Working with Trauma Survivors Who Are Homeless

An Edited Transcript of the
PATH National Teleconference Call

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Welcome and Introductory Remarks

Tom Lorello

Welcome everyone to the PATH National Meeting: *Working with Trauma Survivors Who Are Homeless*. My name is Tom Lorello from Advocates for Human Potential in Sudbury, Massachusetts. We are the technical assistance contractor for the PATH program, and I'll be the moderator for today's presentation.

There are more than 100 people participating on this call from all over the country, including staff from PATH-funded service provider agencies and representatives of State and Federal government; welcome to you all.

We are pleased to have two nationally recognized experts on trauma with us today, who have prepared a presentation specifically for the PATH audience. Before we begin, I would like to introduce Gigi Belanger of the Homeless Services Branch of the Center for Mental Health Services. Ms. Belanger has worked closely with Dr. Michael Hutner, the PATH Project Officer, to support the PATH program within CMHS, as well as to develop more effective ways of delivering training and technical assistance to PATH programs. Gigi also has a special interest in the topic of trauma among the homeless population, and has been invaluable support in our effort to plan this presentation.

Gigi Belanger

Thank you so much, Tom. I'd like to welcome all of you today on behalf of CMHS and the PATH program. We are very excited to be offering this PATH-sponsored technical assistance on trauma, a topic that has been overlooked for so long. SAMHSA considers it to be very much a priority, so much so that the administrator has incorporated trauma and violence as one of the agency's cross-cutting principals that will guide program, policy, and resource allocation for the immediate and long-term future. Recognizing the importance of the role of trauma, and the etiology and recovery of people experiencing traumas of all types, SAMHSA has a number of ongoing programs looking at improving trauma services for various populations.

Because the issue of trauma is so important to all who come into contact with people who have experienced trauma, everyone—including shelter staff, housing staff, income and benefit eligibility staff, health care providers, and substance abuse and mental health providers—needs to have an understanding of how it affects people. It affects and crosses all systems. We hope that the information that you're going to hear today, while not inclusive, will be helpful to you, and will stimulate your interest in obtaining more information.

On a personal note, I'd like to tell you that I'm so excited that this call is taking place. A lot of work has gone into this; I hope that you will all find it very useful and will want more information at the end. Thank you.

Tom Lorello

Thank you, Gigi. Before I introduce our feature presenters, I'd like to take a moment to establish the context for this presentation and to describe why trauma among homeless people should be important to PATH-funded programs.

Both the research literature and clinical experience suggest that a significant portion of clients who establish a connection with homeless service programs also have a history of traumatic experience. People who have experienced trauma may exhibit behaviors, signs, and symptoms that are difficult to understand without also having an appreciation of the effects of trauma. People who are homeless may have experienced trauma at various points in their lives, and under different types of circumstances. Some may have experienced physical or sexual abuse as a child. Some may have experienced violence with a spouse or a significant other, and many experienced and/or witnessed traumatic events as part of their life on the streets.

Some individuals experience multiple traumatic events over time. Homeless people are a diverse group, but many people living on the streets and in

shelters exhibit signs and symptoms that can present special challenges to outreach and engagement efforts. Common presentations include isolation from social contact, feelings of suspiciousness and paranoia, and a reluctance to establish trusting relationships. In addition, some individuals may appear highly irritable and aggressive, while others may appear passive and have difficulty making even small steps towards change. All of these behaviors can be a source of frustration to PATH providers. They also provide an indication that the person has experienced a traumatic event.

Developing awareness of trauma and its effects is important for any person working with homeless individuals and families. This PATH national presentation provides an introduction to some of the key issues. Our presenters will provide concepts, practical strategies, and approaches to assessing the impact of psychological trauma in the lives of people who are homeless and have mental illnesses, or co-occurring mental illnesses and substance abuse disorders.

They will also discuss research findings on the prevalence of past and current trauma among people experiencing homelessness; provide an overview of common, immediate, and long-term effects of trauma on survivors; provide suggestions for recognizing the effects of trauma in PATH clients; and make recommendations for what PATH staff can do to help. Finally, they will discuss strategies for making PATH programs trauma-informed, a term that we will describe in more detail later. Please note that this presentation is only an introduction to the key issues. We encourage you to download the resources listed on the PATH Web site at www.PATHprogram.com.

Speaker Introductions

Tom Lorello

At this point, I'd like to introduce our featured presenters, Dr. Maxine Harris and Lori Beyer. They both work at Community Connections in Washington, DC. Ms. Beyer is a trauma clinician and trainer at Community Connections who trains clinicians nationally on issues related to trauma. She has over 10 years of experience working with homeless adults who have serious mental illnesses, and those with co-occurring substance abuse disorders. She is a member of the Community Connections trauma workgroup, which developed the Trauma Recovery and Empowerment Model (TREM). She has co-led group treatment interventions in trauma recovery, parenting skills, and domestic violence.

Dr. Harris is the co-director and co-founder of Community Connections, a private non-profit mental health agency in Washington that serves men and women with serious mental illnesses. She is also Executive Director of the National Capital Center for Trauma Recovery and Empowerment. In collaboration with researchers from Dartmouth Medical School, she has been a co-investigator on federally funded studies of homeless women and homeless people with substance abuse disorders. Dr. Harris has authored numerous articles and books, including *Trauma Recovery and Empowerment: A Clinicians Guide to Working with Women and Groups*, published by the Free Press in 1998. She was a contributing author and co-editor of *Using Trauma Theory to Design Service Systems* in *New Directions for Mental Services*, published by Jossey-Bass in the spring of 2001. Thank you both so much for being with us for today's presentation.

I'd like to direct my opening question to Lori. Lori, many of us who work with homeless people have a sense that there are many people living in shelters and on the streets for whom trauma is a central issue. But what do we actually know about the prevalence of psychological trauma among homeless people and particularly those with serious mental illnesses?

Prevalence of Trauma among People Who Are Homeless

Lori Beyer

The prevalence data indicates that trauma and abuse are huge issues for the homeless men and women that we see. Sixty-three percent of homeless women report having been abused by an intimate partner; 27 percent

of those women said the abuse was severe enough that they required medical attention for an injury. Twenty-five percent of the women also said that they were physically or sexually assaulted by someone other than an intimate partner.

That's not surprising, is it? We know that being homeless is dangerous. Living on the streets is very dangerous. If women are going "from pillar to post," they can be seen as vulnerable and as very easy targets. But the abuse that they experienced wasn't just as adults. Sixty-six percent of the homeless women reported being physically abused by a childhood caretaker or another adult in the household, and 43 percent said that they were also sexually abused.

Men report lower numbers. Approximately 33 percent of men report having been physically abused, and 15 percent admit to having been victims of sexual abuse. But probably the most disturbing statistic is that 97 percent of homeless women who are addicted to alcohol or drugs report being physically or sexually abused sometime in their lives. It is important that we keep in mind that admitting abuse is difficult for survivors, and it's especially difficult for male survivors to tell. All survivors feel that the abuse was at least partly their fault. They believe that they deserved it, maybe even that they asked for it in some way. They feel ashamed of themselves, and the abuse becomes their dirty little secret.

Because of this shame and blame, we know that the abuse rates are even higher than what is reported. We found that given the percentage of homeless people that have been abused, it is most helpful to assume that everyone who walks in your door is a survivor. If you start with that assumption, then you'll look at symptoms and behaviors with the possibility that trauma is a factor.

The services that you provide will also be more compassionate and more caring. So you will start looking at a homeless man addicted to drugs not just as a substance abuser, but as someone who might have turned to drugs to forget his horrible memories of abuse or to soothe himself.

