Surviving the Trauma of Homelessness

PRE-TREATMENT STAGES OF CHANGE, INTERVENTIONS AND OUTCOMES

02/2017 jconolly@nhs.net

Introduction I

- **Pre-treatment Therapy** Is an **ENHANCED psychological response** to the extreme challenges homeless people face **attending**, **engaging with** and **making use of** available help.

- **Homeless people** start from a different **baseline** to that of **housed** populations. So much so that:……..

Introduction II

- **Mainstream Services**, including **Personality Disorder** ones do not accept homeless people.

- **Homeless people**, must progress through several **preliminary stages** before being in a position to be evaluated with mainstream progress measures, developed for Housed populations.

Introduction III

- **Interpersonal** and **Narrative** Markers of **increasing engagement with therapeutic relationships** are the most meaningful indicators of progress, and often are the

- **Precursors** to the changes which more mainstream treatments measure.

Challenges of Homelessness

- **'Tri-morbidity',** a combination of:

  Physical,

  Mental ,

  Addictions based ill health

- With roots in histories of **complex trauma** ,including **child neglect** and **abuse**

(Faculty for Homeless & Inclusion Health Standards,2013)

The Extra Challenges of Homelessness…

- Limited **Time Horizon**
- Competing Priorities/Multiple clashing appointments

- **Personality Disorder**
- Re-triggering of **'Trauma Reaction',** due to lack of safe shelter

- A History of **'Toxic help'**

- Chronic **Shame** and **'Negative Identity'**

- **Insecure Attachment Styles-** little **'Epistemic Trust'** (faith in validity and relevance of transmitted knowledge, Fonagy et al, 2014).

Homelessness and Personality Disorder (PD)

The American Psychiatric Association defines *Personality Disorders* as:

'relatively stable, enduring, and *pervasively maladaptive patterns* of *coping, thinking, feeling, regulating impulses,* and *relating to others'.*

(Bleiberg, Rossouw and Fonagy, 2012)

Complex Problems

People with personality disorders have increased risks of suffering additional mental health problems, such as:

- Anxiety,
- Depression
- *Addictions*
- *Brief Psychotic episodes*
- Recurrent deliberate self harm
- Suicide
- Eating disorders

PD patient Treatment challenges

- Hard to comply
- Access own thoughts & feelings, and articulate them
- Not responsive to logic and experimentation
- Difficult to engage in a collaborative relationship
- Problems are pervasive not readily identifiable as targets of treatment
- People seek validation and empathy for their suffering rather than learn how to deal with it

(Young at al, 2003)

Specialist PD Centres offer

2 Years Treatment once to twice weekly, according to severity

- Patients have to have **stable accommodation**
- Are **addiction free**
- **homeless people not accepted**

'Street homelessness ..might make it difficult for the person to focus on interpersonal change due to severe housing difficulties

(PD treatment centre guidelines, Jan 2018).

Homeless people & History of 'Toxic Help'

- Abuse in care

  Care home scandals.

- Ineffective/limited treatment

  PD** not addressed – confirms **Negative Identity.

- 'Therapeutic Dissonance'

  *Therapist confuses patient, but **Patient blames themselves** for it.*

- Social Dissonance *need for **'re-socialisation',** into **patient role***

(Conolly, In Press, 2018b).

Chronic shame

The shame of an abused child is:

- ‘’an intense and destructive sense of **self disgust**, verging on **self-hatred**’’.(Fonagy et al, 2003), p45).
- **Therapy** can inadvertently **reactivate** this:

  Due to the **Power imbalance** between patient and therapist, where Patient exposes their most intimate thoughts and feelings without reciprocity (Herman,2012).

  - **Levi** (2018, see book) quotes one Patient as reading the word Therapist as :

    “The-rapist”

‘Negative Identity’

- When certain groups do not live up to social norms they become stigmatised and their **identities invalidated**.
- Especially if their **‘condition’** is **visible**, **prevents them contributing**, and is **not understood**.
- This **stigma** becomes internalised as a ‘Negative Identity’ with feelings of **deep shame**. (Goffman,1968).

jconolly@nhs.net

Attachment and Inter-personal Style

'Attachment Theory':

Early experiences of care are internalised and

determine our **relationship style** throughout their lifespan.

