

HEALING HANDS



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Homelessness & Family Trauma: The Case for Early Intervention

This edition of Healing Hands presents an overview of one of the most pressing issues confronting homeless families and clinicians that serve them — the effects of domestic violence, abuse and neglect on young children. The following articles discuss conditions under which clinical interventions are warranted and report strategies used by HCH practitioners to prevent the intergenerational cycle of trauma and homelessness from recurring. Two workshops offered at the National HCH Conference on May 30, described on page 6, will explore these issues in more detail.

Sonya is a composite of many shelter children, but her story is typical. You will find children like her in almost any family shelter. Like Sonya, many homeless children face daily struggles in almost every facet of their lives as they move from place to place with their families, often several times within a school year. Congregate living in shelters or with multiple families in housing intended for only one enhances their exposure to contagious diseases. Without easy access to health care, chronic illnesses are often undetected and untreated until they become emergencies. Hunger, interrupted sleep, and the stress of itinerant living frequently interfere with normal development and school performance.

At least 1.35 million children are homeless at some time during the year, representing about 30% of people known to be homeless in the United States, and more than 40% of homeless children are under the age of five.^{1,2} Those seen by HCH clinicians are usually accompanied by single, homeless mothers, struggling to manage the dual roles of wage earner and homemaker without a place to call home. More than 90% of these women have been victimized by severe physical, sexual or emotional abuse by intimate partners or spouses, and 43% were sexually molested as children.^{3,4,5} As a result, many suffer from posttraumatic stress disorder (PTSD). In many homeless families, the children witness violence regularly and are at risk for developmental delays, behavioral problems, and repetition of the cycle of trauma and maltreatment.

Sonya is a slight, inquisitive seven-year-old girl living with her mother and younger brother in a shelter, homeless for the second time. Sonya is very protective of her little brother, and people sometimes call her "little mommy." Between stays, she lived with her paternal grandmother and her aunt, as well as in a car with her mother. She switched schools four times in the last two years, and skipped nursery school and kindergarten. Sonya struggles to keep up in second grade, but is clearly bright and shows great effort. Some mornings she is hungry and can't concentrate. She has missed many school days because of asthma. Sonya's natural curiosity sometimes results in scolding by adults. Her mother keeps many appointments in search of housing and her welfare-to-work program. She is not always available to help Sonya with her daily needs. Yet Sonya's mother is affectionate with her children, and her father visits the children weekly.

Rachel Kirzner, MSW, Philadelphia, Pennsylvania

"Although homeless women report more painful and chronic health conditions than other low-income women, they perceive many barriers to health care," explains **Ellen Bassuk, MD**, Director of the National Center on Family Homelessness in Newton Centre, Massachusetts. A mother who fears authority figures or being touched may be reluctant

to seek medical care for herself or her children. Keeping clinical appointments may be impossible for a parent who is unable to afford childcare or take time off from work. “These women can’t sit in a waiting room for 45 minutes,” remarks Bassuk, whose research focuses on the effects of trauma on poor and homeless women and their children.^{6,7}

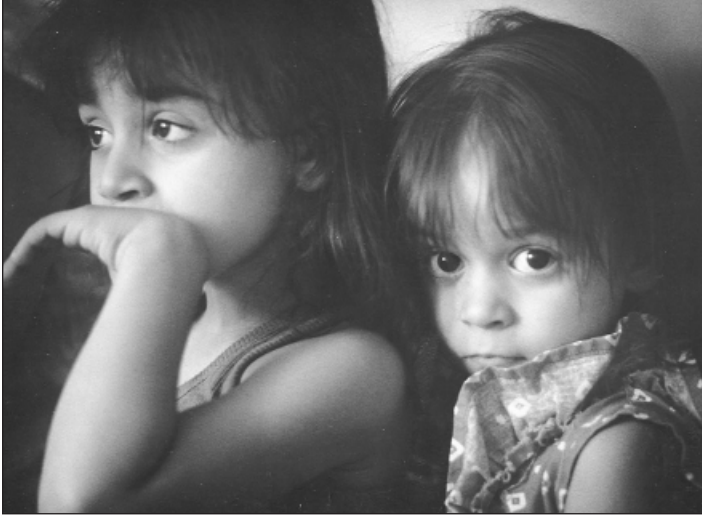


Photo by the National Center on Family Homelessness

EFFECTS OF TRAUMA ON MOTHERS Violence is such an everyday experience for many homeless mothers that they may not identify it as unusual. But the debilitating physical symptoms reported by these mothers point to family environments fraught with anger, threats and abuse, says **Cheryl Zlotnick, DrPH, RN**, Center for the Vulnerable Child at Children’s Hospital, Oakland, California. The parent’s problems and the child’s are intertwined.

