Homelessness as Psychological Trauma

Broadening Perspectives

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Most mental health literature on homelessness has focused on characteristics that may be risk factors for homelessness. The authors of this article argue that homelessness itself is a risk factor for emotional disorder and use the construct of psychological trauma—focusing on social disaffiliation and learned helplessness—to understand the potential effects of homelessness. Psychological trauma is likely among homeless individuals and families for three reasons. (a) The sudden or gradual loss of one's home can be a stressor of sufficient severity to produce symptoms of psychological trauma. (b) The conditions of shelter life may produce trauma symptoms. (c) Many homeless people—particularly women—become homeless after experiencing physical and sexual abuse and consequent psychological trauma. Research suggests that negative psychological responses to traumatic events can be prevented or mitigated by a supportive and empowering posttrauma environment. The implications of trauma theory for improving the psychosocial conditions of homeless people are discussed.

Homelessness has become a national tragedy that affects individuals and families throughout the United States, including increasing numbers of women and children (Institute of Medicine, 1988; Rossi, Wright, Fisher, & Willis, 1987; U.S. Conference of Mayors, 1986; U.S. General Accounting Office, 1988, 1989). Safe, adequate, and affordable housing is the most pressing need of homeless people. However, as the number of homeless people increases (Rossi, 1990; U.S. Conference of Mayors, 1987), it is also essential to identify and address associated mental health issues. Most recent literature on the relationship between mental health and homelessness has described attempts to identify individual characteristics that may be risk factors for homelessness (e.g., Breakey et al., 1989; Wood, Valdez, Hayashi, & Shen, 1990). In contrast, we argue that homelessness is itself a risk factor for emotional disorder (see, e.g., Dohrenwend & Dohrenwend, 1974; Institute of Medicine, 1988; Rivlin, 1986) and we propose that psychologists can play an important role in addressing the psychological consequences of homelessness, regardless of the presence or absence of prior mental health difficulties.

In this article, we use the construct of psychological trauma as a means of understanding the potential effects of homelessness on individuals and families. Psychological trauma refers to a set of responses to extraordinary, emotionally overwhelming, and personally uncontrollable life events (Figley, 1985b; Van der Kolk, 1987a). These events may be discrete and clearly bounded, such as rape, or prolonged and ongoing, such as battering or combat (see, e.g., Figley, 1985b; Van der Kolk, 1987b). A wide range of symptoms or psychological conditions have been included under the rubric of psychological trauma, many of which involve the rupture of interpersonal trust and the loss of a sense of personal control. Each of these phenomena will be discussed in more detail later in this article.

Trauma theory and research may provide a useful lens through which to view and understand the experience of homelessness in at least three respects. First, the event of becoming homeless—of losing one's home, neighbors, routines, accustomed social roles, and possibly even family members—may itself produce symptoms of psychological trauma in some victims. Typically, the transition from being housed to being homeless lasts days, weeks, months, or even longer. Most people living on the street or in shelters have already spent time living with friends or relatives and may have experienced previous episodes of homelessness (see, e.g., Shinn, Knickman, & Weitzman, 1989, 1991; Sosin, Piliavin, & Westerfelt, 1991). The loss of stable shelter, whether sudden or gradual, may produce symptoms of psychological trauma. Second, among those who are not psychologically traumatized by becoming homeless, the ongoing condition of homelessness—living in shelters with such attendant stressors as the possible loss of safety, predictability, and control—may undermine and finally erode coping capabilities and precipitate symptoms of psychological trauma. Third, if becoming homeless and living in shelters fail to produce psychological trauma, homelessness may exacerbate symptoms of psychological trauma among people who have histories of victimization. For these people, homelessness may constitute a formidable barrier to recovery.

We do not attempt to prove that homelessness causes psychological trauma. Rather, we draw on psychological trauma theory to elucidate preliminary empirical and

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anecdotal findings, to highlight the benefits of applying psychological theory to the study of homelessness, and to offer potentially fruitful avenues for further research. In the first section of this article we review selected literature on psychological trauma and consider in greater depth its relationship to homelessness. In the second section we examine the mental health and social policy implications of viewing homelessness as a cause of, or contributor to, psychological trauma. We argue that mental health professionals can use their understanding of psychological trauma to make shelters and other settings more responsive to the needs of homeless people. We conclude that improving the conditions of shelter life could prevent the development of psychological trauma or mitigate its most damaging symptoms.

