ZERO TO THREE Corner

Working With Families Experiencing Homelessness: Understanding Trauma and Its Impact

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Natural disasters often result in homelessness. The trauma associated with the loss of home, safety, and a sense of security have a significant impact on how children and adults think, feel, behave, cope, and relate to others. Understanding trauma and its impact is essential to providing quality care to families who are experiencing homelessness. Becoming "trauma-informed" requires that service providers tailor their services to meet the unique needs of trauma survivors and avoid additional harm. In this article the authors explore the impact of trauma on families experiencing homelessness in the United States, and identify concrete strategies that can be used to address these families' needs.

Homelessness is a devastating experience that significantly impacts the health and well-being of adults and children. Families with children comprise 34% of the homeless population and this number is growing (U.S. Department of Housing and Urban Development, 2007). In the United States, one in every 50 children experience homelessness—approximately 1.5 million children (The National Center on Family Homelessness, 2009). Forty-two percent of children who are homeless are less than 6 years old (Burt et al., 1999, 2000). Families enter the homeless service system because of various factors that include lack of affordable housing, unemployment, limited access to resources and supports, health and mental health issues, and experiences of violence.Eighty-four percent of families experiencing homelessness are female-headed (U.S. Department of Housing and Urban Development, 2007). The typical sheltered family is comprised of a mother in her late twenties with two children (Burt et al., 2000).

The prevalence of traumatic stress in the lives of families who are homeless is extraordinarily high. Often these families have experienced ongoing trauma in the form of childhood abuse and neglect, domestic violence, and community violence, as well as the trauma associated with poverty and the loss of home, safety, and sense of security. These experiences have a significant impact on how children and adults think, feel, behave, relate to others, and cope. Traumatized families have a unique set of needs and require tailored services. In this article we explore the impact of trauma on homeless women and children and describe concrete strategies and promising practices that can be used in a variety of community-based settings to address their needs.

WHAT ARE THE EXPERIENCES OF MOTHERS AND CHILDREN WHO ARE HOMELESS?

Alice is a 26-year-old woman who lives in a shelter with her daughter, Sarah, and son, Matthew. Alice's exposure to violence began in childhood, when her father hit her frequently. In adulthood, soon after she was married, Alice's husband was imprisoned for theft. After his release, the marriage became violent. Over the course of 3 years, Alice left her husband 15 times.

The violence in Alice's life is a common story among homeless families. Mothers who are homeless frequently have significant histories of interpersonal violence. Traumatic events such as childhood physical and sexual abuse, family separation, and domestic violence in adulthood take a severe toll on families, often increasing their risk of experiencing additional traumatic life events (see box Defining Trauma). For these families, becoming homeless adds another layer of traumatic stress.

DEFINING TRAUMA

WHAT MAKES AN EXPERIENCE TRAUMATIC?

- Involves a threat to one's physical or emotional well-being.
- Is an overwhelming experience.
- Results in intense feelings of fear and lack of control
- Leaves people feeling helpless.
- Changes the way a person understands himself/herself, the world, and others.

TRAUMA IN THE LIVES OF HOMELESS MOTHERS

Rates of violence among homeless women are extremely high (Bassuk et al., 1996; Browne & Bassuk, 1997; D'Ercole & Struening, 1990; Wood, Valdez, Hayashi, & Shen, 1990). Bassuk et al. (1996) documented that 92% of homeless mothers had experienced some form of physical or sexual assault over the course of their lives, mostly in familial or intimate relationships. During childhood, 43% of homeless women reported being sexually molested, usually by multiple perpetrators (Bassuk et al., 1996). Violence continues into adulthood with 63% of homeless mothers reporting severe physical assault by an intimate male partner (Browne & Bassuk, 1997).

While growing up, nearly half of homeless mothers lived outside of their homes at some point and 20% spent time in foster care (Bassuk, Buckner, et al., 1997). Disrupted attachments, whether they are due to abuse and neglect or family separations, have a significant impact on future relationships, emotional health, use of social supports, and development of coping skills. Homeless mothers who enter adulthood without the skills necessary to manage stress are considerably more vulnerable to the destructive impact of violence and poverty, and subsequent experiences of homelessness and other traumatic stressors (Bassuk, Perloff, & Dawson, 2001.

In addition to childhood and adult experiences of violence, researchers have found that being homeless is itself traumatic (Goodman, Saxe, & Harvey, 1991). First, homelessness adds an additional layer of vulnerability and deprivation that may increase a family's risk for continued exposure to various forms of violence. Second, the process of becoming homeless involves the loss of belongings, community, and sense of safety. Third, living in shelters is isolating and can lead to a loss personal control (Goodman et al., 1991). Homelessness can also trigger symptoms associated with past traumatic stressors that may hinder a family's ability to move back into stable housing (Goodman et al., 1991).