(Bowlby, 1997, 1998a, 1998b, Fonagy, 2001, Holmes, 2006, Wallin, 2007, Daniel, 2015)

Attachment Styles

Four Attachment Styles have been identified:

1. Secure
2. Avoidant
3. Ambivalent
4. Disorganized

The Ambivalent and Disorganized Styles are especially associated with **Borderline Personality Disorder** (Daniel, 2015).

Ambivalent Attachment Style

- **Caregivers** were unpredictable, sometimes caring, sometimes absent.
- Individuals *learnt to* exacerbate their needs in order to get attention.
- This *discourages others from helping them, as they are* overwhelmed by the sheer Intensity of their needs,
- and they dismiss such patients as 'Over the Top' , ' Attention Seeking' or ' Manipulative'.

Disorganized Attachment Style

Children here, had **caregivers** who were ***frightening*** and who put them in the 'double-bind' situation of **needing their support** but **feeling more distressed** by them.

When adult, they will **approach others for help** but will fundamentally **disbelieve their genuine motivation to help them,** thus:

- a pattern of presenting in an **acute crisis** mode only,
- And therefore **no opportunity** for stabilisation and treatment

Avoidant Attachment Style

- **Caregivers** here, stressed independence and were **dismissive/punitive** to the expression of needs/ vulnerabilities.
- As Adult, dismissive of their own needs and rarely approach others for help**.**
- When they do, they feel intense shame and extremely uncomfortable with empathy

Secure Attachment Style

- *People here **do not tend** to be chronically homeless*
- Caregivers were **attentive and responsive** to their needs
- Will ***readily turn to others** for help*, and ***make good use** of the resources available to them*

Pre-treatment Therapy

Based on **Jay levy's** Pre-treatment Principles and Engagement Stages for outreach work with Homeless people. (Levy, 2013, p 32).

"It is from the safety of a trusting relationship and the development of a common language that it becomes possible to offer the **person** potential resources and services that resonate well in the world of the homeless".

Five Pre-treatment Therapy

1. Pre-Engagement
2. Engagement
3. Contracting
4. Action
5. Maintenance

Pre-Treatment Therapy Stages 1

1. Pre-engagement
   - Earn trust, Person Centred skills
   - Demonstrate care vs ‘case management’ only.
   - Understand Patient Language , Especially non verbal & affective
   - Understand patient ‘life-script’ and barriers to engagement

Pre-Treatment Therapy Stages 2

2. Engagement

- Re-script patient life
- Re-frame history of ‘Toxic Help’,
- Contextualise Self- Blame
- Inspire Hope
- treatment & support options for Short, Med and Long term aspirations.

Pre-Treatment Therapy Stages 3

Contracting

- Patient developed enough ‘Epistemic Trust’..
- ..To accept Alternative Life Script..
- ..And to Accesses Treatment(s)

Pre-Treatment Therapy Stages 4

Action

- Accesses Treatment
- Initiate life changes
- Establish support networks, medical, social, 3rd sector (AA)

Pre-Treatment Therapy Stages 5

Maintenance

- Sustains Changes
- Ongoing use of support networks

Mainstream Markers of Change

These are numerous and include change in:

- Symptomology and distress
- Welfare and quality of life measures
- Social activity and socio-economic engagement

However, most apply to mainstream treatments delivered to housed populations.

Homelessness A Special Case

Homeless people

- Begin from a very different baseline,(tri-morbidity, all pervasive problems, trauma responses and coping strategies)
- Are exposed to continual 'Re-triggering' - suffer from Negative ID and Chronic Shame.
- Main challenge Engagement and 'Epistemic Trust' – the trust in the authenticity and personal relevance of interpersonally transmitted knowledge (http://societyforpsychotherapy.org/epistemic-trust-psychopathology-and-the-great-psychotherapy-debate, 26.01.2018)

Markers of Insecure to 'Earned Secure' Inter-personal Style

- Each of the four Inter-personal styles has distinct Relational and Narrative features (Daniel, 2015,p115 and p117).
- Progress from Insecure to 'Earned Secure' style of relating can be monitored via them, and is totally Individual specific.
- It is suggested that these be used to show progress in Engagement with and Trust in Pre-treatment relationships.