Psychological Trauma as a Consequence of Homelessness

The category *psychological trauma* has been used to explain a variety of symptoms and conditions commonly found among victims of extraordinary stress (see, e.g., Figley, 1985b; Van der Kolk, 1984, 1987b). Many of these symptoms have been grouped to form the diagnostic entity *posttraumatic stress disorder* (PTSD) in the revised third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM–III–R;* American Psychiatric Association, 1987). This diagnosis captures the constellation of symptoms common among victims of an acute traumatic event, including persistent reexperiencing of the traumatic event through intrusive recollections, dreams, or dissociative states; a numbing of general responsiveness manifested by a restricted range of affect or a markedly diminished interest in significant activities; and persistent symptoms of increased arousal, such as irritability, angry outbursts, hypervigilance, and sleep disturbances. Other symptoms included under the more general rubric of *psychological trauma,* and common among victims of chronic or ongoing trauma, include substance abuse, self-mutilation, intolerance of intimacy, a general sense of helplessness, and a sense of isolation and existential separateness from others (Figley, 1985a; Harvey, 1991).

Individual reactions to potentially traumatic events vary widely, depending on complex interactions between person, event, and environmental factors (Harvey, 1991; Koss & Harvey, 1991; Toro et al., 1991). The nature and duration of the event or events, the age and predisposing attributes of the victim, and the reaction of the larger community each play a role in determining the nature and extent of a victim's response (Green, Wilson, & Lindy, 1985; Harvey, 1991).

Recently, Smith (1991) investigated the prevalence of PTSD among a sample of 300 randomly selected homeless single women and mothers in St. Louis, Missouri. Using the Diagnostic Interview Schedule (DIS; Robins, 1981; Robins & Helzer, 1984), she found that 53% of the respondents could be diagnosed as exhibiting full-blown cases of PTSD. In addition, data from clinical observations, self-reports, and empirical studies suggest that at least two commonly reported symptoms of psychological trauma—social disaffiliation and learned helplessness—are highly prevalent among homeless individuals and families. These phenomena are discussed below, first in the context of trauma theory and then in the context of homelessness. The relationship between preexisting psychological trauma and current homelessness is also explored.

Social Disaffiliation

A key feature of psychological trauma is the felt and real experience of social disaffiliation. Bowlby (1969, 1973) described the human need for intimate and long-lasting attachments as a biological imperative that results from long-term evolutionary development. According to this theory, feelings of safety and connection are essential for children to attain the emotional security necessary to develop self-reliance, autonomy, and self-esteem. In adulthood, relationships with others continue to provide a fundamental sense of existential meaning and self-worth.

Building on Bowlby's work, Van der Kolk (1987a) proposed that the essence of psychological trauma is the perceived severance of secure affiliative bonds, which damages the psychological sense of trust, safety, and security. "Trauma occurs," he wrote, "when one loses the sense of having a safe place to retreat within or outside oneself to deal with frightening emotions or experiences" (p. 31). Janoff-Bulman and Frieze (1983) described the same phenomenon from a social cognition perspective. They noted that trauma victims "no longer perceive themselves as safe and secure in a benign environment" because they "have experienced a malevolent world" (p. 5).

Trauma victims' sense of being without sanctuary in a world filled with malevolent forces is often compounded by actual failures of social support networks and by the social withdrawal of those on whom the victims have relied for support. People often react to victims by rejecting them. Some people are unsympathetic because they see victims as somehow responsible for their fate (Lerner, 1970; Ryan, 1971). Others do not want to associate with victims because they perceive them as "losers" (Bard & Sangrey, 1979). Still others perceive victims as depressed and therefore unpleasant to be with (Coates, Wortman, & Abbey, 1979). These and various other reactions can confirm and amplify victims' subjective feelings of isolation and so become obstacles to recovery from psychological trauma.

Homelessness, like other traumas, may produce a psychological sense of isolation or distrust as well as the actual disruption of social bonds. Anecdotal accounts (e.g., Hirsch, 1989; Kozol, 1988) reveal how becoming homeless strips people of most of their accustomed social roles. In most cases, homeless people can no longer fulfill their obligations as workers, neighbors, friends, or caregivers (Kozol, 1988). Many shelters and transitional facilities separate husbands from wives and teenage boys from their parents (Molnar, 1989), thereby diminishing the opportunities for homeless people, particularly family

members, to perform their accustomed social roles. Patterns of relating to others, developed over a lifetime, are interrupted. Homeless people can lose faith in their own ability to care for themselves and in the willingness of others to help them, and may develop an abiding sense of distrust of others.

A number of empirical studies have provided evidence that social disaffiliation, a core feature of psychological trauma, is characteristic of many homeless individuals. Some researchers have suggested that social disaffiliation often precedes homelessness. Studies conducted in three cities demonstrated that homeless respondents were nearly twice as likely never to have married than were respondents who were not homeless (Farr, Koegel, & Burnam, 1986; Fischer, Shapiro, Breakey, Anthony, & Kramer, 1986; Roth, Bean, Lust, & Seveanu 1985). In another study comparing 536 domiciled and homeless persons in Chicago, Sosin, Colson, and Grossman (1988) found that the homeless respondents were more likely to have experienced out-of-home placement as children and were more likely to have lived alone as adults than had their domiciled counterparts.

