Seeing the Trauma of Homeless Women

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Seeing the Trauma of Homeless Women

Abstract

Homeless women are recognized as a vulnerable group in North America. They have difficulty being accepted in society and in their own communities. Given these realities, they lack a support system and are at higher risk for re-traumatization in their environment. As a social work practicum student at My Aunt’s Place, a shelter for homeless women in Regina, Saskatchewan, I witnessed the re-traumatization of homeless women during their healing process while staying in the temporary residence. I focused on trauma-informed practice (TIP) to understand their trauma and crisis intervention skills that support problem solving in the complex situation they face, including domestic violence, substance abuse, victimization, unstable housing, poverty, and sexism. My goal was to learn how to assist these women to find their strengths and regain control and power over their lives. Upon completion of the practicum, I reflected on my own personal development as a social worker with a view toward strengthening my own skill set and abilities within the context of social work practice, ethics, and values.
Seeing the Trauma of Homeless Women

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Seeing the Trauma of Homeless Women

Table of Contents

Abstract ................................................................................................................................. 2
Acknowledgments ............................................................................................................... 3
Table of Contents ............................................................................................................... 4
Chapter 1: Introduction .................................................................................................... 6
  1.1 Introduction ............................................................................................................... 6
  1.2 Rationale for the Practicum ..................................................................................... 6
  1.3 Practicum Objectives and Learning Activities/Skills .............................................. 7
  1.4 YWCA Regina–My Aunt’s Place .............................................................................. 8
Chapter 2: Theoretical Perspectives .............................................................................. 12
  2.1 Introduction ............................................................................................................. 12
  2.2 Ecological Systems Theory .................................................................................. 12
  2.3 Trauma Theory and Homeless Women .................................................................. 15
    2.3.1. Post-Traumatic Stress Disorder (PTSD) .......................................................... 16
    2.3.2 Complex Post-Traumatic Stress Disorder (Complex PTSD) ............................ 17
  2.4 Recovery Process Model ....................................................................................... 18
    2.4.1. Stage 1: Safety ................................................................................................. 18
    2.4.2. Stage 2: Remembrance and Mourning ........................................................... 19
    2.4.3. Stage 3: Reconnection .................................................................................... 20
  2.5 Summary ................................................................................................................. 20
Chapter 3: Homeless Women’s Environments and Experiences in Canada .............. 21
  3.1 Introduction ............................................................................................................. 21
  3.2 Housing Shortages ................................................................................................. 21
  3.3 Feminization of Poverty ......................................................................................... 22
  3.4 Patriarchy ................................................................................................................ 24
  3.5 Gender and Ethnic Identity .................................................................................... 25
  3.6 Domestic Violence ................................................................................................ 27
  3.7 Mental Illness .......................................................................................................... 27
  3.8 Substance Abuse ..................................................................................................... 28
  3.9 Resources for Homeless Women ............................................................................ 28
  3.10 Summary ............................................................................................................... 29
Chapter 4: Service Interventions and Models at My Aunt’s Place ............................ 30
  4.1 Introduction ............................................................................................................. 30
  4.2 Trauma-Informed Practice (TIP) .......................................................................... 31
    4.2.1 The Practice of Building Trauma Awareness .................................................. 31
## Seeing the Trauma of Homeless Women

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.2.1.1 Systematic TIP Training</td>
<td>32</td>
</tr>
<tr>
<td>4.2.1.2 Trauma Awareness for the Residents</td>
<td>33</td>
</tr>
<tr>
<td>4.2.2 The Practice of Emphasizing Safety</td>
<td>34</td>
</tr>
<tr>
<td>4.2.2.1 A Safe Physical Environment</td>
<td>35</td>
</tr>
<tr>
<td>4.2.2.2 A Safe Social-Emotional Environment</td>
<td>36</td>
</tr>
<tr>
<td>4.2.2.3 A Safe Cultural Environment</td>
<td>37</td>
</tr>
<tr>
<td>4.2.3 Rebuilding Residents’ Competency and Control</td>
<td>40</td>
</tr>
<tr>
<td>4.2.3.1 Accompaniment</td>
<td>41</td>
</tr>
<tr>
<td>4.2.3.2 Problem Identification and Provision of Well-Rounded Information</td>
<td>41</td>
</tr>
<tr>
<td>4.2.3.3 Self-Determination</td>
<td>41</td>
</tr>
<tr>
<td>4.2.4 Strengths-Based Approach</td>
<td>42</td>
</tr>
<tr>
<td>4.2.4.1 Building and Emphasizing Successful Experiences</td>
<td>43</td>
</tr>
<tr>
<td>4.3 Crisis Intervention</td>
<td>44</td>
</tr>
<tr>
<td>4.3.1 Types of Crises</td>
<td>45</td>
</tr>
<tr>
<td>4.3.2 Implementing Crisis Intervention</td>
<td>46</td>
</tr>
<tr>
<td>4.4 Summary</td>
<td>52</td>
</tr>
</tbody>
</table>