TRAUMA IN THE LIVES OF CHILDREN WHO ARE HOMELESS

Children who are homeless often live in chaotic and unsafe environments where there is frequent exposure to various forms of violence, including domestic violence, physical and sexual abuse, unpredictable adult behaviors and responses, and dramatic life changes such as moving from place to place, family separations, and placement in foster care. Within a single year, 97% of children who are homeless move up to three times, 40% attend two different schools, and 28% attend three or more different schools (The National Center on Family Homelessness, 1999). Nearly one quarter of children who are homeless have witnessed acts of violence within their family, a significantly higher rate than children in the general population (The National Center on Family Homelessness, 1999). Children who are homeless frequently worry that they will have no place to live and no place to sleep (The National Center on Family Homelessness, 1999). Many worry that something bad will happen to their family members. More than one half are frequently concerned about guns and fire (The National Center on Family Homelessness, 1999).

An unsafe or disrupted relationship with a primary caregiver is one of the most traumatic experiences that a child can face and has a profound impact on health and well-being. More than one third of children who are homeless have been the subject of a child protection investigation (The National Center on Family Homelessness, 1999). Twenty-two percent of children who are homeless are separated from their families (The National Center on Family Homelessness, 1999). About 12% of children who are homeless are placed in foster care, compared to slightly more than 1% of other children (The National Center on Family Homelessness, 1999). Other children are sent to live with relatives.

HOW DO OUR BODIES RESPOND TO TRAUMATIC EXPERIENCES?

Families who are homeless have encountered many threats to their physical and emotional well-being. In order to understand and work with children and adults who have experienced trauma, it is helpful to consider how our bodies are designed to respond to stress and threat.

THE BODY'S RESPONSE TO THREAT

The brain contains a natural alarm system designed to detect and evaluate potential threats and activate physical responses to keep the body safe. When the alarm system detects a threat (e.g., a loud noise, a violent situation, neglect), it readies the body to respond by releasing chemicals that lead to various physical responses such as sweating and increased heart rate and breathing. In these moments, humans respond to stress in one of three ways: fight (actively doing something to the source of the threat), flight (avoiding the stressor), or freeze (shutting-down in the face of the threat). People all experience threats to their well-being from time to time (e.g., a car accident, witnessing a frightening event, experiencing a natural disaster). These experiences may be scary, but may not be "traumatic." Oftentimes, a stressor becomes traumatic when attempts to fight, flee or freeze do not help a person to escape the threat in the way he expects, and he is left feeling helpless, fearful, and out of control (see box Understanding Triggers).

UNDERSTANDING "TRIGGERS"

The term "trigger" refers to reminders of past traumatic experiences that people encounter in the present. Triggers may include sights, sounds, smells, feelings, or experiences that are associated with a previous traumatic experience (Kinniburg & Blaustein, 2005). When exposed to a trigger, the trauma survivor's brain remembers this as a danger signal based on past experiences and immediately prepares the body to respond.

COMPLEX TRAUMA

The term "complex trauma" is used to describe prolonged, persistent traumatic stress that often originates within the caregiving system during critical developmental stages and leads to immediate and long-term difficulties in many areas of functioning (Cook et al, 2005). Most commonly, it is associated with disrupted attachments. Given the prevalence of chronic interpersonal violence, along with the stress associated with daily survival in an often unsupportive system, the experiences of homeless mothers and their children often fit the definition of complex trauma. Homeless adults and children, as well as other chronically traumatized individuals, are constantly on-guard and prepared to respond to danger. Nearly any threat or danger becomes a reminder of past trauma, and these families are constantly engaged in emergency fight, flight, or freeze responses. This level of physiological arousal has a significant impact on thinking, planning, problem-solving, managing physical and emotional states, and sustaining secure and trusting relationships (van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola., 2005).

HOW DO TRAUMATIC EXPERIENCES IMPACT MOTHERS AND CHILDREN WHO ARE HOMELESS?

Homeless women struggle with poor physical and emotional health compared to the general population.

IMPACT ON MOTHERS' PHYSICAL AND EMOTIONAL HEALTH

Some physical issues may come from injuries associated with violence, while other complaints may represent a deeper physiological response to chronic trauma that results in somatic symptoms or "body memories" (Bassuk, Melnick, & Browne, 1998). More than one third of mothers who are homeless have a chronic physical health condition. For example, they have ulcers at 4 times the rate of other women, and higher rates of asthma, anemia, and hypertension than in the general population (Bassuk et al., 1996; Weinreb, Goldberg, & Perloff, 1998).