Other research evidence, particularly in the area of family homelessness, suggests that homelessness may also precipitate or exacerbate feelings of interpersonal distrust and foster social isolation. In a recent study comparing the quantity and quality of social relationships among a sample of 50 homeless mothers and 50 housed mothers receiving Aid to Families with Dependent Children (AFDC), Goodman (in press) found that the homeless women scored significantly lower on a measure of degree of trust of others as sources of help. Although the relationship between homelessness and distrust revealed in this study was correlational rather than causal, qualitative sections of respondent interviews support the idea that a large proportion of the homeless mothers felt less able to trust others because they had not been protected from homelessness by friends, relatives, and social service providers.

Further evidence comes from a comparison of two studies, each of which investigated the social networks of homeless mothers at different points in the transition to homelessness. Shinn et al. (1989, 1991) found that newly homeless mothers (i.e., those making first-time requests for shelter) were actually more likely than housed mothers on AFDC to have a living mother, grandmother, or close relative and to have seen these contacts recently. In contrast, Bassuk and Rosenberg (1988) found that mothers who had been homeless for a longer period of time reported significantly fewer supports than did their housed counterparts. When asked to name up to three individuals on whom they could count in times of stress, 74% of the housed and only 26% of the homeless women were able to name three adults. A comparison of these studies reveals relatively higher levels of social isolation among mothers who have spent time in shelters than among women just entering the shelter system, suggesting that homelessness may precipitate or coincide with a rapid disintegration of social networks.

Learned Helplessness

Although Van der Kolk (1987a) emphasized the relational ruptures wrought by a traumatizing event or series of events, other researchers have stressed the sense of helplessness that often ensues from such events (e.g., Flannery, 1987; Peterson & Seligman, 1983; Walker, 1978; Wilson, Smith, & Johnson, 1985). These authors viewed the sense of helplessness as a core element of psychological trauma and used the construct of learned helplessness (e.g., Seligman, 1975) to understand the diminished sense of efficacy and self-worth that is prevalent among trauma victims (Figley & McCubbin, 1983; Walker, 1978). People are said to experience learned helplessness, a phenomenon that is often accompanied by profound depression, when they lose the belief that their own actions can influence the course of their lives (Seligman, 1975). Research indicates that learned helplessness is most likely to occur when people hold themselves personally responsible for their situations, perceive the situations as long-term, or believe that the situations are caused by global rather than specific factors (Garber & Seligman, 1980). However, it should be noted that some behaviors that appear to reflect learned helplessness may actually be adaptive responses to an environment that does not offer alternatives to continued victimization (Flannery & Harvey, 1991).

Behaviors indicative of learned helplessness may be consequences of homelessness because, like other traumas, becoming homeless frequently renders people unable to control their daily lives. Homeless people, whether they live in the streets, in cars, in shelters, in welfare hotels, or in other temporary accommodations, experience daily assaults on their sense of personal control. They may depend on help from others to fulfill their most basic needs, such as eating, sleeping, keeping clean, guarding personal belongings, and caring for children. Although the poverty that precedes most homelessness (Rossi, 1990) is itself likely to engender feelings of homelessness and depression (e.g., Holzer et al., 1986), homelessness, by adding a new dimension of deprivation, is likely to greatly exacerbate these feelings.

Although researchers have not yet directly investigated the extent of learned helplessness among homeless people, they have documented high rates of depression, a component of learned helplessness, among the homeless. For example, in Breakey et al.'s (1989) survey of homeless people in Baltimore, affective disorders were the most frequently identified *DSM–III–R* Axis I diagnoses other than substance abuse. In a study of homeless women in New York City, D'Ercole and Struening (1990) reported that on a commonly used measure of depression, their respondents obtained a mean score well above that used as a cutoff for clinical depression. These findings are not proof that homelessness leads to depression, as depression has also been shown to precede homelessness (see Breakey et al., 1989; Koegel, Burnam, & Farr, 1988). However, they are consistent with the theory that becoming homeless and living in a shelter can exacerbate a person's sense of helplessness and thus heighten the risk of depression.

