Trauma and Resiliency Informed Care and Homelessness

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Executive Summary

Traumatic stress occurs when an individual experiences an event, series of events, or set of circumstances that are so physically or emotionally challenging, harmful or threatening that they overwhelm the available internal and/or external resources and interfere with ability to cope effectively. Traumatic stress is of particular concern for individuals experiencing homelessness, where trauma may result from past events in childhood, events leading up to becoming homeless, and/or events that occur during a period of being without permanent shelter. People who provide assistance in homeless service systems of care are not always aware of the trauma that occurred in the past when they encounter a client, may not be prepared to offer trauma and resiliency informed environments needed to achieve maximal outcomes, and/or may not have expertise or training to offer trauma-specific treatment. By definition, “trauma and resiliency informed care” includes an understanding of the multiple levels and kinds of trauma clients experience, the environmental and procedural actions that can ensure access or facilitate effective use of care, and the evidence-based interventions used to treat trauma-related symptoms and disorders.

There are six well-established core values necessary for trauma and resiliency informed care including 1) safety, 2) trustworthiness/transparency, 3) peer support; 4) empowerment/choice/voice; 5) collaboration/mutuality; and 6) cultural/historical/gender diversity. When these are present, outcomes are improved and participants can experience growth, empowerment, and healing.

This report will discuss the potential effects of trauma and traumatic stress on people experiencing homelessness, the systemic factors that are important considerations, well-established individual and organizational interventions, and examples of trauma and resiliency informed approaches in homelessness service provider organizations.
Background

As services have developed to help people experiencing homelessness over the last several decades, the impact of traumatic stress was not considered nor was the research connecting trauma to a person’s health and wellbeing over time (Felitti et al., 1998). More recently, service providers began to recognize that homelessness in itself is a traumatic experience and that prior trauma, such as adverse childhood events, is likely to generate higher rates of homelessness. This is evidenced by the 5% of women and 77% of men experiencing homelessness who also reported experiencing at least one adverse childhood event (Goodman, Saxe, & Harvey 1991; Roos et al., 2013). Thus, there is an critical need to consider traumatic stress in relation to the crisis of homelessness.

Figure 1.
Prevalence of Adverse Child Experiences (ACE) Among Those With and Without Lifetime Homelessness
Biologically Based Effects and Symptoms

Understanding and practicing trauma and resiliency informed care begins with recognizing that trauma is pervasive and taking it into account when exploring client responses, designing service environments, and developing program activities (Fallot & Harris, 2009). Considering the possibility that traumatic stress reactions may be woven into an individual’s behavior, coping strategies, and responses can be a key element in achieving effective outcomes related to housing and well-being. Traumatic stress occurs as a result of one or more events or situations that are intensely frightening and threatening, where an individual is overwhelmed and becomes unable to sufficiently regulate internal reactions leading to intense distress that can become long-lasting (McVicar, 2013; Lupien, 2018). Traumatic stress can be differentiated from everyday stress, which is managed by the body’s normal regulatory system for adaptation to the everyday challenges of being alive (McVicar, 2013). Thus, human beings have capacity to adapt to normal life stressors related to things such as changing weather, using transportation, coping with work demands, providing care-giving for family members, etc. (Jester, McEwen & Lupien, 2010). If, however, the stressor is intense, life-threatening, excessive, overwhelming, and/or endures for long periods of time, traumatic stress may result. Traumatic stress has been defined medically as a chronic condition characterized by the toxic dysregulation of the human body’s network of nervous systems and intracellular stress-regulating mechanisms (Lupien, 2018). The experience of traumatic stress can have lasting adverse effects on an individual’s physical, social, emotional, and spiritual wellbeing.

After experiencing extreme or multiple events of a frightening or threatening nature, adults and children may develop unhealthy (pathological) symptoms that meet criteria for trauma and stress related disorders such as Post-Traumatic Stress Disorder (PTSD) and Acute Stress Disorder (ASD) (American Psychiatric Association, 2013). Symptoms include re-experiencing the traumatic event through flashbacks, distress after exposure to traumatic reminders, avoidance of trauma related stimuli, and negative thoughts or feelings that began or worsened after the trauma (American Psychiatric Association, 2013). Changes may occur in physical arousal or reactivity, leading to very low energy or conversely intense emotional arousal and related reactions that don’t seem to match the situation. Survivors may react secondarily to these conditions through lowered self-esteem or self-confidence based on high levels of anxiety and/or shame, potentially seeing themselves as fundamentally flawed or inadequate.
They may also generalize their fear, perceiving the world as a pervasively dangerous place (Marzillier, 2014). Another result of this toxic state is often impaired memory and trauma related memory triggers (Lupien, 2018). Information registered during times of high stress may not become encoded as time-sequenced or connected information; instead, the conscious recollection may show up as non-coherent or separated fragments of memories related to the senses, movement, or emotions. These are often re-experienced in the body and recalled only in fragments triggered by a particular smell, sound, image, or behavior sequence (Radulovic, 2017), interfering with narrative recall of events and including significant emotional discomfort. In a related symptom, traumatic amnesia or memory loss may occur or, conversely, trauma-related memories may be enhanced and repeat in a compulsive or repetitive pattern (Radulovic, 2017).
Trauma and Homelessness

