisis Centers. (2023). CT.gov - Connecticut's Official State Website. https://portal.ct.gov/DCF/Press-Room/Press-Releases---Latest-News/Governor-Lamont-And-DCF-Announce-Opening-Of-Four-Childrens-Urgent-Crisis-Centers

National Conference of State Legislatures. (2022). Adverse Childhood Experiences. https://www.ncsl.org/health/adverse-childhood-experiences

Philadelphia ACE Survey | ACES Philadelphia. (2012). https://www.philadelphiaaces.org/philadelphia-ace-survey

Rahman, K. (2023). Texas Rep horrified by circular saw barriers: "Designed for war." Newsweek. https://www.newsweek.com/texas-rep-horrified-circular-saw-barriers-1820175

Rutter, A. (2021). The Relevance of the Adverse Childhood Experience International Questionnaire to Working Children: Knowledge Gaps and Implications for Policy Makers. Children, 8(10), 897. https://doi.org/10.3390/children8100897

Stevens, J. E. (2015). The Adverse Childhood Experiences Study — the largest, most important public health study you never heard of — began in an obesity clinic. ACEs Too High. https://acestoohigh.com/2012/10/03/the-adverse-childhood-experiences-study-the-largest-most-important-public-health-study-you-never-heard-of-began-in-an-obesity-clinic/

World Health Organization. (2020). Adverse Childhood Experiences International Questionnaire (ACE-IQ). https://www.who.int/publications/m/item/adverse-childhood-experiences-international-questionnaire-(ace-iq)