The Impact of Trauma on Individuals

Tom Lorello

We would expect traumatic experiences to have a profound influence on someone, but without having such an experience ourselves, it is difficult to fully comprehend. Can you help us understand how the experience of trauma actually affects a person?

Lori Beyer

We know that childhood abuse has long-lasting effects. I think we would like to assume that the effects of the abuse remain part of an individual's childhood experience. Unfortunately, that's not the case. Survivors of childhood physical and sexual abuse experience the impact throughout their lives and in various ways. They experience it through trying to have relationships as adults. Many of them still struggle with depression. It's been an obstacle for many of the homeless people you are seeing, in terms of being able to set goals for themselves and make plans for themselves. So those childhood experiences are still affecting them in their adulthood.

We also see that the impact of abuse can be felt in areas that seem to be unrelated to the abuse itself. So we're not talking about the effect of the abuse just in their sexual relationships. We also see it come out when they have a supervisor at work who is trying to give them some helpful criticism and critiques. But they experience that as emotional abuse, thinking, "You can't pay me minimum wage and criticize me like that." Therefore, they may have difficulty being able to hold that job because of their past experiences.

We also know that those experiences of abuse in childhood betray their core assumptions about themselves, about their family, about their world. We all come into the world believing we're good people. We deserve good things. But what a trauma survivor learns is that somehow the rules are different for me. I don't always get good things. Terrible things are happening to me, and where are they happening?—most often in the family. They are being abused by

someone that they should have been able to trust, by someone who should have been taking care of them. So that core assumption about the family being a safe place that's going to protect them is also shattered.

Many abuse survivors try to tell someone. They try to let someone know what's going on, and oftentimes, they're not believed, or they're told that it was their fault. Therefore, they find out that the world isn't a safe place. They learn that even when they tell people, they aren't believed.

We also know that trauma survivors experience it in unique ways. They don't all experience the trauma the same. But what is common among them is that they all develop coping strategies to help them live through these very painful situations, during which they felt that their lives were in danger, where their lives were in danger. They were hopeless and helpless. These coping strategies that they develop helped to get them through.

Now these coping strategies are being labeled, and they're being labeled as problematic. They are being labeled as symptoms that need to be treated. We need to understand that these current problematic behaviors and symptoms really originated as legitimate and courageous attempts to cope with, or to defend against, this awful trauma that they were experiencing.

For example, we were working with a woman who identified herself as a compulsive list maker. She told us that she had lists of everything. She had lists of how many sweaters she had, what she would need if she went to South Dakota. She told us she had a list of what she needed to do for the next month. She also told us that she had so many lists she couldn't even get herself out of the apartment in the morning.

We asked her, "Where do you think this list making came from? Where did this behavior start?" She thought for a moment, and then she said, "You know, I think it started when I was about 11. It was about the same time that my dad started abusing me." And we said, "What were the lists of at that time?" She said, "I'd make a list of what I was going to do on Saturday. First, I would put on the list that I'm going to go to Katie's house. Then I'm going to go to Girl Scouts, and then to the library, and then to the neighbors across the street." Then she'd give the list to her mom, and her mom would say, "Okay, you can do that."

So what did the list do for her? It kept her out of the house and it kept her away from her abuser. That list kept her safe. It was kind of like her "get out of jail free" card. If that list-making worked for her on Saturday, what do you think she then did on Sunday, and Monday, and Tuesday, or any other time that she felt unsafe? She would make a list. Now that was pretty creative of her, wasn't it? I'm not sure that I would have thought of that strategy at 11 years old.

We need to remember that people are adaptive, and a trauma model frames survivor symptoms as adaptations, rather than as pathology. So a trauma survivor that was abused learned that she could not express her anger and rage, because if she expressed her anger and rage at her perpetrator, what would happen? She would get hurt worse. So she learned to stuff those emotions. Now she's an adult who is not able to express her feelings toward the person with whom she's upset. Therefore, she's experienced by helpers, by people like us, as someone who is emotionally unstable. She's labile. You can never predict what she's going to do. But rather than labeling her as someone with borderline personality disorder, it's much more helpful and hopeful to see this as an adaptation that she needed to adopt in order to survive her very, very difficult environment.

We need to understand that every symptom has helped a survivor in the past and continues to help in the present in some way. This adaptation model emphasizes the resiliency and our human responses to stress. It helps survivors and those of us who are trying to treat them to recognize them as having strengths and inner resources, rather than defining their symptoms and behaviors as weaknesses and as failures.

Signs and Symptoms of Trauma

Tom Lorello

Are there specific manifestations of this that we see on the streets and the shelters? There are lots of behaviors that we see that we certainly have difficulty making sense of. What kinds of specific signs and symptoms of trauma might we be aware of when working with people on the streets and in the shelters?

Lori Beyer

Tom, I think that's a really good question, because often trauma survivors don't come out and just tell you their story. They don't typically show up at your shelter or at your door saying, "I'm a trauma survivor, please help me." Rather, they tell us things in their behaviors, in the ways that they act. It's almost as if we need to be able to read between the lines. We need to remember that this is the secret they've kept for years, and they've kept it because they tried to tell someone before who wasn't able to hear it, who told them it was their fault. So instead, now they've shut down. They are not necessarily going to tell you that, or at least not until you have a trusting relationship with them.

They give us these signs, and sometimes we misread those signs because we are only viewing them possibly as homeless and drug-addicted, or homeless and mentally ill. But if we begin to factor in their traumas, then their behaviors take on a whole new meaning.

For instance, how about the homeless person that you're working with who wears layers and layers of clothing? Now think about this. If they've been sexually assaulted, they want to learn how to protect themselves. So the more layers of clothing, the harder it is for them to be touched and violated again. What if the sexual assault has left them thinking, "If only my breasts weren't so noticeable?" So then the layers of clothing would make their breasts less evident, helping to provide that very tangible layer of protection from being revictimized.

Have you ever wondered how some of the homeless people we work with wear so many layers of clothing in the summer? Sometimes in 95 degree heat, we're thinking, "Wow, how can they do that?" Trauma survivors learn how to disconnect themselves from their bodies. Their bodies have caused them too much pain. So they numb themselves, and they are no longer even aware of their body temperatures.

Now this can lead to other problems, such as problems of not being aware of pain or infections. I had a client come to me one day who was in excruciating pain, and I didn't know what to do. I took her to the emergency department, and she was diagnosed with a urinary tract infection. When the doctor came to talk to me, she said, "I don't understand, she let this infection go on for so long that it's traveled to her kidneys. How was she able to ignore it and stand this pain?"

She was able to ignore it because she is a trauma survivor and she had disconnected from her body, so she was not feeling the pain until it became so acute, that she finally had to ask for help with it. That's how severe that disconnection from their bodies can be.

Another behavior you might have noticed is the need to be on guard at all times. Sometimes you might see this in the shelters with someone who's not able to sleep at night. They might not be able to tolerate someone standing behind them in line, and these behaviors can sometimes be labeled as being paranoia. And maybe you've even scheduled a visit for them to see the psychiatrist.

Now let's think of this behavior from a trauma survivor's point of view. The trauma survivor knew that he had to be on guard, or on watch, at all times. He had to know if his perpetrator was in the house or not. He had to be aware of the perpetrator's moods. These things were crucial because it meant the difference between being hurt again or not.

Remember, the only person that survivors learned that they could rely on was themselves, because they learned early on that other people weren't protecting them from these terrible things that were going on. So they learned to be what we call hypervigilant.

