Psychology of the Homeless

- Community Compassion Outreach
- February 19, 2020
- Michael Todt, Ph.D., Presenter

Agenda

- Statistics on Homeless and Mental Illness
- Mental Health Diagnoses of Homeless
- Core Strengths of the Homeless
- Important Psychological Issues That Affect Life and Services: Trauma, Learned Helplessness, Social Disaffiliation
- Broad-based Intervention Strategies for Homeless: Pre-Treatment, Psychologically Informed Environment, Trauma Informed Care
- Native Americans and Behavioral Health
- Public Perceptions of the Homeless: Why Negative Attributions

Some Sources of Information

- Cross Cultural Dialogues on Homelessness. Edited by Jay Levy with Robin Johnson. Ann Arbor, MI: Loving Healing Press, 2017.
- National Alliance for Mentally Ill
- American Psychological Association
- National Law Center on Homelessness and Poverty
- Mental Illness Policy Organization
- Substance Abuse and Mental Health Services Administration (SAMHSA)-"Behavioral Health Services for People Who Are Homeless" and "Behavioral Health Services for Native Americans and Alaskan Natives"
- 2019 HUD Point in Time Survey

Limitations to the Information

- Psychology: understanding and prediction of human behavior; **understanding/predicting individual behavior can be difficult**
- Statistics on the homeless likely underestimate and difficult to gather
- Statistics on mental illness likely underestimate and depend on who, how, and when a diagnosis is made, especially true of homeless
- Research on effective treatments with homeless adults limited compared to children and young adults
- Research on the behavioral causes of homelessness limited because homeless need to trust in order to verify personal information and not an important population to study
- Presentation: data based


DRUG ADDICTION
PTSD
MENTAL ILLNESS
DOMESTIC VIOLENCE
ASSISTANCE CUT
INCOME INEQUALITY
LGBTQ FAMILY REJECTION
ALCOHOLISM
STUDENT DEBT
IF ONLY THE HOMELESS PROBLEM WAS ABOUT ONLY BEING HOMELESS.

Basic National Statistics on Homeless

- Greater than 500,000 on any given night
- Homeless increased from 2018-2019 (552K/557K) but declined from 2007-2019 (647K/557K) both in U.S. and in Colorado
- 2-3 million/year have an episode of homelessness
- 2019 HUD PIT National Survey-60.5% male, 38.7% female, .08% transgender/other
- PIT 2019 National Survey-6.5% vets; other estimates-11% vets
- PIT 2019 National Survey-47.7% Caucasian; 38.8% African American; 3.2% Native American; 1.3% Asian; 22% Hispanic Latino vs 76% non-Hispanic Latino
- Other estimates: African-Americans-42%; Causcasion-39%; Asian-2%; Latino-13%; Native American-4%

Basic National Statistics on Homeless

- Majority of homeless have some physical disability or physical issue(s)
- 40% of those incarcerated have history of homelessness; 17% homeless at time of arrest
- Major causes: poverty, inadequate education, high drop-out rate, unemployment, jail, domestic violence, mental illness
- Mental illness 3rd largest contributor to homelessness (lack of treatment, difficulty living with others)
- High rates of victimization (rape, robbery, abuse)
- 15% survivors of abuse

We Are All Potentially One Step Away……

Colorado Homeless-2019 PIT Survey Identified and Self Report

- Total Homeless-9619 (Decrease from 2018)
- Households without children-6992 (73%)
- Hispanic/Latino-2209 (23%); Non-Hispanic Latin-7410 (77%)
- Female-3238 (34%); Male-6289 (65%); Transgender-54; Gender Non-conform-38
- Black-1678 (17%); White-6251(65%);Asian-65 (.6%%); American Indian-586 (6%); Multiple Races-939 (10%); Native Hawwaiian-100 (1%)
- Severe MI-2639 (27%); Chronic Substance Abuse-2378 (24%); Victims of Domestic Violence-900 (9.3%); Vets-1068 (11%)
- La Plata County-Increase from 2018 to 2019 from 91-192 persons

