

Trauma Interventions for Homeless Families — Innovative Features and Common Themes

Families

represent a significant proportion of people who experience homelessness, accounting for as much as 40 percent of the homeless population. They are predominantly single mothers with one or more minor children. Recognizing that many homeless families have multiple needs requiring attention and that there is little knowledge about how best to respond to their needs, the federal Substance Abuse and Mental Health Services Administration (SAMHSA) initiated the Homeless Families Program in 1999.

This is the first multisite study to focus on interventions for homeless families in which the mothers have psychiatric and/or substance use disorders. Previous research finds that the majority of homeless mothers have histories of childhood and/or adult sexual and/or physical abuse. They often face such additional challenges as low education levels, limited employment skills and histories, poor credit ratings, and criminal justice involvement. These challenges underscore the importance of effective interventions to ensure that families achieve residential stability.

Researchers are studying the impact of comprehensive, multifaceted, time-limited interventions (ranging from three to nine months) for women who meet the study criteria. The interventions, most of which are of an intensive nature, share several key characteristics. They are:

- ***Comprehensive and continuous.*** Addressing basic needs, housing, mental health, substance abuse, and trauma issues in a coordinated way; and drawing on both formal helping systems and natural supports, including spirituality.



Before fleeing her husband in Phoenix, Arizona, Laura Holly Pennington and her children lived in terror. Her husband would carry his fully loaded gun back and forth following them from room to room. After 11 incidences of spousal abuse and 11 calls to the police, Laura Holly had received no help or understanding. In desperation and fear for her and her children's lives, she fled with her two young children.

Hiding from an abuser, the three slept in a park where other people who were homeless stayed. She remembers sleeping on blankets placed on top of garbage bags used as a barrier to bugs. Most mornings she and her children would wake up covered with ants.

For 20 months, Laura Holly and her children lived in a homeless shelter where she remained terrified of her abuser and received no help with this ongoing trauma. Through the United Methodist Outreach Ministries (UMOM) shelter, she learned about Fresh Start, a resource center for abused women, where she learned to deal with life's hard edges using affirmation, a skill taught to her by her mentor. Laura Holly explained, "She gave me back my confidence and taught me to feel like a beautiful person again. I'm living proof of that. All it takes is a bit of recovery and healing. You just need someone to guide you there."

Laura Holly eventually got back on her feet by working three part-time jobs. She became involved in the Consumer Advisory Board at UMOM and joined the Homeless Families Program Consumer Panel. She found herself traveling to Washington, DC, to meet with researchers and Federal officials to discuss the needs of families who are homeless. Laura Holly joined the Arizona site research team and interviewed mothers who were homeless. She now works as Marketing Director of Fairway Independent Mortgage Corporation and has been appointed to the UMOM Board of Directors. Her goal is to buy a house for herself and her children.

- **Individualized.** Building on strengths, tailoring services to personal needs and preferences, encouraging individualized goal-setting, and ensuring cultural sensitivity.
- **Family oriented.** Recognizing and supporting the role of the mother as primary caregiver, provider, and parent; treating the family as the focus of interventions; and assessing and addressing children’s needs in the context of family.

Each site has a multifaceted intervention that is compared with either “treatment as usual” or an alternative treatment approach to examine the intervention’s effects on changes in mothers’:

- Residential stability
- Psychological distress
- Trauma recovery
- Substance use/abuse

The study is also examining changes in the general well-being of the participants’ children, including emotional and/or behavioral issues and school attendance.

The cross-site evaluation is enabling researchers to identify the dimensions of interventions associated with positive outcomes in these areas. These promising practices will be described, widely disseminated, and recommended for broader replication in programs serving homeless women and their children.

Homeless Families Program Sites

The eight competitively selected sites participating in the Homeless Families Program are located in Albany County, New York; Connecticut; Pennsylvania; Phoenix, Arizona; Westchester County, New York; St. Louis, Missouri; Wake County, North Carolina; and Worcester, Massachusetts. While the sites all provide relatively intensive, comprehensive, time-limited services and treatment, each site has different characteristics and has adopted a different model of intervention.