Anecdotal accounts provide further support. In a poignant description of homeless families in New York City shelters and hotels, Kozol (1988) recorded one mother's sense of helplessness and despair:

> There's a crucifix on the wall. I ask her: "Do you pray?" "I don't pray! Pray for what? I been prayin' all my life and I'm still here. When I came to this hotel I still believed in God. I said: 'Maybe God can help us to survive.' I lost my faith. My homes. And everything. Ain't nobody—no God, no Jesus—gonna help us in no way. God forgive me. I'm emotional . . . I'm scared to sleep. If I eat, I eat one meal a day. My stomach won't allow me. I have ulcers. I stay in this room. I hide." (p. 67)

Learned helplessness theory suggests that the real absence of control in the lives of homeless people eventually can engender a generalized passivity. The ongoing experience of helplessness may lead to an apparent unwillingness on the part of some homeless people to fight for themselves or to utilize the often meagre services available to them. Some may come to view their daily difficulties with apparent indifference, as if they do not expect to move into better circumstances, whereas others may become overly dependent on social service or mental health professionals. In either case, as the stressors inherent in being homeless persist, feelings of helplessness and the passivity these feelings engender can become entrenched and pervasive (Flannery, 1987).

Trauma Histories Among Homeless People

A growing body of literature suggests that a significant proportion of homeless people, especially women, have histories of traumatic victimization. In an investigation of the rates of victimization experiences among homeless women with and without children in New York City (D'Ercole & Struening, 1990), 43% of 141 respondents reported being raped by a family member or other adult, 74% reported being physically abused, and 25% reported being robbed. In a study comparing homeless and housed mothers in Boston, Bassuk and Rosenberg (1988) found that 41% of the homeless and only 5% of the housed respondents reported physical abuse in their childhoods; 41% and 20% respectively reported that they had been battered in at least one adult relationship. And in a study comparing newly homeless and housed mothers in New York City, Shinn, Knickman, and Weitzman (1989, 1991) found that 11.4% of the shelter requesters, compared with only 6.5% of the housed mothers, reported childhood histories of physical abuse; 9.9% and 4.2%, respectively, reported childhood sexual abuse; and 27% and 16.6%, respectively, reported having been abused or threatened as adults.

Finally, in a recent study comparing the prevalence of histories of physical and sexual abuse among 50 homeless mothers and 50 housed mothers receiving AFDC in two New England cities, Goodman (1991) found that although there were no significant differences between the two groups on three of the four types of abuse investigated, the prevalence of abuse among both groups was extraordinarily high. Fifty-seven percent of the total sample reported having been physically abused in childhood, 46% reported having been sexually abused in childhood, 67% reported adult physical abuse, and 37% reported adult sexual abuse. Indeed, 89% of the total sample had experienced some form of physical or sexual abuse in their lifetimes.

Many homeless women may therefore bring symptoms of psychological trauma to their new circumstances. Some may present with clear diagnoses of PTSD, others with histories of alcohol and substance abuse, and still others may suffer from social disaffiliation and learned helplessness. Thus, even when becoming homeless or living under the extraordinary stress of shelter life do not produce symptoms of psychological trauma, homeless people may nevertheless manifest such symptoms. For these people, homelessness may exacerbate existing psychological difficulties and complicate the recovery process. The traumatic effects of abuse and homelessness may compound each other to produce even greater psychological damage.

Treatment and Policy Implications

Viewing homelessness as a psychologically traumatic experience has a number of implications for psychologists and other mental health practitioners. Given that the presence and severity of psychological trauma depends in large part on community response to victims and the overall environment in which they function (see, e.g., Green et al., 1985), improving the psychosocial conditions of shelter life could mitigate or even prevent the development or exacerbation of psychological trauma.

In this section, we offer some examples of services and systemic interventions that might result from the application of trauma theory to the understanding of homelessness. Several of the examples we cite are drawn from initiatives that have been undertaken by innovative shelter providers throughout the country (Goodman, 1989). Shelters and other settings in which homeless individuals and families reside and function must promote social connections among homeless people and between homeless people and their communities. Routines must be developed that ensure safety, offer support, encourage mastery, and preserve, enhance, or restore feelings of self-worth and efficacy. Such efforts should be part of a comprehensive service program that includes, at minimum, case management (to coordinate services and link them with the housing search process), job training, child care, medical care, substance abuse treatment, psychological and educational services for children, and transportation to needed services (Bassuk, Carman, & Weinreb, 1990).

Several caveats to this discussion should be noted. First, because researchers have not yet addressed the processes by which homelessness effects people, and systematic studies of programs for homeless individuals and families have not been conducted (Saxe & Goodman, 1990), the suggestions that follow are offered tentatively, as guidelines for services and interventions that should

be tested empirically for their effectiveness. Second, these suggestions are not aimed at homeless people who suffer from major mental illnesses such as schizophrenia, as they are likely to require a more specialized array of services. Third, the present discussion focuses on homeless people in emergency or transitional shelters rather than on those who live on the streets or stay with friends. Fourth, the specific effects of homelessness on children are not addressed here, although children may suffer most from the deleterious conditions of shelter life (Bassuk & Rosenberg, 1990; Bassuk, Rubin, & Lauriat, 1986; Molnar, Klein, Knitzer, & Ortiz-Torres, 1988; Rafferty & Rollins, 1989). Finally, although the following comments focus on improving shelter conditions, people who have suffered the trauma of homelessness may continue to need psychological and other supportive services even after they regain permanent housing.

