Trauma Matters

Fall 2022

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

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

Intimate Partner Violence: A Public Health Crisis

by Ashley Starr Frechette, MPH

The Connecticut Coalition Against Domestic Violence (CCADV) is the state's leading voice for victims, survivors, and the agencies that serve them. CCADV defines intimate partner violence (IPV) as a pattern of abusive behavior in an intimate relationship where one partner tries to control and dominate the other. The behavior may be coercive in nature or physically or sexually abusive, with the victim oftentimes left feeling scared, confused, dependent, and insecure.

CCADV has 18 member organizations across the state that served 38,989 victims and survivors during the 2021 fiscal year—a 5% increase over the previous year. IPV has no boundaries: it affects people of every age, gender, sexual orientation, race, and socioeconomic status. IPV is a serious public health crisis that needs to be addressed statewide.

IPV affects the overall health of victims and survivors, even after the violence has ended. Research conducted over the past 30 years has consistently demonstrated that being victimized by an intimate partner increases one's risk for developing depression, PTSD, substance use disorders, and suicidality, as well as a range of chronic health conditions. The risk increases even further when individuals are pregnant and postpartum. For women in the United States, IPV is more prevalent than breast cancer and diabetes combined. Both breast cancer and diabetes are discussed consistently by health and community providers, yet healthy relationships are hardly ever asked about or educated on. Involving health and community providers in the discussions around healthy relationships and where to seek resources is necessary to fully support patients and their families.

Education is an important and proactive way to address IPV and reduce the long-term health consequences associated with it. During the height of the COVID-19 pandemic, CCADV developed a telehealth script that can easily and safely be used to educate individuals on the IPV resources available in CT. This script can be used virtually or in person and is based on the validated CUES (Confidentiality, Universal Education + Empowerment, Support) method, developed by Futures Without Violence. The idea behind CUES is to increase IPV education during every patient or client interaction. Many times, experiences with IPV and the trauma associated with it can damage an individual's sense of safety and self-efficacy, leaving individuals lacking trust. Utilizing an educational script with everyone can ensure that disclosures do not have to be made to receive information on the resources available in CT.

CCADV encourages all health and community providers to make education on healthy relationships a normal part of each patient interaction.

"Since the isolation of the COVID-19 pandemic, we have started talking about healthy relationships with all of our patients & families. Relationships can have serious impacts on overall health. We want to let you know that CT has a 24/7 IPV hotline, called Safe Connect. Safe Connect Advocates understand complicated relationships, and all services are free, safe, confidential, and voluntary. If you, or anyone you know, might benefit from these resources, you can call 888.774.2900, or email & live chat with an advocate at www.CTSafeConnect.org."

This very simple script takes less than one minute to provide and increases the

understanding that healthy relationships are an important part of overall health. Resources and free trainings are available to all health and community providers. For more information, contact Ashley Starr Frechette at astarrfrechette@ctcadv.org.

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Ashley Starr Frechette is the Director of Health Professional Outreach at the Connecticut Coalition Against Domestic Violence. She holds a Master of Public Health degree from Northeastern University. In her role at CCADV, Ashley educates and trains health and community providers across the state and oversees the health professional outreach advocacy program.

Featured Resources: CTStronger & NIH Emotional Wellness Toolkit

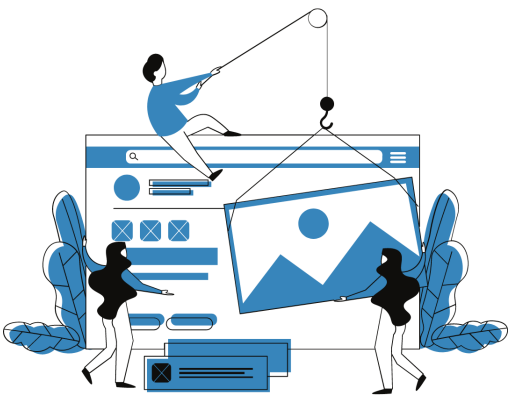
By Eileen M. Russo, MA, LADC

Resiliency, while often described as part of someone's character, is actually a set of skills and resources fueled by encouragement, hope, and connection.

"Resilience is not a permanent trait . . . even the most seemingly resilient people can be drained by relational poverty and ongoing stress, distress, and trauma."