Albany County, NY

The Albany program targets homeless families as they leave homeless and domestic violence shelters for housing in the community. The intervention is a modification of the Critical Time Intervention model,¹ providing

supportive, trauma-sensitive services to families in transition to permanent housing.

Connecticut

The program in Connecticut serves homeless mothers with substance abuse problems who are at risk of losing their children to protective custody. Most of the families reside in homeless shelters or are living doubled up. Others live in residential treatment programs or on the street. Intensive case management is provided by teams in Danbury, Hartford, New Britain, Stamford, and two agencies in New Haven.

Pennsylvania

The Pennsylvania program operates in residential treatment programs in West Chester and Lancaster for mothers with substance abuse problems or co-occurring disorders who are homeless or living doubled up with others, and their children. The intervention is a therapeutic community treatment program enhanced with a trauma recovery group and assistance to facilitate the transition from residential treatment to housing.

Phoenix, AZ

The Phoenix site is an emergency shelter program providing up to 120 days of shelter and supportive services to homeless women and their children. Key components of the intervention are intensive case management and counseling based on a motivational interviewing model.

St. Louis, MO

In St. Louis, a homeless service provider works with mothers living in shelters, transitional housing facilities, or doubled up with family or friends. The intervention is multidimensional family assistance, offering outreach and engagement followed by multisystemic, comprehensive services.

Wake County, NC

In North Carolina, five agencies provide varying services to homeless women and their children. The key ingredient of the intervention is intensive case management with support or “wrap-around” services. The program uses a modification of the wrap-around services planning model of individually designed sets of services from multiple agencies.

Westchester County, NY

The Westchester program site is a transitional apartment program designed as an intermediate step for homeless families prior to obtaining permanent housing. The intervention is transitional housing with the Family Critical Time Intervention model of intensive support and services.

Worcester, MA

The Worcester program offers interventions for homeless families within the context of a Federally funded community health center. The intervention uses a family-centered and multidisciplinary team approach, which includes a physician, nurses, psychologists, and family advocates. This team integrates mental health, trauma, and parenting services with primary health care.

Not getting help to recover from the abuse stopped me being the person I was destined to be. Without addressing the impact of childhood and adult trauma, recovery from addiction is too difficult for most women to achieve.

—Ladelle Cole

The Need for Trauma Interventions and Trauma-Sensitive Services

Most women who become homeless are trauma survivors. A large proportion has experienced childhood sexual abuse and/or violence. Many have been abused as adults. Their histories of abuse often stretch from childhood through the present day. The impact of sexual and physical abuse can be profound and long lasting, affecting many aspects of women's lives in painful and harmful ways.

With training and support, service providers can help trauma survivors understand and deal with the effects of their traumatic experiences. The Homeless Families Program recognizes the importance of this issue, and is exploring the impact of trauma-sensitive and other recovery approaches being used by the sites.

All of the Homeless Families Program sites incorporate trauma-sensitive services into their approaches. Program staff are trained to recognize, interpret, and respond to behaviors and symptoms that are common to survivors of abuse. Many of the projects also incorporate specific trauma recovery interventions as part of their service array. They are using therapeutic models that have been demonstrated to be helpful and have lasting benefits for trauma survivors.

Five Approaches to Trauma Recovery and Trauma-Sensitive Services

Trauma recovery is one of the primary outcomes in the Homeless Families Program evaluation. Five of the eight programs' trauma interventions are described below. These models share some important similarities, but also have distinct features. Key characteristics common to all five sites' trauma intervention strategies include the following:

- Training in trauma-sensitive services to help staff understand specific symptoms and behaviors as reasonable coping responses to traumatic experiences.
- Offering women both individual therapy and psychoeducational support groups.
- Strongly encouraging participation in trauma recovery, but not requiring it as a condition of receiving services.
- Helping women understand the relationship between their histories of abuse and current difficulties and develop healthy coping behaviors, relationships, and parenting skills.
- Placing a priority on staff team-building, opportunities to support one another, and **self-care** in recognition that this work can be highly stressful and challenging.

Additionally, the Connecticut, Phoenix, and St. Louis programs incorporate motivational interviewing² as the conceptual basis for their work on trauma recovery. Motivational interviewing is a goal-oriented, client-centered counseling style for eliciting behavior change by helping clients to explore and resolve ambivalence.