Along with physical health issues, mothers experiencing homelessness struggle with high rates of mental health and substance use issues (Bassuk, Buckner, et al., 1997; Bassuk & Rosenburg, 1988; Bassuk et al., 1996; D'Ercole & Struening, 1990; Ingram, Corning, & Schmidt, 1996). High rates of posttraumatic stress disorder (PTSD) among homeless and extremely poor women are well-documented (Bassuk, Buckner, Perloff, & Bassuk, 1998; Bassuk, Dawson, et al., 2001; Bassuk, Melnick, & Browne, 1998; Bassuk et al., 1996; Browne, 1993; North & Smith, 1992). More than one third to one half of homeless mothers have experienced PTSD—a rate 3 or more times greater than among women in the general population (Bassuk, Buckner, et al. 1998; Weinreb, Buckner, Williams, & Nicholson, 2006). In addition, 85% of homeless mothers report a history of major depression (Weinreb et al., 2006). Given high rates of violence and mental health issues, it is not surprising that women who are homeless also have twice the rate of drug and alcohol dependence as in the general population (Bassuk et al., 1996). As a result of these challenges, women who are homeless and have experienced chronic trauma have considerable difficulties trusting others and accessing help and support for themselves and their children.

IMPACT ON CHILDREN

Tyrone is a 3-year-old child living in a homeless shelter on the south side of Chicago. His family includes his 4-year-old sister, a 1-year-old brother, and their mother. Tyrone exhibits significant developmental delays in the areas of cognition, language, and motor skills. His emotional functioning is marked by erratic responses toward his mother and other adults and excessive crying spells. In therapy, the child's mother disclosed that Tyrone had witnessed repeated incidents of domestic violence.

ATTACHMENT

The health and well-being of a parent is inextricably linked to the health and well-being of her child. The quality of the parent–child relationship has a profound impact on a child's awareness of self and others, social and emotional development, and school adjustment (National Scientific Council on the Developing Child, 2004). Parents who have been traumatized often have greater difficulty being responsive and sensitive to their children's needs (Osofsky, 1999). Disrupted parent–child relationships can impact all aspects of a child's functioning, beginning at the most fundamental, neurobiological level. Research suggests that "relationships children have with their caregivers play critical roles in regulating stress hormone production during the early years of life" (National Scientific Council on the Developing Child, 2005, p. 3). Experiences such as abuse, neglect and maternal depression can lead to elevated levels of stress hormones that may impact brain development and future coping skills. In addition to the neurobiological impact of stress associated with disrupted attachments, research shows that children who have a parent with a mental health issue are at greater risk of presenting with developmental delays, struggling with psychosocial and academic problems, and developing psychiatric diagnoses (Nicholson, Biebel, Hinden, Henry, & Stier, 2001).

The level of fear and unpredictability in the lives of children who are homeless can be extremely damaging to their growth and development, especially to the formation of secure attachment relationships. Family violence and separation threatens physical and emotional connections. Mental health issues, such as the high rates of depression seen in homeless mothers, significantly impede a parent's ability to bond with her child. As a consequence, children who are homeless often present with developmental delays and physical and emotional health challenges.

DEVELOPMENT

The experiences of children who are homeless, both prior to and after becoming homeless, have a significant impact on growth and development (Bassuk & Rosenberg, 1990; Bassuk & Rubin, 1987; Bassuk, Rubin, & Lauriat, 1986; Rafferty & Shinn, 1991). Studies of children who are homeless cited by Rafferty and Shinn have documented developmental delays, including difficulties with attention, speech delays, immature peer interactions, language disabilities,

and cognitive delays. Bassuk and her colleagues noted that children who are homeless demonstrated significant delays in language development, gross motor skills, fine motor skills, and social/personal growth. More than half of homeless preschoolers showed at least one major developmental lag.

PHYSICAL AND EMOTIONAL HEALTH

Children who are homeless are often in poor physical health (American Academy of Pediatrics, 1996; Rafferty & Shinn, 1991; The National Center on Family Homelessness, 1999). They are more likely than children in the general population to suffer from acute illnesses such as fever, ear infection, cough, stomach problems, and asthma, as well as chronic diseases such as sinusitis, anemia, asthma, bowel dysfunction, eczema, visual problems, and neurological deficits (American Academy of Pediatrics, 1996; The National Center on Family Homelessness, 1999). Nearly 70% of infants, toddlers, and preschoolers who are homeless have chronic illnesses (The National Center on Family Homelessness, 1999). Children who are homeless and families living in poverty lack routine and timely medical care. They often have poor nutrition associated with a lack of money to provide adequate meals (The National Center on Family Homelessness, 1999). In addition, some health issues are related to experiences of trauma (American Academy of Pediatrics, 1996). A lack of consistent health care prior to and while homeless combined with the stress of homelessness itself contributes to poor health outcomes for children (The National Center on Family Homelessness, 1999).

