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NSO
Neighborhood Service Organization

Homeless Services
COMPREHENSIVE, CONTINUOUS, INTEGTRATED SYSTEMS OF CARE

TRAUMA, CHRONIC HOMELESSNESS, & ATTACHMENT
Course Outline

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I. Introduction
   a. (slide 3) "The Takeaway": Substance use and mental illness are only the fuel that ignites and/or sustain homelessness - poor connections with others is the true foundation of homelessness and without addressing it, we doom the client to future housing loss.
      i. Our stabilization efforts when housing the chronically homeless, whether using Housing First or other approaches, have focused too much on the client's psychiatric and/or substance abuse conditions when our efforts should be focused on trust and relationship building and emotional self-regulation that have been damaged by years of multiple traumas which have destroyed their ability to interact with the community in a healthy manner. This workshop will help attendees recognize that what often contributes most significantly to repeated homelessness and broken placements is the client's chaotic relationships with others (patterns learned and reinforced through childhood and adult trauma) then introduces approaches, that must be used by all service providers to help the client work toward emotional stabilization and (re)build the attachments that sustain us in life.
      ii. We got here because our funding focus is conflicting w/our clinical training, which tells us (constantly) to "do less so the client can do more"; often our program or agency goals say things like "end homelessness" as if we have that much power or control; this translates into us "throwing services" at clients, because doing so can be measured objectively while clinical activities such as engagement cannot.
      iii. The services are important but have to conducted within the context of building a relationship if they are offered at all – often the client can fulfill his/her service needs w/o or w/little help from us
      iv. We also got here because we also "throw services" at clients to avoid forming connections w/them – how many times do we refer out because we are in someway overwhelmed by our clients' or our own issues? Our clients are not pleasant and easy to care for nor do they offer immediate (if ever) gratitude for much of the care we offer. Giving them a service allows us to

look at ourselves in the mirror and still believe that we did something – fulfilled our goal of doing service to others and manage the rejection we face constantly

b. If you don't have an emotional reaction to what I'm saying, I've not done my job. If I upset you and you decide to ignore me, I've not done what I've come here to do. But if you walk out of here, cursing my name, and while going home, calming down you start to think of how you going to do things differently, I will smile.
c. Learning Objectives* (slide 4)
    i. To identify how poor attachment and underdeveloped trusting skills impairs a client's effective functioning in the community
        1. Definitions and Functional Concepts of:
            a. Attachment
            b. Trauma
            c. Substance Use and Mental Illness/Emotional Impairment
            d. The connection to homelessness and other negative outcomes
    ii. To learn how to use techniques adapted from PCT, DBT and MI to prompt clients towards pro-social activities through improved emotional regulation.
    iii. To infuse trauma-informed care into effective care coordination and team-based care management.
d. KEEP IN MIND (slide 5)
    i. The brain is responsible for everything we do, allowing us to laugh, walk, talk, create and hate – it allows us to be human. Our brain's functioning is a direct reflection of our experiences. (Perry, B.D. Integrating Principles of Neurodevelopment into Clinical Practice Introduction to the Neurosequential Model of Therapeutics (NMT). The Child Trauma Academy. PowerPoint Presentation. 2011)
        1. So to talk about changing behavior, we have to talk about the brain and impacting its functioning
        2. Psychotropic medications are not enough in part because they only change the flow not the directionality
        3. Abstinence is not enough because it does not rebuild misdirected brain circuitry
    ii. For centuries scholars have known to some degree that the capacity to express full human potential is related to the balance of developmental opportunities and challenges. (Perry, B.D. & Hambrick, E.P. The Neurosequential Model of Therapeutics. Reclaiming Children and Youth [www.reclaiming.com]. Fall 2008, vol 17, #3)
        1. A childhood w/o trauma does not automatically equate to a good adulthood
        2. Growth is about successfully meeting challenges appropriate to intellectual and emotional functioning of the person BUT

3. When challenges overwhelm the person, growth is possible only with the support of others and the surrounding community.