The sites' approaches to trauma recovery are briefly described below, including examples of both their shared and innovative features.

Approach one Connecticut

The trauma intervention model most often used in the Connecticut program is Trauma Adaptive Recovery Group Education and Therapy (TARGET), a psychoeducational and skill-building intervention that addresses complex posttraumatic stress disorder (PTSD) resulting from early developmental trauma in individuals who are in recovery from chronic addiction, severe mental illness, domestic violence, or other forms of acute trauma.³

Selected clinicians in the treatment programs partnering with the Connecticut program were trained in the TARGET psychoeducational model. They use this skill-set to help mothers recognize and gain a greater sense of efficacy in addressing their own and their children's posttraumatic "alarm reactions." This enables staff to empathize and provide practical assistance to mothers in situations that elicit traumatic stress reactions that in the past seemed unmanageable to both mothers and staff. For many women, this has been the first step in understanding their traumatic experiences and stress reactions as not only manageable, but as the key to finding within themselves the hope, courage, and skills to make a difference in their own and their family's life.

The TARGET approach to trauma sensitive outreach, engagement, and case management includes the following elements:

- Reframing stigmatizing clinical and social labels (e.g., diagnoses, stereotypes of trauma survivors, social welfare categories) with a down-to-earth explanation of traumatic stress
- Shifting the focus of trauma recovery from an emphasis on trauma memories and traumatic experiences in the past to the "unfinished emotional business" of trauma in the present



Ladelle Cole's earliest memory is of being molested by a grown brother when she was 6 years old. Ladelle's alcoholic mother often worked third shift, and her brother would take advantage of her absence to sexually abuse Ladelle. When drinking, her mother called her names like whore and worse, so Ladelle thought what her brother did was her fault and that the abuse was okay with her mother. The sexual assaults continued until Ladelle was 12. One night when her brother broke through her locked bedroom door, she escaped by jumping out a window. She hid outside until her mother came home and, this time, called the police.

Introduced to marijuana at age 14, Ladelle was hanging out in bars, drinking, and snorting coke at 16. By 18, Ladelle was freebasing. Years later, when she was on the run from the police, Ladelle's two young children lived with her mother who was now sober. After being arrested for a fight, Ladelle asked for drug treatment. She was placed in a drug treatment facility for women instead of serving a six-year sentence. No one in the two treatment programs she attended ever asked her about childhood abuse or any other trauma. Once she initiated a conversation about her sexual abuse with a case worker, but when she got no response she never brought it up again.

Although Ladelle had not been successful in earlier treatment programs, this time she completed the program but left without any place to go or idea of what to do next. She moved back into her mother's house. Although her mother was sober, other family members continued to use. For the first time, Ladelle clearly saw the impact of drugs on her family and became determined to get her children out of that environment. Ladelle found help through a case worker and was able to move out with her children.

Ladelle now works as a parent educator at the Coordinating Council for Children in Crisis in New Haven, Connecticut, with women who are at risk of losing their children due to their drug use. She struggles as she watches the revolving treatment door so many mothers use while trying to find their way to recovery. "Not getting help to recover from the abuse stopped me being the person I was destined to be," Ladelle says. "Without addressing the impact of childhood and adult trauma, recovery from addiction is too difficult for most women to achieve." Ladelle is rightfully proud of living the past seven years substance free and just as proud of her sons, ages 13 and 2, and daughter, age 11. She received a grant from the Connecticut Behavior Health Network to produce *Dare to be Free*, a book of her recovery poetry. Ladelle is a member of the Homeless Families Program Consumer Panel. She plans to earn a BA degree in substance abuse counseling.

Key Features of Trauma Adaptive Recovery Group Education and Therapy (TARGET)⁴

Trauma Adaptive Recovery Group Education and Therapy (TARGET) is a psychoeducational and skill-building intervention designed for women and men with complex posttraumatic stress disorder resulting from early developmental trauma who are in recovery from chronic addiction, severe mental illness, domestic violence, or other forms of acute trauma.⁵

TARGET can be delivered in educational or support groups or on a one-to-one or family basis by outreach workers, case managers, clinicians, and/or peer mentors. The basic concepts can be taught in a single brief encounter or in a series of more intensive sessions.