Chapter 5: Self-Reflection and Social Work Values and Ethics ............. 53

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.1 Introduction</td>
<td>53</td>
</tr>
<tr>
<td>5.2 Self-Determination: Cultural Clash Regarding Substance Abuse</td>
<td>53</td>
</tr>
<tr>
<td>5.3 Social Work Competence in Consultation Skills</td>
<td>55</td>
</tr>
<tr>
<td>5.4 Social Justice: The Faith to Challenge the Unfairness</td>
<td>56</td>
</tr>
<tr>
<td>5.5 Summary</td>
<td>57</td>
</tr>
</tbody>
</table>

Chapter 6: Conclusion ........................................................................ 58

Reference ......................................................................................... 60
Chapter 1: Introduction

1.1 Introduction

This report will provide an account of my experience as a Masters of Social Work practicum student at My Aunt’s Place in Regina, Saskatchewan. In Taiwan, I worked as a youth caseworker in a group home. Most of my clients had experienced trauma and had detachment issues. However, without enough trauma background knowledge or a well-rounded family preservation policy in Taiwan’s social welfare system, I faced many barriers to assisting clients with problem solving of complex personal and structural issues. As a result, I witnessed my clients, most of whom were young, repeating their parents’ negative life experiences soon after they left our program in Taiwan. I realized that only if we understand family difficulties, especially those of primary caregivers, can we break the cycle of intergenerational trauma and crisis to make possible an improved life-journey for at-risk youth.

Therefore, my report focuses on how we assist individuals to recover from trauma to make it possible to pursue a better life. In this report, I draw on trauma-informed practice (TIP) to understand homeless women’s traumatic experiences that are the result of complex personal and structural challenges of domestic violence, substance abuse, victimization, unstable housing, poverty, and sexism. The report also focuses on the therapeutic intervention needed to address the complex situations faced by homeless women. The report concludes with a reflection on my own personal development as a social worker, focusing on the enhanced learning, skill set and abilities I acquired.

1.2 Rationale for the Practicum

As a graduate student in Canada, I was interested in understanding the major challenges faced by primary caregivers, who are overwhelmingly women, and the
Seeing the Trauma of Homeless Women

obstacles they face in overcoming those challenges. Accordingly, I selected a practicum setting where I could work with at-risk women. I decided to focus on homeless women because they are among the most vulnerable subgroup because of the complex situations they face, such as domestic violence, substance abuse, victimization, unstable housing, poverty, and sexism. In addition, most of them are lone parents or soon-to-be-mothers.

As an international student from Taiwan, my role was to understand the current situation of homeless women in Canada (especially in Saskatchewan) and to identify therapeutic approaches that assist women in breaking the cycle of trauma and homelessness.

1.3 Practicum Objectives and Learning Activities/Skills

Given my academic interest in women’s issues, my first learning objective was to understand the interconnections between homelessness, trauma, cultural norms, and poverty as experienced by women and their children in Saskatchewan. During my practicum, I became aware of how Canada’s history and federal and provincial social policies impact homeless women. I also participated in a meeting in Regina to identify strategies to end homelessness, and I visited different agencies. I spent one week observing the work of service providers at the YWCA Outreach Program to expand my knowledge of community resources in Regina. These involvements were useful to me as I acquired comprehensive and professional knowledge of the issues facing homeless women in Regina.

My second learning objective was to develop practice skills rooted in social work practice that required me to work effectively with homeless women. As an international student, learning how to complete assessments and developing practice skills was important to me. Therefore, I conducted a literature review and identified
Seeing the Trauma of Homeless Women

trauma theory as a critical tool to help me better assess clients’ current situations and identify their needs. After finishing the literature review, I was able to recognize the trauma symptoms of clients by their reactions. I consulted with more than 10 clients and four frontline workers and reviewed more than 30 clients’ case files at My Aunt’s Place.

Trauma-informed practice and crisis intervention are two major practice models that informed my placement learning objectives. Not being previously familiar with these two interventions, I gained much knowledge by observing the workers at My Aunt’s Place and participating in frontline-worker staff meetings.