They're constantly on guard, looking around, asking questions, and often being very suspicious of other people's motives and intentions. They learned all this to help to keep them safe.

They might even refuse to go to a shelter because they feel that they're better able to take care of themselves on the street than in a shelter, where they don't know what's going to happen, and they're in close confines. We need to keep in mind, again, that the abuse is perpetrated by someone in the home. It's someone who they should have been able to trust, but they learned that they couldn't trust those people who were in charge of their care. So trust really becomes the first casualty of abuse.

What do you try to establish with the people that you're serving? We try to establish a relationship based on trust, don't we? That's one of the hardest things that most of our trauma survivors do.

I want to mention another thing that can be difficult, and that might be the person who refuses to bathe. You've asked them to keep up their hygiene. The staff is complaining. The other residents are complaining. It may be that not bathing is another way that they protect themselves. It keeps people at bay. People are less likely to get close to you to sexually assault you, or even to establish a relationship. As a trauma survivor, people have hurt you, so you've learned that it's better to isolate yourself than to be hurt again.

I am also wondering if people have ever scheduled a doctor's or a dental appointment for one of your clients, and then they don't show. For a trauma survivor, especially one who has experienced sexual abuse, a visit to the doctor almost guarantees a flashback or a memory of past abuse. If they were ever forced to give oral sex, a visit to the dentist will almost certainly bring back those memories. At the very least, remember that when someone goes into a doctor's office or a dentist's office, they almost always feel a loss of power and control. "The doctor's more powerful than I am. The doctor knows more. The doctor uses words that I don't understand. He asks personal questions that I'm not comfortable with." The doctor is in control of the situation, and the survivor is not. That's very difficult for survivors to, again, lose that power and control.

Another behavior that can be difficult sometimes is that we're often confronted with refusals. What we might consider the rules, such as taking prescribed medication, following the program rules, and so forth, again bring up the issues of power and control, which are huge for survivors. They are often tired of being told what to do by people who they don't necessarily trust, and who they doubt have their best interests at heart. So when they're not allowed into the decision-making process, they'll sometimes assert their right to refuse in order to take back some of the control.

Do you also work with people who are participating in the sex trade? Sometimes trading sex for drugs or money is also related to the abuse that they experienced. What we know in regard to people who've been sexually abused is that, when they're introduced to sex at an unnaturally early age, they're more likely to engage in sex themselves at an early age. What they learn is that sex is not a loving act. Rather, it's become a commodity to be traded for what they want.

Many survivors were given gifts in order to make them more compliant so they wouldn't tell the secret. So they learned to "space out," or disassociate during the sexual abuse. When I say disassociate, I'm referring to that spacing out. Again, this is an important coping mechanism that most survivors have. The situation is too difficult for them to handle, so they space out. They get themselves mentally out of the room, where these difficult things are happening. That's what our trauma survivors do while they are prostituting. They disassociate in order to get themselves through the experience.

Now what about self-destructive, sometimes self-sabotaging behaviors that you see? Another thing we know from trauma survivors is that they learned early on that their lives are not going to be as good as other people's lives. I remember one survivor talking about how she watched television, and she knew that her life wasn't like *Father Knows Best.* She knew that what was going on in the home was different from other people's experiences. They internalize

this, and they learn that "my life is not like other people's lives." They are given messages during their emotional abuse that they're bad, that they're worthless, that they'll never amount to anything.

They have internalized these messages. Some of them tell us, "It's like a tape recorder going off in my head, and those messages keep going round and round. I keep hearing that message, 'You're worthless. Why can't you be like your brother? You'll never amount to anything.'" Then they start believing it, and they start acting it out. They think to themselves, "Why should I go to this job interview? They'll never hire me. Why set myself up for it?"

We also know from trauma survivors that they begin to believe that their life is not going to be as long as other people's lives. They have a sense of a foreshortened future, so it's harder for them to set long-term goals. They might think to themselves, "I know you keep talking to me about going to those GED classes, but why should I bother? I might not even be around to finish it."

I'm also wondering if some of you work with homeless people who are constantly struggling with suicidal thoughts. Our trauma survivors tell us that they need to know that if the pain ever gets too great, they have a way out. It's as if it's their ultimate and last-ditch effort to have some power and control. One woman I was working with told us that knowing that she can end it all allows her to get out of bed in the morning because she knows that if the pain becomes too great, she has a way out of this very difficult experience.

Implications for Practice

Tom Lorello

Thank you, Lori. At this point, I'd like to switch gears a little bit. There's an awful lot of information to absorb, but I want to begin thinking about what to do with this new information. I'd like to address my next question to Maxine. Maxine, how would you recommend that PATH staff proceed, based on this information? Can you discuss how this information has implications for conducting critical interventions?

For example, should PATH staff doing outreach ask people about traumatic experiences as part of outreach interventions? Should a history of trauma always be assumed, even in outreach when people are living on the streets? What kind of things can a worker do to help create a sense of safety for a trauma survivor living outdoors?

Maxine Harris

One of the things that you have to remember when you ask questions is, only ask questions where the answer makes a difference. If, for example, you have no treatment programs for trauma survivors, and you have no differential treatment for trauma survivors, then you have to stop and ask yourself, "Why am I asking the question to begin with?" One of the things that concerns me as we get more sophisticated about trauma assessment is that we will start asking questions, and then when people give us answers, we'll sit there somewhat dumbfounded because all we have to offer is the assessment we just made; we have no differential treatment.

So whether you are an outreach worker or working in a shelter, only ask questions when it matters, because you don't want to fall into the trap of being voyeuristic, probing, or intruding. All of those things are potential triggers for trauma survivors, who have felt intruded upon in some many ways. One of the things that you can do is just let people know that you know that bad things have happened to them, and that you know that trauma, abuse, and violence have an impact on people's lives.

In our intake procedure, we essentially make a statement that we assume that most people have had some experience with violence and victimization. That often opens the door for people to say a little bit about what their personal experience has been without asking a probing question. But what it does more than anything is say to people, "We get it. We know that this matters. We know that this is important, and if you receive services from us, if you allow us to

become part of your life in some way, we will not overlook this all-important dimension."

You asked, "Should you assume trauma?" Absolutely; it's kind of a no-brainer. If somebody's living on the street, and has been for awhile, I think you've got to assume that they have been violated, if not prior to their tenure on the street, certainly during that time.

The issue then for an outreach worker is, given that you are probably dealing with somebody who has been violently victimized, how do you create an atmosphere in which that person can feel safe? The very first thing that you need to do is be clear about your own boundaries. When we do consultations to shelter staff, people sometimes get very empathic, very concerned about helping folks. They don't want to see somebody out there without resources, without food, and they will extend themselves in ways that seem very human, but may be experienced honestly as a violation of boundaries by somebody whose personal space has been violated repeatedly.

I think you need to be clear. What's your function? What role do you have with an individual? If you are there to provide blankets and sandwiches, then that's what you do. You don't extend beyond that because people immediately get suspicious. Their immediate assumption is, "There it is, another one who wants more from me than they should, another one who's going to take advantage of me." So be clear about your own boundaries. Be clear about what your role is. Tell people what you're planning to do.

If you are there to give them a ride to a shelter, let them know, "I'm going to ask you if you'd like to get into my car. We're going to drive about a mile or so, and when we stop, I'm going to get out. I will be going somewhere else. You are then free to stay at the shelter if you would like." Give people a very clear preview of coming attractions and no surprises. Trauma is about being surprised; it is about the unexpected. You think that you are going to choir practice, but you're not. You're going to see somebody who is going to fondle you when the lights go out. So you want to avoid circumstances that surprise people.