As discussed above, experiences of loss or events that impact the parent–child relationship can have a significant impact on a child's sense of safety and well-being and result in intense emotional responses. In addition to physical health complications, children who are homeless have 3 times the rate of emotional and behavioral problems compared to non-children who are homeless (National Child Traumatic Stress Network, 2005). Children who are homeless have high rates of anxiety, depression, sleep problems, shyness, withdrawal, and aggression (Bassuk & Rosenberg, 1988; Bassuk & Rubin, 1987). In a study of preschool-age homeless and poor housed children, Bassuk and colleagues (Bassuk, Weinreb, Dawson, & Perloff, 1997) found that children who are homeless had significantly higher externalizing scores on the Child Behavior Check-List (Achenbach &Edelbrock, (1983) and slightly higher internalizing scores. They also found that 12% of children who are homeless had clinical problems such as anxiety, depression, and withdrawal, and 16% had behavior problems evidenced by severe aggression and hostility. High scores on the Child Behavior Check-List were most closely predicted by length of time in foster care, experiences of physical abuse, death of a childhood friend, and mother's emotional status (Bassuk, Weinreb, et al., 1997).

HOW CAN SERVICE PROVIDERS RESPOND TO FAMILIES EXPERIENCING HOMELESSNESS?

Case managers, clinicians, child care workers, educators, school liaisons, and shelter staff all work with children and families who are homeless. Given the high rates of trauma among the homeless population, how can providers work with these family members most effectively? To meet the needs of this population, providers must move toward a new way of providing care. Becoming "trauma-informed" means learning about trauma and its impact and using this knowledge to tailor services and avoid additional harm. In the following section, we outline concrete strategies for providing trauma-informed care to children and families who are homeless and can be applied in various service settings.

1. EDUCATING STAFF

Educating all providers in an organization about traumatic stress and its impact is essential to providing trauma-informed care. Trauma survivors, particularly those who have experienced multiple traumas, have developed survival skills that have helped them manage past traumas. These survival strategies (e.g., substance abuse, withdrawal, aggression, self-harm) were adaptive when the original trauma occurred, but can be confusing and difficult to understand and manage since they often interfere with achieving current goals. Without understanding trauma, providers may view a parent as "manipulative," "oppositional," or "lazy." Instead, these behaviors may be better understood as trauma-based responses used to manage prior overwhelming feelings and situations. Professionals may label a child as "hyperactive," "oppositional," "shy," or "spacey," when these behaviors may be fight, flight, or freeze responses to on-going stress. Adequate training ensures that all providers understand these responses as adaptive and offer consistent, trauma-sensitive responses.

Basic education for all service providers working with homeless families must include:

- Information about the homeless service system, resources, families' experiences living in shelters, and the medical and mental health needs of this population;
- Education about the impact of traumatic stress on children at different stages of development, and how traumatic stress affects early attachments;
- Training on the developmental stages and tasks accomplished during each stage—particularly birth to 6 years, as this is the age range of many children who are homeless; and
- An understanding of attachment, including types of attachment (e.g., secure vs. insecure) and the relationship between attachment and the development of coping skills, identity, and future relationships.

2. CREATING SAFE ENVIRONMENTS

"My son never had problems sleeping until just before we came to the shelter. We moved a lot in the past year. Before coming to this shelter, we stayed with a friend. My son was sitting on a bed and nearby gunfire frightened him. One bullet passed through the apartment and just missed him. Since then, he can't sleep, unless he's next to me. It's worse in the shelter because we have less privacy. The staff is great and try to help, but he's just scared all the time."

Traumatic experiences challenge people's idea that the world is a safe and predictable place, and often leave people feeling insecure and distrustful of others. The loss of home leads to an additional loss of safety, security, and control. To begin to heal, families must feel safe. Physical safety is critical—especially in the immediate aftermath of a traumatic event, but it is also important for clients to feel emotionally safe. Emotional safety involves the need to feel protected, comforted, in control, heard, and reassured. For children this need is often met by their primary caregivers. However, when the whole family has been affected by traumatic stress, children and their caregivers need service providers to help them feel physically and emotionally safe. Service providers must examine their physical space and overall culture or environment to develop strategies for promoting safety and modeling this for parents and other family members.