“Trauma is the predominant mental health issue for homeless mothers, and is frequently but not inevitably linked to PTSD,” explains Bassuk. “Clinicians should be aware of the pathway of violence to clinical depression and frequent ‘self-medication’ with alcohol or illicit drugs. Every clinician who sees homeless women should ask about violence in their lives — perhaps not on the first or second visit, but after trust is gained. Questions about physical, emotional and sexual abuse should be asked in a sensitive way, reassuring the patient that violence and trauma are common.”

Most homeless mothers don’t see the connection between their own trauma and depression and developmental or behavioral problems that are evident in their child, but the earlier these problems are identified and addressed, the better the outcomes for both parent and child, says Zlotnick. Many HCH practitioners can identify trauma and its manifestations in the behavior of homeless children and do something to help, even if they aren’t mental health professionals qualified to diagnose PTSD. A formal diagnosis is not necessary for constructive action — only to initiate particular kinds of treatment that usually require referral to a specialist.

Clinicians must start early to break the intergenerational cycle of family homelessness, contends Zlotnick. Successful interventions can be intensive and time-consuming, but letting these mothers and their children fall through the cracks in fragmented service systems is even more costly.

EFFECTS OF TRAUMA ON CHILDREN Children’s earliest experiences are among the factors that determine their emotional health and achievements later in life. Their coping skills are shaped by relationships with their primary caregivers and other social interactions. In families with unstable housing, the parent-child relationship is particularly fragile, which can perpetuate the cycle of homelessness. Recent research supports the contention that early interventions to improve parenting skills and develop constructive responses to trauma by these mothers can foster normal emotional and cognitive development in their children.

Scientific evidence is growing that maltreatment of young children can “rewire” the developing brain, producing changes in both brain function and structure. Depression, aggressiveness, anxiety, memory problems, posttraumatic stress disorder, and attention deficit hyperactivity disorder (ADHD) are common results, according **Martin Teicher, MD, PhD**, Director of the Developmental Biopsychiatry Research Program at McLean Hospital, the largest psychiatric affiliate of Harvard Medical School.

Teicher and his research associates have found that childhood abuse is associated with diminished left brain development. “This finding may help explain why some survivors of childhood abuse have overly strong negative emotional responses (a key property of the right brain), and diminished capacity to use language and logic to evaluate options (a key property of the left brain).”⁸

Teicher has proposed investigating protective factors in the environment that may mitigate the impact of childhood maltreatment. “Genes are fundamentally involved in the overall architecture of the

WHAT HCH CLINICIANS CAN DO

1. Look for evidence of trauma in homeless families and assess its impact on children. As you gain the parent’s trust, explore the potential effects of homelessness, domestic violence, substance use, and/or mental illness on the child.
2. Do something effective with this information. For example, suggest strategies for dealing with tantrums (“acting out”), and model them so the mother can see what you mean.
3. Be gentle. Don’t make the parent feel that the child’s behavior problems are her/his fault.
4. Follow up; determine whether a referral to a mental health professional or other specialist is appropriate.

Cheryl Zlotnick, DrPH, RN, Oakland, California,

brain,” he explains. “The infant’s brain is like a sponge, with many more connections and neurons than an adult’s. But these lessen over time. We trade plasticity for processing speed as we age. Experience selects which connections remain. The environment sculpts the brain, and these changes persist into adulthood. We do not know how reversible they are.”

BEATING THE ODDS Some homeless people manage to lead stable adult lives despite a history of maltreatment in childhood. “A family member, service organization or teacher helped these homeless children beat the odds, graduate from school, and start new lives,” asserts **Susan Stephens-Groff, MD**, Medical Director and founder of the school-based clinic, Thomas J. Pappas School for Homeless Children, Phoenix, Arizona.

Mainstream mentoring programs are very helpful, but homeless children require long-term, intensive attention by adults as authority figures and role models. “Mental health is threatened, particularly for children with comorbidities or whose parents are incarcerated or chronically absent,” says Stephens-Groff, who mentored a homeless youth with severe asthma for ten years. One of six children by three fathers whose family was split up by Child Protective Services, the young man, now 20 years old, successfully attends a local university.