iii. Trauma is at the center of the client's troubles – the recent talk about trauma and trauma informed care is not new but an attempt to remind us of something those of us who work in foster care already know that the horrors come in many forms

1. Our understanding of trauma has been fragmented and politicized
2. Individuals representing different clusters of individuals who had one trauma fought over the same dollars by arguing for the public's pity and thus their dollars
3. Until now, we failed not only to see the similarities across individuals in different ways but we also failed to recognize that most of our clients are traumatized multiple times, in multiple ways

II. Definitions and Functional Concepts

a. Attachment

i. (slide 6)"Attachment is a deep and enduring emotional bond that connects one person to another across time and space" (Ainsworth, 1973; Bowlby, 1969).

ii. "Most of the work in the study of attachment came from the research works of John Bowlby (1907-1990) who focused on the attachment between children, particularly babies and toddlers and their parents.

iii. The mother–child bond is the primary force in infant development, according to Bowlby's attachment bond theory.

1. However, subsequent research has indicated that attachments were most likely to form with those who responded accurately to the baby's signals, not the person they spent most time with. Schaffer and Emerson called this sensitive responsiveness.
2. Many of the babies had several attachments by 10 months old, including attachments to mothers, fathers, grandparents, siblings and neighbors. " (McLeod, S. A. (2009). Attachment Theory. Retrieved from http://www.simplypsychology.org/attachment.html)
3. (slide 7)The attachment bond theory and current brain research points to the relationship between infants and primary caretakers as responsible for:
    a. The shaping all of our future relationships
    b. The strengthening or damaging our abilities to focus, be conscious of our feelings, and calm ourselves
    c. The ability to bounce back from misfortune

iv. (slide 8) Therefore, child to parent interactions that result in a successful, secure attachment, are those where both parent and child can sense the other's feelings and emotions.

1. In other words, an infant feels safe and understood when the mother responds to their cries and accurately interprets their changing needs.
2. However, this dance does not stop at infancy – the adult must stay attuned through the child's developmental adjustments, conscious of how everything from hormones to peers impact those feelings and shift appropriately because.
3. Unsuccessful or insecure attachment occurs when there is a failure in this communication of feelings.
4. It is critical therefore that potential parents see child-rearing as a long-term investment in a market that must be monitored, studied, and reviewed consistently if a successful outcome is going to be possible.

v. Why is this important?

1. (slide 9) A key component to a successful adulthood involves the ability to effectively relate with others. This is dependent on the ability to:
    a. manage stress
    b. stay "tuned in" with emotions
    c. use communicative body language
    d. be playful in a mutually engaging manner
    e. be readily forgiving, relinquishing grudges
2. Insecure attachment , caused by abuse or neglect (which is the absence or distortion of attachment) will impair these skills." (Segal, J. & Jaffe, J. Attachment and Adult Relationships: How the Attachment Bond Shapes Adult Relationships. www.helpguide.org. Janurary 2013). ….
3. Will be problematic and transudate across a variety of relationships albeit indirectly albeit the more intimate ones the most profoundly

b. Trauma

i. (slide 10) "The Human Factor"

1. Trauma is any stressor that occurs in a sudden and forceful way and is experienced as overwhelming. However, trauma and stress are not the same thing. Certainly, all traumatic events are stressful, but not all stressful events are traumatic. Removing the causes of stress can reverse the symptoms of stress. The symptoms of trauma must be addressed differently because it has a deeper and more far-reaching impact. People who have experienced traumatic events describe feelings of intense fear, helplessness, or horror and later in life and left untreated can become PTSD. These are normal reactions to abnormal or extreme situations.