CREATING A SENSE OF SAFETY IN YOUR PHYSICAL SPACE

Creating a welcoming and relaxing physical environment provides a sense of safety and security that is essential to the trauma survivor who is always on the look-out for danger. This begins from the moment a family walks through the door. The way a family is greeted and oriented to the space can set the tone for developing relationships. Examples include:

- Familiarizing families with the space (e.g., location of exits, choices for where they sit, locations of restrooms).
- Maintaining the overall environment (e.g., fixing things when they are broken, keeping things clean). A well-maintained physical space conveys respect for clients.
- Creating a sense of physical safety by doing the following: keeping the space well-lit, implementing security measures, and informing clients of these measures.
- Providing a space for children to play, particularly if you work in a space that is less child-focused. Child-friendly spaces include developmentally appropriate toys, chairs, and books; colorful pictures and paintings; learning materials and posters with "feelings faces" and "feelings thermometers" to foster skill-building.
- Identifying "safe spaces" for children to go when they are feeling overwhelmed or triggered. These safe places may include: (a) a reading corner in a classroom; (b) the guidance counselor's office or an area of the playroom separate from the main activities; (c) a particular chair in an office; (d) a "calming room" where children can draw, listen to music, rock in a chair, or take a nap; or (e) a multisensory room where children can utilize balls, weighted blankets, mats, etc., to help them calm down. Adults should talk with children directly to help them determine a safe place to go when feeling scared, overwhelmed, or sad. At home, parents can work with their child to identify safe places where they can calm down and relax their bodies. When a child shows signs of distress (e.g., crying, acting out, withdrawing), take the child aside and ask her if she would like to go to her safe place until she feels calmer.

See box "Examining Your Physical Environment" for an example exercise to do with your staff.

MAINTAINING A SENSE OF EMOTIONAL SAFETY

There are strategies for creating a sense of emotional safety within your service setting. These include establishing routines and rituals; recognizing triggers and fight, flight, or freeze responses; and creating safety plans.

Establishing routines and rituals provides the structure and predictability help all people, especially young children, feel safe and secure. For children who have experienced trauma, restoring a consistent and predictable environment helps them recognize that safe places do exist. For providers, this means having a clear, consistent schedule with well-planned transitions. For children who are living in shelters, it is important to provide a clear sense of what they and their family can expect (e.g., what is a shelter, why do families come here, what happens when they leave, what can kids expect, what are their parents' goals). Providers can encourage individual families to establish their own rituals around mealtimes, bedtimes, and after school.

"EXAMINING YOUR PHYSICAL ENVIRONMENT" EXERCISE

Ask your staff to do the following:

- Picture your organization's physical space. Focus on a place where you frequently meet with children and families: the community room, an office, a playroom, a classroom, or a waiting/reception area. What do you see? Notice the physical layout of the room. What about the room's security? What about privacy? What does the overall atmosphere convey?
- Take 10 minutes to draw the space that you just envisioned, with any additions or changes you would make to the space to make it more welcoming or safe for families. Be realistic and honest, but also keep in mind what we have been talking about today.

It is important to recognize triggers and fight, flight, freeze responses.

Shortly after entering a homeless shelter, 3-year-old John became markedly distressed. He resisted change, constantly tested limits, and responded to directions by physically throwing himself on the floor, kicking, and hitting. He was verbally threatening and physically aggressive toward adults and other children.

No matter how young the child, the brain and body responds to traumatic stress and retains memories of these experiences, which may be stored as "felt" or "body" memories of fear, loss, anxiety, and need. Similar situations or experiences in the present may remind children of these traumatic experiences. Potential reminders or "triggers" for children who have experienced trauma may include:

- Loud noises
- Hand or body gestures
- Fighting
- Confusion or chaos
- Transitions
- Change in routine
- Feelings of anger, sadness,

or fear that trigger similar feelings connected to past trauma

- Physical touch
- Emergency vehicles and police and fire personnel
- Certain smells
- Separation from caregivers
- Loss (e.g., of things, people, home)

When faced with reminders of traumatic experiences, children's brains and bodies are programmed to go into automatic fight, flight, or freeze response mode. These behaviors can be very confusing, and there is a tendency to misunderstand or mislabel trauma-related responses (see box Fight, Flight, and Freeze Responses).

As providers working with traumatized children and families, it is essential to identify potential triggers for children and, when possible, avoid them. It is also important to identify potential triggers for parents (e.g., loss of control, feeling put-down or misunderstood, feeling overwhelmed or frightened), to avoid these situations in daily programming. It can be helpful for providers to review their daily interactions with children and families when they enter the program to identify triggers, and strategize about how to eliminate potentially negative experiences for clients (see box Identifying Triggers).

Children who have experienced the trauma of homelessness and family violence are likely to have many triggers. It is helpful for adults to create individualized safety plans for each child that include the following components: (a a list of triggers; (b) a list of "warning signs" that the child is escalating or becoming overwhelmed; (c) responses that are helpful when she is in distress (e.g., physical touch, space away from the group, offering them a specific toy or stuffed animal); (d) responses that are not helpful when the child is in distress (e.g., physical touch, multiple adults attempting to help, offering to call a child's parent); and (e) safe people and places for a child when she needs to calm down.

Staff should create safety plans with children and their parents and share the plans with providers working with the family. For young children, parental involvement in identifying triggers, warning signs, and soothing strategies is essential. This activity offers providers the opportunity to ask parents for assistance in keeping their children safe when the parents are not available. At the same time, providers can use this exercise to educate parents without shaming or blaming them. Providers can encourage parents to use these safety plans at home as well.