Prior History of Traumatic Events:

Stressful and traumatic events during childhood have a strong relationship to lifetime homelessness. Data from the National Epidemiologic Survey of Alcohol and Related Conditions in 2001-2002 and 2004-2005, which included 34,653 participants, highlighted the relationship between adverse childhood experiences and lifetime homelessness (Roos et al., 2013). Researchers found that 85% of women and 77% of men experiencing homelessness has a history of at least one adverse childhood event (ACE) compared to 50% of the general population (Roos et al., 2013). Comparatively, in the 1998 landmark ACE study, 52% of the general population indicated an experience of at least one adverse childhood experience (Felitti et al., 1998).

Significantly, individuals experiencing homelessness often have symptoms of complex trauma due to histories of multiple victimizations. One study of women experiencing homelessness, found that childhood sexual abuse doubled the probability of physical violence and tripled the probability of sexual violence in adulthood (Young, Shumway, Flentje & Riley, 2017). From the perspective of attachment theory, parents who have experienced traumatic events may have lapses in their ability to provide the needed protection and care for healthy development of their children (Cozolino, 2017).

Traumatic Impact of Losing Housing

Ehlers and Clark (2000) developed a theoretical model of Post-Traumatic Stress Disorder as it relates to homelessness. They predicted that a combined lack of inner and outer resources to cope with the threat of imminent homelessness could lead to traumatic stress responses. This is a way to understand how traumatic stress occurs for people who have lost their housing. Data from the 2019 Greater Los Angeles Homeless Count provides the top reasons for housing loss cited by newly homeless individuals (i.e. individuals experiencing homelessness for the first time and for less than a year): financial or unemployment reasons (49%); conflicts with family or household (15%); break-up, divorce, or separation (15%); and problematic alcohol or drug use (11%). Entering into a period of homelessness was precipitated by loss of resources for key basic needs that created significant turmoil and overwhelming life challenges. Thus, a focus on traumatic stress and a recognition of chronic or toxic traumatic responses among persons experiencing homelessnesss is a crucial element for an effective response.
During a period of homelessness, individuals and families may lose a sense of security, predictability, and control due to unsafe conditions and crime victimization. According to the Los Angeles Police Department’s 2018 Report on Homelessness, 76% of crimes committed against persons experiencing homelessness were violent crimes. Homicide, rape, and aggravated assault accounted for the majority (73%) of the reported violent crimes committed against persons experiencing homelessness (Los Angeles Police Department, 2018).

Unsheltered individuals who are also disabled may be at risk of additional external threats, based on health conditions and lack of medical care. In the 2019 Greater Los Angeles Homeless Count, the chronically homeless population (those persons with a disabling condition who have experienced homelessness for at least a year or more than four times in the past three years), reported significant health conditions that were 2-3 times more prevalent than among the population experiencing new homelessness (i.e. for the first time and less than a year). The two most reported conditions among people experiencing chronic homelessness were a mental illness or physical disability – with half of people reporting that they had at least one of the two. Further, 88% of people experiencing chronic homelessness were living on the street (as opposed to in shelters) as of the 2019 Greater Homeless Count, creating higher risk of traumatic stress based on unsheltered living conditions for individuals with these physical and mental disabilities.

**FIGURE 2.**
Top 5 Reasons for Becoming Homeless: Newly Homeless Individual
The presence of traumatic stress in early childhood increases the risk for a range of chronic diseases as an adult (Felitti et al., 1998). A landmark longitudinal study on adverse childhood experiences was conducted over 10 years with more than 17,000 participants who were surveyed during routine care from their primary providers on a wide range of experiences within three categories: abuse, neglect, and household dysfunction (Felitti et al., 1998). The study found that 6.2% of respondents had four or more adverse childhood events (ACEs) that were associated with significantly higher levels of health risks. Respondents with four or more ACEs had four to twelve times the risk for alcoholism, drug abuse, depression, suicide attempts, and one to four times the risk for smoking, sexually transmitted diseases, and severe obesity than respondents who reported no ACEs. In a similar study that focused on the risk of premature mortality as related to ACEs, researchers found a 20-year difference in life expectancy for children who did not receive treatment for their ACEs compared with those who did (Brown et al., 2009).

