FACT SHEET

TRAUMA-INFORMED CARE FOR WORKING WITH HOMELESS VETERANS

According to SAMHSA[1], trauma-informed care includes having a basic understanding of how trauma affects the life of individuals seeking services. Trauma-informed programs and services are based on an understanding of the vulnerabilities or triggers a trauma survivor may experience and how they may impact the way the individual accepts and responds to services. Trauma-informed care has an appreciation of "triggers" and how they impact the way a survivor relates to self, other and the future. It is important to have an understanding of the impact of trauma and how it can change the way a survivor responds to services so that these services and programs can be more supportive, avoid re-traumatization, and promote recovery. To better understand trauma-informed services providers need to know more about trauma and post-traumatic stress disorder (PTSD). This Fact Sheet[2] is designed to provide some core information about trauma and PTSD, including common types of traumas in homeless Veterans and how to assess and treat PTSD.

What is Trauma?

According to the current psychiatric classification system (the Diagnostic and Statistical Manual for Mental Disorders-5), a traumatic event is one in which the person was exposed to: death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence, as follows: (one required)

- Direct exposure
- Witnessing, in person
- Indirectly, by learning that a close relative or close friend was exposed to trauma. If the event involved actual or threatened death, it must have been violent or accidental
- Repeated or extreme indirect exposure to aversive details of the event(s), usually in the course of professional duties (e.g., first responders, collecting body parts; professionals repeatedly exposed to details of child abuse). This does not include indirect non-professional exposure through electronic media, television, movies, or pictures

Emotional and Psychological Symptoms of Trauma

- Shock, denial, or disbelief
- Anger, irritability
- Mood swings
- Guilt, shame, self-blame
- Feeling sad or hopeless
- Confusion, difficulty concentrating
- Anxiety and fear
- Withdrawing from others
- Feeling disconnected or numb
- Sadness

Types of Trauma

There are several types of traumas that may be common in homeless Veterans. These include exposure to:

- Combat
- Interpersonal violence (such as child sexual or physical abuse or adult sexual or physical assault)
- Natural disasters, like a hurricane, flood, or earthquake
- Terrorist attack

Being homeless can also itself be very dangerous and put one at risk for traumatic experiences such as assaults and muggings. Trauma in homeless Veterans may be related to military service but not always.

How Pervasive is Trauma?

The majority of homeless Veterans have experienced at least one potentially traumatic event in their life, and most have likely experienced multiple traumas. Many experience their first trauma prior to becoming homeless.

- Approximately 60% of men and 50% of women experience at least one traumatic event.
- About 7-8% of the population will meet criteria for PTSD at some point in their lives.
- Approximately 5.2 million adults have PTSD in a given year.

What is Post-Traumatic Stress Disorder (PTSD)?

Most people who experience a traumatic event report mental health symptoms shortly thereafter. However, only some individuals will develop PTSD. There are four broad clusters of symptoms of PTSD.

Symptoms of PTSD

1. *Re-experiencing symptoms*

The traumatic event is persistently re-experienced in the following way(s): (one required)

- Recurrent, involuntary, and intrusive memories
- Traumatic nightmares
- Dissociative reactions (e.g., flashbacks) which may occur on a continuum from brief episodes to complete loss of consciousness
- Intense or prolonged distress after exposure to traumatic reminders

2. Avoidance (of internal or external reminders of the trauma)

Persistent effortful avoidance of distressing trauma-related stimuli after the event: (one required)

- Trauma-related thoughts or feelings
- Trauma-related external reminders (e.g., people, places, conversations, activities, objects, or situations)

3. Negative changes in beliefs and feelings

Negative alterations in cognitions and mood that began or worsened after the traumatic event: (two required)

- Inability to recall key features of the traumatic event (usually dissociative amnesia; not due to head injury, alcohol, or drugs)
- Persistent (and often distorted) negative beliefs and expectations about oneself or the world (e.g., "I am bad," "The world is completely dangerous")
- Persistent distorted blame of self or others for causing the traumatic event or for resulting consequences
- Persistent negative trauma-related emotions (e.g., fear, horror, anger, guilt, or shame)
- Markedly diminished interest in (pre-traumatic) significant activities
- Feeling alienated from others (e.g., detachment or estrangement)
- Constricted affect: persistent inability to experience positive emotions

4. Hyper-arousal

Trauma-related alterations in arousal and reactivity that began or worsened after the traumatic event: (two required)

- Irritable or aggressive behavior
- Self-destructive or reckless behavior
- Hyper-vigilance
- Exaggerated startle response
- Problems in concentration
- Sleep disturbance

Additional considerations:

- People with PTSD may also have other problems such as substance abuse difficulties or problems with occupational and social functioning.
- Many homeless Veterans may have mental health problems, including Post-traumatic Stress Disorder (PTSD).