3. CONDUCTING CHILD ASSESSMENTS

Children's needs often go unmet within homeless service settings. The focus tends to be on the parent, who has to find housing, employment, and benefits, etc., and children's needs go unmet. Children living in shelters with their families face a variety of challenges to their well-being and healthy development. The children sometimes display difficult behaviors and a confusing set of symptoms. Young children may lose previously acquired skills (regression) or may have problems sleeping (insomnia, restless sleep) and eating. They may be highly distractible, unable to play for more than a few minutes, or their play may be constricted and repetitive. To adapt to prolonged traumatic experiences, children and adults may develop symptoms that mimic other disorders. Traumatized children may present with symptoms that are consistent with a diagnosis of attention-deficit hyperactivity disorder, bipolar disorder, oppositional-defiant disorder, or reactive-attachment disorder (Cook et al., 2005). Without a thorough assessment that includes a history of trauma, providers may diagnose or label a child on the basis of presenting behaviors and miss the traumatic experiences that may be the source of the symptoms and the necessary focus of treatment (see box Developmental Trauma Disorder).

Including child assessments as a routine part of any intake process

FIGHT, FLIGHT, AND FREEZE RESPONSES

Fight responses to triggers may include:

- Yelling, tantrums, or both
- Swearing
- Hitting or fighting
- Throwing things or damaging property
- Hyperactivity
- Being hyperalert to potential danger

Flight responses to triggers may include:

- Withdrawing (e.g., isolating, curling up in a ball, hiding)
- Not responding to others
- Running away from others
- Regression to an earlier developmental stage

Freeze responses to triggers may include:

- "Spacing out" (e.g. appearing disconnected, forgetting or appearing confused about what just happened, becoming nonresponsive)
- Going to sleep

IDENTIFYING TRIGGERS

Example:
A parent and his child come in for an intake assessment.

Potential triggers include: where he has to sit in relation to the door; what information is shared; understanding what will be done with this information; trusting another person with this information and his child; feelings of embarrassment and shame re: lack of housing, mental health or substance use issues, violence in the home, difficulties parenting; the stress of reliving past traumatic experiences when telling his story.

Staff response may include: A clear explanation of the purpose of the intake and what is done with the information; time for breaks and awareness of when the parent or child appears overwhelmed; confidential spaces to conduct the assessment, a focus on parent strengths and skills.

DEVELOPMENTAL TRAUMA DISORDER

Within the trauma field, experts have suggested a new diagnosis for children who have experienced chronic trauma and adults who have experienced trauma since childhood. Developmental trauma disorder better captures the range of responses and the impact of complex trauma than current diagnoses such as PTSD. The goal is to avoid attaching several diagnoses to a set of symptoms that are better understood as trauma responses. Visit www.traumacenter.org for additional information.

allows providers to focus on the needs of children. Specific questions about mental and physical health, traumatic experiences, and development should be routinely asked. For providers who do not work in shelter settings, questions about housing stability and homelessness should be a routine part of any screening or intake interview. Assessments of infant and early child health and mental health are important, as are questions and measures to assess parenting style, satisfaction, and attachment. Thorough child assessments allow providers to make immediate referrals for further evaluation, and mental health and early intervention services. Because a subgroup of children will require more intensive services, all programs must establish referral networks in the community.

4. BUILDING SKILLS AND CONNECTIONS

When providers understand trauma responses, they can help a survivor better understand her experiences, provide opportunities to practice regaining self-control, and use techniques to de-escalate difficult situations. Important components of support for trauma survivors involve helping them identify specific triggers,; understand what is happening in their brains and bodies, ground themselves in the reality of the present situation, and develop self-soothing techniques and coping skills to manage feelings associated with past traumatic experiences.

SKILL BUILDING FOR CHILDREN

Within the trauma field, experts have suggested a new diagnosis for children who have experienced chronic trauma and adults who have experienced trauma since childhood. Developmental trauma disorder better captures the range of responses and the impact of complex trauma than current diagnoses such as PTSD. The goal is to avoid attaching several diagnoses to a set of symptoms that are better understood as trauma responses. Visit www.traumacenter.org for additional information.

Providers can foster skill building by establishing activities and rituals that help children identify how they are feeling and calm themselves down. The following are some strategies for building these skills:

Feelings Faces and Feelings Thermometers:
Providers and parents can ask children to circle a face that corresponds with the emotion that they are feeling or point to where they are on the "angry" or "sad" or "happy" thermometer.