Social Support

As we noted earlier, many homeless people experience actual disruption of their social bonds as well as feelings of distrust and existential separateness. Researchers have demonstrated that positive social support following a traumatic event can help victims reestablish psychological well-being by enhancing self-esteem and a sense of connection to others (e.g., Janoff-Bullman & Frieze, 1983; Van der Kolk, 1987c). Furthermore, without a support network on which to rely in times of crisis, homeless people may have more difficulty returning to permanent housing and are at higher risk for repeated episodes of homelessness. Helping homeless individuals and families reestablish their relationships and their links to the community will enable them to take full advantage of housing opportunities when these arise.

As a first step, every attempt should be made to help homeless individuals and families enter shelters in their own communities. The effort and expense of travel can impede the maintenance of social ties among homeless people who are removed from their neighborhoods. Physical distance may engender a sense of psychological distance that increases the sense of isolation. Shelter providers should encourage and help homeless residents maintain social networks, thereby building on strengths rather than focusing on deficits (Bassuk, 1990). In many cases, homeless people will have stayed with relatives before becoming homeless, straining and sometimes even exhausting these ties (see, e.g., Shinn et al., 1989, 1991). Once the daily pressure of living together is lifted, social bonds often can be rejuvenated (Goodman, 1989).

Service providers must also help create a sense of interdependence and community within shelters. Staff should ensure that the shelter environment is physically safe and secure, because violence, substance abuse, and other disturbances in the shelter may inhibit occupants from establishing or maintaining social connections. Further, shelter staff can facilitate formal and informal opportunities for residents to share common experiences and develop a sense of mutuality and trust. Comfortable common rooms, such as kitchens or dining rooms, allow residents to congregate and talk, play games, or share housing information. Peer support groups offer more formal opportunities for building supportive relationships. As Van der Kolk (1987c) noted, "Often fellow victims provide the most effective short-term bond because the shared history of trauma can form the nucleus for retrieving a sense of communality" (p. 154). Group members can learn not only that others are trustworthy, but also that they themselves are useful to other people. These groups may be especially helpful to people with abuse histories who need a safe place in which to reveal past experiences (Browne, 1990). Groups may continue even after shelter guests move into permanent housing, thereby supplementing other attachments in the community.

Finally, shelter staff should make every effort to involve residents of local communities in working with their homeless neighbors. Most shelters for homeless individuals and families are not staffed by residents of the immediate neighborhood, because community members are often fearful, distrustful, or even hostile. As a result, homeless people in shelters are stigmatized and further isolated. Some shelters have been successful in enlisting the help of local community members, especially volunteers residing in the same area in which the homeless people formerly lived (Goodman, 1989). These volunteers can help reintroduce homeless individuals into the community.

Personal Control

In addition to enhancing homeless people's sense of community, interventions should be designed to reduce helplessness and increase a sense of personal control. Although some trauma researchers have addressed the importance of helping victims alter their beliefs concerning their own helplessness (e.g., Hartman & Burgess, 1985), others have emphasized the need to make real changes in the post-trauma environment (e.g., Flannery, 1987). In the case of homelessness, we propose that individuals must not only be helped to develop the internal resources to cope with stressful conditions, but also must be provided with as much real control as possible in order to increase autonomy and reduce the possibility of perpetuating traumatic conditions.

For example, shelter residents should have as much of the responsibility for organizing shelter life as they are able and willing to take. Within reasonable limits, residents should negotiate shelter rules among themselves. These rules might govern visiting hours, eating and sleeping times, who may visit the shelter, how and to what extent shelter residents should cooperate in performing chores (such as meal preparation and child-care tasks), and even how shelter funds should be spent. Meetings might also be held to plan upcoming events, to share housing information, or to discuss emerging shelter problems or conflicts.

To help shelter residents gain some control in the world outside the shelter, service providers should give residents as much information as possible about their entitlement to benefits. Shelter staff, moreover, should

collaborate with residents to develop a feasible set of goals, often called a *service plan,* based on clients' needs and wishes and on available resources (Bassuk, 1990). Such a plan should include a reasonable strategy for obtaining permanent housing. Kozol (1988), in his account of homeless families in New York, described the sense of futility and despair that homeless people experience when their goals and daily activities are imposed by unreasonable bureaucracies. For example, they may spend their days searching for an affordable apartment that they know does not exist, driven by the fear that their benefits will be cut if they do not try. Impossible requirements such as these should be eradicated and replaced by goals generated by the clients that are consistent with available services and resources.

