

HEALING HANDS



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Trauma & Homelessness

Trauma — physical, sexual and emotional — is both a cause and a consequence of homelessness. Numerous studies conducted during the past decade identify domestic violence as a primary cause of homelessness in the United States, particularly for women and children, who now comprise approximately 40% of the homeless population. Between 22% and 50% of homeless women surveyed said they left their last residence to escape domestic violence.¹ The prevalence of severe interpersonal violence is significantly higher for women and children in families with incomes below the poverty level, and higher still for homeless women.²

Physical abuse during childhood is a powerful risk factor for adult homelessness,³ and violence experienced by children and adolescents often continues after they become homeless. Individuals flee abuse at home only to rediscover it on the streets or in shelters.

Those who are mentally ill or under the influence of drugs or alcohol are even more vulnerable to attack, and less likely or able to seek help afterwards.⁴ There is a strong correlation between physical/sexual abuse and alcohol or drug dependency among people who experience homelessness.⁵

A recent study in Massachusetts found that 92% of homeless women surveyed had experienced severe physical and/or sexual assault at some point in their lives — 60% by the age of 12. Given these high rates of violence, it is not surprising that many homeless women suffer from emotional symptoms, including major depression (47%), substance abuse (45%) and posttraumatic stress disorder (39%).²

Regardless of age or gender, homeless people are particularly vulnerable to injury, accident and assault. Trauma goes with the territory.

Guidance for Primary Care Clinicians

Trauma survivors are not always obvious to primary care clinicians, whose first encounter with them may be for an apparently unrelated physical complaint. Even when the index of suspicion for domestic violence or child abuse is high, caregivers must tread lightly to avoid discouraging clients from seeking further care. Clinicians must also weigh the moral and legal obligations of their professions regarding protection of client confidentiality, while re-building the trust in human relationships that has been shattered by the experience of trauma. This article provides basic information to help practitioners identify and care for trauma survivors, without further jeopardizing their clients' safety and psychological resiliency.

Clinical research over the past century has confirmed that the psychological effects of physical violence and/or sexual abuse persist long after the traumatic event. In her seminal work, *Trauma and Recovery*, Judith Herman, MD, reviews the history of these investigations, which demonstrate that trauma suffered by combat veterans or prisoners of war is similar in its psychological effects to domestic or other trauma inflicted during times of “peace.”

RECOGNIZING PTSD Posttraumatic stress disorder (PTSD) is the name given to the broad spectrum of psychological and somatic disorders characteristic of many trauma survivors. Complex PTSD describes the psycholog-

ical effects of prolonged trauma, which may be particularly severe in individuals subjected to physical/sexual abuse as young children.⁶

The psychological symptoms of PTSD fall within three main categories:⁶

- **Hyperarousal**, “the persistent expectation of danger:” startles easily, reacts irritably to small provocations, sleeps poorly.
- **Intrusion**, “repetitive reliving of the traumatic experience in thoughts, dreams and actions:” static, sensory flashbacks and nightmares accompanied by terror and rage.
- **Constriction**, “the numbing response of surrender:” detached states of calm or dissociation impeding voluntary action, initiative, critical judgment and perception of reality.

PTSD symptoms reflect the brain’s normal response to trauma; they are not evidence of psychosis.⁶

How can non-mental health practitioners relate these textbook definitions to their own practice? Clinicians must be sensitive to both verbal and nonverbal cues, says Maggie Hobbs, MSW, director of homeless outreach at Community Connections, a mental health clinic in Washington, DC. “Some clients report upsetting symptoms which are characteristic of trauma survivors, such as troubled sleep, nightmares and obsessive, frightening, violent thoughts. Physical symptoms may include vaginal pain or gagging, suffocating feelings, eating disorders or self-mutilation.”

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For many clients, disruptive or distracted behavior may be the only indication of past and/or present violence or abuse. “A client may go into a rage because she is not seen first, no matter how many others arrived before her,” notes Hobbs. “She may come to the office excessively dirty and smelly, or may use foul language. Or she may be quiet, detached and unresponsive when her name is called. She may refuse the most routine medical procedures, such as having a tongue depressor stuck in her mouth.”