2. Unlike natural disasters, human induced traumas tend to be insidious within the home and come with similar (if not the same) terrors within the community, particularly for those living in impoverished areas.
3. Assume that anyone who has lived homeless, either on the streets or in shelters, has been traumatized as homelessness is trauma in and of itself.
4. (slide 12) Most trauma is not a singular occurrence and its impact is cumulative.
5. (Types of trauma - slide 13) However, realize that most of our clients don't identify these experience as traumatic (to close to it) and those who came to homelessness after earlier life traumas are unaware that their current problems and challenges are likely related to those earlier traumas.

ii. The Brain's Response to Trauma*

1. The Basics of How our Brains Work:
    a. (slide 14)The brain develops primarily from the bottom to the top from infancy until the early 20s.
    b. The process is influenced by a host of neurotransmitters, neurohormones, and neuromodulator signals.
    c. (slide 15)These signals help target cells migrate, differentiate, sprout dendritic trees, and form synaptic connections. Some of the most important of these signals come from the monoamine neural systems (i.e., norepinephrine, dopamine, and serotonin).
    d. These crucial sets of widely distributed neural networks originate in the lower brain areas (brainstem and diencephalon)and project to every other part of the developing brain.
    e. (slide 16) This architecture allows these systems the unique capacity to communicate across multiple regions simultaneously and therefore provide an organizing and orchestrating role during development and later in life. (Perry, B.D. Examining Child Maltreatment Through a Neurodevelopmental Lens: Clinical Applications of the Neurosequential Model of Therapeutics. Journal of Loss and Trauma, 14:240–255, 2009.)
2. In the face of any stressor, the brain's stress response system reacts in a "fight or flight" manner
    a. (slide 17)'Fight or flight' responses are normal, survival reactions that prepare us to survive possible or actual fearful or anxiety provoking situations and are attempts to

save our minds and/or our bodies from harm. There are two particular types:

b. Hyperarousal is one of the most common reaction to trauma. It includes increased breathing (panting; shallow, rapid breaths), increased heart rate, muscular tension, racing thoughts, and hyper-attention to the environment. This is the body preparing itself to run or fight or both.

c. Dissociation is when your mind disconnects from the event or physical reality of what is happening. The person may freeze and experience a mind/body split often described by women as "losing time". Denial that the situation is happening immediately following the event is commonly accompanies dissociation and occurs when the women ignores or fails to acknowledge a feelings connected to the event or acts as if what happened was unimportant.

3. (slide 18) 'Fight or flight' reactions become toxic when the stressors are overwhelming, ongoing, and/or the victim is isolated from help.

a. Shonkoff & Garner work points to the "extensive evidence of the disruptive impact of toxic stress, offering intriguing insights into causal mechanisms that link early adversity to later impairments in learning, behavior, and both physical and mental well-being." They (and others) "suggest that many adult diseases should be viewed as developmental disorders that begin early in life and that persistent health disparities associated with poverty, discrimination, or maltreatment could be reduced by the alleviation of toxic stress in childhood. (Shonkoff, J. P. and Garner, A.S. and The Committee on Psychsocial Aspects of child and Family Health, Committee on Early Childhood, Adoption, and dependent care, and Section on Developmental and Behavioral Pediatrics. The Lifelong Effects of Early Childhood Adversity and Toxic Stress. American Academy of Pediatrics-Technical Report, 2012.

b. Trauma also increases the likelihood of physical health problems due to active (smoking, drug use, poor eating habits) and passive (missed follow up appointments, repeated injuries to the same body area, poor nutrition) abuse of the body.