Relaxation Exercises:
1. Breathing activities ("Put your hands on your stomach. Breathe in deeply and pretend you are blowing bubbles." Or "Breathe in— pretending that you are smelling flowers, blow out, like you are blowing out candles).
2. Muscle relaxation (e.g., progressive muscle relaxation from head to feet)
3. "Grounding" activities help children calm down and stay focused on the present when they are feeling overwhelmed or triggered. Activities may include the use of tools or toys that focus on the senses, such as stress balls, soft toys, or a weighted blanket*. Drawing, music and movement (e.g., yoga or play) are also helpful means of expression and grounding for children. *Cross-specialty learning can be very effective here. For example, many of the strategies used by occupational therapists can help disregulated children manage their level of physiological arousal.

Group Activities: Physical and Emotional Awareness for Children Experiencing Homelessness
Physical and Emotional Awareness for Children Experiencing Homelessness (PEACH) is an innovative curriculum that teaches young children (age 4–7 years) about good nutrition, physical activity, and how to deal with the stress of being homeless. At the heart of the PEACH curriculum are sessions on emotional health that are specifically designed to help children living in shelters understand their bodies' reactions to traumatic stress and what to do about it. These sessions help children identify and feel comfortable with a range of emotions and learn strategies that help them feel safe. The program is based on the award-winning OrganWise Guys curriculum, which The National Center on Family Homelessness adapted for shelter settings. The OrganWise Guys are fanciful characters representing the organs in the body. Hardy Heart teaches children how their hearts need love, kindness, and plenty of exercise to stay healthy. Calci M. Bone is also enthusiastic about exercise, almost as much as she is about eating bone-healthy foods such as yogurt and milk. Pepto the Stomach understands that kids need to eat fruits and veggies. He also sometimes gets "butterflys" when he's nervous. These characters and the other OrganWise Guys come to life for children through interactive and engaging materials, including books, videos, and activities.. PEACH is being implemented in hundreds of shelters, health centers, and other community-based agencies around the country. Please visit The National Center on Family Homelessness Web site, www.familyhomelessness.org, for additional information about this curriculum.

Particularly for younger children, who have fewer words to express how they feel, the use of play and body-based activities become a primary way for children to manage stress and develop coping skills (see box Skill Building for Children).

SKILL-BUILDING FOR PARENTS

Children experience the world within the context of their family system and the broader community. Family and community stressors such as poverty, violence, and homelessness have a significant impact on child well-being and development. Resilience literature points to a range of protective factors for children including positive parenting, healthy attachments to caregivers, and community support for families (Masten & Gewirtz, 2006). There are many models for strengthening attachment and building parental skills. However, few of these have been used in shelter settings with families who are homeless. The following are examples of promising and evidence-based practices that have been used with or adapted for work with families experiencing homelessness and that focus on parent skill-building and enhancing family connections:

- **Nurturing Parenting Programs**. Nurturing Parenting Programs are designed to treat and prevent child abuse and neglect and improve parenting skills. The Nurturing Parenting Programs teach age-specific parenting skills along with addressing the need to nurture oneself. The program curriculum consists of separate curriculum for parents and for children. The content of the parent portion of the program focuses on increasing self-esteem and self-concept while teaching nurturing parenting skills appropriate for the age group of the child. The program is administered in two formats: Home-Based and Center-Based. A variety of Nurturing Programs support parents and infants, toddlers and preschoolers, prenatal families, as well as families with older children. Nurturing Programs have been implemented in a variety of settings, including shelters. For additional information, please visit the Nurturing Parenting Web site at www.nurturingparenting.com.

- **Child–Parent Psychotherapy**. Designated a promising practice by the National Child Traumatic Stress Network, Child–Parent Psychotherapy is designed for parents and their children birth to 6 years old. The goal is to improve the caregiver–child relationship, focus on safety, provide education about trauma responses, and mitigate the impact of trauma on development. Child–parent psychotherapy has been used with homeless families residing in domestic violence shelters and transitional housing sites. For additional information, please visit www.nctsn.org.

- **Parent–Child Interaction Therapy (PCIT)**. PCIT was designated an evidence-based practice by the Substance Abuse and Mental Health Services Administration's National Registry of Evidence-Based Programs and Practices. PCIT is a treatment program for young children that is designed to improve the quality of the parent–child relationship and change interaction patterns. Parents are taught specific skills to establish or strengthen a nurturing and secure relationship with their child. PCIT is generally administered by a licensed mental health professional. PCIT has been used with families experiencing homelessness in shelter settings. For additional information about PCIT, please visit www.nrepp.samhsa.gov/programfulldetails.asp?PROGRAM_ID=192.

- **Child–Adult Relationship Enhancement (CARE)**. CARE is a trauma-informed modification of PCIT skills for use by nonclinical providers who interact with traumatized children and their caregivers within a variety of settings. With support from the National Child Traumatic Stress Network, The National Center on Family Homelessness partnered with the Trauma Center in Boston, MA, to adapt CARE for use by paraprofessionals in homeless service systems. CARE offers concrete techniques for interacting with children and managing the types of behaviors and problems exhibited by many traumatized children. Providers using CARE include day care providers, medical care providers, educators, foster parents, social workers, case managers, and staff at homeless shelters. For more information, see www.nctsn.org.