- Dr. Bruce D. Perry, *What Happened to You? Conversations on Trauma, Resilience, and Healing*

Here are some resources that are available and just a click away:



CTStronger

CTStronger (https://ctstronger.org/) is a public education resource produced by the Connecticut Department of Mental Health and Addiction Services (DMHAS). CTStronger provides access to resources and support for Connecticut residents struggling with a variety of mental health and wellness topics, without stigma or judgment.

There is a lot of content on this website, yet it is easy to navigate. The site helpfully validates rather than pathologizes what someone might be experiencing. For example, when you click on "anxiety" in the "I've been feeling..." section, the site describes a little bit about the brain and how during a pandemic, threats can seem to be everywhere. An additional click offers tips for a stronger brain, like taking deep breaths. If someone thinks anxiety is taking over their life, they can call the action line. There are links to online support groups, self-help books and resources such as Toivo (a peer-run, non-profit initiative that includes statewide classes, workshops and a center for holistic healing and stress management), Warm Lines, and fun things to do in Connecticut. There is a separate tab at the top of the website for accessibility, 211, and support coaches for COVID assistance.

CTStronger is a one-stop resource for anyone who would like to know more about how to support their own mental health or are concerned for themselves or others.

National Institutes of Health Emotional Wellness Toolkit

Available in English and Spanish with printer friendly pages, the Emotional Wellness Toolkit offers different "cards" that when clicked provide definitions, tips, and a checklist for each topic area. For example, one of the cards is "cope with loss." By clicking on "flip," one can see a list of tips such as "finding a grief support group," or "be patient—mourning takes time." By clicking "read more," one can view a further explanation of the impact of grief and the types of grief. This main page offers information on 6 key areas, including stress, sleep, and social connection. At the bottom of the page, clicking on 'more resources' moves to an additional page with many links related to the key topic areas.

Both of these web-based resources are user friendly and offer timely information on managing and supporting mental health.

The Impact of Trauma on Breastfeeding Disparities for Black Mothers

By Natasha J. Ray, MS

At the state level, data from the Connecticut PRAMS (Pregnancy Risk Assessment Monitoring System) survey shows that there are racial and ethnic disparities in breastfeeding rates. For example, 84.5% of white, non-Hispanic mothers were breastfeeding in any capacity at 4 weeks after birth, compared to 76.2% of black, non-Hispanic mothers. Additionally, at 8 weeks, 74.3% of white mothers were breastfeeding in any capacity compared to 67.3% of Black mothers. These disparities in breastfeeding rates are based in various social, structural, and historical determinants that affect Black mothers disproportionately. To begin understanding these disparities through an equity lens, we must first look back at history and understand how we got here. Learning about the historical events that have informed attitudes towards—and practices of—breastfeeding in the Black community can be emotionally traumatic, not because of anything that Black women have done, but because of all that has been done to them.

In times of slavery, Black motherhood was valued solely for the purpose of producing more children. Thus, the cycle of exploiting Black mothers and their children began as a selfish and profit-hungry endeavor to fuel the slave trade. Even in pre-Trans-Atlantic slavery, West African women were depicted as animalistic and were highly sexualized, erasing their humanity and inherently altering how they were perceived as both mothers and spouses. The lasting effects of this demonization and hyper-sexualization are currently evident in Black women's ability to breastfeed in public. Because of the potential danger and vulnerability associated with exposing a part of oneself that has historically been hypersexualized, it can be extremely uncomfortable, or even impossible, for Black women to expose their breasts in public in order to breastfeed their children.

In addition to this, wet nursing—the act of breastfeeding and caring for another woman's child—left a harmful legacy within the Black community. Black women who

were enslaved were forced to breastfeed white babies, allowing white mothers to avoid what, at the time, was considered the "messier" parts of motherhood. Many Black mothers breastfed white children at the expense of caring for their own, and had to resort to alternatives, such as cow's milk or dirty water, to feed their babies. This led to high death rates among Black infants. About 20% of white women relied on Black, enslaved women for wet nursing, and the act of wet nursing white infants at the expense of Black infants led to the perpetuation of the "mammy" and "bad Black mother" stereotypes.

Historical trauma, especially as it pertains to the history of breastfeeding, can persist in Black women, manifesting as multigenerational trauma. Combined with continued oppression and the absence of opportunities to heal or access the benefits available to others in society, this can lead to what Dr. Joy DeGruy termed Post Traumatic Slave Syndrome, or PTSS. PTSS is a theory that captures the consequences of multigenerational oppression of Africans and their descendants, resulting from centuries of chattel slavery that was predicated on the belief that African Americans were inherently inferior.

