Questions and Answers

Note: Please note, responses in blue were provided by the presenters, Dr. Stephanie Covington and Dr. Nena Messina.

10/26/20

The Association between ACEs...

Do we have any idea of how suppressed the numbers are for reported abuse from men, given the stigma that still exists in reporting being a victim of abuse (we find a frequent lack of reporting with juvenile males...)?

Dr. Covington: No, we don’t know how suppressed the numbers might be. However, we do find that men will share more openly about their experiences when they have a sense of safety and respect in group.

Why would you feel that "Historical Culture" be factored in or studied only for the last 15 years?

From a participant to everyone: I think that this kind of research has only gained the momentum or importance it deserves within the last 15 years. It is unfortunate for sure.

Dr. Covington: There has been a history of denial in our country in terms of structural racism. Therefore, some of the truth surrounding Columbus and Native Americans, Japanese families in internment camps during WWII, and slavery as a precursor to the deep-seated racism of today has been “hidden.”
What is the correlation/causation between the chronic health conditions and the score of 4+ on the ACEs?

Dr. Covington: The original and subsequent ACE studies indicate that people with a score of 4 or more ACEs experience a higher risk for chronic health problems. This has helped us to understand that trauma can have a physical component as well as a psychological one.

Dr. Messina: See the papers on the reference list. The findings are of correlations and show the increased risk of ACEs related to earlier and chronic substance use and other factors also associated with poorer health outcomes.

How likely are men to report sexual abuse?

From a participant to everyone: I have found the stronger the rapport, the more likely a male will reveal sexual abuse, especially if there is a foundation of compassion.

Dr. Covington: Yes, this is our experience also. In a safe and trusting group, once one man begins to share, others will also share their experiences.

Why are community traumas not included in the ACE study (community violence, natural disaster)? Many of the people in prison come from communities high in violence.

Dr. Covington: When the original ACE questions were designed for the first study, they focused on early childhood events. In order to be able to compare data other researchers needed to use the same questions. This is not to minimize other types of traumatic events.

Dr. Messina: The questions regarding natural disasters, witnessing community violence, etc. are questions that are found in the DSM V and screeners for PTSD. ACE questionnaires are not diagnostic tools. They are only a set of questions related to abuse and household dysfunction.

Are any of the ACEs more impactful, in general, than others?

Dr. Covington: This really depends on the individual. People have differences in their vulnerability.

Dr. Messina: What is found in the literature is that ACEs are highly correlated, meaning multiple types occur together. Some types of ACEs appear to have a different impact on current trauma for women than for men, statistically, see the
Messina, et al., 2010 paper comparing men and women in prison on ACEs and impact on current trauma.

How do you verify between actual trauma and manipulation?

**Dr. Covington:** People who study manipulation have found that the more people experience powerlessness, the more likely they are to use manipulation to meet their needs. A criminal justice setting is one in which many people experience a sense of powerlessness. It is always best to err on the side of trauma as the truth...and help someone feel empowered.

Are there any resources for how to address/inquire as to traumatic events during presentence/psychosocial assessments?

**Dr. Covington:** There are a number of assessment tools. However, there is no reason to do assessments (of anything) unless you plan to provide resources.

Is it true that you should be trained in trauma to ask about it?

**Dr. Covington:** Yes and no. It is very helpful to learn some basics about trauma for your own education and whenever you are working with people. We use peer facilitators in many of our programs and they have basic knowledge.

Does trauma experienced as an adult impact people differently than trauma experienced as children? How so?

**Dr. Covington:** The impact of trauma depends on many factors. However, we do think trauma is often more impactful on children because they are still in development and have fewer internal resources.

**Dr. Messina:** There is also some evidence from the ACEs studies indicating the impact on child development.

As someone who works in intimate partner violence, your book *Beyond Violence* has been immensely helpful. What would be your suggestions for holding women accountable for their violence WHILE still validating their traumatic experiences?