You also want to ask people's permission, "Is it all right if I come into your room? Is it all right if I cross this line on this street and come closer to you?" Permission is never asked of trauma survivors. As Lori said, "power and control are violated repeatedly." So you want to give back to people as much control as possible, and you do that by asking them permission to enter their space.

You also want to only make promises that you can keep. By promises, I mean everything from, "I think there's a bed at the shelter tonight," to more vague promises like, "I'm sure everything will be okay." I remember when I first entered this field almost 30 years ago, I was on a ward in the State hospital and was somewhat overwhelmed, and I was introduced to an older woman who was pretty distraught about her situation. I was distraught because she was distraught, and I said to her, "I'm sure if you work with the staff, everything will turn out fine." She just about hauled off and hit me when I said that because the staff had not been good to her. I didn't know what I was talking about, and I was promising her a somewhat Pollyanna future, just because I wanted to make her feel better and I wanted to make me feel better. Don't do that.

People can smell insincerity, even if it is well-meaning insincerity. If you can't deliver on a promise either for the longer-term or for the immediate future, like tomorrow, don't make the promise. You want to avoid betrayal. You want to avoid intruding on personal space, whether it is physical space or psychological space.

Again, in terms of asking permission, you not only ask permission about moving toward people, you ask permission about entering psychological space. For example, you ask, "Is it all right if I ask you some questions about your children?" If the person says, "No," then the answer is no. Creating safety is as much about what you don't do as what you do.

Rules and Control with Trauma Survivors

Tom Lorello

I want to apply some of what you said to the issue of rule violations, for example, in a shelter or a residential program. The issue gets a little more complicated there for staff who need to maintain some sense of order, safety, and control. If we look at someone resisting or having trouble around the issue of rules, how might we understand that from a trauma perspective? In other words, how do we understand that need to be in control? How might we respond to it, where a particular rule violation that's important to the program is involved?

Maxine Harris

I think Lori answered some of this when she said that it is vitally important for trauma survivors to feel that they have control over their own lives. What trauma does, what abuse does, is take the control away. You are the victim. Someone else is the perpetrator. Someone has control over things so essential, your freedom, your body, sometimes control over your very thoughts, so it makes obvious sense that trauma survivors want to have as much control as possible. Shelter staff and providers in general need to ask themselves what rules are necessary for running a safe and stable shelter. Those are the rules that you want to hang your hat on.

There are, however, other rules that are sometimes arbitrary. They are there because they have always been there; they are rules for the sake of rules. Those, quite frankly, I think you want to do away with. We have had rules at our agency, for example, about handing out money. We manage the money for many of the people who receive services at Community Connections. Sometimes I will hear case managers say, "We only give out money at two o'clock on Tuesday. That's important because if we gave it out all the time, we'd have people coming in all hours of the day." Maybe, but maybe not. Maybe the two o'clock rule is really a rule that has outlived its usefulness. It is a rule that serves the clinician and not the consumer. I would urge people to eliminate rules like that.

I think when you get rid of arbitrary rules, and what's left are the rules that keep people safe, you are on much firmer ground in justifying those rules. Everybody can understand that nobody can bring a weapon into a shelter. What people can't understand is why you can only do your laundry on Wednesdays between three and five o'clock. "Why can't I do it on Thursday?" "Because we always do it on Wednesdays; we do shopping on Thursdays." Those are the kinds of arbitrary rules that often precipitate an explosion.

Tom Lorello

Can you say a little more about that? Because one of the more difficult behaviors that staff have to deal with is angry outbursts. If we assume for a minute that these are due to someone's adaptive way of dealing with a trauma history, how might we understand that? How might a staff person intervene with someone who is getting angry?

Maxine Harris

I'll say something about anger in just a minute, but I want to go back to this issue of control and talk for a second about manipulation. I think that one of the traps providers fall into is they assume that when someone wants to control her environment, she is being manipulative. What I would say to that is, "Yes, she is being manipulative, and so what?" We all want to control our environment. We all want to manipulate the people around us, so that we will get our needs met. The only people who ever get called manipulative are the bad manipulators. If I can get you to do what I want, and you're okay with it, you do not stop and say, "Boy, Maxine is really manipulative." It's only when I'm tripping all over myself and being a bad manipulator that you feel taken advantage of, and you don't like it. It's then that I am likely to get a label.

What I think you need to do when you start to get that feeling that somebody is pushing your limits and your boundaries, is to think about what they want, and how

they can get it in ways that do not compromise other people. Part of the intervention with survivors is to help them gain control and get what they need from the world in ways that are not going to be punished. That's just the healthy growing up that all of us need to learn at some point along the way.

In terms of the angry outbursts, which again can be labeled as manipulative, you need to ask yourself, "What's going on?" Sometimes somebody is angry as a way to maintain boundaries. If I start swearing and screaming at you, you're going to stay away from me. If the behavior is serving that purpose, what you want to do is help people to gain control of their own perimeter without having to be a raging tiger.

However, there are other reasons that you're going to see angry outbursts. One of them has to do with a real failure around affect regulation. People can't regulate or modulate their emotions. One of the things that repeated trauma and abuse does is affect that way the brain operates. Instead of living in an emotional world that has shades of gray, the trauma survivor often lives in a very black and white universe. Things are either fine or they are horrific. When they are horrific, I have to defend myself to the death, and I will do it any way I can. This can be very abusive for staff who are on the receiving end of some of these tirades.

Honestly, in the moment, there isn't a huge amount that you can do. You can absent yourself from the situation. You can ask someone to calm down. But when somebody's got their foot on the pedal, and they're already at 100 miles an hour, standing in front of the car is not a good way to stop it. I think you want to step to the side, get out of the way, and then you're going to work with this person on how to develop the skills to regulate affect. But you don't do that when the car is going full speed ahead.

Trauma Survivors and Disassociation

Tom Lorello

When Lori described earlier how people sometimes seem to space out, she used the term "disassociation." What can you do with that? How can we work with people who are spaced out or disassociating?

Maxine Harris

One of the things that you need to remember is that disassociation is a kind of slipping away; it's a breach in basic focus and attention. What's going on right now is so awful that, if I pay attention to it, I will be overwhelmed. So I shift my attention away to a fantasy, to another world, to a place inside my own head. To bring somebody out of the disassociative state, you have to get their attention. Sometimes you can do that just by calling the person's name. Just speak up. Do it directly. Make eye contact with the individual, and that can sometimes snap the disassociative state. Sometimes you whistle. A colleague of mine used to stand up on a chair and clap. It's an attention getter. That's what you want to do. You want to bring the attention back.

One of the things you don't want to do is touch somebody. You don't want to hug her. You don't want to grab an arm because again, you've got to balance wanting to return somebody from a disassociative lapse with not violating her fundamental boundaries. When you put your hand on someone, you violate her boundaries. So you don't want to do that, but you want to snap your fingers or call her name.

When somebody comes back, what you say to them is, "Do you know what just happened? Do you know that you slipped away?" Then you can ask, "How often does that happen? Do you know what triggers that?" You start to flesh out for somebody some guidelines for understanding their own disassociation. Next, you want to ask the person, "When you do that again, what do you want me to do? What would be most helpful?" If somebody says to you, "What I want you to do is to hold my hand," then you have

been given permission to touch her. The next time out, you feel comfortable doing that.

When you see somebody staring off, remember that all of us do this. That's the other thing to recognize about disassociation. We could not survive in crowded environments, in elevators, in conferences like this teleconference, if we did not zone out occasionally. You can see it by looking in people's eyes. They're not making eye contact, or they've got that glazed-over look, and you know what they're doing at that moment is thinking about what they're going to have for dinner, or where they would rather be than sitting right there with you. So you want to bring them back to the present by things that are called grounding techniques.