“Homeless children who succeed despite adversity have different motivations. Some are driven to succeed by anger at their parents and fear of living in poverty. Others have long-term, nurturing relationships with adults outside their families who help the children keep a balanced perspective. Yet these children love their parents despite homelessness,” she concludes. “No one should underestimate their amazing resilience. Regardless of their physical health and how often they relocate, these children manage to find the nearest school bus stop every morning.”

CLINICAL CHALLENGES HCH clinicians provide the first line of defense for homeless families and are strategically placed to build long-term relationships with parents and children. “Homeless health care clinics limited to primary care need a strong affiliation or collaborative relationship with at least one local mental health agency,” says Cheryl Zlotnick. “Within this agency, one or two known and trusted mental health professionals should be identified to whom HCH clinicians can make referrals.” Most important, clinicians should focus on the symptoms of trauma and maltreatment in homeless families and plan interventions that are developmentally appropriate for each child. ■

Ages & Stages of Development: When to Intervene

For two decades, one-parent families have been one of the fastest growing subgroups of the homeless population.² The typical homeless parent is 30 years old, with two children under age five.¹ These families sometimes move dozens of times before staying in shelters. Living in shelters is stressful for most people, but especially so for families that are fleeing domestic violence.

“Overcrowding, curfews and other shelter rules, plus the phenomenon of parenting in public rather than the privacy of a home, diminish the parent’s sense of autonomy and privacy,” observes Ellen Bassuk. “There are no play areas in shelters or places to store snacks. The threat of losing their children to state custody worries homeless mothers, and the children fear being placed in foster care.”

EARLY INTERVENTION A child’s behavior, the parent’s responses, school reports, and clinicians’ observations provide clues that are useful in determining whether clinical intervention is warranted. “When children witness violence, they get depressed,”

explains Bassuk. They may act aggressive and antisocial, or withdrawn and sad, but these are only clues, not obvious symptoms on which to base a diagnosis. “You need to find out what these children are experiencing in their lives.”

If problems are identified, the best time to intervene is in early childhood, before the threat of family separation becomes a reality, she advises. Child welfare, foster care, and criminal justice systems can further traumatize children. By adolescence, the negative effects of trauma and separation are more ingrained. Mental health interventions with young children may require ten to 30 face-to-face meetings in schools or shelters.

ATTACHMENT PROBLEMS

Homelessness is never the sole criterion for clinical intervention, but should alert clinicians to look for other circumstances behind a family’s problems, says **Lenore Rubin, PhD**, Department of Public Health, Seattle, Washington.

Research confirms that the strongest predictor of emotional and behavioral problems in poor and homeless children is their mother’s level of emotional distress.⁸ A traumatized mother who is depressed cannot fully attend to her child’s basic needs, and bonding and attachment problems may develop.

Bonding is the closeness between a birth mother and her child that develops during pregnancy and childbirth. Attachment is the long-term psychological and emotional connection between parents and children.

“Secure attachments in childhood are important because they foster self-esteem and cognitive development,” explains Rubin. “Although most cognitive and emotional development occurs before age five, each stage of a child’s life builds on the previous one.”

Parents who had poor attachments with their own parents tend to foster poor attachments with their children, observes Rubin. Traumatized children tend to be mistrustful and angry, want total control, and are unable to

form long-lasting relationships.

“Most parents want their children to be happy and successful, but those who have

been victimized by intergenerational violence need special support and help learning parenting skills that foster positive and secure attachments,” she concludes. “The

clinician’s priorities should be to give support, maximize appropriate care, and minimize stress for homeless families. ■

The Parent-Child Dyad: How to Intervene

Two intervention models are recommended for HCH settings by Zlotnick and Bassuk. One targets preschool children through behavioral contracts with youngsters who “act out” in public settings and their mothers. Another features separate psychoeducational groups for mothers with symptoms of posttraumatic stress disorder and their children.

BEHAVIORAL CONTRACTS At the Center for the Vulnerable Child in Oakland California, **Tracy Jones, BA**, provides one-on-one interventions with children enrolled in Head Start preschool programs through Project Spark. All homeless children or those determined to be at risk for homelessness have individualized treatment plans jointly developed by Project Spark and preschool staff, in collaboration with the children’s parents. The children and their parents work toward meeting targeted goals, supported by project staff. Jones normally meets with each child twice a week, for 60 to 90 minutes over several weeks up to a year, depending on the child’s situation and behavior.