**Dr. Covington:** I am glad you are finding *Beyond Violence* helpful. As you know, BV addresses both the violence women have perpetrated as well as the violence they have experienced. There are particular sessions that focus on what women have done. Our experience is that the program facilitates accountability especially in some of the final sessions.
What are effective interventions for getting inmates in the prison setting to open up? Have done group therapy on PTSD, but it is very difficult in that setting, given the setting and inmates' fears that information will leave the group room.

Dr. Covington: Part of running a group focusing on trauma is developing trust in the group. I suggest you pilot Healing Trauma for women and/or Exploring Trauma for men. Even within these short (6 sessions) interventions trust is established and there is sharing.

Are there any evidenced based programs out there that specifically address trauma?

Dr. Covington: Yes, there is a list on some of the slides at the end of the second webinar.

Would utilizing the ACES questionnaire be a good start to understanding the level of possible trauma one has experienced and directing them to appropriate treatment?

Dr. Messina to everyone: If you are going to use the ACE survey, you should be ready to do something with it. Be prepared to deliver the appropriate services.

Now that there are studies on trauma and ACEs, have there been any studies on people who’ve overcome or learn to live with adverse childhood effects from their trauma?

Dr. Covington: Yes, there are studies on resilience and post-traumatic growth. You can probably google these.

Dr. Messina: I think there is also a belief that there are many people who have had ACEs that did not develop lifelong problems or patterns of abuse, thus, perhaps due to some level of resiliency?

I think there is a difference in administering the ACE to adults as to juveniles in correctional/detention facilities? Any work on this?

Dr. Covington: One of the reasons we include the ACE questions for youth, as well as adults, is that it gives them a way to look at and understand their lives. It is often said, “This helps me to connect the dots.”

Has any of your research focused on using the eye movement treatment for PTSD/Trauma with correctional populations?

Dr. Covington: I have been trained in Eye Movement Desensitization and Reprocessing (EMDR) and Emotional Freedom Technique (EFT… tapping). EMDR requires specialized training so this is not used in the interventions I have written. Tapping is a resource used in some of the materials.
Any comment about DBT (Dialectical Behavioral Therapy) for trauma in prisons?

Dr. Covington: Yes, I think DBT can be useful.

Is there curriculum developed to help train those working in correctional settings to better understand and respond to ACEs and trauma?

Dr. Covington: Yes, we have two training curricula: Becoming Trauma Informed for those working with adults and another for those working with youth.

You said 2 people can experience the same trauma where one could react to the trauma and the other may not. Is it due to protective factors or anything else?

From a participant to everyone: Supportive environment, personal resilience.

Dr. Covington: (physical and emotional). Also have a supportive and loving person around you, especially in childhood.

How do you provide these services if you don't have "cooperation" of security staff/administration?

Dr. Covington: Providing any service in a correctional environment requires the support of the administration. Often this is not 100% but it does need the support of some key personnel. In terms of security, it can be more mixed. Sometimes we do our work “in spite of.” Staff training where the staff learn about their own traumas and you help them with self-care makes a big difference.

Dr. Messina: Also, now that there is evidence available, it is easier to substantiate what your suggestions are.

I see the ACES study being considered for increasing treatment within the criminal justice system, however, do you see it being used to help offer treatment services for victims/survivors before they might get involved in the criminal justice system?

Dr. Covington: Yes, this questionnaire is used by many community-based, non-cj programs, including schools, hospitals, mental health services, etc. The big issue after you ask the ACE questions - is then to provide trauma services.
Do you believe trauma could be a mandatory group in the prison system?

*Dr. Covington:* I don’t believe in mandating trauma services. If you provide a group experience where the prison residents feel it’s beneficial, then the word goes out on the yard. We have long waiting lists of 500 people volunteering for the programs.

Looking forward to suggestions for how to help adults with high ACE scores.