Finally, to ensure that available resources actually reach the intended clients, case management should be made available to all shelter residents who may be vulnerable to falling through the cracks of an increasingly complex and fragmented service delivery system. These case managers should be ready to assume a variety of roles including "that of service broker, counselor, ombudsman, and advocate" (Bassuk, 1990, p. 25).

Conclusion

Most discussions of the mental health issues associated with homelessness address intrapsychic and interpersonal risk factors for homelessness. The psychological effects of losing one's home and entering the ranks of the homeless are less well understood. Given the suggestive research evidence presented in this article and the implications of psychological trauma theory, we believe that many homeless individuals and families may be suffering both short- and long-term psychological devastation wrought by homelessness itself. This disturbing but as yet inconclusive evidence makes a more systematic research approach imperative. To assess accurately the unique psychological effects of homelessness, researchers should use an ecological framework (Bronfenbrenner, 1979; Koss & Harvey, 1991; Milburn & D'Ercole, 1991; Toro et al., 1991) that examines individual outcomes in the context of prior psychological resources, social context (including ethnic or racial membership, family and community support, and political climate), community response to homeless individuals and families, and the nature of the recovery environment developed in shelters. Furthermore, for their findings to be useful to service providers and policymakers, researchers should seek to identify the special characteristics or resources of those who respond adaptively to the trauma of homelessness and should examine the nature of recovery environments that seem to prevent or mitigate negative outcomes.

There is widespread agreement that services to the homeless severely mentally ill population must be comprehensive and coordinated and provide for clients' mental health, housing, and support needs (Levine & Rog, 1990). Our analysis suggests that coordinated and comprehensive services should be offered to all people who reside in emergency and transitional shelters. Further, mental health consultation from clinicians and community and social psychologists is essential in the early stages of shelter planning. Training programs should be developed to help shelter staff work effectively with homeless people with diverse needs, many of whom may be suffering from social disaffiliation, learned helplessness, and other aspects of psychological trauma. Such programs increase knowledge and enhance skills among service providers and provide support to staff, thus reducing burnout and high turnover rates (Bassuk, 1990). Involvement of mental health practitioners may lead to shelters that are better designed to empower and support those who must suffer through the indignities of being without a home.

REFERENCES

American Psychiatric Association. (1987). *Diagnostic and statistical manual of mental disorders* (3rd ed. rev.). Washington DC: Author.

Bard, M., & Sangrey, D. (1979). *The crime victim's book.* New York: Basic Books.

Bassuk, E. L. (1990). General principles of family-oriented care: Working effectively with clients. In E. L. Bassuk, R. W. Carman, & L. F. Weinreb (Eds.), *Community care for homeless families: A program design manual* (pp. 25–31). Washington, DC: Interagency Council on the Homeless.

Bassuk, E. L., Carman, R. W., & Weinreb, L. F. (1990). *Community care for homeless families: A program design manual.* Washington, DC: Interagency Council on the Homeless.

Bassuk, E. L., & Rosenberg, L. (1988). Why does family homelessness occur? A case control study. *American Journal of Public Health, 78,* 1097–1101.

Bassuk, E. L., & Rosenberg, L. (1990). Psychosocial characteristics of homeless children and children with homes. *Pediatrics, 85,* 257–261.

Bassuk, E. L., Rubin, L., & Lauriat, A. (1986). Characteristics of sheltered homeless families. *American Journal of Public Health, 76,* 1097–1101.

Bowlby, J. (1969). *Attachment and loss: Vol. 1. Attachment.* New York: Basic Books.

Bowlby, J. (1973). *Attachment and loss: Vol. 2. Separation.* New York: Basic Books.

Breakey, W. R., Fischer, P. J., Kramer, M., Nestadt, G. N., Romanoski, A. J., Ross, A., Royall, R. M., & Stine, O. C. (1989). Health and mental health problems of homeless men and women in Baltimore. *Journal of the American Medical Association, 262,* 1352–1357.

Bronfenbrenner, U. (1979). *The ecology of human development: Experiments by nature and design.* Cambridge, MA: Harvard University Press.

Browne, A. (1990). Family violence and homelessness. In E. L. Bassuk, R. W. Carman, & L. F. Weinreb (Eds.), *Community care for homeless families: A program design manual* (pp. 119–128). Washington, DC: Interagency Council on the Homeless.

Coates, D., Wortman, C. B., & Abbey, A. (1979). Reactions to victims. In I. H. Frieze, D. Bar-Tal, & J. S. Carroll (Eds.), *New approaches to social problems: Applications of attribution theory* (pp. 21–52). San Francisco: Jossey-Bass.

D'Ercole, A., & Struening, E. (1990). Victimization among homeless women: Implications for service delivery. *Journal of Community Psychology, 18,* 141–152.

Dohrenwend, B. P., & Dohrenwend, B. S. (1974). *Stressful life events: Their nature and effects.* New York: Wiley.