Jones also provides case management for parents. For example, she helps mothers facing eviction find shelters that accommodate families on a short- or long-term basis and assists with job searches, health care, and mental health referrals. “The main focus of my work is supporting the parent-child relationship,” she says. “We are striving for better parenting skills and better child behaviors. Most parents want to build a more positive relationship with their children by learning and using effective ways to correct troubling behaviors without harsh discipline.”

An intervention is initiated when a Head Start teacher documents that a child demonstrates poor peer interaction, language difficulties, aggressiveness, withdrawal, or various inappropriate behaviors. The teacher notifies the school disabilities coordinator, who alerts Project Spark. After the parent signs a consent form, Jones conducts up to four classroom observations of the child. If there is a legitimate concern, a meeting is scheduled with the parent, teacher, Project Spark psychologist, and the child interventionist. The team then develops a written behavioral contract, setting goals for both the parent and the child, with the parent’s input and final approval.

One successful intervention concerned a child who refused to take naps at scheduled times. After the contract was approved, the project staff member developed a trusting relationship with the child in the classroom and discussed with him the importance of napping and not

bothering classmates. She proposed such solutions as bringing a favorite toy or playing soothing music at naptime. Another option was taking the child to the nap room before his peers. Desired behavior was continually rewarded with praise.

The mother contributes to good outcomes by detailing family history that may be at the root of her child’s problems and by providing clues to discrepancies between the child’s behavior with the mother and other adults. Jones gently asks the parent about the child’s social environment and events that triggered the family’s homelessness. Nonjudgmental questions about domestic violence, types of discipline employed, and the child’s experiences with other primary caregivers help to elicit relevant information. “A mom may be depressed or have low self-esteem prior to intervention, but when her child succeeds she is greatly encouraged, and a positive difference in her affect often results,” notes Jones.

PSYCHOEDUCATIONAL GROUPS Many group psychotherapy practices emphasize an open-ended, non-directive process. psychoeducational groups, however, have a set number of sessions and are focused on education and skill development. The facilitator, either an HCH staff member or a well-educated consumer, functions as a teacher and trainer. Participants engage in topical discussions and exercises, role-play and feedback. Shelter-based groups have limited but rolling enrollment. Ellen Bassuk recommends such groups for women with PTSD and separate groups for children.

“The purpose of psychoeducational groups is to discuss the effects of violence and reassure participants that their responses to horrific events are normal,” explains Bassuk. Group members learn how trauma affects them and how to cope with intrusive memories and flashbacks. Safety issues and plans are addressed, especially if the persons who abused them are still around and pose danger. A facilitator must monitor these groups because individual stories can sometimes be emotionally overwhelming for both the client and other group members.

SEPARATION The intervention of last resort is separating children from parents who are suspected of extreme or dangerous maltreatment of their children. Mandatory laws for reporting child abuse or neglect vary from state to state.⁹ ■

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"Children are our links to the future. By focusing on the children, we may be able to mitigate the effects of instability and all that is negatively associated with homelessness."

Susan Kline, MN, ARNP, Seattle, Washington

FIRST PEDIATRIC MINI-TRACK AT THE NATIONAL HCH CONFERENCE

The HCH Clinicians' Network is presenting a Pediatric Mini-Track during the 2003 National HCH Conference, May 29-31, in Washington, DC.

The Network's Pediatric Work Group and Education Committee have developed two workshops:

The Impact of Homelessness on the Development of Children and Adolescents

Friday, May 30, 8:30-10:00 a.m.

Presenter: Lenore Rubin, PhD

Designed to address issues from an interdisciplinary perspective, this workshop reviews developmental stages of infants, children and adolescents, specifically on the impact of homelessness on emotional health and development.

Highly recommended for participants who plan to attend the two-part intensive workshop on trauma.

Trauma: Addressing the Mental Health Concerns of Homeless Children, Adolescents, and Their Parents

Friday, May 30, at 10:30 a.m. (Part 1) and 2 p.m. (Part 2)

Presenters: Ellen L. Bassuk, MD, and Phoebe Soares, MSW

This intensive workshop focuses on the extent and nature of victimization, post-trauma responses and specific shelter-based group interventions for homeless mothers, children and unattached youth.

This two-part presentation is useful for new and experienced providers, plus those interested in program design.

For more information about the National HCH Conference, see <http://hchirc.com/conference/default.asp>.

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