*Dr. Covington:* You can find information on specific interventions on one of two websites: stephaniecovington.com and centerforgenderandjustice.org

My cousin and I both experienced the exact same traumas, however, have reacted differently. I work in the CJ system, while he is using drugs and not working. Why do you think this is? He is male, I’m female. That is the only thing that is different. We both have an ACE score of 6. How can I get him to understand this and get help?

*Dr. Covington:* Helping people can be very difficult, especially with drugs involved. You may be able to tell him you have been learning about trauma and realize that many drug users started to use in order to deal with painful life experiences. You can also let him know you are concerned and would help him to find assistance. Just an FYI, there are more differences than male-female. Individuals always have different physical and psychological make-up... and experience the same environment differently.
I have always heard that anyone doing trauma work has to have a graduate degree. But I think you are saying something different. Please explain.

**Dr. Covington:** There are many levels of trauma work. We have peers facilitating trauma-specific interventions. Personal qualities (respect, compassion, commitment, etc.) are the things most important for facilitators.

Can trauma be passed inter-generationally. Such as Residential School Survivors in Canada?

**Dr. Covington:** Yes. Part of the ACE discussion in the 1st series was the discussion of inter-generational trauma.

What about cutters?

**Dr. Covington:** Self-harm is one of the possible responses to trauma. It can be understood as a form of communication and each person may be communicating something different. It can be a cry for help, a sign of self-hatred, a way to feel alive, etc.

Is there evidence to suggest that trauma results in a disruption of communication between left and right hemispheres?

**Dr. Covington:** Yes, this is why EMDR (mentioned above) can be helpful. It helps to reintegrate the brain.

Do small groups work better for some and large for others? Some people are very resistant to groups and it creates more fear. Can it work with just one or two where trust can be built?

**Dr. Covington:** Groups are recommended for work on trauma and size is usually 4-8. However, you can still work with 2-3 but slightly larger is better. Ten group members would be the maximum.
Is there an ideal way to get the incarcerated/residents in a DOC facility to express their trauma in a group setting?

From a participant to everyone: We are relatively successful when we put individuals who have experienced similar traumas in a group together, i.e. combat veterans.

Dr. Covington: This is one possibility. We also conduct groups with a variety of traumatic experiences. It is important for there to be separate groups for men and women. Please look at the trauma-focused interventions we have suggested. We never require anyone to discuss an event unless they want to. Discussing the event is not essential for healing to take place.

Dr. Messina: Yes, currently using a manualized curricula that guides the experience is what is needed. It is not something that should be left to open discussion but to a guided discussion.

Are you aware of any Dialectical Behavioral Therapy research in a Justice Facility setting?

Dr. Covington: No, I don’t.

Will any of these webinars include creating trauma-informed institutional (jail) physical environments, custody-staff training, and specialized treatment and program for SMI and non SMI populations?

From a participant to everyone: Men in Recovery by Stephanie Covington works well.

Dr. Covington: Yes, webinars 2 and 3 discussed these topics.

Which one of these would be best for Juveniles? Are they just for adults?

Dr. Covington: For adolescents, we have Voices for girls and A Young Man’s Guide to Self-Mastery for boys. Descriptions on the stephaniecovington.com website.
Could you discuss helping those who have fear of ongoing trauma, i.e., inmate with fear of what could happen/re-occur when they are deported to their home countries? Many were victimized in many ways and fear that happening again. Some are now open about their LGBTQI in the US, but their country of origin is not welcoming of this.

**Dr. Covington:** Helping people to find ways to be safe is important and sometimes the options are very limited. Teaching grounding exercises often helps people cope with their anxiety and depression.

Is there evidence to support reduced recidivism rates for participants over a period of time with corrections populations?

**Dr. Covington:** We have evidence of reduced recidivism when *Beyond Violence, Helping Women Recover* and *Beyond Trauma* have been implemented in a CJ setting.

Why is a guided session to address trauma in a group setting more encouraged than an open-discussion format? What are the consequences of doing it in an open-discussion format? If we are unable to provide a guided manual, should we avoid discussion about trauma?