Interpersonal Markers I

	Secure	Avoidant	Ambivalent	Disorganized
1. Proximity-Distance	**Value & Enjoy Proximity**	Prefer Distance	Want Proximity but uncomfortable with it	**Fear Proximity but lost without it**
2. Trust and Expectations of Others	**Trusting and have positive Expectations**	Fear Rejection, try to ignore feelings of insecurity	Fear Abandonment or losing Attention- expect the Worst	**Strong Distrust of Others, Fear boundary violations**
3. Attitude to seeking/getting Help	**Open**	Prefer managing alone	Strong Desire for Support	**Fear Help but Lost without it**

Interpersonal Markers II.

Marker	Normal	Avoidant	Ambivalent	Disorganized
4. Expression and Regulation of Emotions	**Balanced expression of Positive & Negative emotions**	Limited Expression, False Positivity, suppression of Negative Emotions	Frequent, Dramatic focus on emotions, intensify Negative Emotions	**Absent or Chaotic expression of Emotions – Problems Regulating Emotions**
5. Self-Image and Esteem	**Nuanced - Solid**	'Magnified' to compensate for Low Self-Esteem	Low, dependant on interpersonal validation	**Low, Incoherent Self-Image**
6. Self-Disclosure	**Open, but doses according to context**	Reticent	Open, but not always context specific	**Reticent, but prone to sudden 'breakthroughs'.**

Interpersonal Markers III

	Normal	Avoidant	Ambivalent	Disorganized
7. Dependence-Independence	**Comfortable in committed relationship but also Autonomous**	Greatly values Independence from Others	Feels Dependent on Others – seeks relationships out	**Strong conflict between desire for Independence and feelings of Dependence**
8. Conflict Management	**Has constructive strategies**	Uncomfortable – avoids them	Great attention to Conflicts - escalates	**Conflict may lead to breakdown – inappropriate behaviour**
9. Empathy	**Cares for Others**	Limited – 'Cold'	Preoccupied by Others but misattributes and 'projects'.	**Own fear/helplessness hinders this.**

Narrative Markers I

	Normal	Avoidant	Ambivalent	Disorganized
1. Coherence and Credibility	**Coherence between the different narrative levels – Narrative appears Credible.**	Contradiction between General descriptions and Specific episodes	Incoherence due to lack of convincing generalization and 'common thread'.	**Un-integrated Trauma-related material destabilizes it.**
2. Balance in Descriptions	**Balanced positive and negative description of features in Self/Others**	Present Self and Others in positive light – marked by 'cliches'.	Often Negative, Reproachful, 'Authoritative' descriptions of Others.	**Incoherent, contradictory, suddenly changing descriptions of Self and Others.**
3. Dramatization – Downplaying Emotions	**Open re difficulties without appeal to Pity**	Downplaying of Difficult incidents or feelings	Dramatizes difficulties and appeals to Pity	**Sudden shifts between Dramatization**

Narrative Markers II.

Narrative Markers II	Normal	Avoidant	Ambivalent	Disorganized
4. Description of Emotions	**Descriptions of incidents inc Well regulated descriptions of Emotions**	Few and undifferentiated description of Emotions	Narrative permeated by Emotions 'demonstrated' not described	**Absence of integrated descriptions of emotions, anxiety may leak**
5. Abstraction/specificity	**Balance between Generalisation and Details**	Relatively abstract, poor on episodic detail	Rich on specific episodic material, but often in fragments & no common thread	**Both abstraction and episodic fragments are present, but are poorly integrated**
6. Consideration of listener	**Can put Self in Listener's place, and give necessary introductions.**	Tendency to 'shut down topics', and cut off Interlocutor	Often get carried away by detail of what discussing, and 'get lost', do not address the topic/questions	**Can be in own world with no sense of listener, may frighten the listener at times.**

Narrative Markers III

Narrative Markers III	Normal	Avoidant	Ambivalent	Disorganized
7. Verbosity	**Appropriate amount of relevant information**	Short, telegram-like descriptions	Long accounts including much irrelevant documentation	**Shifts between Reticence and Verbosity.**
8. 'Narrative Orderliness'	**Narrative well organised, time, place, people are marked and introduced.**	Narrative is organized but can be hard to follow due to internal contradictions	Jumps in time and place and persons, private phrases unclear 'filler words'	**Abrupt shifts in narrative related to trauma material**
9. Mentalization	**Self & Others are described as thinking & feeling- eye for different**	Emphasis on the concrete – few & sketch like descriptions of	Many accounts of people's thoughts & feelings with authoritative	**'Magical reasoning' and lack of mentalization in**

Conclusion

- Homeless people have a variety of challenges above and beyond those of 'tri-morbidity', **Personality disorders** and Complex Trauma.
- These include, Toxic Histories, **re-occurring triggering** of the Trauma Response, Negative ID, Chronic Shame and extremely little 'Epistemic Trust'.
- This makes the process of **engaging with 'Treatment'** PIVOTAL.
- It has been argued that for Homeless people, it is markers of that **deepening Engagement** which are the most **meaningful indicators of progress**, and often are the precursors to the changes which more mainstream treatments measure.