Given the many social, structural, and historical determinants that impact the accessibility of and decisions around breastfeeding, it is important to understand that breastfeeding is not the sole responsibility of the mother; all of us, especially clinicians and other healthcare providers, play a role in breastfeeding outcomes. If we want those outcomes to improve, we need to recognize that we all have a responsibility to support Black mothers in their breastfeeding journeys.

The following is an excerpt from "Addressing Maternal and Child Health Inequities Through Care," by Kathleen O'Connor Duffany, PhD, and Natasha J. Ray, MS, first published in Focus*, a special publication of the Yale School of Public Health, Spring 2022.*

Through the CDC-funded Racial and Ethnic Approaches to Community Health (REACH) program, the Community Alliance for Research and Engagement (CARE), co-housed at Southern Connecticut State University (SCSU) and the Yale School of Public Health (YSPH), works with community partners and residents to address health inequities related to nutrition, physical activity and access to community clinical care. A primary focus of our nutrition initiative is supporting parents in their intentions to chest/breastfeed.

While the science is clear on the important health benefits of breastfeeding for infants and mothers, new mothers can face a number of barriers to both initiating and continuing breastfeeding. These barriers include poor health care provision and lack of access to lactation support services (due to lack of transportation, childcare duties, recovery from birth and inflexible work hours). Additional barriers come in the form of workplace policies that do not meet lactation accommodation requirements, cultural norms against public breastfeeding and a lack of laws guaranteeing paid maternity leave.

While studies have shown there are no racial or ethnic differences in intentions to breastfeed between non-Hispanic white mothers and non-Hispanic Black mothers, the ability to meet those intentions does differ. Black mothers face additional barriers to breastfeeding that are rooted in systemic racism, including a lack of appropriate representation in outreach materials; a lack of representation among breastfeeding support service providers; a legacy of violence and oppression related to the role of wet nurses in the context of slavery; and a disproportionate rate of preterm births among Black women, which makes breastfeeding more complicated. Excess stress associated with bias, discrimination or racism experienced particularly by Black people, and the aggressive marketing of infant formula in Black communities also present barriers to Black women. It is important to acknowledge how the racial inequities we see in breastfeeding today cannot be separated from their historic roots in slavery and the persistent and systemic racism that has followed.

To identify structural barriers to breastfeeding among communities of color and inform future initiatives, CARE's students, staff and faculty are working with our community partners and residents on a variety of studies.

To read a summary of the studies mentioned above, visit the Yale School of Public Health's website at: https://m.yale.edu/zqf7

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Natasha J. Ray, MS, is the director of New Haven Healthy Start, chair of the Center for Research Engagement at the Equity Research and Innovation Center, and community lecturer at OPHP at the Yale School of Public Health.

Ask the Experts: An Interview with Tammy Sneed

By Colette Anderson, LCSW

Tammy Sneed is the director of the Office of Human Trafficking Services and the Human Anti-trafficking Response Team (HART) for the Connecticut Department of Children and Families. She also serves as a Clinical and Community Consultation & Support team member and is on the editorial board of Trauma Matters.

MS. ANDERSON: Could you start by telling us how you became interested in the human trafficking work that you're doing?

MS. SNEED: Sure, you know it was interesting over the years—kind of understanding what was happening to our youth in the community. What we were seeing for quite a bit of time was, kids were running away, right? Kids were taking off from congregate care, from foster care, and we were really concerned about what was happening to them when they were out there on their own without any type of adult supervision. And they were coming back with some really bad things happening to them. We had an amazing person leading one of our divisions of DCF back in those days, and he convened a group so that we could actually talk about what was happening to our youth.

And at that time, I was the director of gender-responsive services. My focus for years has been really looking at services for girls. And girls, they're different than boys, right—we know that, we've learned

that over the years, but we had to pay attention to what was happening to our girls in these particular scenarios. And I would hear awful things about them being raped, sexually assaulted, and physically abused, but we had to dive underneath that, and really take a look at what was going on. At the same time what we learned is there was a phenomenon going on where kids were being used, being purchased for sex, and at that time we didn't have the language; we weren't talking about child trafficking. But we were learning that people were giving kids things, giving kids places to live, giving kids transportation, in exchange for sex acts.