**From a participant:** Some healing needs to occur before moving to open discussion.

**Dr. Covington:** Having a structured group is a more therapeutically sound practice when working with survivors because it helps to build a sense of trust. The group structure is the same each week and therefore, is predictable. This is also helpful when people feel internally fragmented. There are guided manuals available.

How do you screen for appropriateness of participants and their readiness for trauma treatment? How do you approach keeping participants safe/stable in between group sessions when they are interacting in the milieu and the therapeutic work they are doing could be triggering them in the prison setting?

**Dr. Covington:** We do not screen people in or out of our groups...they volunteer. I only suggest screening out someone who is unable to participate and benefit from the group due to SMI without appropriate medication. We have found that group members support each other between sessions and they learn ways to manage their triggers.

**From a participant to everyone:** Thorough screening of group members is also critical to make sure they are appropriate to participate in the program.
Is there recidivism data you can present on these programs?

**Dr. Covington:** We only have recidivism rates for programs that were funded to track people upon release. See note above about those programs.

What pre/post assessment tools are used in the research that NENA is discussing?

**Dr. Covington:** On the Envisioning Justice Solutions and stephaniecovington.com websites you will find the research papers that list the assessment tools used.

What evaluation tools were used for the outcomes?

See the above answer.

I would also like to know "Have any of these programs been used or shown effectiveness with youth (ages 13-17 years old)?"

**Dr. Covington:** We have a large ongoing RCT (Randomized Controlled Trial) project on Voices for girls, as well as early information from pilot groups. For boys and A Young Man's Guide to Self-Mastery we have pilot information.

In your ACE's assessments what questions do you use for experiences and environments?

**Dr. Covington:** The original 10 ACE questions are very specific for experiences and environments.

Is Beyond Violence specific to women that perpetuated violence or been victims of violence?

**From Dr. Messina to everyone:** Beyond Violence is created for women who have histories of violence as well as those who have perpetrated violence. There are published papers on the results of these studies from both California and Michigan corrections.

Is there facilitator training for Beyond Violence?

**Dr. Covington:** Yes, facilitator training is available for all the program materials. In addition, the facilitator guides are very complete.
Why is a guided session to address trauma in a group setting more encouraged than an open-discussion format? What are the consequences of doing it in an open-discussion format? If we are unable to provide a guided manual, should we avoid discussion about trauma?

**From a participant:** Many times, if it isn't guided, it can derail and cause harm when folks are initially disclosing trauma. Some healing needs to occur before moving to open discussion.

See earlier answer to similar question.

Are individuals who complete the program less likely engage in behavior that put them in the SHU?

**From a participant to everyone:** Yes - warden at our women's prison states she has observed a significant change for the better in inmate behavior during and after completion of the program.

**Dr. Messina:** Yes, we have seen reductions in violence, reductions in levels of risk, and releases of lifers.

Which specific instruments did you use in your brief therapy program to measure depression, anger, anxiety, etc?

**Dr. Covington:** See answer above about two websites with the research papers listing the instruments used.

Any information/recommendation for trauma responsive curricula/programming for youth/teens would be greatly appreciated.

**Dr. Covington:** *Voices for girls* and *A Young Man’s Guide* for boys. Can find descriptions on website: stephaniecovington.com

What books or workbooks would you recommend for a small jail where the average individual is here less than 7 days?

**Dr. Covington:** For starters I suggest using the *Brief Conversation*... see prompt on home page of website: stephaniecovington.com
Becoming Trauma Informed and Moving to Trauma Responsive

What if the prison rehabilitation is healthier than their communities? Considering the social determinants of health? In the inner city of Chicago would this work? Disinvestment is a seed to the school to prison pipeline.

Dr. Covington: When communities are struggling it’s even more important to do this work.

Has there been any research concerning any negative impact that having children 'imprisoned' with their mothers has on children?