Focus of Intervention

- Understand how trauma changes the body and brain's healthy self-protective stress reactions into *extreme alarm response* that can become a *traumatic stress disorder*.
 - Learn to draw upon personal strengths in order to reset the body's stress alarm, beginning with a three-part focusing skill ("SOS") that leads into a *practical 7-step "FREEDOM" approach* to managing current stressors and pursuing life goals.
 - Intensive training and ongoing clinical and case management consultation.
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- Addressing gender, socioeconomic, and cultural biases as sources of "invisible wounds" that cause or compound traumatic stress
 - Providing a series of interlinked steps to restore the full capacity for reflectively responding to, rather than reacting against, stressors that reenact traumagenic dynamics

Recognizing the importance of trauma recovery in the lives of homeless women with children, the evaluation of the Connecticut model includes measures of mothers' complex PTSD and trauma histories; children's trauma history, PTSD, and behavior problems; and mothers' alliance with their outreach providers. The researchers hope to better understand how traumatic stress affects homeless women, their children, and the mother-child relationship, and how best to address trauma while strengthening parenting and a working alliance in the helping relationship.

Approach TWO Pennsylvania

The trauma intervention model being used in Pennsylvania is Trauma Recovery and Empowerment (TREM), a group psychoeducational and skill-building intervention that addresses sexual, physical, and emotional abuse in women.⁶ The TREM curriculum was modified, in consultation with Maxine Harris, Ph.D., to enable women to complete all modules during their planned six-month time in residential substance abuse treatment. TREM uses a manual-guided curriculum with groups led by counselors who have received extensive training on the TREM model from Dr. Harris's staff.

This 18-week version of TREM encompasses all of the topics included in the original 33 week model. These include:

- **Empowerment:** sessions on gender identity, self-esteem, interpersonal boundaries, and female sexuality
- **Trauma recovery:** sessions on understanding sexual, physical, and emotional abuse; relationship of abuse to psychological and emotional symptoms, addictive behaviors, and relationship difficulties
- **Advanced trauma recovery:** sessions on family issues; decision-making; communication; self-destructive behaviors and relationships; feeling out of control; and personal healing
- **Closing rituals:** truths and myths about abuse; what it means to be a woman

The TREM model was selected for the Pennsylvania project because of the commonalities in the philosophy and approach used by TREM and the therapeutic community model. Both models emphasize taking responsibility for one's actions and mutual self-help. Both approaches also use the group process as an integral part of the treatment. Women are encouraged to work together in a strengths-based approach aimed at taking personal responsibility for themselves and their children, learning to take control of their lives, and gaining a positive sense of self and hope for the future.

Key Features of Trauma Recovery and Empowerment (TREM)⁷

Trauma Recovery and Empowerment (TREM) is a group psychoeducational program led by trained clinicians and designed for women who have histories of emotional, sexual, and/or physical abuse. Created by Maxine Harris, Ph.D., and the Community Connections Trauma Work Group, TREM originally consisted of 33 structured group sessions that addressed empowerment, trauma recovery, advanced trauma recovery issues, and closing rituals.

Two of the SAMHSA Homeless Families Programs, working in consultation with Maxine Harris and Community Connections, have modified TREM. The Phoenix program modified TREM for use in a homeless family shelter. The Pennsylvania program modified TREM for use in a residential substance abuse therapeutic community. Both modifications contain the following features:

Focus of Intervention

- Recovery skills
- Feelings/symptom management
- Current functioning/socialization skills

Core Assumptions

- Current behaviors and/or symptoms may have originated as legitimate coping responses
- Childhood trauma leads to poorer coping skills in adulthood
- Traumatic events (specifically sexual and physical abuse) sever connections to self, family, and community and disrupt awareness of feelings, thoughts, and behaviors
- Women who have been abused repeatedly feel powerless and question their ability to attain desired goals

Techniques

- Cognitive restructuring
- Skills training
- Psychoeducation
- Peer support
- Contained exposure/sharing of experiences (brief, focused, woven into psychoeducational and recovery skill goals)
- Empower by eliciting and validating client participation