Not surprisingly, some of them have to do with planting your feet firmly on the ground. You might even say to somebody, "I saw you look just then like you were zoning out a little bit, or spacing out. I want you to put your feet on the ground right now. Feel the ground under your feet. That brings you into the present. Sit in the chair; put your arms on the chair arms and push down." Anything that brings back a sensation of bodily integrity grounds people in the here and now.

Sometimes you might say to somebody, "Right now, I want you to look around this room and find three objects that are the color blue." What this does is make an individual be present in the moment. I can't be thinking about what I'm going to have for dinner, or I can't be thinking about living on Fantasy Island, if I'm looking around the room, looking for a blue pair of socks or a blue shirt, or something like that. So these are things that return someone to the present moment.

The important thing about these techniques is not that you help people when you're present, but you teach them how to do it when you are not there. If you disassociate, for example, when you're on the bus on your way to a doctor's appointment, you will miss your stop. You can say to somebody, "What I want you to do the next time you ride the bus is to count all the chairs on one side, multiply by two, and then count all the chairs on the other side." You can't zone out when you're doing a concrete task like that.

Tom Lorello

Would your answer be any different if we were talking about an initial contact with somebody on the streets, like an outreach contact, where I know there is often a concern about not being too intrusive initially? For example, getting someone's attention who is spaced out, is that something that you would recommend doing on an initial outreach contact? Or is that something that assumes a certain relationship has been built?

Maxine Harris

I think that you want to be very careful whenever you deal with somebody on the street, who you don't know, whose potential for violence is unknown to you. I'm more likely to do things like this with somebody I'd encounter in a shelter, who is already connected in some way to another person or to the service system. I think you want to proceed more cautiously with people who you don't know. Some of the people on the street are people with dual diagnosis, with psychiatric illness. But sometimes, you may run into someone, as was the case with us not long ago, who was a drug dealer in hiding on the street from a rival drug gang. I don't think I'd like to clap my hands in the face of somebody like that.

Trauma Survivors and Medical Care

Tom Lorello

Lori also spent some time talking about how health care procedures and visits to medical clinics may be retraumatizing. Do you have any suggestions for how to support somebody going for a medical appointment?

Maxine Harris

I think Lori mentioned the problem that trauma survivors have with medical appointments. Let

me just repeat a little bit about what the medical paradigm is, so that you get a full appreciation of what this might be like for a trauma survivor. You go into a space that you do not control, a space that is often sterile and formal and cold, both psychologically and often physically. Think of the last time you were at the doctor's. They have you partially undressed. You're sitting there shivering, waiting for somebody to walk into a room who will then touch you, probe you, and stick things into various orifices. When you describe it in those raw clinical terms, it's a wonder any of us ever goes to the doctor for anything. But when you have a history of being violated and probed when you thought that you were going to be taken care of, you can image that medical visits are automatic trauma triggers for most survivors.

You want to try to remove as many of the potential triggers as possible. You want to talk in advance with a practitioner about making the space more hospitable, which may mean allowing the survivor to have a companion, someone of her choosing who goes into the room with her, who stays there with her and talks her through the experience. You certainly want to have explained to the survivor in advance exactly what is going to happen. More and more doctors are doing this now, especially on some of the most intrusive exams, like gynecological exams, where they will say in advance, "This is where I'm going to touch you. This is what I'm going to do, this should take about 30 seconds," anything that gives the survivor advance knowledge about what is going to happen.

You also want to make sure that the things I said earlier about asking permission and not violating boundaries are part of the experience of going to the physician, and this is where you have to be an advocate in advance and talk to the provider to make sure that he or she is willing to be on board. A provider who thinks that this is ridiculous should be crossed off your list as a provider who can work with trauma survivors.

You also may need to divide the medical appointment into very small increments. For example, most of us can go for a full 20 or 30-minute exam. We may be a little shaken up. It may be somewhat unpleasant, but we can get through it. For the survivor, you may need to say, "Today we're going to get your blood drawn. Tomorrow they're going to do this part of the exam. In a week, you'll come back, and they will do this other part of the exam," so that it's manageable in little doses.

For some people who are absolutely phobic about going, and who need a medical procedure, you may have to arrange with the provider for the person to be given a tranquilizer or some kind of anesthetic in advance. We had one woman who needed to be put out in order to have teeth pulled. She had very bad oozing gums. The teeth absolutely needed to be pulled, but when awake, she would not allow somebody to stick his hands in her mouth. She agreed to be anesthetized, in order to have the procedure go forward. You may need to really work with somebody about what circumstances will allow them to feel safe, in order to carry on with a medical procedure.

Tom Lorello

How about the experience of homelessness itself? Is it possible that homelessness can traumatize or retraumatize a person?

Maxine Harris

I think the answer to that is pretty obvious. Thinking about what it would mean to be homeless, it's a pretty horrifying experience. I think that the amount of victimization and violence that goes on the streets is pretty overwhelming. Let me actually turn the question around a little bit. Obviously, homelessness is traumatizing. What I would argue is that only a trauma survivor can tolerate homelessness. If you are not a first-class disassociator, you will not be able to survive on the streets. It's a funny kind of symbiotic relationship between the dynamics of trauma and the realities of homelessness.

Tom Lorello

Okay. We have actually had a number of questions come in over the Internet, and I'd like to make sure I get to those before we run out of time. Before we get too far away from the issue of disassociation,

somebody e-mailed in a question about disassociation asking, "Isn't it true that people can disassociate involuntarily? Sometimes, just a feeling can be reminiscent of an earlier trauma that makes a person disassociate. Is that accurate?"

Maxine Harris

That is accurate. I don't want to imply that disassociation is a conscious process. I think that what may well have happened at the very beginning, when abuse first occurred, is that there was an attempt to consciously escape from an overwhelming experience. You can't run away physically, so you run away psychologically. The problem with a disassociative defense, and I think Lori mentioned this around the issue of an adaptation that gets out of control, is that you no longer disassociate when you want to. You disassociate when the disassociation wants to happen. There are all kinds of circumstances in your environment that trigger a disassociative state.

I had an interesting experience with a woman in one of the groups that I was running. Somebody passed around a box of chocolates. She quickly gobbled up a couple pieces of candy, and proceeded to disassociate for the rest of the group, and was almost impossible to bring back. Her perpetrator had used candy as a way to seduce her into the abuse, so that candy, which seemed very tempting to her, was also a trigger for a disassociative state. Sometimes the things that trip disassociation are not things of which we are aware.

Tom Lorello

This question comes from New Hampshire. "Why do trauma survivors feel they will not live a long life?" That's something that I think Lori mentioned during her presentation.

Lori Beyer

I think through their experiences, they are left with a sense that awful things have happened to them. They've lived through physical abuse, through sexual abuse, their bodies being beaten on, being violated. For many of them, it turned into a wish that they wouldn't have a long life, but for some of them, they felt that, "I'm not going to live through this, it's not possible for me to live through this pain." Internally, they were carrying so much pain; some of them even described it to us this way: "I feel like I'm going to explode. The hurt and the pain is so great." They're left with the feeling that they're constantly in danger, that they could constantly be a victim, and that terrible things are going to happen to them. This leaves them with the thought, "I am going to have a shorter life than other people. I am going to be a victim again. My life could very possibly end."