Regardless of whether they have been labeled as sad, bad, or mad, most women who have been overwhelmed by their histories of trauma do not identify trauma as their main problem when they request or are referred for treatment.⁹

—Maxine Harris, PhD

APPROACHING THE TOPIC “Clinicians need to be flexible about introducing the topic of trauma,” cautions Jennifer Smith, PhD, a clinical-community psychologist at the 45th Street Clinic in Seattle, Washington. Smith does outreach at two domestic violence shelters and a general family and women’s shelter, where she sees a large number of trauma survivors. “There is no simple formula, but establishing trust first is essential,” she says.

Linda Ruble, PA/C, ARNP, medical director at South Side Center, an outreach clinic in Des Moines, Iowa, concurs. “First I establish rapport — learn something about the client, explain who I am and that we are here to help. When it begins to feel comfortable, I ask how things are going for the person generally — whether she is working, looking for a job, able to sleep, feeling OK, having trouble getting personal supplies.”

At some point, Ruble looks the client in the eye, expresses general concern for her safety, and gently asks, “Do you ever feel threatened or at risk of physical or sexual abuse? That is sometimes true of people in shelters or on the street.” Then she mentions available community services. If the client seems frightened, she leaves the information within easy reach

and excuses herself briefly from the room.

“This approach opens more doors for men, women and children than it closes,” Ruble says. “If clients seem turned off, I back off. If they are receptive but hesitant, I don’t talk about specifics, just say, ‘I know my questions are uncomfortable for you, but if you ever feel like it, let’s talk. We’re here for you if you need us.’ Providers should let the client set the pace.”

“Adult trauma survivors have to make up their own minds about how they are going to protect themselves, which is a very complicated process and potentially dangerous,” warns Smith. Women are most often successful in leaving when they have spent a lot of time carefully planning it beforehand; leaving impulsively incurs more risks. Once victims of domestic violence leave home, their vulnerability to murder or further harm from the perpetrator increases by 70%–75%.⁷

“Tread carefully,” advises Smith. “Give as much information as your client is ready to receive. Let her know there are resources available whenever she is ready for help, and ways to plan safely to escape from harm.”

For a wealth of information about clinical encounters with domestic violence victims, psychologist Anne Ganley, PhD, at the King County HCH in Seattle, recommends resource and training materials published by the Family Violence Prevention Fund.⁸

CONFIDENTIALITY LIMITS If a client is ready to discuss a traumatic experience, one of the ways in which Smith establishes trust at the outset is to discuss confidentiality guidelines in detail. She explains that because she works as part of a team at the clinic, she shares information relevant to clients’ care with her colleagues there. Nothing goes outside the clinic except in a few situations involving safety issues: if someone is in danger of hurting herself or someone else; if she learns of any abuse or neglect of a child or adult who can’t take care of her/himself, even if it happened years ago; or if she is ordered to testify or turn over records by a court (e.g., in child custody cases). These are the reporting requirements for a PhD in psychology in Washington State.

Legal and ethical constraints and customs about information sharing vary somewhat among professions and from state to state. Clinicians should know what their professional and legal requirements are.

Even after being told about legal obligations which might breach confidentiality, most of Smith’s clients are willing to continue therapy. Those who are hesitant are not pressed; their choice is respected. “The key thing is to be straight and honest. At every choice point, give the client enough information to make a clear decision, in a form that matches the level of readiness to handle and understand it.”

REFERRALS Smith advises medical practitioners to seek assistance from a caseworker or other mental health clinician only when the client is receptive to a referral. “Ask if she would like some support or help. Keep her confidence unless legally required to share it.” A referral may not be realistic. This needs to be a decision the patient makes.

“When dealing with adult trauma survivors, one of the most important things caregivers can do is to give them choice — something they have been denied as part of their traumatic experience,” Smith emphasizes. For these clients, choice is a first step in individual empowerment, which is an essential part of healing.

SCREENING TOOLS At the invitation of the Bureau of Primary Health Care, researchers at The Better Homes Fund in Newton, Massachusetts, are developing a screening tool to aid health care professionals in the diagnosis of patients whom they believe to be victims of current or past abuse. Another phase of this project will be to develop guidelines for appropriate psycho-educational intervention and referral.