Incidence of Mental Illness

- 1.1% of adults live with schizophrenia; 2.6% of adults live with bi-polar disorder; 6.9% of adults with one depressive episode/year
- 18.1% of adults experience anxiety disorder, including PTSD, obsessive (thoughts)-compulsive (behavior) disorder
- Mood disorders (depression, dysthymia, bi-polar) 3rd most highest cause for hospitalization for adults 18-44 years of age
- 41% of adults and 62.9% of adults with serious mental illness received treatment for a mental health condition in past year
- People with serious mental illness die 25-30 years sooner, largely due to treatable physical conditions

Some Consequences of Mental Illness

- Suicide-10th leading cause of death; 2nd leading cause for people 10-24
- 90% of people who die by suicide show symptoms of mental health condition
- Denver: 71% of homeless have mental illness or PTSD; 59% have long term substance abuse issue
- Denver: those between 25-40 are 9 times more likely to die from opioid overdose; opioid commonly used for pain which is common in homeless
- Non-compliance to meds is as high as 50%
- Acute Issues Involved with Homeless and Mental Illness: acute/chronic physical problems, untreated disabilities (sight, hearing), cognitive issues (memory, concentration, attention), transition from jail or inpatient hospitalization, history of trauma

Homeless and Mental Illness-National

- 18.5-20% of total U.S. population experiences an episode of mental illness per year (19.1% in 2018, 47.6 million people); similar/higher for homeless?
- 20-25% of homeless have serious mental illness compared to 4-6% of population (20.1% in 2018)
- 40-45% of homeless have a history of a mental illness diagnosis
- 3.7% of homeless have co-occurring substance abuse and mental illness and 19.3% of substance abusers experience some form of mental illness
- In Los Angeles, 50% of homeless have mental and physical illness diagnosis; 60-70% with a mental illness diagnosis had an issue with substance abuse
- 50% of those with chronic mental illness begins by 14 years of age; 75% by 24 years of age
- 26% of those in shelters had serious mental illness
- African-Americans and Hispanics use services at ½ rate of Caucasians and Asians

Common Mental Health Diagnoses for Homeless

- Disclaimer: Accurate diagnosis requires interviews, observations, and testing to confirm a diagnosis and use of diagnostic categories (DSM-5, ICD-10)
- Substance Abuse (most common): addiction/dependence; alcohol, pills, marijuana
- Mood disorders: depression, dysthymia, bi-polar
- Psychosis: schizophrenia (hallucinations, delusions)
- Affective Disorders: anxiety, PTSD, panic attacks
- Character Disorders: anti-social, dependent, paranoid
- Adjustment Disorders: depression, anxiety, mixed

Core Strengths of the Homeless (Positive Psychology)

- Resilience
- Ability to take action and survive under adverse circumstances
- Determination in the face of stress
- Adaptation
- Street smarts
- Maneuver through the service system
- Personal strengths

Core Psychological Issue for Homeless: Trauma

- Trauma: set of responses to extraordinary, overwhelming, and personally uncontrollable life events; discrete, prolonged or ongoing, e.g., combat, living in cold, hunger
- Event of becoming homeless, e.g., loss of job/shelter/friends
- Ongoing conditions of being homeless, e.g., living in shelter, lack of predictability (sleep, eat, safety)
- Trauma exacerbated for those with victimization history (abuse, homeless)
- Reactions: intrusive recollections/dreams/dissociative states, numbing of responses, diminished interest, increased arousal (sleep, anger, hypervigilance), substance abuse, self-mutilation, intolerance of intimacy, helplessness, isolation, “existential” separateness
- Individualized reaction: person, event, environmental specific
- Study in NYC homeless women and trauma: 43% raped, 74% physically abused, 25% robbed

Why Can't Homeless People Get Jobs?