Farr, R. P., Koegel, P., & Burnam, A. (1986). *A study of homelessness and mental illness in the Skid Row Area of Los Angeles.* Los Angeles: County Department of Mental Health.

Figley, C. R. (1985a). From victim to survivor: Social responsibility in the wake of a catastrophe. In C. R. Figley (Ed.), *Trauma and its wake: The study and treatment of post-traumatic stress disorder* (pp. 398–415). New York: Brunner-Mazel.

Figley, C. R. (Ed.). (1985b). *Trauma and its wake: The study and treatment of post-traumatic stress disorder.* New York: Brunner-Mazel.

Figley, C. R., & McCubbin, H. I. (Eds.). (1983). *Stress in the family: Volume II. Coping with catastrophe.* New York: Brunner-Mazel.
Fischer, P. J., Shapiro, S., Breakey, W. R., Anthony, J. C., & Kramer, M. (1986). Mental health and social characteristics of the homeless: A survey of mission users. *American Journal of Public Health, 76,* 519–524.
Flannery, R. (1987). From victim to survivor: A stress management approach in the treatment of learned helplessness. In B. A. Van der Kolk (Ed.), *Psychological trauma* (pp. 217–233). Washington, DC: American Psychiatric Press.
Flannery, R., & Harvey, M. (1991). Psychological trauma and learned helplessness: Seligman's paradigm reconsidered. *Psychotherapy, 28,* 374–378.
Garber, D. S., & Seligman, M. E. P. (1980). *Human helplessness.* New York: Academic Press.
Goodman, L. A. (1989). *Community of Hope.* Unpublished manuscript.
Goodman, L. A. (1991). The prevalence of abuse in the lives of homeless and housed poor mothers: A comparison study. *American Journal of Orthopsychiatry, 61,* 489–500.
Goodman, L. A. (in press). The relationship between social support and family homelessness: A comparison study of homeless and housed mothers. *Journal of Community Psychology.*
Green, B. L., Wilson, J. P., & Lindy, J. D. (1985). Conceptualizing post-traumatic stress disorder: A psycho-social framework. In C. R. Figley (Ed.), *Trauma and its wake: The study and treatment of post-traumatic stress disorder* (pp. 53–69). New York: Brunner-Mazel.
Hartman, C. R., & Burgess, A. W. (1985). Illness-related post-traumatic stress disorder: A cognitive behavioral model of intervention with heart attack victims. In C. R. Figley (Ed.), *Trauma and its wake: The study and treatment of post-traumatic stress disorder* (pp. 338–355). New York: Brunner-Mazel.
Harvey, M. R. (1991). *An ecological approach to the treatment of trauma victims.* Manuscript submitted for publication.
Hirsch, K. (1989). *Songs from the alley.* New York: Ticknor & Fields.
Holzer, C., Shea, B., Swanson, J., Leaf, P., Myers, J., George, L., Weissman, L., & Bednarski, P. (1986). The increased risk for specific psychiatric disorders among persons of low socioeconomic status. *The American Journal of Social Psychiatry, 6,* 259–271.
Institute of Medicine. (1988). *Homelessness, health, and human needs.* Washington, DC: National Academy Press.
Janoff-Bulman, R., & Frieze, I. H. (1983). A theoretical perspective for understanding reactions to victimization. *Journal of Social Issues, 39*(2), 1–17.
Koegel, P., Burnam, A., & Farr, R. K. (1988). The prevalence of specific psychiatric disorders among homeless individuals in the inner city of Los Angeles. *Archives of General Psychiatry, 45,* 1085–1092.
Koss, M. P., & Harvey, M. R. (1991). *The rape victim: Clinical and community interventions* (2nd ed.). Newbury Park, CA: Sage.
Kozol, J. (1988). *Rachel and her children: Homeless families in America.* New York: Ballantine Books.
Lerner, M. (1970). The desire for justice and reactions to victims: Social psychological studies of some antecedents and consequences. In J. Macaulay & L. Berkowitz (Eds.), *Altruism and helping behavior* (pp. 205–229). San Diego, CA: Academic Press.
Levine, I. S., & Rog, D. J. (1990). Mental health services for homeless mentally ill persons: Federal initiatives and current service trends. *American Psychologist, 45,* 963–968.
Milburn, N., & D'Ercole, A. (1991). Homeless women: Moving toward a comprehensive model. *American Psychologist, 46,* 1161–1169.
Molnar, J. (1989, August). *A developmental profile of children and families in poverty.* Paper presented at the 97th Annual Convention of the American Psychological Association, New Orleans, LA.
Molnar, J., Klein, T., Knitzer, J., & Ortiz-Torres, B. (1988). *Home is where the heart is: The crisis of homeless children and families in New York City.* New York: Bank Street College of Education. (ERIC Document Reproduction Service No. ED 304 228)