In addition to a lifetime increase in health risks, research has also shown that trauma can be transmitted from one generation to the next through social and economic systems that are perpetuated over time as well as due to impacts on sensitivity or reactivity to stress in human genes that can be transmitted from one generation to the next (McGowan, et al., 2009). Thus, a range of historical, familial, cultural, and biological factors have been associated with the intergenerational transmission of trauma for such diverse groups as Cambodian refugees of the Pol Pot war (Sack et al., 1994), Canadian Aboriginals (Pearce et al., 2008), European Jews (Bierer et al., 2014), and ethnic groups in the United States such as Native, Japanese, and African Americans (Stevens, Andrade, Korchmaros, & Sharron, 2015; Nagata, Kim, & Nguyen, 2015; Graff, 2014; Deuster et al., 2011).

Impact of Marginalization and Oppression

Trauma related to the impact of oppression may be based on race, gender, or other differences, or the intersection between multiple factors that lead to marginalization, discrimination, and lack of equitable access to key resources. These factors require attention and care to design specialized responses and systemic restructuring for healing to occur (Comes-Diaz, 2016; Hardy, K.V., 2013). Critical race theory (CRT) helps to understand the relationship between systemic racism, power, and trauma.
It provides a practical theoretical framework for analysis of the trauma of homelessness as complicated by race (Wetterau, 2015; Ortiz & Jani, 2010). From the perspective of CRT, institutional arrangements are socially constructed mechanisms that reflect the beliefs and values of the dominant society (Ortiz & Jani, 2010). The current systems of institutions and practices in the United States, were created with the dominant society’s assumptive worldview (i.e. traditional Euro-American culture) and therefore are likely to misunderstand the needs of or harm people of color (Guinier & Torres, 2002). Effective strategies for addressing and preventing trauma from a CRT perspective will address the socio-cultural, physical, and economic environments of communities and build on indigenous knowledge, expertise, and leadership to produce healing solutions that are culturally responsive (Pinderhughes, Davis, & Williams, 2015).

Given that racism-related stress and racial trauma are the consequences of systemic factors affecting the interaction between individuals and their environment where power is used to subjugate or harm some people and reward others, this variety of stress and trauma can intersect with ACEs to complicate or heighten their impact. For people of color, issues in this area may include daily racism microstressors (i.e. microaggressions) and chronic-contextual stress, which results in varying levels of emotional, physical, and psychological discomfort and pain (Troung & Museus, 2012). Symptoms of racism-related stress may include depression, headaches, anxiety, stomach/digestive issues, self-doubt, dissociation, physical pain, nightmares, insomnia, fatigue, increased heart rate and hypertension, difficulty concentrating, and lack of motivation and productivity (Troung & Museus, 2012). Troung and Museus (2012) found that individuals experiencing racism-related stress may strengthen family and church support systems to adapt but may also develop responses such as resistive behaviors to maintain personal integrity (Ortiz & Jani, 2010). For example, a person of color may dislike the intrusiveness and judgmental approach of government programs like Temporary Assistance for Needy Families (TANF) so avoid potentially upsetting experiences by missing appointments, possibly losing benefits (Ortiz & Jani, 2010). Similarly, students may respond to negative educational environments with aggressive behavior by missing classes or dropping out, which can affect their academic records and achievement (Ortiz & Jani, 2010).
An understanding of the traumatic context when responding to behavior is key. The connection between racism, traumatic stress, and homelessness has been well established and continues to be relevant (Olivet, Dones, & Richard, 2019; Jones, 2016). According to the 2019 Greater Los Angeles Homeless Count, 33% of individuals experiencing homelessness in the City of Los Angeles were black, yet black people represent 8.9% of the population in Los Angeles (U.S. Census, 2010). Structural violence was identified as a burden on black individuals experiencing homelessness (LAHSAa, 2019). The 2019 LAHSA report for the Ad Hoc Committee on Black Persons Experiencing Homelessness noted that, “racial discrimination prevents Black people from securing rentals of their choice.” (LAHSAa, 2019).