Around the same time, the department got a call, to an amazing colleague who initiated this work about 15-years ago, that federal law enforcement was going to do an operation because they suspected there were some undocumented victims of human trafficking that were believed to be children. Here's that word again, right? So we're looking at our kids, what's happening to them, and we're hearing about this exchange; now we're getting a call from federal authorities saying they might be recovering kids that are victims of human trafficking. All the lights are going on, and we dove into it—we had to understand what was going on, and the realization hit us hard.

We started pulling together folks in the Department internally to really look at what this meant to our kids, and what we had to do to really take this on as a department. Over the years the work really evolved to where we are now, it's really about *Connecticut* addressing this issue; HART was no longer about just DCF; we're a partner, and we have lots and lots of partners right now. That's how HART has evolved into this tremendous statewide effort.

MS. ANDERSON: What can you share about what the work is like, and what the challenges are that the individuals are facing as you bring them into care?

MS. SNEED: There's lots of challenges but I always like to start with the strengths. These kids are resilient. When you look at what these kids have gone through, they are *really* resilient kids, but they need those supports and services. They need some very specific things put in place so they can truly exit the life and become successful adults.

And it's a challenge. I think one of our biggest challenges in the state is services: having enough services in our state to meet the needs of the kids. And at the same time, we are seeing a significant uptick in regard to the number of kids that are being victimized. We've had some service development over the years, but now, the number of kids we're getting, our service development hasn't been able to catch up. And it takes very special providers to do this work.

When I teach about human trafficking and child trafficking, I talk a lot about the similarities to domestic violence. Lots of times, these kids don't want help, so when we're bringing these kids in, when they're being recovered, or they're being picked up by their parents, they don't necessarily want to come back into a safe and sound environment. And it's not their fault. Because of what they went through, because of their histories of trauma, it's a process for them. But sometimes it's really hard for adults, the general communities, and even other professionals, to understand that dynamic. We then start to blame the kid for not wanting to come back in, when we should be really thinking about, "What are some of the things we can put into place so they actually do want to come back in?" We have to weather that storm with them.

MS. ANDERSON: I think about the trauma this has to have on the individuals. Are there any specific things being developed by your service system to help these kids with the trauma in their lives, or are there any specific treatment models being implemented?

MS. SNEED: It's interesting; right now, across the country, there's no evidence-based treatment specifically for this population. We're seeing some evidence-based treatments do some promising work with victims, but really no evidence-based program for these types of victims, whether you're talking about kids or adults. There's lots of research being done, so I think we're going to have some good stuff in the future. They have been looking at TF-CBT (Trauma-Focused Cognitive Behavioral Therapy) as a possible treatment for this population, but the kids are very, very unique.

What is interesting, and what we've learned about this, is many times—I would say 90-plus percent of the time—these kids have prior histories of abuse and neglect: trauma. And we might bring them back into care, right? And we may be saying, "All right, we have to address this trafficking. We have to get this to stop, we have to keep them safe," and kids have told us, and we have learned, that oftentimes it's not the trafficking itself that needs to be the primary area that we're addressing in the immediate; lots of time the kids will tell us, "It's not what's happening to me right now, it's the fact that my dad sexually abused me for 5 years of my life. And now I'm in this situation, and at least this person is consistent in my life." One kid told me that her trafficker was the first person that got her cough medicine and soup when she was sick.

So a lot of this is about fulfilling the needs of the kids at that moment, and then we can get into that clinical piece, and we need to find out what do they need at that point. And it's not automatic—"All right, we need to get this kid into this particular treatment program"—it's a process for them.

MS. ANDERSON: It sounds like before these kids are even in the system for trafficking, they've already had quite a few ACEs (Adverse Childhood Experiences), and then this just compounds those adverse experiences. If there is not yet any evidence-based treatment specific to child trafficking, what are important things that you would suggest therapists keep in mind in the work they're doing with these individuals?

MS. SNEED: I think the most important piece, whether you're talking about therapists or any other treatment provider that's working with these kids, is consistency. They need that consistency. They need unconditional support, even when they go back and they make some really unsafe decisions, and then they're coming back in again. Some of the data tells us that kids and adults will go back to the life seven times on average: very similar to domestic violence. So the life is filling something for them that they have not been able to fulfill themselves, or through their families. And we have to figure out what that is and provide those positive supports, that adult in their life who's going to be consistent, even if they make some bad choices the first few times around. Who's still going to be there for them.