c. Describe the ACE study

iii. How Secure Attachment Mitigates Trauma in the Brain

1. (slide 19) We are neurologically wired to have empathic relationships however it is easily overridden by fear, jealousy, and greed.
2. We have the neurological "equipment" to effectively manage trauma but, particularly as children, need external support to do it.
3. "One recurring observation about resilience and coping with trauma is the power of healthy relationships to protect from and heal following stress, distress, and trauma."
    a. Just as there are neuronal systems for stress there are mediating systems in the brain built through positive, supportive relationships with others.
    b. This powerful positive effect of healthy relational interactions on the individual is at the core of relationally based protective mechanisms that help us survive and thrive following trauma and loss.
    c. (slide 20) Individuals who have few positive relational interactions (e.g., a child without a healthy family and clan) during or after trauma have a much more difficult time decreasing the trauma-induced activation of the stress response systems and therefore will be much more likely to have ongoing symptoms (Perry, B.D. Examining Child Maltreatment Through a Neurodevelopmental Lens: Clinical Applications of the Neurosequential Model of Therapeutics. Journal of Loss and Trauma, 14:240–255, 2009.)
    d. (slide 21) The "clan" or community's response cannot be one of shame or pity, both are disempowering.
        i. Empathy is critical - Empathy is defined as seeing someone's picture of their world (not "walking in their shoes").
        ii. Empathy is a partnership – the focus should be on understanding the pain of the person and not fixing it then using one's conscious mind (the frontal lobes) to regulate one's emotional reaction (limbic system) to the picture one sees.
        iii. The community must keep in mind that every traumatized victim wants justice.

c. Behavioral Health
    i. (slide 22) Mental Illness and Substance Abuse are just as likely residual effects or accompanying factors to trauma as they could be risk factors for abuse.
        1. Substances produce a "reward" reaction in the brain similar "to the extreme" of that which comes naturally. For many abuse survivors,

alcohol or drugs help elevate intrusive memories and a semblance of control over their feelings

2. Many people with a psychotic diagnosis report that the voices they hear are those of their abuser – which makes many question if many of them aren't schizophrenic but actually suffering from PTSD
3. There is some question if there is a correlation between rising rates of mild cognitive impairment and undiagnosed fetal alcohol spectrum disorder. Those who grow up in homes where substance abuse and physical violence are paired are at risk from traumatic head injuries due to untreated concussions
4. (slide 23) The malleability of the brain shifts during development, and therefore the timing and specific ''pattern'' of (the abuse or) neglect influence the final functional outcome.
    a. A child deprived of consistent, attentive, and attuned nurturing for the first 3 years of life who is then adopted and begins to receive attention, love, and nurturing may not be capable of benefiting from these experiences with the same malleability as an infant.
    b. In some cases, this later love is insufficient to overcome the dysfunctional organization of the neural systems mediating socioemotional interactions
    c. Even when children do receive mental health services, neglect-related issues are rarely appreciated as having a distinct pathophysiology and pathogenesis" from abuse and ….. (Perry, B.D. Examining Child Maltreatment Through a Neurodevelopmental Lens: Clinical Applications of the Neurosequential Model of Therapeutics. Journal of Loss and Trauma, 14:240–255, 2009.)
    d. There is little more than acknowledgement of a connection between the child's negative behaviors and the toxic stress in their lives
5. The clinical implications speak to the importance of the timing of developmental experience
    a. The very same traumatic experience will impact an 18-month-old child differently than a 5-year-old.
    b. Similar traumatic experiences occurring at different times in the life of the same child will influence the brain in different ways; in many cases, the previous exposure has sensitized the child, making him or her more vulnerable to future events.
    c. A more subtle clinical implication trauma's influence on higher order functions such as speech and language or

socioemotional communication – (slide 24) the child's brain is stuck in 'fight and flight' and has no time for learning only to worry and protect him/herself from the next assault. This also means an overanxious, impulsive, dysregulated child will have a difficult time participating in, and benefiting from, services targeting social skills, self-esteem, and reading, for example. (Perry, B.D. Examining Child Maltreatment Through a Neurodevelopmental Lens: Clinical Applications of the Neurosequential Model of Therapeutics. Journal of Loss and Trauma, 14:240–255, 2009.)

d. Many of our clients have neurological systems similarly impaired, as evidenced by their current impulsive behaviors. This (slide 25) impulsivity is enhanced by the drugs taken and the drama-ladened lifestyles surrounding the drug using community forwhich they socialize.
e. Yet, we ask them to control those impulses to complete CBT or other cognitively-based programming both in our inpatient and outpatient substance abuse treatment, mental health or integrated programs. (slide 26)
    i. Impulsive control is learned and does not happen magically
    ii. Impulse control is as much about (re)training the brain as it is about stilling the body
    iii. Impulse control is about recircuiting the brain, away from an automatic "fight or flight" spiral through safe attachments with others
f. (slide 27) Recovery cannot occur in isolation. It can take place only within the context of relationships characterized by belief in persuasion rather than coercion, ideas rather than force, and mutuality rather than authoritarian control—precisely the beliefs that were shattered by the original traumatic experiences (Herman, 1992).