Peterson, C., & Seligman, M. E. P. (1983). Learned helplessness and victimization. *Journal of Social Issues, 2,* 103–116.
Rafferty, Y., & Rollins, N. (1989). *Learning in limbo: The educational deprivation of homeless children.* New York: Advocates for children of New York, Inc.
Rivlin, L. G. (1986, Spring). A new look at the homeless. *Social Policy,* 3–10.
Robins, L. (1981). National Institute of Mental Health Diagnostic Interview Schedule. *Archives of General Psychiatry, 38,* 381–389.
Robins, L., & Helzer, J. (1984). *PTSD section for the Diagnostic Interview Schedule.* Unpublished manuscript, Washington University, St. Louis, MO.
Rossi, P. H. (1990). The old homeless and the new homelessness in historical perspective. *American Psychologist, 45,* 954–959.
Rossi, P. H., Wright, J. D., Fisher, G. A., & Willis, G. (1987). The urban homeless: Estimating composition and size. *Science, 235,* 1336–1341.
Roth, D., Bean, J., Lust, N., & Seveanu, T. (1985). *Homelessness in Ohio: A study of people in need.* Columbus: Ohio Department of Mental Health.
Ryan, W. (1971). *Blaming the victim.* New York: Vintage Books.
Saxe, L., & Goodman, L. (1990). Research issues for homeless families. In J. P. Morrissey & D. L. Dennis (Eds.), *Homelessness and mental illness: Toward the next generation of research studies* (pp. 88–93). Washington, DC: National Institute of Mental Health.
Seligman, M. E. P. (1975). *Helplessness: On depression, development and death.* San Francisco: Freeman.
Shinn, M., Knickman, J., & Weitzman, B. (1989, August). *Social relationships and vulnerability to becoming homeless among poor families.* Paper presented at the 97th Annual Convention of the American Psychological Association, New Orleans, LA.
Shinn, M., Knickman, J. R., & Weitzman, B. C. (1991). Social relationships and vulnerability to becoming homeless among poor families. *American Psychologist, 46,* 1180–1187.
Smith, E. (1991). [Patterns of alcoholism in subsamples of the homeless]. Unpublished raw data.
Sosin, M. R., Colson, P., & Grossman, S. (1988). *Homelessness in Chicago: Poverty and pathology, social institutions and social change.* Chicago: University of Chicago School of Social Service Administration.
Sosin, M. R., Piliavin, I., & Westerfelt, H. (1991). Toward a longitudinal analysis of homelessness. *Journal of Social Issues, 46*(4), 157–174.
Toro, P. A., Trickett, E. J., Wall, D. D., & Salem, D. A. (1991). Homelessness in the United States: An ecological perspective. *American Psychologist, 46,* 1208–1218.
U.S. Conference of Mayors. (1986). *The continued growth of hunger, homelessness, and poverty in America's cities.* Washington, DC: Author.
U.S. Conference of Mayors. (1987). *Status report on homeless families in America's cities: A 29-city survey.* Washington, DC: Author.
U.S. General Accounting Office. (1988). *Homeless mentally ill: Problems and options in estimating numbers and trends.* Washington, DC: Author.
U.S. General Accounting Office. (1989). *Homelessness: Homeless and runaway youth receiving services at federally funded shelters.* Washington, DC: Author.
Van der Kolk, B. A. (Ed.). (1984). *Post-traumatic stress disorder: Psychological and biological sequelae.* Washington, DC: American Psychiatric Press.
Van der Kolk, B. A. (1987a). The psychological consequences of overwhelming life experiences. In B. A. Van der Kolk (Ed.), *Psychological trauma* (pp. 1–31). Washington, DC: American Psychiatric Press.
Van der Kolk, B. A. (Ed.). (1987b). *Psychological trauma.* Washington, DC: American Psychiatric Press.
Van der Kolk, B. A. (1987c). The role of the group in the origin and resolution of the trauma response. In B. A. Van der Kolk (Ed.), *Psychological trauma* (pp. 153–172). Washington, DC: American Psychiatric Press.
Walker, L. E. (1978). Battered women and learned helplessness. *Victimology, 2,* 525–534.
Wilson, J. P., Smith, W. K., & Johnson, S. K. (1985). A comparative analysis of PTSD among various survivor groups. In C. R. Figley (Ed.), *Trauma and its wake: The study and treatment of post-traumatic stress disorder* (pp. 142–172). New York: Brunner-Mazel.
Wood, D., Valdez, B. Hayashi, T., & Shen, A. (1990). Homeless and housed families in Los Angeles: A study comparing demographic, economic, and family function characteristics. *American Journal of Public Health 80,* 1049–1052.