CE 2.5 ANCC Contact Hours

Professional Case Management
Vol. 19, No. 4, 161-170

Trauma-Informed Care: A Paradigm Shift Needed for Services With Homeless Veterans

Stephanie Dinnen, MS, Vince Kane, MSW, and Joan M. Cook, PhD

ABSTRACT

Purpose of Study: Exposure to traumatic events is a highly prevalent, although often overlooked, aspect in the lives of homeless veterans. In this study, the prevalence and correlates of potentially traumatic events, including posttraumatic stress disorder, in the homeless veteran population are presented.

Findings/Conclusions: Presently, there exists a lack of trauma-informed case management services for homeless veterans. Failing to recognize the association between trauma and homelessness may lead to further victimization, exacerbate mental health symptomology, and hinder a provider's ability to effectively intervene on behalf of homeless veterans.

Implications for Case Management: Subgroups of homeless veterans such as those who served in the Vietnam and post-Vietnam era, more recent returnees from Iraq and Afghanistan, women, rural-residing veterans, and those who are justice involved, are discussed for unique trauma histories and service needs. Barriers to receiving trauma-informed care among homeless veterans are reviewed. Information to assist providers in assessing trauma histories and current best practices in the treatment of posttraumatic stress disorder are noted. Suggestions for how this document can be used in varied organizational settings are made.

Key words: *homeless, PTSD, trauma-informed care, veterans*

Homeless men and women, many of whom are suffering from a disability, are living on the streets of our communities. Because of its transient nature, the exact prevalence of homelessness is not known., However it is estimated that on a single night in January 2013, there were 610,042 people experiencing homelessness in the United States, including 394,698 people who were homeless in sheltered locations and 215,344 people who were living in unsheltered locations (Housing and Urban Development [HUD] Annual Homeless Assessment Report, 2013). Of these men and women, 57,849 are veterans, men and women who once defended our nation. While veterans make up only a small portion of the total U.S. population (7%), veterans make up more than 12% of homeless adults (Veterans Healthcare Administration Office of Rural Health, 2013). While homelessness among the veteran population has experienced a significant decline (down 24%) since the beginning of the VA and the Federal Strategic Plan in 2010, it remains a major public health problem (HUD Annual Homeless Assessment Report, 2013).

Ending homelessness has been named a top U.S. federal priority (U.S. Interagency Council on Homelessness, 2010). Indeed the Obama Administration's initiative "Opening Doors" pledged to end chronic homelessness and homelessness among the veteran population in 2015 (U.S. Interagency Council on Homelessness, 2010). One way to assist in the achievement of this goal is to address the effects of exposure to traumatic events and their potential mental health sequelae in homeless veterans.

Trauma-informed care (TIC) is a perspective that acknowledges the pervasive influence and impact of trauma on an individual, their provider, and the organization delivering case management and other supportive services. There is no singular definition of what constitutes TIC, but across descriptions there are three recurrent themes: (1) basic understanding of trauma (including behavioral responses to and symptoms of trauma, training, consultation, and supervision in screening, assessment, and treatment), (2) creating an environment of physical and emotional safety for the trauma survivor and providers (i.e., ensuring privacy, confidentiality, respecting cultural differences,

Address correspondence to Joan M. Cook, PhD, Yale School of Medicine, NEPEC/182, 950 Campbell Avenue, West Haven, CT 06516 (Joan.Cook@yale.edu).

The authors report no conflicts of interest.

DOI: 10.1097/NCM.0000000000000038

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and awareness of trauma triggers), and (3) adopting a strengths-based approach to services (i.e., fostering skill-building, mastery, resiliency and rebuilding control through choice and empowerment; Elliot, Bjelajac, & Fallor, 2005; Hopper, Bassuk, & Olivet, 2010; Jennings, 2004; Ko et al., 2008; Prescott, Soares, Konnath, & Bassuk, 2007). Failure to adopt a trauma-informed perspective can inhibit mental health recovery and treatment or service retention as well as lead to retraumatization (Elliot et al., 2005).