Psychological Issue: Learned Helplessness

- Feature of trauma
- Sense of helplessness, “I’m not in control of my life…circumstances are”
- Loss of belief that one’s own actions can influence the course of one’s life
- View of self as personally responsible for situation that is long term or global (not specific) “My fault that I’m homeless and poor”
- Learned helplessness can lead to becoming homeless or a consequence of being homeless
- Life: an assault on my well being, loss of self control, need others to fulfill basic needs, high rates of depression
- Real lack of control in one’s life leads to passivity, not fighting for self, and getting services
- “my situation is hopeless and I’m helpless to change it”

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Man Who Lives Everywhere Lives Nowhere ...

Atlanta's Skid Row
atlantastudies.org

Psychological Issue: Social Disaffiliation

- Intimacy and attachment: biological imperative and key to self-reliance and self esteem
- Social disaffiliation generally precedes homeless; trauma feature
- Social disaffiliation: minimal/lack of social network, social supports; move away from people, not towards others
- Homeless may view themselves as losers, unpleasant, own fault which leads to more isolation and distrust
- Since no longer able to fulfill formal roles, lose faith in their ability and willingness if they need help which promotes further distrust
- Homeless: 2 times more likely to be unmarried, more likely to have had out-of-home placement (foster), lived along as adults
- Homeless leads to more distrust which leads to more isolation

Intervention Strategy: Pre-Treatment

- Establishing the circumstances and relationships conducive to engaging in effective psychotherapy and other treatments
- Develop psychological resilience, trauma informed to avoid trauma reactance; **focus on attachment and style of relating**
- Client-centered: Carl Rogers (unconditional positive regard, active listening, empathy, congruent, active client involvement)
- Elements
  - safe environment (physical and personal)
  - Positive psychology: emotions, engagement, relationships, meaning, achievement
  - Common language construction: meet client where he/she is at
  - Facilitate and support change
  - Cultural and ecological considerations: support person to transition to new services

Components of Trauma-Informed Care

Substance Abuse for Mental Health Services Administration, 2014

Intervention Strategy: Trauma Informed Care

- Homelessness and trauma are peas in a pod; homeless caused by or exacerbated by trauma
- Trauma psychology informs how services are provided to avoid re-traumatization
- Used in a variety of settings, e.g., behavioral health, schools, hospital
- Guiding Principles
  - Safety: physical and psychological
  - Peer support and mutual self help
  - Collaboration and mutuality
  - Empowerment, voice, choice
  - Cultural, gender, historical issues

Psychologically Informed Environment

- A PIE has 5 elements:
  - A psychological framework
  - Relationships
  - Staff support and training
  - The physical environment
  - Evidence generating practice

- Trauma informed care can be used as a psychological framework for PIE. It helps us to understand the impact of trauma and adverse childhood experiences over a person's lifetime.

Intervention Strategy: Psychologically Informed Environment

- Complementary to trauma informed care
- Uses methods informed by psychology and frameworks; from how to think about clients to how a building is designed
- Takes into account the thoughts and feelings of those in the environment
- Key Elements:
  - Relationships
  - Staff support and training
  - Physical environment and social space
  - Psychological framework
  - Evidence generating practice