When we're talking about the therapist, it's really important that they're consistent, that they follow through with the kid. With these kids, you can't tell them you're going to do something and not do

it, because it takes a lot of time to build trust with them. And even in that clinical setting, you're not going to get their trust for a while. It's going to take time for them.

Really, it's about that consistency—it's about building that trust with them and being unconditional. It's not about judging them or scaring them or telling them that what they're doing is dangerous. It's all about being on that journey with them.

MS. ANDERSON: That must be really hard, because we know within the behavioral health system, there's been a lot of turnover during COVID, and a lot of agencies are struggling to invest in the education of clinicians who will stay with them long enough to employ what they've learned. Is that affecting the work in any way?

MS. SNEED: Absolutely. And we're seeing that across the board with this population, with the clinicians. They may have a case manager that they're working with, even in child welfare. If their worker changes, any kind of relationship with these kids that continues to be changed, hurts the progress of that child. I'll give you an example: we had a foster mom that was amazing with this population, and she had a kid, and the kid on occasion would take off. And the mom did a marvelous job doing safety planning with the kid, in this case it was a girl, talking to her about, you know, "If you end up taking off, I don't want you to, but if you do, alright, I want you to call me at this number when you need some help. I want you to know that if you can't get me—for some reason, I don't answer the phone—I want you to know that this person who is my sister, she's going to pick up the phone," but really being planful with the kids. And then, when they come back, it's not about, "Alright, you're grounded, I want your phone," it's really about, "I am so glad you're back. I was really worried about you."

Sure, there could be consequences, but none of it should be a surprise to these kids. So really having that kind of approach that it's going to be a journey with them. It's not going to be that quick turnaround, and that consistency is important.

If that foster mom were to give up after that second time that kid ran away, and that kid goes into another foster home, it becomes almost impossible for that kid to really make that connection that they need. So we need that person to be there for the long haul and celebrate the little successes. That's the other piece here: when I train our providers, our congregate care providers, it's not *if* they're going to run, it's *when* they're going to run. But if you notice that this kid typically takes off every time this person calls her, and then she's gone for 4 or 5 days, and suddenly you're seeing that it's been a week and a half and she hasn't gone anywhere—make notice of that. That is awesome, right? "I'm really, really happy that you're home more often." And maybe the next time it's 2 or 3 weeks they go without taking off, and that's success for these kids. But it's that person on that journey with them still being there when they say, "Alright, I'm ready to come back home."

MS. ANDERSON: And it sounds like it's a multi-family approach, and if the individual's family is a foster parent, the parent needs to be involved in the treatment and the planning in order to ensure that they learn the skills they need to recognize the success, even though it may seem small to us.

MS. SNEED: Absolutely. And the other important piece in this is whether it's a foster family, whether it's biological family or kin that's working with these kids, that's really stressful. If you know a kid is going back to their trafficker, and every time they are with them, they get beat up—physically beat up—and now that child makes that decision to go back again, that's *hard*. You're there. You're thinking, "Oh my goodness, what is going to happen to this child?" It's hard, and they need support, too.

Early on in this work, I remember a foster parent making all the calls, her kid took off, and she was scared to death for this kid. And one of the reactions from the agency that was working with this foster mom was, "Well, you did all the right things, so just go get some sleep now." That mom's not going to sleep, right? What are some of the other things you could talk to mom about to help her kind of take this down a little bit, so maybe she can go relax later? But it's not about, "Alright, you made the call, go get some sleep."

MS. ANDERSON: Teaching them even about the healing arts and some of the mindfulness meditations and things they could do to nurture themselves, because they're in these high stress situations.

MS. SNEED: Absolutely, and then talking to them about vicarious trauma, right? It's tough, it's really tough work, whether it's your kid or not. It's really, really tough, because you want to keep these kids safe. But a lot of it is counterintuitive. We tend to think, let's take their phone, let's take their computers, take, take, take, take, take, right. And I've done it, I've raised five kids. I've done it. But with these kids, and with kids in general, they're going to still get the technology. They are amazing at finding ways to be able to communicate. It's more about how you safety plan. "So you have a phone, I don't want you to go, I'm really concerned about this person," having those really tough discussions with them, and at the end of the day, putting that phone number in there so when they are ready to come back, they can get the help that they need.

MS. ANDERSON: What keeps you going? This work seems so hard.