The purpose of this article was to help case management providers understand how trauma impacts the lives of the homeless veterans. As such, information is presented on the prevalence and correlates of potentially traumatic events, including posttraumatic stress disorder (PTSD), in this population. In addition, the unique trauma histories and service needs of multiple subgroups of homeless veterans are reviewed. Barriers and facilitators to TIC among traumatized homeless veterans are noted. Information to assist in assessing trauma histories is discussed. Basic theory and treatment rationale for evidence-based treatments for PTSD are presented.

Organizations that serve homeless populations vary widely in their affiliation as well as education, training, and licensing of their staff. As a means of simplification, all individuals providing case management services in social, health care, or mental health care settings to homeless veterans are referred to throughout by one term, providers. The term "case manager" encompasses a broad spectrum of professionals, with varying levels of experience, training, and professional responsibility. Case managers may include associate- or bachelor-level professionals providing service coordination but not specific treatment or intervention delivery: individuals with advanced degrees providing basic psychological intervention (e.g., skill building, psychoeducation) in addition to service coordination and licensed providers delivering specialized mental health care.

Prevalence and Correlates of Trauma and Relation to Homelessness

About 50% of American women and 60% of American men experience at least one traumatic event such as natural disasters, life-threatening accidents, combat, interpersonal violence, and childhood abuse (Kessler, Sonnega, Brommet, & Nelson, 1995). While no epidemiological investigation on the prevalence of trauma or subsequent mental health disorders has included civilian homeless individuals, rates from convenience samples have been reported at 90% and higher (e.g., Buhrich, Hodder, & Teesson, 2000; Goodman, Saxe, & Harvey, 1991; Kim, Ford, Howard, & Bradford, 2010; Taylor & Sharpe, 2008). For example, 90% of homeless men and women in Sydney, Australia, had experienced lifetime trauma (Buhrich et al., 2000). In a sample of 100 homeless women and mothers recruited from two New England cities, 89% reported lifetime physical or sexual assault (Goodman et al., 1991). In another study of 239 homeless men who utilized a North Carolina homeless shelter, 68.2% reported childhood physical abuse and 55.6% childhood sexual abuse, whereas 71.1% reported adult physical assault and 53.1% adult sexual assault (Kim et al., 2010).

Posttraumatic stress disorder is one mental health disorder that may develop as a result of exposure to trauma. Not all individuals who experience a traumatic event develop PTSD; the lifetime estimate of PTSD in the general population is 6.8% (Kessler et al., 2005). Subthreshold or partial PTSD (wherein all but one or two criteria are present) is also prevalent and a clinically significant problem (Pietrzak, Goldstein, Southwick, & Grant, 2011). The lifetime estimate for subthreshold PTSD in the general population is 6.6% (Pietrzak et al., 2011). Exposure to trauma has been associated with numerous other mental health problems (Pietrzak et al., 2011), physical concomitants (Boscarino, 1997; Schnurr & Green, 2004), and impairments in occupational and social functioning (Kessler, 2000).

Research indicates that for some individuals, trauma and PTSD make one more susceptible to homelessness. Homeless individuals often experience their first traumatic event and subsequent development of PTSD symptomology before becoming homeless (Goodman et al., 1991; North & Smith, 1992; Taylor & Shapre, 2008). For example, in a sample of 600 homeless men and 300 homeless women randomly selected from St. Louis shelters and day centers, North and Smith (1992) found that nearly 75%

of those who developed PTSD did so before they became homeless.

Exposure to trauma also increases when one is homeless (Goodman et al., 1991; Perron, Eitzman, Gillespie & Pollio, 2008). Homeless individuals are exposed to an increased risk of criminal violence and nonviolent crimes (Williams & Hall, 2009), detachment from support systems, increased risk of substance abuse overdose, and desensitization to potentially dangerous situations as a result of repeated exposure (Perron et al., 2008).