Less clinically driven or formal strategies for fostering parent–child attachment and parent skill-building include the following:

- Providing parent education. Providers can take the opportunity to educate parents about child development, attachment, and trauma and its impact on children. Information can help foster healthy relationships between parent and child and increase parent skills.
- Modeling healthy interactions. How staff work with parents can impact how the parents respond to their children. How staff work with children (e.g., tone of voice, eye contact, asking permission around personal space, asking them about their needs) serves as a model for parents.
- Having fun. Strengthening parent–child relationships through activities such as family nights and joint parent–child groups and activities (e.g., cooking, drawing).

See Learn More for education and training resources for providers working with families who are homeless. These resources contain additional information about trauma and trauma-informed care that include the strategies discussed above.

CONCLUSION

Families who are homeless face multiple challenges as they attempt to stay together, obtain permanent housing, and access necessary supports and resources. Violence and family disruption have a significant impact on the health and well-being of children and adults. Given the high prevalence of trauma in the lives of families who are homeless, it is imperative that service providers understand the impact of traumatic stress on adults and children and adopt a trauma-informed approach. Trauma-informed practices include creating safe environments, conducting thorough assessments, and helping parents and children build on strengths and learn new skills. Families who are homeless come into contact with service providers in a variety of settings (e.g., shelters, mental health agencies, child welfare departments, schools, and child care centers). Becoming trauma-informed involves creating an integrated web of service systems that are united in the goal of open communication, cross-

system education, and joint service planning to best assist families in their transition from homelessness.

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Ellen Bassuk, MD, is founder and president of The National Center on Family Homelessness, the nation's preeminent authority on family homelessness. As a clinical researcher, psychiatrist, and advocate, she is at the forefront of research and evaluation, program design, and service delivery on behalf of children who are homeless and their families. Dr. Bassuk's extensive research on the impact of homelessness on children and families, and the role of violence, trauma, and mental illness in their lives has made vital contributions to understanding this national tragedy. Her leadership roles on applied research projects include the Worcester Family Research Study, the nation's most comprehensive longitudinal study of sheltered homeless and low-income housed families and their children. She is currently project director for the National Child Traumatic Stress Initiative's National Collaborative for Trauma Surviving Homeless Children, directs the National Resource Center on Homelessness and Mental Illness, and is technical project director for the federal Chronic Homelessness Initiative.

Dr. Bassuk is a board certified psychiatrist and an associate professor of psychiatry at Harvard Medical School. She is a graduate of Brandeis University and Tufts University School of Medicine, and was awarded an Honorary Doctorate of Public Service from Northeastern University. She served as editor-in-chief of the American Journal of Orthopsychiatry.

LEARN MORE

National Child Traumatic Stress Network (NCTSN)
www.nctsnet.org
NCTSN offers facts and strategies for working with traumatized children for a range of service providers including educators, general public, mental healthand medical professionals, child welfare workers, parents and caregivers, and religious professionals.

The National Center on Family Homelessness
www.familyhomelessness.org
The following resources are available to download:

- *Developing Trauma-Informed Services for Families Experiencing Homelessness An Interactive Training Video and Guide.* This training video and manual includes information about traumatic stress and trauma-informed care and includes concrete suggestions for incorporating trauma-informed practices and activities for skill-building.
- *A Long Journey Home: A Guide for Creating Trauma-Informed Services*. This document offers concrete suggestions for shifting organizational culture, attitudes, and response to those they serve to create trauma-informed environments.
- *What About You? A Workbook for Those Who Work With Others.* This workbook includes education about burn-out and secondary trauma, along with activities to address the self-care needs of individuals and organizations.
- *Trauma-Informed Organizational Toolkit for Homeless Services.* The *Toolkit* includes an *Organizational Self-Assessment, User's Guide, and How-To Manual* for becoming trauma-informed. This *Toolkit* is designed for use in homeless service settings, however, many of the ideas and suggestions are applicable to other professionals working with families who are homeless, traumatized or both.

Homeless Resource Center
www.homeless.samhsa.gov

- *Homelessness and Traumatic Stress Training Package.* This training package includes a trainer's guide, power-point slides, a trainer's script, hand-outs, and evaluation materials. This package includes activities and ideas for ways to provide trauma-informed care in shelter settings. Many of these ideas can be applied more broadly to other service settings working with children and families who are homeless.
- *Shelter From the Storm: Creating Trauma-Informed Homeless Services*. This report outlines current trends and promising models for developing trauma-informed homeless service systems and organizations.

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