Dr. Messina: Sometimes in other countries, young children might have nowhere else to go other than to stay with their mothers. It may be the safest place, given the environment in prison is not what you might envision.

When they changed the wording in signage did they see a meaningful impact on the population seeking services?

Dr. Covington: Yes, even changing the signage can begin to change the environment. It is a step, not the destination.

What impacts do we see for the correctional staff? More job satisfaction? Decreased turnover?

Dr. Covington: Yes, plus a safer environment.

Dr. Messina: Yes, one of the things I often hear from the staff and wardens is the change in staff attitude, the change of the overall feel of the yard and the buy in for the program and culture change. Also, when someone who is trained leaves a particular facility, they ask to have the training brought to their new facility.

There are some cultures that do not embrace outside help due to fear of spouse or family member. How do we reach out to them?

Dr. Covington: In addition to the programs being voluntary, the “word on the yard” is what motivates people to want to participate. Many diverse cultures are in the groups.
Have there been any cost/benefit analyses which takes into consideration these positive impacts on both residents and corrections officers?

**Dr. Covington:** None that we know of. This is an important consideration moving forward.

Anyone know of a trauma informed facility for mental health in UTAH?

**Dr. Covington:** Sorry, no.

How can I get a reference for the difference in ACEs among men and women?

**Dr. Covington:** I think this research paper by Dr. Messina will be listed in the resource section for these webinars.

In addition to changing the environment, has consideration been given to change the look of inmate clothing and traditional prison outfits?

**Dr. Covington:** Yes, different jurisdictions do different things. This is more common in Scandinavian prisons than in US.

Do you feel that this is just a Pygmalion effect?

**Dr. Covington:** No. It can increase a sense of dignity and respect.

Do you have a list compiled of the various facilities that have made these changes?

**Dr. Covington:** If you email me directly, I can give you a partial list.

From a participant to everyone: I once ran a drug and alcohol facility for adolescent females. I ensured all of my staff were trained in trauma responsive training which helped in not only understanding our population but helped improve safety amongst staff and residents. Do you think this should be mandatory in all detention and correctional facilities?

**Dr. Covington:** Yes, it is very important.

Are there tools those of us working in community corrections could use?

**Dr. Covington:** Yes. The materials we have discussed are used in the community and in custodial settings. Some of the programs have two versions: one for CJ and one for community.
The ACEs (original) is not representatives of people of color. I know there are other versions of ACEs which includes discrimination, bullying, etc. Do you know if these revised tools are validated?

**Dr. Covington:** WHO has adapted the original ACE questions and Philadelphia also has an adapted list. I do not know about validation.

**Dr. Messina:** Very good question, the new version are taking into account environment. But yes, most of the ACEs are taking into account household dysfunction. But that is not necessarily culturally unrepresentative. I think maybe you are referring to symptomology of PTSD, whereby some symptoms may be ordinary life for inner city life...such as witnessing violence/death.

Comment from a participant to everyone: I actually administer the ACEs to high school students as a preventive tool and recently expanded it to include racial discrimination, witnessing violence, bullying, witnessing someone in the household who had a suicide attempt, and the violence items have now topped the charts among all other items in the survey. We work with primarily youth of color.

**Dr. Messina** to everyone: Please be careful. The ACE questionnaire is only that. A questionnaire. Without appropriate services, you are only asking questions.

Comment from a participant to everyone: Ms. Covington I feel honored to put a face to the author of the amazing curriculum that I have utilized in facilitating groups with both men and the women in a residential treatment facility for alcohol and substance abuse. It produces phenomenal outcomes.

Is there a practice that can help us educate victims/the community to help them understand that these changes aren't taking away from the "punishment" of an offender, but it is helping to create a better life & prevent further harm to them & others when these people are released?

**Dr. Covington:** People need to understand that the courts determine sentences as punishment and the prisons are for rehabilitation. Also, restorative justice often helps the community to see the value of programming in prisons.