A diagnosis of any severe mental illness is a risk factor for homelessness (National Coalition for Homelessness, 2006). Among veterans, the presence of a mental health disorder is the strongest predictor of homelessness following military discharge (Department of Veterans Affairs Office of the Inspector General, 2012). In addition, PTSD is associated with an increased risk of recurrent or chronic homelessness. In a sample of formerly homeless veterans, PTSD was associated with an 85% increased risk of becoming homeless again (O'Connell, Kasprow, & Rosenheck, 2008).

Three interrelated pathways to homelessness have been hypothesized: social selection, socioeconomic adversity, and traumatic exposure (Tessler, Rosenheck, & Gamache, 2001). "Social selection" suggests that individuals with serious mental illness or severe substance abuse "drift down" the social strata, becoming disenfranchised, socially isolated (e.g., loss of peer groups), and economically challenged (e.g., unable to work, low levels of education), ultimately leading to homelessness. Socioeconomic adversity proposes that poverty leads to homelessness. Finally, traumatic events are thought to indirectly lead to homelessness because of the severity of related mental health symptoms, interference with the ability to maintain employment, and strained interpersonal relationships and diminished social support.

Among the veteran population, there exist numerous misconceptions about the causes of homelessness. In the wake of the post-Vietnam/Middle East I era it was assumed that homelessness was solely the result of postwar adjustment issues. However, specific pathways into homelessness among veterans have also been identified (Hamilton, Poza, Hines, & Washington, 2012; Rosenheck & Fontana, 1994). These routes include childhood adversity, trauma during military service, and postmilitary abuse or difficulties.

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Subgroups of Homeless Veterans

Vietnam and Post-Vietnam/Middle East I Era Homeless Veterans

Many of the data on homelessness among veterans were collected during the 1980s and 1990s. Indeed, the first national survey of homelessness in the veteran population took place in 1987 (Burt & Cohen, 1989). Early data demonstrated that veterans who served in the post-Vietnam/Middle East I era (1975–1989) but prior to the Gulf War I (1990–1991) were at the greatest risk for experiencing homelessness, four times as likely as their nonveteran peers. Veterans who served during Vietnam (1971–1975) were by contrast 1.4 times more likely than nonveterans to be homeless (Rosenheck, Frisman, & Chung, 1994). Such data challenged the previously held belief that homelessness was related only to combat exposure and subsequent readjustment issues. Veterans of the post-Vietnam/Middle East I era were less likely to see combat than World War II or Vietnam veterans and yet had significantly higher risk of homelessness.

Post-Vietnam/Middle East I era veterans represent the first all-volunteer force and have higher incidence of psychiatric and substance use disorders than World War II and Vietnam veterans (Rosenheck et al., 1994). It is theorized that in the aftermath of Vietnam, military service held such negative public opinion that it became a last resort for many who had no other career opportunities (Rosenheck et al., 1994), thus leading to a force with higher rates of psychopathology. The higher risk of homelessness in this post-Vietnam/Middle East I era cohort was replicated in a second study conducted 10 years later (Gamache, Rosenheck, & Tessler, 2001).

Veterans of the Vietnam and post-Vietnam era are aging and, as such, may require additional, unique age-related services. At present, not all homeless services may be equipped to address age-related needs. For instance, they may have age-related medical comorbidities that require medication dispersal and, thus, the presence of a licensed medical practitioner on-site. Vietnam and post-Vietnam/Middle East I era veterans were also socialized during a time when mental health stigma was high. Furthermore, PTSD was not yet well studied and only entered the

psychiatric classification system in 1980, and at the time of their service, no validated interventions for PTSD existed. As such, these veterans may require basic psychoeducation about trauma and its concomitants.

Veterans From Wars in Iraq and Afghanistan

There are various unique risk factors for traumatic mental health problems in the cohort of veterans who served in Operation Iraqi Freedom/Operation Enduring Freedom (OIF/OEF), including repeated and extended deployments, unprecedented numbers of National Guard and Reservist deployments, and younger age of entry into the Armed Forces (Hoge et al., 2004). Homelessness following military separation among these veterans has been associated with younger age and enlistment at a lower pay grade (Department of Veterans Affairs, 2012). In addition, homeless OIF/OEF veterans were more than twice as likely to be diagnosed with a mental health disorder or traumatic brain injury (TBI) at the time of discharge from active duty (Department of Veterans Affairs, 2012). One investigation of 994 homelessness OIF/OEF veterans enrolled in a community outreach program found rates of PTSD among this cohort was more than five times as high as rates found in previous eras (Tsai, Pietrzak, & Rosenheck, 2013).