Stages of Change in Treating the Homeless

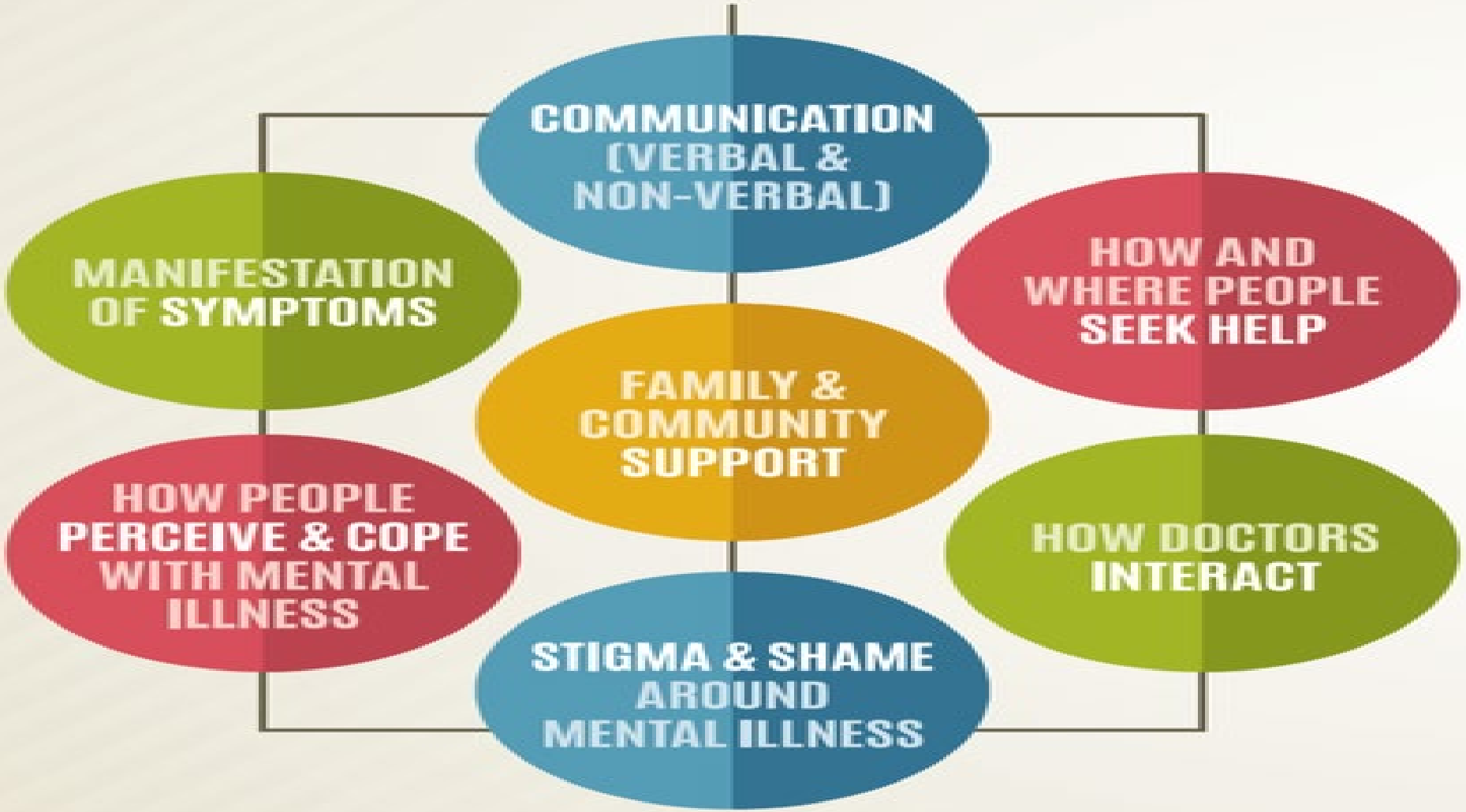
- Precontemplation-view behavior as non-problematic
- Contemplation-think about behavior, ambivalent about their behavior
- Preparation-decide to change
- Action-commitment, alternative activities, new relationships
- Maintenance-6 months sustained change

Most Important Element of All

Permanent and *supportive* housing and permanent and supportive shelter

How Can Race/Ethnicity/Culture

INFLUENCE MENTAL HEALTH?



Native Americans and Behavioral Health (SAMHSA)

- Native Americans between 25-40 account for 40% of all native suicides
- Less likely to drink than whites but more likely to binge, have alcohol disorder
- Experience anxiety at a higher rate and depression at lower rate than general population
- Seek mental health treatment at rate second only to whites
- High rates of suicide, domestic violence, and substance abuse a function of exposure to a greater degree of risk factors: poverty, unemployment, trauma, historical trauma, loss of traditions
- Most natives experience one episode of trauma and historical trauma
- Women: high rate of victimization; 2 times more likely to be assaulted and raped than general population; assault and rape by non-native men
- 70% of Native Americans live in urban area

Native American Conception of Mental Illness

- Health is holistic-little distinction between mental and physical illness
- Health of one affects all
- Healthy-living in harmony, both internally and externally
- Illness may be purposeful or personified, e.g., broke a natural law so now in a state of disharmony and individual responsible