The project is being conducted under the leadership of Ellen L. Bassuk, MD, in cooperation with the HCH Clinicians’ Network research committee. The screening instrument, currently being validated at six test sites in different regions of the country, will be available this summer. Preliminary results will be presented during a session at the National Health Care for the Homeless

Conference in Washington, DC, "Violence in the Lives of Homeless Women," on Friday, May 1, 8:30–10:00 a.m.

Nurses at George Washington University Medical Center ask five questions of all adult patients entering the emergency room about their exposure to violence — whether during

the past month or year they have been threatened or hurt with a weapon, physically or sexually assaulted in specified ways, or have been afraid of physical harm from an intimate partner. If the answer is Yes to any of these questions, they are asked what their relationship is to the person who hurt them, and whether police were notified.

More extensive questions are asked of patients identified as trauma survivors, to evaluate their current risk. Increased emergency room utilization has been positively correlated with a history of severe abuse. ■

Therapeutic Tools for Mental Health Professionals

A variety of treatment alternatives is available to mental health professionals to help alleviate pain and dysfunction associated with physical and sexual abuse. Choice of the most appropriate intervention depends on the severity and duration of trauma, the client's stage of recovery, and the clinician's expertise and comfort level with a given technique. Practitioners who treat homeless persons are further limited in the therapeutic options they can offer by the resources and services available to indigent clients in their community. For example, prolonged individual therapy may not be a practical option for many HCH clinics. This article sketches the stages of recovery and their corresponding goals, points readers to a practical guide for group therapy and a descriptive summary of therapeutic alternatives, and suggests ways in which clinicians who treat trauma survivors should care for themselves.

STAGES OF RECOVERY According to psychiatrist Judith Herman, MD, recovery from trauma occurs in three stages: the establishment of safety, remembrance and mourning, and reconnection with ordinary life. Although their sequence is rarely linear, "...in the course of a successful recovery, it should be possible to recognize a gradual shift from unpredictable danger to reliable safety, from dissociated trauma to acknowledged memory, and from stigmatized isolation to restored social connection."

Interventions vary according to the stage of recovery. Consensus on the most effective treatment of PTSD awaits more carefully controlled outcome studies, Herman concludes.⁶

GROUP & OTHER THERAPIES Group therapy has been found to be particularly effective for survivors of prolonged, repeated trauma. Survivors of recent, acute trauma usually choose to wait several weeks or months before beginning group therapy. In the meantime, "get to know your referral resources," advises Linda Ruble. "If individual therapy isn't an option, religious professionals can be helpful." Despite their promise, groups must be carefully focused and structured to avoid being counterproductive. What's more, organizing successful groups is far from simple, warns Herman.⁶

To assist practitioners in this often daunting task, 27 clinicians at Community Connections, a nonprofit mental health clinic in Washington, DC, decided to write a hands-on guide to a recovery intervention with women, under the leadership of Maxine Harris, PhD. Five years later, with the help of 500 participating trauma survivors, their efforts resulted in the publication of *Trauma Recovery and Empowerment: A Clinician's Guide for Working with Women in Groups*.⁹ The manual details an 11-week curriculum with a different topic for each 75-minute, weekly session.

Community Connections has also produced *Approaches to Trauma Services*:

The core experiences of psychological trauma are disempowerment and disconnection from others. Recovery, therefore, is based upon the empowerment of the survivor and the creation of new connections. Recovery can take place only within the context of relationships; it cannot occur in isolation.

—Judith Herman, MD

A Descriptive Summary, which lists a variety of techniques within seven general categories of trauma intervention — Cognitive-Behavioral Therapies, Power Therapies, Dynamically-Informed Therapies, Group Treatments, Consumer/Survivor Initiatives, Holistic therapies and Inpatient treatment programs. For each intervention listed, the authors have included a description, key references, available outcomes research and specification of clients for whom the intervention is appropriate.¹⁰

"The more comfortable and confident I've become as a clinician, the simpler my thinking has become about what is most useful in therapy," remarks Jennifer Smith, PhD. "Particularly with homeless clients, it is important to be truly present and completely honest. If they just want to meet me, see what I'm about and then leave, that in itself can be a valuable encounter which lays a foundation of trust for future encounters." [*For helpful resources which Smith recommends using with clients, see reference 11.*]

CLINICIAN, HEAL THYSELF Most important of all, Smith reminds clinicians who work with trauma survivors — take care of yourselves! "We all live in the same world our clients do, and many of us have experienced the same kind of trauma they have. If we aren't well grounded personally, we can't be effective professionally." This is what she recommends:

- Establish a network of colleagues engaged in similar work.
- Work in a healthy organization that supports quality of care for clients and self-care for clinicians.
- Set boundaries for what and how much you do: how many long-term clients you will accept, how often you are on call, whether to endure trauma workshops full of gory details.
- Get the support you need from consultants and medical staff, friends and loved ones.
- Know that you can't do it all. If clients aren't ready to move forward, just be an ear for them. Find symbolic ways to "get rid of the toxic stuff patients dump on you."