III. Trauma and Homelessness
    a. "When children learn to be empathetic they naturally behave less aggressively. . .when students develop emotional literacy they can begin to talk about their feelings, frustrations and anger without acting out." "We have to be able to understand our own experiences emotionally to have a better relationship with others in the world and also to engage deeply in dialogue, to take other people's perspective and examine our own. . . "Many of our young people don't have the capacity to struggle productively with other people around their ideas and not shut down if they're feeling uncomfortable." (Schwartz, K. Empathy: the Key to Social &

Emotional Learning. 1/30/2013. http://blo gs.kqed.o rg/mindshift/2013/01/empathy-the-key-to -so cial-and-emo tio nal-learning/).

b. "When we experience trauma, our trust in the world, our relationships, and ourselves are often broken." (Sharp, C. It's All About Relationships. National Council Magazine. 2011, Issue #2)
c. Maltreatment disrupts this hardy process; trauma, neglect, and related experiences of maltreatment such as prenatal exposure to drugs or alcohol and impaired early bonding all influence the developing brain. These adverse experiences interfere with normal patterns of experience-guided neurodevelopment by creating extreme and abnormal patterns of neural and neurohormonal activity. (Perry, B.D. Examining Child Maltreatment Through a Neurodevelopmental Lens: Clinical Applications of the Neurosequential Model of Therapeutics. Journal of Loss and Trauma, 14:240–255, 2009.)
d. Trauma and Homelessness (slide 28)
    i. Relationship between the two is bidirectional
    ii. Being homeless is traumatic
    iii. Being homeless increases the likelihood of re-traumatization and re-exposure to violence and sexual assault/exploitation for both men and women

IV. What could work
    a. General ideas (things that anybody, no matter your job title, can easily apply in your practice tomorrow)*
        i. (slide 29) Trauma, MI, & SA should be addressed simultaneously but not necessarily in equal measure.
        ii. Formal therapy or treatment may not be the answer – sending someone or making a referral "to treatment" is not a good initial response because it sends a message of rejection.
        iii. Ideally, address the "low hanging fruit" first with "rounds of applause" for the smallest of successes
        iv. (slide 30) Mental health issues with more complex treatment needs may not be responsive to behavioral methods (Mee-Lee, D. Tips and Topics. February 2013). Staying away from drugs/alcohol may be the only change the client will be able to manage while in inpatient care and look for the mental health issues to escalate.
        v. Assume trauma existed (if from nothing else but the time of homelessness) and look for signs of other traumas in behaviors that arise from the client's ongoing behaviors
        vi. (slide 31) Assume that negative behaviors will escalate once the person is housed, particularly if the person has never lived alone before and give more attention immediately after placement (when you normally think things are settled) – talk to your clients about and prepare for the loneliness

vii. When asking clients about trauma history don't forget to check into head injuries, fights, concussions, broken bones, and resulting trips to the ER due to them to determine the possible presence of a TBI

viii. Use education to help eliminate stigma (slide 32)

1. Teach clients how substances and trauma have hijacked their brain and kept them in addiction as well as tied to a CMH – they still think their use is about a lack of self-control
2. Help them label the trauma in their lives – they think it is either their fault or that it is normal
3. Stay hopeful particularly when they are not

ix. At each encounter, take 2 to 5 minutes to engage and not work on some task – just talk to your clients!

b. "The Harder Stuff"

i. (slide 33) <u>Spend more time building rapport and trust with the client and postpone completing tasks for as long as you can</u>