Common Mental Illness Disorders Among Native Americans

- Most common is trauma, stress, anxiety, bipolar, depression
- High rates of stress lead to decreased daily functioning and suicidality
- High rate of co-occurring mental illness with substance abuse
- Depression often associated with traumatic stress
- High rates of trauma-suicide, domestic violence, physical and sexual assaults, accidents which lease to major stress disorders

Historical Trauma

- Source of grief, anger, shame which leads to substance abuse and suicidality
- Historical Trauma-”cumulative emotional and psychological wounding across generations, include life spans, that emanates from massive group trauma”
- Historical trauma-”legacy of traumatic events a community experiences over generations and encompasses social and psychological responses to the event:
- Historical trauma-”soul wound”
- Also applies to Blacks, Hispanics, Asians (people of color)

Historical Trauma Cycle

- History of trauma/historical trauma **which leads to**
- Traumatic stress, emotional and physical reactions **which leads to**
- Increased risk of substance abuse/dependence which makes one vulnerable to suicide, PTSD, anxiety and depression **which leads to**
- Increase risk of other trauma (accidents, violence, physical/sexual abuse **which leads to**
- History of trauma/historical trauma **which leads to new cycle**
- While certainly applies to Native Americans, historical trauma can apply to any person of color given their history

SAMSHA Consensus Panel on Native Behavioral Health: Recommendations for Native Behavioral Health Programs

- **Historical trauma**-need to recognize, acknowledge, address; lies at heart of substance abuse and mental illness; incorporate into assessment; each tribe has their own story
- **Holistic view**-substance abuse, mental illness not a disease, diagnosis, moral failure, nor maladies; symptom of imbalance of one's relationship with world; healing/treatment include of spiritual, emotional, physical, social, behavioral, cognitive; integrate all
- **Mental illness/substance abuse**-function of cultural loss; healing requires connection to Native community
- **Recognition of tribal sovereignty**

SAMSHA Consensus Panel on Native Behavioral Health

- **Significance of community**-need community participation (if not, then paternalistic); what services are needed and how to render; importance of connectedness and relationships
- **Cultural Awareness**-provider must know how his culture affects his world view so as to see that in others; without this, then prejudge and discount; “white privilege and white fragility”
- **Culturally Responsive Service**-right of language, safety, supportive
- **Environment**-facility accessible, culturally appropriate
- **Respect for Many Paths**-evidence based practice not the only way

Culturally Responsive Relationships

(For Native Americans, Blacks, Hispanics, Asians, and ????)

- Be who you are, use your experience; not theory
- Listen, respect silence
- Adjust eye contact (know how eye contact works in the tribal culture)
- Observe the non-verbal
- Determine and value linguistic preference
- Use hopeful language; avoid labeling
- Be flexible with time
- Anticipate and use laughter (humor a means of surviving)
- Give things time to work
- Provide practical information and therapy
- Be open to new ways

Homeless and Public

- Yale Study (2017): attitudes changing compared to 20 years ago; view homeless problem as external, more support for services to aid homeless
- Public Health Study (2016): more compassion, more support for government services, more liberal attitudes
- Washington Post (2017): strong support for aid and housing but little support for panhandling and sleeping in public places; “Disgust Factor”-want to avoid but not dislike; high disgust more supportive of housing, services but not panhandling and sleeping in public places

CITY FRUIT

Why Some of Public Struggle with Homeless

- Dispositional Attribution Theory: homelessness caused by some internal characteristic and within control of person of the person, e.g., laziness, lack of intelligence
- Situational Attributional Theory: homelessness caused by some external factor outside person's control, e.g., economy, poor educational systems
- Non-conforming behaviors are linked to dispositional issues
- Confirmation bias: find evidence to support our beliefs; more true of highly educated and equally true for liberals and conservatives
- Minimal contact leads to non-evidence based views acquired from non-evidence based sources
- U.S. values personal liberty, individualism.

Thanks and take time to be compassionate to all you meet!