Trauma Recovery Skills

- Self-awareness (bodily states, motivational states)
- Self-protection (establishing safe and manageable interpersonal boundaries)
- Self-soothing (feeling/symptom management)
- Emotional modulation (controlling intensity and expression of emotional states)
- Awareness of impact trauma has had on self and family
- Consistent problem-solving
- Appropriate parenting
- Evaluating and improving judgment and decision-making
- Importance of taking responsibility for oneself

In addition to TREM, all women in the Pennsylvania program receive group and individual counseling that addresses substance abuse, mental health, and parenting issues. As these issues are closely related to the women's histories of abuse, clinicians address trauma throughout the course of their work with clients, as well as in the weekly TREM group.



The Phoenix program is using a comprehensive, multipronged approach to trauma intervention in a large family shelter setting. Motivational interviewing is the overarching model guiding staff's work with homeless mothers. The strategies include:

- **Individual counseling:** Counselors and case managers validate experiences of and reactions to trauma, draw connections between trauma and current lifestyles or choices, offer a trusting relationship, and empower mothers to consider positive change.
- **TREM –10 (Trauma Recovery and Empowerment):** As in the Pennsylvania program, the Phoenix program views the strengths-based TREM curriculum as a natural fit with the family shelter's approach. Staff received extensive training on the TREM model from its developers. In consultation with the developers, the TREM curriculum was shortened from 33 to 10 weeks, and incentives and daycare were added. TREM is run as an "open group," meaning that women can join at any time. These adaptations were included to meet the needs of the women at the Phoenix program,

who may enter or leave the shelter at any point during the 10-week session cycle.

The TREM-10 curriculum includes the following sessions:

- ✓ Introduction and what it means to be a woman
 - ✓ What do you know and how do you feel about your body?
 - ✓ Physical boundaries
 - ✓ Emotional boundaries
 - ✓ Self-esteem
 - ✓ Self-soothing
 - ✓ Intimacy and trust
 - ✓ What is physical, sexual, and emotional abuse?
 - ✓ Decision-making, trusting your judgment
 - ✓ Feeling out of control
- **Self-help group:** The *Women Who Love Too Much* group is a safe place where women are encouraged to learn from one another and share their stories as they gain insight into the addictive nature of their relationships. The hope is for women to appreciate themselves as they are rather than to feel they must sacrifice for others in order to be valued. The women are encouraged to continue to attend similar groups in the community after they leave the shelter.

Implementing trauma interventions in a large family shelter that has specific rules and ways of operating has been a challenge for the Phoenix project staff. Sensitizing shelter staff to the need for flexibility and building an understanding of how trauma affects women is an ongoing process. Shelter staff receives training to help them reframe trauma-related behavior as coping skills—a natural response to abuse—rather than as manipulative. They also learn to respond in ways that are empowering rather than judgmental or enabling.

Key Features of Motivational Interviewing⁸

Motivational interviewing is a client-centered counseling style for eliciting behavior change by helping people to explore and resolve ambivalence.

Spirit and style of motivational interviewing

- Motivation to change is elicited from the client and not imposed from without
- It is the client's task, not the counselor's, to articulate and resolve his or her ambivalence
- Direct persuasion is not an effective method for resolving ambivalence
- The counseling style is generally a quiet and eliciting one
- The counselor is directive in helping the client to examine and resolve ambivalence
- Readiness to change is not a client trait, but a fluctuating product of interpersonal interaction
- The therapeutic relationship is more of a partnership than an expert/recipient relationship

Therapist strategies

- Seeking to understand the person's frame of reference, particularly via reflective listening
- Expressing acceptance and affirmation
- Eliciting and selectively reinforcing the client's own self-motivational statements, expressions of problem recognition, concern, desire and intention to change, and ability to change
- Monitoring the client's degree of readiness to change and ensuring that resistance is not generated by jumping ahead of the client
- Affirming the client's freedom of choice and self-direction

Motivational interviewing differs from more aggressive styles of confrontation. Motivational interviewing:

- Does not argue that the person has a problem and needs to change
- Does not offer direct advice or prescribe solutions to the problem without the person's permission or without actively encouraging the person to make his or her own choices
- Does not use an authoritative/expert stance, leaving the client in a passive role
- Does not do most of the talking or function as a unidirectional information delivery system
- Does not impose a diagnostic label
- Does not act in a punitive or coercive manner

In St. Louis, the program is using a cognitive behavioral model of trauma intervention based on Stages of Healing.⁹ This therapeutic intervention is carried out through individual counseling by the program’s social worker and counselor. The goals of this intervention are to help mothers achieve positive and nonabusive social networks; understand the links between trauma and homelessness, substance abuse and mental health issues; and gain hope for the future and skills to deal with the issues they will face as they move to stable housing with their children. Clinical staff is trained in motivational interviewing, which underlies all aspects of their work.

Mothers are encouraged to participate in two psychoeducational groups, the *Women’s Group* and the *Trauma and Safety Group*, that meet for 12 sessions each. These groups are integrated with work on Stages of Healing and share similar aims. The groups provide an important opportunity for women to support and learn from one another and to learn and discuss skills and strategies for parenting, stress reduction, safety, and self-awareness.

Several other important features of the St. Louis project’s approach are

- The project intentionally includes male as well as female staff on clinical teams in order to provide opportunities for women to develop trust and positive helping relationships with men.

Key Features of Stages of Healing¹⁰

This cognitive behavioral model is based on an understanding of the Stages of Healing, with each stage building on the last. Victims of abuse operate under an extreme level of stress that affects every aspect of their behavior and how they react. Clinical work attempts to build trust and a sense of safety, while enabling women to move past the abuse so that it is not an ever present threat.

Interventions

- Therapeutic journaling or remembering
- Schema Therapy to reduce the use of maladaptive coping styles and get back in touch with core feelings; to heal early experiences; to learn how to move out of self-defeating response patterns as quickly as possible; and, eventually, to get emotional needs met in everyday life.
- Motivational interviewing
- Psychiatrist available

Victim Stage Pillars

- Safety — stabilization, boundaries, assessments, SUDS (Subjective Units of Distress Scale), and triggers
- Empowerment — therapeutic commitments, resource installation, and support
- Education — normalization, simplicity (e.g., written diagrams)

Survivor Stage Pillars

- Triggers
- Desensitization
- Healthy coping behaviors
- Relationships
- Life patterns and choices — schema work
- Life/trauma integration

Thriver Stage Pillars

- Integration of trauma
- Spiritual “gifts”
- Living life
- Healthy sexuality
- Play (sexual and nonsexual)
- Vision of the future
- Healthy and appropriate responsibility
- Healthy risk-taking
- Future “flare-ups” plan

Outcomes

- Positive and nonabusive social networks
- Understanding of link between trauma, homelessness, substance abuse, and mental health
- Hope and skills for the future.

- Understanding and addressing cultural differences is key to engaging and working with women who have been homeless. The project has made it a priority to ensure a culturally diverse and culturally competent staff.
- Spirituality is an area that many women who have been homeless consider important. Project staff have learned to be open and willing to engage women in exploring spirituality and the role it plays in their lives and in their recovery from trauma.

Approach Five Worcester

The Worcester program, based in a community health center, provides both formal trauma recovery interventions and trauma-sensitive comprehensive care to mothers who are homeless. This trauma recovery approach features:

- **Addiction and Trauma Recovery Integration Model (ATRIUM).**¹¹ Counselors trained in the ATRIUM model lead 12 sessions that include psychoeducational, process, and expressive activities designed to address key issues related to trauma and addiction.
- **Parents Achieving Self-Efficacy (PASE)** is a three-pronged approach that the Worcester program developed and is piloting. PASE is designed to engage women as mothers and to promote healing and recovery through this vital role. PASE includes both health center and outreach-based consultation with mothers and a mothers' group where women discuss strategies and tools to help them be more effective parents and to understand how their parenting has been affected by their experiences of abuse and violence.
- Individual therapy with mental health clinicians trained to recognize and address trauma-related issues.