MS. SNEED: Well, it's twofold. Professionally, with HART we have about 1,000 members across the State of Connecticut. We have amazing providers. We have amazing HART liaisons at DCF, MDT Coordinators, law enforcement partners that are phenomenal, so it really feels like we're all in it together. It's not weighing heavy on any one person, and I think that helps a lot. So if I'm having a couple of bad days, or we had a case that really didn't go well, and I'm really, really worried, we support each other. And then the other thing is, like you said, having my own personal boundaries. Spending time with my family.

I got invited to an event on a Saturday in September, where there's a lot of stuff going on during the week, and I said I can't do it. I'm going to be with my family that weekend. Because you have to take care of yourself, too.

MS. ANDERSON: If there was one thing everyone should know about human trafficking, what would it be?

MS. SNEED: It is happening everywhere. And it's not just kids that score high in the ACEs. Yes, we see the vast majority of kids have prior histories of abuse and neglect, scoring high in the ACEs. But we do have a decent number of kids that are coming from the perfect home, with everything in place, without any kind of histories, being lured in. Because the challenge is—and I think this is really important—kids have normalized this behavior. And until we start to educate kids about what this is,

we're not going to be able to reduce those numbers. And we have curricula to educate kids, right? We do. And kids have told us, kids that have been victimized and been in the life, they have told us very directly that they wish they knew about this before it happened to them.

MS. ANDERSON: So it's not something that's in all the schools at this point.

MS. SNEED: It's not. In Connecticut, every school faculty person has to be trained within 6 months of hire, and then every 3 years. Some schools are amazing, they are all over this, doing a great job—and some schools are not in compliance.

The schools that are doing amazing work in this are also bringing us in to teach and educate parents, and they're also bringing us in to educate the kids. But until we can get in front of those schools, it's an upward battle at this point. It's probably the most important thing we can do, and it's interesting; even when I've had schools that are resistant, but brought us in because of legislation, they've told me at the end, "This is so important, we don't know why we were so resistant," and they start to identify kids. They're like, "Oh my goodness, we have this kid, and now I'm looking at this kid and I'm like, 'That is probably what was happening to them.'" It's just getting this in front of people: once you hear about child trafficking, there is no going back.

I will tell you, parents have gotten us into schools much easier than any other means. They'll come to a community training, they'll say, "Why aren't you in this school?" I'm like, "We send a letter to everybody, we're happy to be there, but we just haven't been invited yet," and lo and behold! We get invited in.

MS. ANDERSON: Is there anything else you want to share before we end our talk?

MS. SNEED: I think we hit on the most important piece, which is education, but it's education for all of us. We need more community events, because the information is not out there. One thing I keep saying is, we need more public service announcements. People in general need to understand that this is happening. When I looked at the data through COVID—from 2020 to 2022, watching the trends—and then looked at our data prior to COVID, right now, we are at the highest peak we've ever been. The last quarter, from April, May, and June of this year, we had 100 new referrals. We have never had that many referrals since we started this work, probably 15 years ago. It's very, very scary.

And at the same time, there was some data released from the National Center For Missing and Exploited Children that there's been a 98% increase with traffickers trying to lure kids in online. So the other educational piece, right here in front of us, is Internet safety. We do some trainings. Parents need to get educated. It is so important, because we're seeing kids as young as 7, 8, 9 years old, being lured in by bad actors on the internet, and really bad things happen. We have a lot to do, a lot of education. Everybody needs to understand this—we really have to get to the prevention piece!

To request training please reach out to DCFHART@CT.GOV.

For more information on DCF HART, visit: https://portal.ct.gov/DCF/HART/Home

This interview has been abridged for length and clarity.
To listen to the full version, visit:
www.womensconsortium.org/podcasts

Who's Been Reading Trauma Matters? Carol Huckaby!

Carol Huckaby is the Board President for the Connecticut Women's Consortium. She has a master's degree in community psychology from the University of New Haven and a master's degree in Women's Studies from Southern Connecticut State University. Carol has over thirty-five years' experience training organizations and non-profit agencies in a variety of topics. She currently serves as the Director of the Master of Science in Human Services program at Albertus Magnus College in New Haven. Her areas of interest include the effects of trauma, race, gender, and class for marginalized women. Prior to her role at Albertus Magnus College, Carol served as the Statewide Director of Programs for the Connecticut Council of Family Service Agencies and Director of Education and Training for the Connecticut Women's Consortium.

Carol Huckaby, Board President of the Connecticut Women's Consortium

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www.womensconsortium.org

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