Veterans of these recent conflicts are also more likely to become homeless in a shorter period of time following military discharge than veterans of previous eras (National Alliance to End Homelessness, 2010). This may be, in part, due to a lack of transitional services but has also likely been exacerbated by a protracted recession in the U.S. economy and jobs market in recent years. Indeed, the unemployment rate among veterans aged 20–24 is 19% (U.S. Bureau of Labor Statistics, 2013). Under- or unemployment and the resulting financial strain likely contributes to unstable housing.

The literature on TBI in homeless populations is relatively sparse, even less well researched is TBI in homeless veteran populations. Traumatic brain injury, often called the "signature injury" of the OIF/OEF wars, affects an estimated 300,000 veterans (Hoge et al., 2008). Traumatic brain injury appears to be both a risk factor for homelessness and an increased risk when homeless (Topolovec-Vranic et al., 2012). Traumatic brain injury has been associated with decreased income and decreased levels of social support, which increases risk for homelessness (Topolovec-Vranic et al., 2012). There is also a strong association between TBI and PTSD. In one study of more than 2,000 OIF/OEF veterans, of the 10% who had a mild or moderate TBI diagnosis, 44% met criteria for concurrent PTSD (Hoge et al., 2008). However, the limited studies on TBI among the homeless typically have small sample sizes, are composed of mostly males, rarely use validated screening tools, and are poorly representative (Topolovec-Vranic et al., 2012).

There has been little-to-no systematic investigation of the unique care needs of homeless veterans with TBI. Individuals with TBI may exhibit emotional and behavioral problems as a consequence of their injury (National Association of State Head Injury Administrators, 2006). Cognitive deficits may impede a veteran's ability to engage in rehabilitation programming or they may require one-on-one assistance, which can stress organizational time and resources. Furthermore, social service organizations often lack a qualified individual or specialized training in neurobehavioral issues.

Women and Families

Since 2001 women have been serving in the Armed Forces in unprecedented numbers (U.S. Census Bureau, 2012). Their increased service has also led to an estimated 141% increase in the number of homeless women veterans between 2006 and 2010 (U.S. Government Accountability Office, 2011). Military service is associated with a threefold increase in experiencing homelessness among women veterans (Gamache et al., 2003) compared with their nonveteran peers.

Homeless female veterans are also three times as likely as their housed counterparts to have received treatment for military sexual trauma (Washington et al., 2011). In one study comparing homeless and shelter-residing women veterans, a majority had received treatment for military sexual trauma prior to the first episode of homelessness, implicating sexual trauma as a unique risk factor to homelessness among women veterans (Washington et al., 2011). However, women veterans are also likely to have experienced combat-related traumas. One recent investigation of homelessness among male and female Iraq and Afghanistan veterans reported of 109 female veterans studied; 75.3% reported combat-related PTSD (Tsai, et al., 2013).

There are also gender differences in the predictors of homeless veterans' length of time in the community without rehospitalization following graduation from a VA inpatient substance abuse program (Benda, 2006). Namely, childhood sexual abuse and adult sexual assault were the strongest predictors of rehospitalization for women veterans as were loss of a family member during the 2-month posttreatment period and physical abuse across the lifespan.

Homeless female veterans are likely to require different services than the homeless male population, including gender-specific medical care, physical and mental health care for physical and

sexual assault, and access to care for children and families (North & Smith, 1992). In an investigation of proximal factors related to service use among homeless female veterans, the most frequent barriers to service utilization were limited access (e.g., lack of women-only treatment groups), lack of information about services available, and lack of coordination across services. Many also had described negative reporting experiences during their military careers of seeking treatment (particularly for sexual assault) and being ignored or punished (Hamilton et al., 2012).