Strategies for Shelters and Street Programs

Tom Lorello

Thank you. We have another question that came in over the Internet that wasn't addressed to anybody in particular. "What about shelter workers who have little or no training and encounter the signs and symptoms of trauma? What should they do? Who should they contact?"

Maxine Harris

I'm glad you asked that because I think what you don't want to do is to take a teleconference like this, or a couple of articles, or maybe something you've seen in the media, and feel that you should transform yourself into a trauma clinician. To really deal in a psychotherapeutic way with trauma issues requires a fair amount of training. I think that what you want to do in your own community is to have a list of individual providers, group providers, and support groups where you can refer people who have trauma histories, and who want to do more extensive recovery work. What you want to do as a shelter provider is to be someone who is sensitive to trauma, and who does not inadvertently revictimize people, by either triggering trauma responses or minimizing the impact of the trauma and the abuse.

Tom Lorello

Dr. Harris, we've touched on some of the ways that individual staff members may take the issue of trauma into account on the streets and in the shelters, but let's shift our focus now to the entire agency. In the book you co-authored, you go into detail about the steps programs can take to become trauma-informed. For example, what kinds of things should we consider as we hire new staff?

Maxine Harris

I'm glad to answer that, but let me say something about what it means to be trauma-informed before I say that. I think that just as staff should know about mental illness, its various manifestations, its origins, and its treatment, and just as they should know about substance abuse and its etiology, they also need to know about trauma. This is really the third prong in understanding who ends up in the service delivery system, whether it is the homeless shelter system, the mental health system, or the criminal justice system. Trauma, physical and sexual abuse, especially in childhood, needs to be something that all staff are aware of and have some understanding of. A system starts to become trauma-informed when trauma education becomes a standard part of the training that all staff undergo.

When you understand the fundamental role that trauma has, you will find that providers undergo almost a rather radical paradigm shift. Instead of seeing trauma as just something else that people have had to contend with, you move it to a central place and start to see other things—like the mental health symptoms, the addictive responses, the ongoing domestic violence—as all growing out of initial experiences of trauma and abuse. It becomes the central organizing construct around which everything else revolves. That is the transformation of a system from just a trauma-knowledgeable system, to a truly trauma-informed system.

When you hire staff and start to think about who you're going to add to your system, you want to ask some questions about trauma knowledge. What do people already know about abuse? Have they had any formal training, and what are their biases and prejudices? Do they think, for example, that trauma is something that people should get over? "It happened 20 years ago. You're a grown woman now; you should just get past this." If somebody says, "Yes, that's what I think," this is a bad response. You don't want to hear that because trauma is not something that you just get over. It is something that lingers, something whose impact is felt for a long time. You don't want survivors to be blamed because they can't just snap their fingers and make the memories magically go away.

You also want to find out what people think about domestic violence. If providers say to you, "I think anybody who wants to can leave a violent relationship," again that is the wrong answer. If people tell you, "I think that when a woman gets beat up on the street, she probably asked for it," that is the wrong answer. You are not looking for the trauma genius, but you are looking to see who has basic beliefs and attitudes that will be difficult to change, beliefs and attitudes that, when it's 2 a.m. on a Saturday night, are going to come out and be the source of revictimization for women in a shelter.

Tom Lorello

How about agency policy and procedures; how would being trauma-informed show up there?

Maxine Harris

You want to take a look at your standard policies and procedures that might be troubling to trauma survivors. For example, are there policies about bringing contraband into the shelter? One of the most difficult things in some shelter systems and in addictions programs in prisons is that the policies and procedures around contraband demand full-body searches, cavity searches. This is obviously retraumatizing to women. It would be traumatizing if you were not a trauma survivor, but it certainly is traumatizing for someone who has been through that experience. So you want to take a look at your policy with respect to contraband and searching people's bodies, searching their space.

You want to see what the policy is with respect to calling the police. When the police get called, if there's violence in the shelter, do the police drag people out in handcuffs? Do they storm in with clubs waving, and that kind of thing? This is the kind of behavior that will be retraumatizing, not just to the person involved, but to everybody.

We had a situation where a woman was taken from our waiting room in chains by the police. It was terrible for her, but I can tell you that the real fallout were the other people sitting in the waiting room, many of whom were survivors who had a very, very difficult time witnessing that kind of rough, heavy-handed treatment of another person. We had to help people understand what had happened, why it had happened, and why the police felt that they needed to act in the way that they did.

You also want to check policies and procedures with respect to accusations of sexual abuse or sexual harassment. What does the shelter do if a woman says that someone is harassing her, or someone has abused her? Is there an immediate assumption that the person is telling the truth? Are there policies and procedures for how that kind of information is handled? Or is the immediate assumption, "She must be lying. She's probably manipulating, and besides, she works as a prostitute." Those are the assumptions that are not trauma-informed, and that serve to revictimize and to make the environment an unsafe place for a survivor.

Tom Lorello

How about in regard to supervision and training of staff, are there any ways that being trauma-informed would change what we do there?

Maxine Harris

I think you want to make supervision available for people, but perhaps one of the most important things to say to people is, "If the experience with a particular individual pushes your buttons, then let us know, and we will make sure that that person works with somebody else wherever possible." Remember trauma survivors are not only in the homeless population, they're in the provider population, too. There is some suggestion that 15 percent to 30 percent of all adult women have been sexually victimized at some point in their lives. That means me, women listening to this conference call, other clinicians who work at Community Connections, and other similar kinds of agencies, have stories of our own. So we need to be given permission to take care of ourselves when something is triggering or is difficult for us.

I've had two incidents where clinicians have come to me about events that were personally difficult for them. What they were asking me is, "Would I protect them?" As Lori mentioned, we know what happens in the initial traumatic situation if other adults know what is going on, and they do not take care to make the child safe, either because they don't feel strong enough or powerful enough or they don't believe what's going on. As supervisors or directors of programs, we need to make it a safe environment for the people who work there. When we do that for them, we give them the power to do that for the individuals with whom they work.

Housing Programs for Trauma Survivors

Tom Lorello

Dr. Harris, your book makes the point that trauma can affect residential stability. For example, if abuse occurred in the home, then home may have a very different meaning than we might assume because it becomes associated with danger, rather than safety, as Lori talked about earlier. In the light of this, how might we make housing programs trauma-informed?

Maxine Harris

I'll tell you what we've done here at Community Connections. We have developed a continuum of housing options. I think what you can't do is assume that one shoe fits all. Assuming that everybody wants to have her own independent apartment and live by herself is not true. For some people, living alone in a single apartment, even though it is the middle class dream, may be a very scary place to be. Someone may

be haunted by memories, by ghosts of the past, and feel really unsafe in a single apartment. Other people may feel that it is dangerous to share a room with somebody else. Some people may feel that sleeping during the night when it is dark outside is not a safe time to sleep, so you need to have a range of options.

We have group homes that are staffed. We have group homes that are not staffed, where just a community of women live together. We have shared apartments. We have single apartments. We have transitional apartments, and we have single family homes. All of those are available as options, with the support of clinicians varying as much as a woman and her family may feel necessary.

You want to give people control over their living environments as much as possible by having, either through affiliations or connections with other providers, as many options open to them as possible. Do not make assumptions. More than once, we have found a very nice apartment in a safe neighborhood for a woman, who then chose to sleep on the street outside of her apartment because she still felt safer on the street, where she could at least look around and be on guard in case of an attack. So you want to have as much choice and as many individualized options as possible available to women.

Working with Children Who Are Trauma Survivors

Tom Lorello

I have one other question that came in over the Internet. This has to do with the issue of working with children. Most PATH programs work with adults, but some serve children. The question is, "Is there anything specific to children that would be helpful for us to know, and is there anything helpful for school staff to understand?"