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- Recognize and take pleasure in the strides your clients make. Let yourself resonate to their courageous acts. ■

RESOURCES ON TRAUMA & ABUSE

1. National Coalition for the Homeless fact sheet on Domestic Violence and Homelessness, Feb 1999, <http://nch.ari.net>.
2. Browne A and Bassuk SS. "Intimate violence in the lives of homeless and poor housed women....," *Am J Orthopsychiatry*, 67(2): 261-278, 1997.
3. Herman DB, et al. "Adverse childhood experiences: are they risk factors for adult homelessness?" *Am J Public Health*, 87(2):249-255, Feb 1997.
4. McMurray-Avila M, Gelberg L, Breakey WR. "Balancing act: clinical practices that respond to the needs of homeless people," presentation at HUD/HHS National Symposium on Homelessness Research, Oct 1998.
5. Breslau N, et al. "Psychiatric sequelae of posttraumatic stress disorder in women," *Arch Gen Psychiatry*, 54(1):81-7, Jan 1997; Chilcoat HD, Breslau N. Posttraumatic stress disorder and drug disorders: testing causal pathways," *Arch Gen Psychiatry*, 55(10):913-7, Oct 1998.
6. Herman, Judith L. *Trauma and Recovery*, 2nd edition. New York: BasicBooks, 1997.
7. Jacobson NS and Gottman JM. *When Men Batter Women: New Insights into Ending Abuse*. New York: Simon & Schuster, 1998.
8. Family Violence Prevention Fund, San Francisco. *Improving the Health Care Response to Domestic Violence: A Resource Manual for Health Care Providers*, 1995. For an extensive list of health care materials, call 415/252-8900.
9. Harris Maxine, et al. *Trauma Recovery and Empowerment: a clinician's guide for working with women in groups*. New York: The Free Press, 1998.
10. Community Connections, Washington, DC. *Approaches to Trauma Services: A Descriptive Summary*, 1-53, 1998. Contacts: Maxine Harris, PhD, 202/608-4794; Jerri Anglin, MSW, 202/608-4791.
11. NicCarthy G. *Getting Free: You Can End Abuse and Take Back Your Life*. Seal Pr Feminist Pub, 1997; White EC. *Chain Chain Change: for Black Women in Abusive Relationships*. Seal Pr Feminist Pub, 1995
12. National Association of State Mental Health Program Directors (NASMHPD). "Responding to the behavioral healthcare issues of persons with histories of physical and sexual abuse," National Trauma Experts Meeting, Apr 1998; annotated bibliography on Trauma & Mental Health, July 1998; 703/739-9333; <http://www.nasmhpd.org>.
13. National Domestic Violence Hotline: Call 800/799-7233 for a referral to the hotline in your state.
14. Sidran Foundation and Press, 2328 West Joppa Rd, Ste 15, Lutherville, MD 21093, 410/825-8888; <http://www.sidran.org>. ■

Symposium on HIV/AIDS & Homelessness

In March, the Bureau of Primary Health Care and the HIV/AIDS Bureau sponsored a symposium of 30 HCH consumers, clinicians, researchers, administrators and advocates to respond to a draft paper on HIV and homelessness.

The well-received paper was authored by John Song, MD, who has participated for nearly a year in the HIV/AIDS Task Force of the HCH Clinicians' Network. When finalized, the paper will be a useful guide for clinicians struggling to surmount the obstacles that homelessness poses for effective HIV prevention and treatment, and will also delineate important policy concerns revealed at the intersection of homelessness and AIDS.

The final draft of Dr. Song's paper, incorporating comments from the March symposium, will be presented in a session at the National HCH Conference on April 29, 10:30 a.m. – 12:00 noon. ■

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