Training in trauma-sensitive approaches is key to the program's ability to work with homeless mothers and their children. Staff is trained using components of

Key Features of Addiction and Trauma Recovery Integration Model (ATRIUM)¹²

The Addiction and Trauma Recovery Integration Model (ATRIUM) is a 12-session group approach to trauma and addiction recovery developed by Dusty Miller, Ph.D., and Laurie Guidry, Ph.D. ATRIUM uses a biopsychosocial framework to respond to the complex treatment needs of trauma survivors. Using an integrated approach that addresses the body, mind, and spirit, this model can be used with both individuals and groups to facilitate healing and empowerment. Each session includes a didactic component, a process section to allow participants to share their own experiences pertaining to the topic, an experiential component to teach new ways of responding, and a homework assignment guided by a handout that reviews both the educational and experiential content of the session.

Methods and topics

- Psychoeducational, process, and expressive activities
- Addresses key issues linked to trauma and addiction: anxiety, sexuality/touch, self-harm, depression, anger, physical complaints and ailments, sleep difficulty, relationship challenges, and spiritual disconnection
- Information about the body's response to traumatic stress, along with effects on mind and spirit
- Self-care, self-soothing (the relaxation response and mindfulness training), and self-expression (the expressive component).

Curriculum

- **Theory of Trauma Reenactment:** creating safety, understanding trauma reenactment, addictions and trauma reenactment
- **Impact of Trauma Reenactment on the Mind:** finding emotional balance, managing anger, moving beyond anxiety and fear
- **Impact of Trauma Reenactment on the Body:** the body remembers, your body as a gift, touch and intimacy
- **Impact of Trauma Reenactment on the Spirit:** from reenactment to reconnection, environmental healing, the journey toward hope.

the *Risking Connection* training curriculum.¹³ Through training, staff are encouraged to make a major shift in their thinking about homeless mothers with histories of trauma. For example, what may have been construed as treatment-resistant or noncompliant behavior often results from prioritizing parental responsibility and making choices in the face of few options. Training also helps to create a supportive environment to address the impact that this intensive work may have on staff.

The Worcester medical providers know that women who are victims of violence often seek health care. They use this opportunity to screen mothers for childhood and adult violence and the mental health issues and substance abuse that often accompany traumatic experiences. The medical staff is trained to validate women's experience and to help women make connections between traumatic experiences and physical symptoms. These are important therapeutic first steps. Efforts to avoid retraumatization and unnecessary medical procedures are a high priority. This helps to develop trusting and safe relationships in what can be a potentially challenging environment for women with trauma experiences.

Project team members work with staff from many other community-based agencies to help them understand the impact of abuse on women and to modify their approaches to better respond to the needs of women experiencing homelessness.

Implications for Policy and Practice

A major cross-site evaluation question for the Homeless Families Program is the extent to which the projects' trauma interventions are effective in helping women reduce the effects of past trauma. Although the evaluation is still in progress and the effectiveness of the interventions not yet known, the principal investigators and other key staff interviewed were able to distinguish two groups of factors that contribute to successful implementation and that may be important to effectiveness. They are:

Make programs welcoming and comfortable for homeless mothers who have experienced sexual and physical abuse.

- The trauma intervention approach that a program adopts should fit the overall climate and philosophy of the program in which it is being implemented.
- A strengths-based approach to services helps staff and homeless mothers focus on women's abilities and potential and gives them hope.
- All staff having client contact, as well as the women themselves, should be taught to treat women with respect and model trustworthy behavior, such as following through on commitments.

- Shelters or other group residential settings should make an effort to limit rules or regulations to those necessary for safety and avoid punitive strategies.

Hire and train staff with the qualifications, skills, and experience needed to work effectively with homeless mothers who are trauma survivors.

- Projects underscore the need for staff to have realistic expectations regarding the process of change and growth, understanding that they alone cannot change the lives of women who have multiple challenges and long histories of abuse.
- Women in recovery who have dealt with abuse themselves can make good counselors and are often skilled at engaging and responding to other women with histories of trauma.
- Maintaining a nonjudgmental approach while also supporting personal responsibility is particularly helpful in encouraging women to talk about their histories and the issues that affect them, as well as helping them realize that they can make better choices for themselves and their children.

Endnotes

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