1. For case managers, it is likely not to take any more time than it currently does to complete tasks but you will have less resistance from the client while doing it
2. For therapists, you will increase your retention rates because you can join the client in the real reason they are in treatment (and not the one that is in the computer)
3. For psychiatrists, you will also increase your return rate because you'll more likely get the diagnosis and the medication right the first time (and if you don't, your client will feel safe enough to tell you)
4. Exception: unless the client is asking directly for something tangible – then make that an engagement activity through learning all there is to know about the request
5. When do you stop? When do you know a client trusts you and you can now go on to the "real therapy"? NEVER but here are some hints that you are moving in the right direction:
    a. Six months+ have passed and the client reaches out to you in a nonmanipulative manner
    b. When the client shamefully admits to about a recent negative behavior w/o prompting
    c. When a client expresses concern about you without prompting or acts protectively toward you
    d. When the client starts talking about other issues or aspects of his/her life (previously unknown to you) that are important to them
    e. When the client talks about history before the trauma or loss – history that explains why the trauma was bad for him/her – it speaks volumes about the pain

f. When the client stands just a little bit straighter when s/he sees you

ii. Improve your skills instead of the number of trainings you go to:
   1. Schools no longer dedicate sufficient class or internship time to foster the critical interpersonal skills necessary engage, support, and encourage clients in their change process
   2. Single day workshops are only an introduction to concepts and day(s) long trainings are typically too large to provide the individualized attention everyone needs
   3. Everyone needs help identifying our "bad clinical habits" which typically arise more from our frustration than from the client's noncompliance – the current state of clinical supervision that therapists get (and unfortunately case managers typically don't) tends to concentrate more on administrative tasks and only on client interactions if you're in trouble and the agency is afraid of a lawsuit

iii. It doesn't happen because
   1. It is expensive
   2. People entering the industry are not well advised as to the amount of time and energy really required to do this work right then by the time they complete school, they are wallowing in debt and eager to start their career, unwilling to do additional school
   3. Providers do not have the flexibility of time or dollars to support the attendance to such trainings

iv. (slide 34) What skills need constant attention?
   1. Listening to learn and clarify to the client that you know not just what s/he is saying but what s/he means – you are tuned in
   2. Empathic Conceptualization or understanding the client's behavior within the context of how the client sees the world and him/herself in it (and thus why the behavior makes sense)
   3. Targeting Timely, Appropriate Change Strategies – having a 'bag of tricks' that help build the client's
      a. Self-awareness
      b. Brain capacity to better tackle toxic stress
      c. Empowerment

v. (slide 35) Three approaches seem to build these skills, person-centered therapy, motivational interviewing, and dialectical behavioral therapy; I like these because
   1. They force the care provider to shut up and not do anything at least in the beginning
   2. They remind us of the boundary between our care and the client's change process (and the penalties for crossing that line)

3. They respect the brain science and use it to inform practice

vi. Brief Overview: Person-Centered Therapy (slide 36)
   1. Created by Carl Rogers (1902-1987) who had the belief that there is a core "inner self" that seeks harmony; this inner self will therefore motivate a client to change.
   2. It's main technique is a fierce adherence to and the creation of a non-judgmental environment in the therapy process by which the psychotherapist gradually helps the client to find a solution for his/her problem by him/herself. The six core principles are (Rogers, "Client-centered Therapy." (1951):
      a. Therapist-Client Psychological Contact: There should be a proper bonding between the therapist and the client.
      b. Client Incogruence or Vulnerability: The client's vulnerability and anxiety compel him to continue his relationship with his therapist.
      c. Therapist Congruence or Genuiness: The therapist is also deeply involved with his client. He shares his own experiences with his clients.
      d. Therapist Unconditional Positive Regard (UPR): The therapist accepts the client unconditionally without passing any judgement on his/her actions, feelings or attitudes
      e. Therapist Empathic Understanding: The therapist feels intense sympathy for his client. He/she genuinely feels or experiences the same feelings and emotions of his/her client.
      f. Client Perception: The client perceives at least to a certain extent that the therapist genuinely accepts him unconditionally and understands his feelings.
   3. (slide 37)For information on trainings in your area, contact:
      The New Center
      3166 N. Lincoln Ave. Suite #325
      Chicago, IL 60657
      773-405-3541 Phone
      http://www.thenewcenterchicago.com

vii. Brief Overview: Motivational Interviewing (slide 38)as a counseling style is based on the following assumptions:
   1. Ambivalence about and change is normal and constitutes an important motivational obstacle in recovery.
   2. Ambivalence can be resolved by working with your client's intrinsic motivations and values. A valuable exercise for overcoming ambivalence is having the client list the pros and cons of using substances and the pros and cons of not using substances.