Maxine Harris

The kind of acting out that you see with children is, not surprisingly, typical for their age and circumstances. We all act out around what is available to us, so children are likely to be truant from school, to physically remove themselves from what may feel like, at times, an unsafe environment. They will probably disassociate during class, causing them to be labeled as learning disabled because they don't track what's going on; they don't follow what the teacher is saying. They may be hypervigilant in class, spending more time looking at their peers, snooping around, wanting to know everybody's business because they need to know what's going on around them in order to feel safe.

You're going to see more anger, more kind of conduct disorder in children who have been traumatized. You would see some of the kinds of things that Lori described in an adult survivor, the disassociation and anxiety, even depression. Depression in children is more likely to look like anger and irritability than it does like sadness, so you're going to be looking for those kinds of things.

One of the things that we have discovered in the last couple of years is that we have had to offer services for children. You cannot treat mothers without also making available to them a range of direct services for their children. Initially, we had the assumption that if mothers got better, their kids would automatically get better. While some of that is true, you do need to have affiliation agreements with providers who serve children, or set up those services yourself. This is tough, because in most cities where I've had some dealings, services for children are in even greater demand and are scarcer than services for adults.

Question and Answer Period

Tom Lorello

Thank you. I think we should move into the question and answer period at this point.

Q. What resources are available for indigent clients who are trauma survivors?

Maxine Harris

All of the clients we serve are indigent. At least in the District of Columbia, either the city provides the contracts for providers to work with indigent clients, or people get brought in under Medicaid and reimbursement happens that way.

Q. Are you aware of any particular programs in detention centers or prisons, where correctional officers or other personnel are trained to be more helpful and knowledgeable of trauma survivors who are incarcerated?

Lori Beyer

For three years, we did a project at the women's prison in Jessup, Maryland, where we offered groups for survivors of trauma. The prison system there did some education with the correctional officers in regard to trauma. I know that they probably didn't do enough, as is the case with most jails and prison systems. We are aware of a new program that's coming out, funded by SAMHSA for jail diversion, trying to offer alternatives. They have recognized that trauma is an issue and are seeking solutions.

We've also done presentations for the drug courts in regard to how they can incorporate the knowledge of trauma as they're seeing people who are being sentenced for drug offenses. There is definitely the knowledge out there. However, typically the people who receive the most education and the most training are the providers, but we need to expand the knowledge base. We need to expand our training, whether it's to the support staff, the custodian, the receptionist, or the night staff who have so much face-to-face contact with the individuals we serve. So often, it's the support staff who say and do harmful things because they are well-intentioned but not well-trained. I would say the same in regard to correctional officers. It's an issue that still needs to be addressed, and the training needs to be provided for all staff members.

Q. When you notice that people are getting past the initial crisis and actually maintaining connection with the program staff, are you finding then that people are responding to more in-depth individual therapy? What's the next step in recovery?

Maxine Harris

I'm glad you asked that. What we have found actually is that once people are past the initial phase of engagement, and certain basic needs have been stabilized—whether it's the need for medical care or for housing—what starts to make sense is group intervention, not individual work. One of the things that we've spent a lot of time on here is developing and refining a group intervention for trauma survivors that specifically addresses some of the deficits around empowerment, boundary setting, and relationship development and some of the skill deficits that women bring in around communication and making judgments and decisions. We help them to have a framework for understanding the traumatic event and its impact on their lives. Individual work I think is problematic for a couple of reasons. One reason is that it's just so expensive, and the limited number of providers makes it out of reach for many of the individuals with whom we work, and indigent people in general.

We also have preferred a group model because one of the very important things for survivors is to know that they are not alone; that they are not the only woman on the face of this earth who has felt so bad and so shamed and so devastated. Just the very act of being part of a recovery group is often in and of itself a critical dimension of recovery.

So I would argue strongly for a group intervention. As I said, we developed one here, the Trauma Recovery and Empowerment Model (TREM). There's one that's been developed out of Boston by Lisa Najavits called Seeking Safety. There's another one, the ATRIUM model, which was developed by Dusty Miller and her colleagues in western Massachusetts. They are somewhat similar with slight variations.

Q. I want to know if you're familiar with any neurological studies in people who suffered from trauma, and whether you're aware of any permanent brain changes and any medications that can be helpful in treating trauma.

Maxine Harris

I think that is certainly van der Kolk's position [Bessel A. van der Kolk, M.D.; see www.traumacenter.org], that there is real brain change that takes place. Obviously, you're familiar with this research that has been both published and presented by him. The repeated flooding by the individual of this powerful affect actually changes the way the brain functions. I think that's what I was talking about earlier when I talked about the deficits in emotional modulation. The ability to feel in increments seems to be lost for many trauma survivors.

There are a number of psychiatrists who are experimenting with Prozac-like medications, with some of the mild anti-anxiety medications, things like BuSpar®. I think if you are interested in having medication as an additional therapeutic tool, you want to find a psychiatrist to collaborate with who understands the impact of trauma on affect regulation in particular, and who is willing to work with you and with individuals around prescribing appropriate medication.

Now one of the tricky things about this is that something like Klonopin®, for example, which does help to calm some of the anxious, panicky feelings that many survivors have, is a drug that some psychiatrists are reluctant to prescribe to people with addiction histories because it is a drug with a street value. So you need to choose a psychiatrist who is up on the latest innovations and is willing to work with trauma survivors to quiet some of their internal storm, in order to help them eventually develop ways to calm themselves down that don't necessarily involve medication. We use things like meditation, journaling, and other kinds of self-soothing strategies to help women bring these kinds of affective outbursts under control.

Q. We have a question about vicarious trauma for people working with the clients who are dealing with trauma. Do you have suggestions for ways to replenish yourself so that the trauma is not personalized?

Lori Beyer

That's a very important question. Maxine mentioned before how many people in the field, whether they're survivor clinicians themselves or just working with the trauma survivors, are impacted by hearing the stories. We can re-experience that trauma through having flashbacks and nightmares of our own. Others of us start changing our lifestyles. We can't read the newspaper anymore or watch certain movies or television programs because it reminds us of the trauma, and that's too difficult.

In response to your question regarding how we replenish ourselves, I think that we all do it in various ways. People do it through exercise. People do it through companionship with family, with their children, with pets that are important to them. Other people talk about the need to process it; having their own therapists that they're able to talk to is very important for some people.

In addition to having personal strategies, we also want to think about ways in which agencies can support people who are working with trauma survivors, how agencies can provide supervision, making sure that supervisors are informed. Workers need to feel that they can trust their supervisors, in order to talk about these issues, and that the organization supports the use of mental health days and vacation days for staff to replenish themselves.

At one organization, the people who were working with trauma survivors decided that once every two weeks, they were going to get together and have a brown bag lunch. They were going to use that time to talk about working with trauma survivors, how it's affected them, strategies for doing it more effectively, and for taking care themselves. So there are ways that you can help yourself that don't necessarily have to come from the top; you can share experiences with

your coworkers, and you can find ways to take care of yourself to avoid the vicarious traumatization.

Maxine Harris

I think the first thing you have to do is recognize what the signs are of vicarious traumatization. You want to look for things like being unduly irritable, grumpy, and grouchy, reacting to a stressful day as if it were the end of the world. Somebody tells you a sad story and you find yourself crying and feeling overwhelmed; these are the kinds of things you want to look for. If you would rather do paperwork than talk to a person, that may be a sign that you've just had too much. When you notice those things, you want to do those kinds of things that Lori suggested around taking care of yourself either with colleagues or individually.