Trauma is highly prevalent in homeless mothers (Bassuk & Weinreb, 1996; Williams & Hall, 2009). In a purposive sample of 75 homeless mothers, 67% met diagnostic criteria for PTSD (Williams & Hall, 2009). More than half reported their worst event occurred before they became homeless. Number of lifetime traumatic events, lifetime PTSD, and the presence of childhood trauma independently were related to current traumatic stress symptoms. There are no available statistics on homelessness among veteran mothers. The typical homeless family includes a mother in her late twenties and two young children (Burt & Laudan, 2000). Trauma and the experience of homelessness for a mother may be compounded by feelings of guilt and shame surrounding her children. Many homeless shelters service adults only and organizations that shelter women and children often do not allow men, potentially separating families. In addition to their own trauma history, homeless mothers may require parenting education and intervention to address the needs of their children. There are no available statistics on homelessness among veteran mothers.

Rural Veterans

Military veterans disproportionately reside in rural or mostly rural areas (Veterans Healthcare Administration Office of Rural Health, 2013). In fact, an estimated 6.1 million veterans live in rural areas; of these, one third served in the most recent wars, and of which only 50% (3.1 million) are enrolled in the VA Health Care system (Veterans Healthcare Administration Office of Rural Health, 2013). While homelessness among veterans in cities has declined, the incidence of homelessness among veterans in rural and suburban areas is on the rise (U.S. Interagency Council on Homelessness, 2012). In states with a large rural population, veterans may compromise as much as 25% of the entire homeless population (U.S. Interagency Council on Homelessness, 2012).

Veterans in rural areas are more likely to be homeless for longer periods of time, less likely to receive a mental health diagnosis and more likely to experience serious comorbid medical, dental, and vision problems, and less likely to receive public assistance (U.S. Interagency Council on Homelessness, 2012). This may be due, in part, to a lack of infrastructure to support the homeless in rural areas, often requiring an individual to travel large distances to receive care (National Alliance to End Homelessness, 2010). The most challenging need for rural veterans experiencing homelessness is likely to be geographic distance from services. One promising development for effectively treating rural veterans has been the advent of telemedicine.

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Justice-Involved Veterans

Prior incarceration has been identified as a risk factor for homelessness in the general and veteran populations (Rosenheck & Koegel, 1993). Approximately 12% of the U.S. state and federal prison population is composed of veterans, not including those on probation or parole (Mumola, 2000). In a study of 30,000 incarcerated veterans, 30% were classified as having a history of homelessness, more than five times the rate of past homelessness in the general population (Tsai, Rosenheck, Kasprow, & McGuire, 2014).

Risk of homelessness following incarceration may differ by era. The likelihood of homelessness following incarceration was found to be higher in veterans who served in the initial all-volunteer force following Vietnam than in veterans who served in theater or in other eras (Greenberg, Rosenheck, & Desai, 2007). Although veteran minorities are less likely to have a criminal justice history than their nonveteran peers, homelessness after incarceration was highest among Black veterans compared with veterans of other races (Greenberg et al., 2007).

Traumatic exposure in incarcerated veteran populations is high. In one study of 129 incarcerated veterans, 87% reported at least one trauma (Saxon et al., 2001). Incarcerated veterans may be more likely to have experienced severe combat exposure during their service than nonincarcerated veterans (Greenberg et al., 2007). Combat exposure has been linked to increased aggression, violence, and antisocial behavior, which may in turn increase risk for incarceration (Greenberg et al., 2007). Rates of

serious mental illness and substance abuse are higher in incarcerated populations, both veteran and civilian (Center for Health Care Evaluation, 2013). In a sample of 30,000 incarcerated veterans, 79% had a mental health disorder (Tsai et al., 2014).