How Pervasive is PTSD?

It is believed that PTSD occurs in:

- Approximately 11-20% of Veterans of the Iraq and Afghanistan wars
- Approximately 10% of Gulf War Veterans
- Approximately 30% of Vietnam Veterans

Trauma-Informed Care

Helping Traumatized Homeless Veterans

When working with homeless Veterans, health care providers should be prepared to:

- Screen for trauma and PTSD in homeless Veterans
- Be aware of the association between homelessness, trauma, and PTSD
- Normalize Veteran reactions to trauma
- Educate Veterans about trauma effects and PTSD
- Refer Veterans to appropriate services for trauma treatment

Barriers to Trauma-Informed Care for Traumatized Homeless Veterans

There are numerous provider, Veteran and systems barriers to providers delivering and Veterans receiving trauma-informed care.

- Provider barriers can include lack of awareness, discomfort in asking about trauma/PTSD and lack of information about referral services.
- Veteran barriers can include emotional pain (such as self-blame or shame), the belief that talking about his/her traumatic experience will make it worse, and the belief that VA providers cannot be trusted.

Do's and Don'ts for Assessment of Trauma and PTSD

Remember, the goal is not for Veterans to disclose any or all details of their traumatic experiences but rather to feel safe, develop trust, and ultimately become more functional.

- Do not appear to doubt or disbelieve the Veteran's account of what happened.
- Do not ask questions or make statements that suggest that you hold the Veteran responsible for traumatic experiences, like: "What were you doing in a place like that?"
- Do express your care and concern: "I am sorry that this has happened to you."
- Do have a non-judgmental attitude.
- Do normalize trauma reactions and responses; say things like: "You are not alone," or "This has happened to other Veterans."
- Do validate the experience and its effects: "That must have been very frightening."

Other considerations:

- Trauma survivors frequently decline referrals -- this may be especially true of homeless Veterans.
- Most people who have been traumatized just want to forget about it, hoping it will go away by itself.
- Veterans may not realize the connection between homelessness, trauma and PTSD. They may not realize the toll trauma may have taken upon their emotional and physical health (e.g., depression, PTSD, chronic pain syndromes).

Evidence-Based Psychotherapies for PTSD

There are two evidence-based treatments for PTSD that the VA is engaged in disseminating nationally. These are **Cognitive Processing Therapy (CPT**) and **Prolonged Exposure (PE)**.

- CPT is a 12-session trauma-focused treatment that can be delivered in a variety of formats, including group, individual or combined group and individual format. CPT involves helping individuals increase their understanding of unhelpful thought patterns about a traumatic event and teaching alternative, healthier ways of thinking.

- PE is a trauma-focused, manualized, individual therapy which is completed in 8 to 15 sessions. PE exposes individuals to trauma-related situations that are objectively safe but presently avoided due to trauma-related distress (in vivo exposure). Individuals are also exposed to trauma memories by having the person repeatedly recount out loud the details of their most disturbing event (imaginal exposure).

More Information

For additional information, contact Karen A. Guthrie, LICSW, Senior Consultant at the National Center for PTSD (NCPTSD) and the National Center on Homelessness among Veterans (NCHAV). Ms Guthrie works to increase utilization of trauma informed care and homeless Veterans' access to evidence based treatment for PTSD. She may be contacted through NCPTSD's Consultation Program, which assists all VA staff in providing care to Veterans with PTSD. Email Ms Guthrie at PTSDconsult@va.gov or call the Consultation Program directly at (866)948-7880.

---

[1] Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services

[2] Information for this fact sheet came from Dr. Joan Cook, PhD, Yale University and National Center for PTSD, and Vince Kane, Director of the VA National Center on Homelessness Among Veterans. Dr. Cook hosted a conference in April 2013 at the Yale School of Medicine to present the basic knowledge, skill set, and methods needed to effectively treat patients, "Advancing the Science of Education, Training and Practice in Trauma." The conference welcomed 60 national experts in psychology, social work, and psychiatry for three days of interactive working groups. The competencies focused on scientific knowledge about trauma, psychosocial assessment, psychosocial intervention, professionalism, and relational systems. Dr. Cook and Mr. Kane developed the fact sheet based on pertinent recommendations from the conference.