3. The alliance between you and your client is a collaborative partnership to which you each bring important expertise.
4. An empathic, supportive, yet directive counseling style provides conditions under which change can occur. However, direct argument and aggressive confrontation may tend to increase client defensiveness and reduce the likelihood of behavioral change.
5. (slide 39) The Motivational Interviewing Network of Trainers (MINT) is an organization established by the developers of MI, William R. Miller and Stephen Rollnick – they offer a variety of training options: http://www.motivationalinterviewing.org

viii. Brief Overview: Dialectical Behavioral Therapy (slide 40)

1. Developed by Marsha Linehan in the 1980s and has been proven as highly effective with individuals who have significant behavioral problems, particularly suicide attempts, eating disorders, and substance abuse
2. Primary Principles
    a. Uses a biosocial theory to explain negative behaviors
    b. Points to the biological dysfunction of the emotional regulation system which interacts with an invalidating, chaotic or perfectionistic environment further combined with fears of being abandoned
    c. There are assumptions that these clients are:
        i. Doing the best they can
        ii. Want to improve and get better
        iii. But are plagued by feelings of emptiness
        iv. And need to learn new behaviors in all relevant context
    d. DBT teaches
        i. client tolerance for unwanted feelings and fearful situations
        ii. clients to learn how to accept the moment as it is while they make attempts to change it
        iii. clients to objectively analyze situations so to make the best response based on the largest amongst of objective information as possible
3. Has a series of skills-building exercises done in group and individual sessions to enhance motivation to change, anticipate stressors, and better manage triggers.
4. (slide 41) Behavioral Tech, LLC, founded by Dr. Marsha Linehan, trains mental health care providers and treatment teams who work with complex and severely disordered populations to use compassionate, scientifically valid treatments and to implement and

evaluate these treatments in their practice setting.
http://behavioraltech.org

V. Summary of Concepts* (slides 42-46)
   a. Our clients are not mentally ill addicts who have no place to live but humans whose souls have been shattered and the keep trying to put the pieces together.
   b. We "throw" services at clients to prove to funders that we are doing something and out of fear that anything we do won't work.
   c. Although we have a lot left to learn, we know more than ever how the brain works in the face of trauma – we need to use this knowledge to guide our treatment.
   d. Attachment, trauma, and behavioral health (mental illness and substance use) are intertwined, so picking them apart is a waste of time.
      i. We are born to bond with others. That bond helps us manage passing, intermittent stressors.
      ii. When the stressors overwhelm us or the "clan" fails to effectively support us and the stressors continue to explode the brain gets stuck in a "fight or flight" mode of functioning.
      iii. Being stuck there makes us vulnerable to other traumas, health problems, inhibits learning, and lends us toward behavioral patterns that alienate us from potential supports as well as the larger community.
      iv. Long-term living in a "fight or flight" world, will drive mental illness – substances are that temporary escape that more often than not "fuels the fire"
   e. Rebuilding attachment ("establishing trust and rapport") needs more time than we currently give to it if we hope to increase the client's likelihood of success – overlaying numerous services just fragments an already fragmented person.
   f. The worker's engagement skills are critical and must be constantly nurtured, typically outside of the traditional education environment and more extensively than what one gets in typical workshops or trainings.
   g. However, there are some simple, client engagement activities anyone can do within any environment without training or "changing the system".
   h. The principles and approach of three therapy models PCT, MI, & DBT, seem to have the foundation for the development of a more effective approach for the highly traumatized homeless population.