TIC for Homeless Veterans

The development of a trauma-informed perspective within homeless service settings is in its infancy with little consensus on a common framework, program models, and dissemination and implementation strategies (Hopper, Bassuk, & Olivet, 2009). On the basis of a literature review, Hopper and colleagues (2009) summarize the core principles of TIC for homelessness:

1. trauma awareness through staff training, consultation, and supervision;
2. organizational restructuring to incorporate an understanding of trauma at the system level (e.g., adapting current policy to prevent revictimization),
3. an emphasis on physical and emotional safety for the homeless individual and provider (e.g., awareness of triggers, clear rules and boundaries, confidentiality),
4. respecting the individual's choices and promoting efficacy and self-control over their lives, and
5. fostering a strengths-based approach (as opposed to deficit-oriented) focusing on skill-building and future-oriented goals.

There are numerous barriers to accessing appropriate care for homeless veterans experiencing trauma-related mental health issues. One prominent barrier is the lack of routine screening for trauma among this population. Given the prevalence of trauma in the lives of homeless veterans, it is important that providers routinely ask about the presence of trauma, both current and lifetime. Although PTSD is commonly found in veterans experiencing homelessness, it may go undetected because of the multiple layers of need and competing physical, social, and psychological comorbidities. Providers who fail to recognize the association between trauma and homelessness in veterans may inadvertently maintain cycles of chronic homelessness.

Routine obstacles to the detection of a history of trauma and PTSD symptomology can include lack of provider awareness, time, or discomfort with asking about trauma as well as lack of training in valid assessment tools. Provider attitudes and beliefs can hinder the identification of trauma-related psychopathology. Providers may be reticent to ask about trauma or may fear that asking about trauma may cause the veteran to be upset or feel offended or retraumatized. In addition, providers may feel unprepared to handle a positive endorsement of trauma or PTSD, may feel that it is not their job, or may be unaware of relevant mental health service referrals.

Homeless veterans can themselves complicate detection and treatment because they may have been multiple-traumatized and have past negative reporting experiences. They may not recognize or may minimize the experience of and effects from trauma. The majority also described betrayal of trust in past relationships and subsequently had anxiety about engaging in treatment and attending groups.

Homeless veterans may additionally lack life skills that make them susceptible to further victimization, and treatment should focus on addressing these deficits. A study of the relationship between trauma, depression, coping, and mental health service among impoverished and shelter-residing women found these women to lack basic life skills such as money management, seeking and obtaining employment, locating permanent housing, independently completing self-care and home management activities, managing stress, and parenting (Rayburn et al., 2005).

Psychological Assessment and Treatment

Providers play an important role in the provision of TIC. When a veteran discloses a traumatic event, it is important to first respond with empathy and validate their experience. Because many homeless may have had prior negative reporting experiences, providers can break down barriers to treatment engagement and retention by establishing rapport, trust, and a space of emotional safety for the veteran. Although not all providers will participate in the provision of psychotherapy, initial inquiries about trauma represent an opportunity to provide a positive, corrective clinical encounter that may help engage them in trauma-focused treatment.

There are several evidence-based treatments for PTSD (Cahill, Rothbaum, Resick, & Folette, 2009; Foa, Keane, Friedman & Cohen, 2009; VA/DoD, 2010). Two cognitive–behavioral interventions for PTSD that have been identified as front-line treatments in veteran and active duty populations (VA/DoD, 2010) are cognitive processing therapy (CPT) (Resick & Schnicke, 1996), based on cognitive therapy (Beck & Emery, 1985), and an exposure-based intervention, prolonged exposure (PE; Foa, Hembree, & Rothbaum, 2007). Cognitive processing therapy is derived from cognitive therapy for depression (Beck & Emery, 1985) and challenges maladaptive thinking patterns. Prolonged exposure is a cognitive–behavioral intervention with roots in behaviorism and aids the patient in confronting

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emotion-invoking, trauma-related stimuli to neutralize the stimulus (Foa & Kozak, 1986).

Randomized controlled trials demonstrate slightly more favorable outcomes for veterans in PE as compared with CPT (Steenkamp & Litz, 2013). However, not all veterans will benefit from these therapies. Indeed, following two of the largest randomized controlled trials for CPT and PE in veterans, more than 50% of participants still met criteria for PTSD (Monson et al., 2006; Schnurr et al., 2007). A recent review of psychotherapy for military-related PTSD suggests that treatment noncompletion and participation refusal rates are high among these two treatments, although the exact reasons are not well understood (Steenkamp & Litz, 2013). Importantly, although validated interventions exist for the treatment of PTSD, none of these have been adapted for or empirically tested and found effective in homeless populations.