Synergistic trauma, a theory about the impact of structural violence (Pinderhughes, Davis, & Williams, 2015), explains how structural violence affects people of color, preventing individuals from meeting their basic needs which ultimately leading to negative outcomes. Persons of color who experience institutional racism, implicit biases from individuals in positions of power, discrimination, and who live in communities with high levels of violence or trauma, are more likely to develop complex-PTSD (Pinderhughes, Davis, & Williams, 2015). Systems of care developed with consideration of oppressed and marginalized populations must adapt various practice and research methods to capture the subjective truth of the “other.” Typical methods of identifying, acknowledging, understanding, and sharing the experiences of individuals were founded on Euro-American-based theories and did not take marginalization or structural issues into account. CRT, however, emphasizes recognition that the intersection of an individuals’ gender, ethnicity, social class, sexual orientation, educational achievements, resident status, religion, and other subordinating variables contribute to one’s social, political, and economic access and opportunities, as well as shape identity and behavior (Ortiz & Jani, 2010; Wetterau, 2015; Carbado, Crenshaw, Mays, & Tomlinson, 2013). Ortiz and Jani (2010) recommend that practitioners and researchers consider their own social position and become aware of their assumptions related to etiology, causation, and healing.
Trauma and Resiliency Informed Care (TIC) in Organizations

Trauma and resiliency informed care (TIC) is an approach to operating, designing, and maintaining systems of care, “whose primary mission incorporates knowledge about trauma and the impact it has on the lives of consumers receiving services” (Harris, 2004, Slide 2). The goal is to ensure a sense of security and autonomy to the consumer-survivor by preventing re-traumatization and promoting resilience (Harris & Fallot, 2001). One challenge to this effort is that administrators, clinicians, and support staff often experience stressors related to providing care as well as maintaining their personal wellness and safety. These stressors manifest as vicarious trauma, secondary traumatic stress, compassion fatigue, and PTSD (Pearlman & Caringi, 2009; Huggard, 2007; Figley, 1995; Bride et al., 2009). The lifetime PTSD rate for social service providers is three times that of the general population (Bride et al., 2009). Experts such as Harris and Fallot (2001) emphasize that trauma and resiliency informed approaches must include awareness of all elements of TIC, while supporting both care-givers and consumers.

The fundamental difference between traditional and trauma and resiliency informed organizations is the collective and comprehensive understanding of trauma and the effects of traumatic stress by all participants, including executives, administrators, clinicians, staff, and consumers (Harris & Fallot, 2001). In trauma and resiliency informed systems, program design includes an understanding of trauma-related neurophysiological experiences, social and institutional factors such as racial oppression, power differentials, the environmental and procedural elements that can interfere with access or effective use of care, and the evidence-based interventions used to treat trauma-related symptoms and disorders (Harris & Fallot, 2001). Funding sources and service organizations have begun to recognize that TIC has potential to improve relationships between service systems and consumers, thus strengthening ability to gain and sustain housing stability.

Evidence Based Interventions for Trauma Survivors

Trauma-specific services focus on accurately assessing clients and then addressing traumatic stress to facilitate recovery, using evidence-based interventions. The American Psychological Association’s PTSD treatment guideline strongly recommends the following as evidence-based psychotherapies for PTSD in adults: cognitive behavioral therapy (CBT) (Beck, Emery, & Greenberg, 1985), cognitive processing therapy (CPT) (Beck, Sloan, Chard, Schuster, & Resick, 2012) and suggests the use of eye movement desensitization and reprocessing therapy (EMDR) (Shapiro 1995; Shapiro 2001).
In addition, there is growing research pointing to the presence of iatrogenic effects, where traumatic stress with potential lasting negative impact on patients has been identified in hospitals and residential clinics where coercive practices and activities have been traditionally used to maintain client behavioral control. The physical restraints and punishments that may have been used to enforce rules are now recognized as a trigger for trauma-related reactions when patients have histories of significant traumatic stress (Paksarian, et.al, 2014; Moos, 2012). Given that these techniques may either precipitate or trigger traumatic reactions in patients, substantial preparation, proactive planning, and strong TIC infrastructure can help to mitigate harm as part of a trauma and resiliency informed system of care. Coercive practices can trigger trauma-related reactions and should be avoided if possible, although it has also been recognized that administrators, clinicians, and support staff often experience stressors related to providing care as well as maintaining their personal wellness and safety and patient control mechanisms in some form may be necessary (Harris & Fallot, 2001). Thus, trauma and resiliency informed care requires an effort to balance and respect the needs of all parties.