References

Bleiberg, Rossouw and Fonagy, ' Adolescent Breakdown and Emerging Borderline Personality Disorder', Chptr 18, pps 463-509, in ' Handbook of Mentalizing In Mental Health Practice', **2012,** Bateman and Fonagy, (Eds), American Psychiatric Publishing, Inc. Washington DC, London England.

Bowlby, J., 'Attachment', 1997, Pimlico Edn.

Bowlby, J., 'Separation, Anger and Anxiety', 1998a, Pimlico Edn.

Bowlby, J., 'Loss, Sadness and Depression', 1998b, Pimlico Edn.

References 2

Conolly, J., 'A Pre-treatment Therapy Approach for Single Homeless people - The Co-construction of Recovery/Discovery', Chapter 7, in 'Social Exclusion, Compound Trauma and Recovery: Applying Psychology, Psychotherapy and PIE to Homelessness and Complex Needs', **In Press (2018a)**, Ed, P. Cockersell, Jessica Kingsley Publishers.

Conolly, J., 'Pre-treatment Therapy: A Central London Counselling Services' Enhanced Response to Complex Needs Homelessness ', Chapter 4, in 'Cross-cultural Dialogue on Homelessness'. **(2018b)**, Eds, Jay S. Levy and Robin Johnson, LH Press, Ann Arbor, Michigan.

Daniel, S. I. F., 'Adult Attachment Patterns in a Treatment Context – Relationship and Narrative', 2015, Routledge.

References 3

Faculty for Homeless and Inclusion Health, 'Standards for commissioners and service providers', Version 2.0, September, 2013.

Fonagy, P., 'Attachment and Psychoanalysis', 2001, Karnac.

Fonagy, P. and Target, M.T., 'Psychoanalytic Theories – Perspectives from Developmental Psychopathology', 2003, Whurr Publishers.

.

References 4

Fonagy, Luyten, and Allison (2015). Epistemic Petrification and the Restoration of Epistemic Trust: A New Conceptualization of Borderline Personality Disorder and Its Psychosocial Treatment. Journal of Personality Disorders: Vol. 29, No. 5, pp. 575-609.https://doi.org/10.1521/pedi.2015.29.5.575

Goffman, E., ‘ Stigma: Notes on the Management of Spoiled Identity’, 1968, Penguin

References 4

Herman, J. L., 'Shattered shame states and their repair', Chapter four in ' Shattered States – Disorgnized Attachment And Its Repair', 2012, Yelin, J., and White, K., Eds, Karnac Books Ltd.

Holmes, J., 'The Search for the Secure Base – Attachment Theory and Psychotherapy', 2006, 5th edn, Routledge.

Holmes, J. and Slade, **A.,** ' Attachment in Therapeutic Practice', 2018, Sage Publications ltd.

References 5

Levy, J. S., 'Pretreatment Guide', 2013, L H Press Inc.

Levy, J. S.,'Cross-cultural Dialogue on Homelessness'. **In Press (2018)**, Eds, Jay S. Levy and Robin, Johnson, LH Press, Ann Arbor, Michigan.

References 6

Maguire, N.J., Johnson, R., Vostanis, P., Keats, H. and Remington, R.E. 'Homelessness and complex trauma: a review of the literature. (2009) Southampton, UK, University of Southampton (Submitted). See http://eprints.soton.ac.uk/69749/ cited in 'Healthcare for Single Homeless People', p12, Department of Health, March 2010, Office of the Chief Analyst.

PD treatment centre guidelines, (Jan, 2018). https://www.cnwl.nhs.uk/service/guidelines-for-referrals/

References 7

Wallin, D. J., ‘ Attachment in Psychotherapy’, 2007, The Guildford Press.

Young, J., E., Klosko, J., S., and Weishaar, **M., E**, **2003**, ‘Schema Therapy’, The Guildford Press.