What you also want to do is to give yourself permission to take a pass on a particular individual who may be more than you can handle. I think many of us who have had professional training learned that it is our problem if we cannot work with somebody. We need to learn how to get over our problem, so that we can work with everyone. I think that's really a misguided notion; one way you take care of yourself is you step back from somebody who is, for whatever reason, more than you can handle at the time.

Q. We were wondering if you have any creative approaches to assisting folks who have been traumatized and have difficulty parting with their belongings, which then becomes a barrier to coming off the street.

Lori Beyer

I think your question gets at what we have seen with some of the trauma survivors in terms of obsessive compulsive behaviors and what those belongings represent to them. To part with those belongings represents a huge loss. And they have had so many losses in their lives, beginning with the first relationship with that caretaker who didn't take care of them and who didn't protect them from the abuse, to the many losses that they experienced throughout their lives. So when you ask them to give up some of those possessions, they're going to experience it as another loss and as not having power and control in the situation. I understand that it can be an impediment sometimes, but really try to work with someone to understand what those belongings represent to her and try to come up with some type of middle ground, if you can.

We had a situation where someone needed to get rid of things. It required that her clinician be with her going through each thing, bag by bag. And sometimes, it was very frustrating that she could only get rid of a couple of things. The agency helped her to find a place, someone's garage, where they were willing to store the belongings. It was a very painful process, but we all learned so much about what those belongings represented to her, and why she needed to have control over that situation, going through each bag to tell us what was acceptable that she get rid of and what wasn't.

If we had taken control of that situation and had said to her, "Look, this is the way it is," we would have lost her; she would have refused to have contact with us. We would have then just become another blacklisted provider who "doesn't understand where I'm coming from." It was not an easy process, but certainly something that we needed to walk through with her, and we learned so much from it.

Q. I'm wondering if you can address the issue of refugees and immigrants from war-torn countries who have trauma experiences, how much that's similar to the trauma that you've been discussing of people in this country who have been physically, sexually, or emotionally traumatized. What's the overlap in terms of experience and strategies that we can use to work with them? We're in Portland, and I'm wondering if you have this problem in Washington or on the East Coast.

Maxine Harris

I think it's an interesting question. It's perplexing that here in the Nation's Capital we actually do not have a large refugee population. Most of the homeless people that we work with are African American,

born in the DC area. Every once in a while, we get somebody from one of the other States, who feels compelled to come and visit the Nation's Capital with a message for the President. But we tend not to get folks, in part because I think we don't have a lot of industry here and a lot of places for people to blend in and find work. There's a whole new field in refugee trauma in the women's movement. Laura Prescott and Andy Blanche are folks who have worked with women from Sarajevo, women from Macedonia, and women from Somalia, for example. They've dealt with issues around not just their displacement from their homelands, but enormous problems of witnessed violence, where people's entire families, villages, and neighborhoods were decimated, where everybody was raped and violated. I think this is a kind of PTSD *en masse* for people who have lived through that.

Also, Barton Evans is someone who has written about refugee trauma with respect to people who come to this country seeking political asylum and who are terrified about the safety of family and friends back home. So they have very mixed emotions about seeking any kind of help or saying what they know or what they saw.

I think while the sexual and physical abuse in childhood that we're talking about is a cousin of the refugee abuse that you may be seeing, the problem experienced by refugees who have been so totally torn from everything that is familiar is a different kind of phenomenon. I would refer you to some of the folks who are working on this more specifically.

Gigi Belanger

May I cut in momentarily, Maxine? This is Gigi Belanger at SAMHSA. For those callers who are interested in more information about refugee mental health, SAMHSA has a Refugee Mental Health Program. You can contact the Acting Branch Chief at (301) 443-7790. They provide technical assistance in this area.

Maxine Harris

I think what that says is how much SAMHSA has also recognized that this is a separate and distinct area and needs its own attention. For those of you who are in areas where there is a high refugee population, I would suggest that you follow up on Gigi's recommendation and contact the Branch at SAMHSA

Q. A follow-up on the issue of groups: Can you say a few words about candidates that you feel are not appropriate for groups, or people that you would screen out?

Lori Beyer

Thanks for the question. I think we really want to give everyone possible a try in a group. Oftentimes, the criteria is that someone has to be psychiatrically stable or they have to be clean and sober. What we would like to do is have them come into the group to see what it's like, to see whether or not they feel comfortable, if they can tolerate the group, and so on.

I know that for some of your programs, you might think, "How could we possibly have someone who's drunk or high coming to group?" It's been overwhelmingly our experience that these people don't come to group, that if they are actively using, group is not their first priority. I can't think of even five examples where we've had difficulties, where we thought that people had come to group when they were using. In regard to people's psychiatric stability, we really tailored our group to be able to work with people wherever they were at.

If they had cognitive impairments, we wrote the language in such a way that they would be able to understand it. We put a high premium on defining every term that we use; it doesn't do any good to talk about self-esteem if people don't know what self-esteem is. We can't assume that, and this is a psychoeducational group, so we are going to explain what self-esteem is so that we're all on the same page. We're going to make it possible and accessible for anyone to be able to be in this group.

We also believe it's important that we help them to contain their affect and the stories that they're going to tell. We don't want them to be spilling and flooding. They can retraumatize themselves. They can also retraumatize the other people in group. This

really makes is possible for them to be able to do the trauma recovery work and to be in the group, because we are helping them to contain that affect, and we are helping to contain the stories so that they can do the work.

Our model is not one where we seek to exclude people; rather, we really wanted it to be a model that was inclusive, because we're working with the same people you're working with. With these people, if we said, "If you miss five groups, you can't come back," we would have an empty room because our people do miss sessions. So we needed a type of intervention, a type of treatment, that was really accessible to a very vulnerable population, an unpredictable population, a population that is going to have good times and bad times but we're going to see them through it. Whether they need to go into the hospital and be detoxed, or become more psychiatrically stable, they're welcome back into the group.

Maxine Harris

The model that Lori's describing, which we call Trauma Recovery and Empowerment or TREM, is a 28-session group intervention. We have just completed a several year study that SAMHSA has funded looking at the TREM model, with more than 150 who participated in groups, and we found that 75 percent of the women who entered groups attended 75 percent of the sessions. So when you consider that we are screening no one out, and anybody who comes into the program is welcome into the group, we've been pretty impressed that three out of four women come to 75 percent of all the sessions.

Q. Could you speak more about mental health and dual diagnosis, and how to differentiate or more accurately diagnose to appropriately refer the trauma client?

Maxine Harris

I think that the referral for the trauma client really should flow from her desire to pursue trauma issues. In addition to the groups that we run, we are now offering individual counseling for people who seek it. I can tell you those who have been referred by clinicians, who thought they needed to do trauma work, do not do that well because it's somebody else's agenda. I think that if someone identifies trauma issues, but does not want to work on those issues, that needs to be respected. You may say to that person, "I think some of these symptoms would either go away or be muted if you did some work on these issues. But that is your choice." You don't want to intrude psychologically on somebody's space, by insisting that they address trauma issues. That should be their choice. So the referral is not based on what symptoms you see, but it is based on the stated request of the survivor herself.

Tom Lorello

I think we're actually just about out of time. I'd like to encourage everyone to visit the PATH Web site. If you do have other questions that weren't answered, I would encourage you to visit the discussion page and ask your questions there.

Finally, thanks to our featured presenters, Maxine Harris and Lori Beyer of Community Connections. Thank you so much for your very thoroughly prepared presentation today. Thanks to Gigi Belanger of the CMHS Homeless Services Branch.