The Six Core Values of Trauma and Resiliency Informed Care (TIC)

In trauma and resiliency informed systems, a comprehensive approach is used. This includes organizational policies, procedures, and programs that are developed from the framework of six core values. All members of trauma and resiliency informed organizations interact and make decisions through the lens of these values: (1) safety; (2) trustworthiness and transparency; (3) peer support; (4) collaboration and mutuality; (5) empowerment, voice, and choice; and (6) cultural, historical, and gender issues (Fallot & Harris, 2009; Elliot, Bjelajac, Fallot, Markoff, and Reed, 2005). Trauma and resiliency informed organizations respond to the prevalence of traumatic stress by conducting a thorough organizational assessment and putting the knowledge of trauma-specific principles, processes, and therapies into practice (Substance Abuse and Mental Health Services Administration, 2014), along with an ongoing process of self-reflection and adjustment. In recent years, the concept of resilience has been added to emphasize the strengths inherent in persons who have experienced traumatic stress, along with their capacity to heal and grow.
As adapted from SAMHSA’s Tip 57 (2014), Fallot & Harris (2009), and Ott, Pinard, Ithiphol, & Olwig (2017), trauma and resiliency informed organizations engage in the following activities:

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<tr>
<th>Commitment</th>
<th>Formalizing a commitment and intention to use trauma and resiliency informed guiding principles;</th>
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<tr>
<td>Strategic Planning</td>
<td>Adopting a formal organizational plan to implement and support delivery of TIC within the agency;</td>
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<tr>
<td>Maintenance</td>
<td>Maintaining consistent reevaluation and development of trauma and resiliency informed policies, procedures, and re-assessments;</td>
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<tr>
<td>Infrastructure</td>
<td>Establishing an infrastructure to initiate, support, and guide ongoing changes that reflect the needs of the participants;</td>
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<tr>
<td>Involve Consumers</td>
<td>Involving key stakeholders, including participants with histories of trauma, in all aspects of the organization that affects them or their population;</td>
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<tr>
<td>Assessment</td>
<td>Conducting annual or bi-annual assessments as to whether and to what extent the organization’s current policies, procedures, and operations either support TIC or interfere with the development of a trauma and resiliency informed approach.</td>
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Each of these activities reflects a commitment to participatory engagement, both by the individuals and families served and the staff (Ott et al., 2017). The processes require a depth of inquiry and involvement of people within all roles or levels of an organization (Ott et al., 2017).
To locate and advance the voice of the marginalized researchers and practitioners it can help to ask the following questions:

“What are the theoretical presumptions applied to the services?

How do these fit with perspectives of people for whom these services are designed, particularly in relation to their culture and location?

Are services relevant culturally and politically, and will they make a real difference in people’s lives?

(Ortiz & Jani, 2010).

With consideration of these questions, the CRT tenet to listen to the voices of the “other” can be a vehicle for healing and empowerment. It has been recommended that helping professionals use an approach wherein they assume the role of a learner/teacher. This stance will help them find ways to mold existing practices to fit the social location of clients and fully engage the “other” to ensure relevance (Ortiz & Jani, 2010). A holistic approach that incorporates a clients culture, spirituality, civic action, and collective healing has been coined “healing centered care” by Shawn Ginwright, Ph.D (Ginwright, 2018).
Tips for Practice

The practical application of trauma and resiliency informed care principles will be different in every organization. Each approach will be specific to the organization’s culture, requiring actions leading to decentralization of power and questioning of traditional methods or practices. Use of TIC tool kits is recommended as a starting point; however, depending on the climate at the organization, execution may be drastically different. The following are some tips beyond the toolkits, derived from professional experience, that may resonate universally.

**Personnel**

- Communicate values, expectations, and frameworks related to trauma and privilege/oppression on job descriptions, employment interviews, and performance evaluations to ensure a fit between employees and agency practices with a goal of ensuring consistent alignment
- Incorporate concepts related to trauma, equity, diversity, and oppression into every training, case discussion, and client-facing activity to familiarize, broaden understanding, and ensure appropriate practices so that the concepts are fully embraced and utilized

**Responding within organization**

- A good place to start is the first encounter and/or intake process
- It is helpful to build in opportunities to teach and practice grounding, stimuli reduction, other helpful behavior protocols consistently within groups, meetings, gatherings
  - Honor individual micro experiences by beginning formal processes that require engagement (i.e. meetings, individual supervision, appointments etc.) with informal or formal grounding or orientation of the senses as well as personal de-escalation
  - Take every opportunity to re-frame incidents with a trauma-informed lens by providing psychoeducation and discussion of oppression and marginalization
- Bring in consumers to provide feedback, make recommendations, provide training, and offer leadership
  - They can become mentors to newer consumers
  - Their assistance with design of new protocols, policies, etc. can be essential elements
  - They can help ensure that cultural equity and diversity is considered through design of a supportive infrastructure and the power structure is realigned appropriately
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