Other evidence-based treatments for PTSD include eye movement desensitization and reprocessing (EMDR; Shapiro, 2001) and stress inoculation therapy (Meichenbaum, 1996). Eye movement desensitization and reprocessing is a multimodal therapy demonstrated to have significant efficacy with PTSD populations and was generally equally efficacious to PE (Rothbaum, Astin, & Marsteller, 2005). Eye movement desensitization and reprocessing remains somewhat controversial due to its use of guided eye movements (typically finger tracking) during trauma processing (Davidson & Parker, 2001). Stress inoculation therapy is an anxiety-management treatment that includes muscle relaxation, breathing retraining, guided-self-dialogue, and in vivo exposure among other key elements (Meichenbaum, 1996).

Mindfulness-based interventions, such as acceptance and commitment therapy (Walser & Westrup, 1998) and mindfulness-based cognitive therapy (Segal, Williams, & Teasdale, 2002), combine elements of cognitive therapy (e.g., cognitive flexibility) with the addition of mindfulness-based practices (e.g., meditation) to increase awareness of thoughts and emotions. However, they have typically been used as an adjunct to evidence-based treatments for PTSD or in the treatment of other mental health disorders such as depression. However, not all patients experience significant relief following cognitive–behavioral interventions for PTSD and evaluations are currently under way to examine the efficacy of mindfulness-based interventions as stand-alone treatments for PTSD. Various other innovative interventions addressing specific symptoms of PTSD such as acupuncture, yoga, and virtual reality therapy have some demonstrated support, although these studies have been small and are in need of large-scale replication (for review, see Cloitre, 2009).

Implications for Case Managers

When working with homeless populations, it is important to be aware of the likelihood of past and future traumatic events and the effects on mental and physical health. Trauma-informed health care providers are essential for engaging homeless veterans in treatment and connecting them with appropriate trauma treatment services. Thus, it is important that providers and organizations servicing homeless populations receive training in and employ a trauma-informed perspective. It is important for providers to create an environment for safe disclosure, validate the veteran's experience, normalize posttraumatic reactions, and provide appropriate referral.

It is hoped that this article may serve as an informative, but concise and easily transmittable, training document for organizations and case managers serving homeless veterans in any capacity such as shelter, food, and other supportive services as well as specialized mental health treatment. Adopting a trauma-informed perspective requires an organizational paradigm shift, whereby all aspects of the organizational culture are reviewed and reinterpreted from a trauma-informed approach. Thus, this document, in whole or in part, may serve as an education and training tool for staff of all education and licensing levels within an organization serving homeless veterans.

For further information, including guidance on the specific processes for serving homeless veterans, resources are available through the Department of Veterans Affairs National Center on Homelessness Among Veterans (www.endveteranhomelessness.org/education), including trainings on working with women and rural and justice-involved veterans. In addition, the Department of Labor Women's Bureau (2010) has produced a web-based training and downloadable manual titled, "Trauma Informed Care for Women Veterans Experiencing Homelessness."

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Stephanie Dinnen, MS, is Research Coordinator for the Department of Psychiatry, Yale School of Medicine. Her research interests include the phenomenology, symptomology, and treatment of mental health disorders in older adult populations, specifically, trauma in the lives of older adult women.

Vince Kane, MSW, is Director of the National Center for Homelessness Among Veterans and the Director of the Housing and Urban Development—VA Supportive Housing (HUD-VASH) Program. He has been the site PI on numerous research projects including the Federal Partners Initiative for Chronic Homeless Veterans.

Joan M. Cook, PhD, is Associate Professor of Psychiatry for the Yale School of Medicine and researcher for the National Center for PTSD. She is funded by the National Institute of Mental Health to study the implementation and sustainability of evidence-based psychotherapies for PTSD in community settings.