1.4 YWCA Regina–My Aunt’s Place

In order to fulfill the aforementioned learning objectives and to gain a deeper understanding of homeless women in Regina, I chose YWCA Regina–My Aunt’s Place as my practicum placement. My Aunt’s Place is a non-profit shelter for women and their children, and it is the only homeless shelter for women and their children in Regina. My Aunt’s Place is designed as a temporary emergency shelter for homeless women, and it often serves as the first place of service for women at risk whether they are homeless or not.

The YWCA in Canada is one of the largest and longest-standing organizations providing multi-services for women. It was first established in the 1870s in Toronto, Montreal, Quebec City, and Halifax (YWCA Canada, 2014). The YWCA’s role of providing shelters is the most efficient and safe way to help women stay away from abuse and violent circumstances (Tutty, 2006). Across Canada, the YWCA has 31 shelters and provides over 1,000 beds for women to stay in on a short-term basis while they explore long-term plans for their independence and protection from all forms of abuse (YWCA Canada, 2014). In 2009, YWCA Regina built My Aunt’s
Seeing the Trauma of Homeless Women

Place. The shelter provides a safe place where residents can stay for 28 days. According to a YWCA–My Aunt’s Place (2017) internal survey, 560 clients used the shelter’s services during the previous year. This number includes 137 children who came to the shelter with their mothers.

The focus of most women’s shelters in Canada is to provide a safe place for women and their children who are facing intimate partner violence (IPV). Fewer shelters focus on homelessness as the presenting problem because of the stigma associated with homeless women (Tutty, Ogden, Giurgiu, & Weaver-Dunlop, 2013). Most homeless women at the shelter have endured traumatic situations including IPV for a long time before their arrival at the facility. Typically they are facing a crisis, such as an escape from an abusive or violent environment and have nowhere to go.

My Aunt’s Place follows the “housing first” model: 1) it provides temporary shelter for single women and women with children; 2) it finds affordable and safe homes for women; and 3) it connects women with additional supportive services (YWCA Regina, n.d.).

Gaetz, Scott, and Gulliver (2013) indicate that the housing first model moves homeless people into independent and permanent houses as soon as possible. It also provides additional support services using the recovery perspectives model by viewing the clients’ traumatic experiences from their perspective. To address the clients’ trauma, all the shelters of YWCA Regina follow the principles of TIP, with a focus on client experience, history, and past and present relationships. This focus assists homeless women to better understand and address the trauma and crises they confront.

My Aunt’s Place’s initial responsibility is to determine what type of trauma precipitates clients’ homelessness. It uses an assessment tool with 21 categories that
Seeing the Trauma of Homeless Women

help to identify the reasons why a woman is seeking shelter services. The assessment categories include family relationship breakdown, eviction, financial crisis, insufficient income, and substance use (My Aunt’s Place–YWCA Regina, 2017). My Aunt’s Place workers help women apply for federal and provincial government benefits including social assistance to deal with their financial crisis. However, owing to the stigma of homelessness, the shelter must advocate for women on a regular basis to ensure their access to social programs and services. For example, many residents have suffered from mental illnesses for many years, which means they need long-term financial support. However, most of them remain in the Transitional Employment Allowance (TEA) program because they are unable to provide appropriate documents.

Furthermore, the shelter assists women with finding safe and affordable housing. Most of the women have addiction issues and mental illnesses (e.g., post-traumatic stress disorder [PTSD], complex PTSD, panic attacks, depression) caused by their traumatic experiences, making it difficult for most of them to maintain stable homes. Equally important, YWCA Regina has outreach workers that provide additional support to clients after they leave the homeless shelter (YWCA Regina, n.d.).

Collaborating and including the women in the decision-making process forms an integral part of the YWCA’s work. The inclusion of the women in decision-making processes helps shelter workers focus on the women’s traumatic experiences and their adaptation to them.

The learning experiences I had at My Aunt’s Place are outlined in the following chapters. Chapter 2 describes the theoretical perspectives I use: ecological systems theory, trauma theory, and the recovery process model. Ecological systems theory guides the discussion of the environmental issues impacting homeless women
Seeing the Trauma of Homeless Women

in Canada. Trauma theory and the recovery process model provide the important theoretical background to my practicum interventions at My Aunt’s Place. Chapter 3 is a literature review focusing on homeless women’s experiences in Canada both at the micro- and macro levels. In Chapter 4, I outline how social work theory and practice address homelessness traumas. I discuss how TIP and crisis intervention were applied by staff at My Aunt’s Place to support homeless women in rebuilding their self-esteem, behavioral assessment, and making better life choices.

The shelter provides valuable practical services to clients and their children to ensure a safe and supportive living environment for them while assisting them with “housing first” as well as connecting them to other community resources to reduce the risk of them developing a pattern of repetitive homelessness. Chapter 5 focuses on what the practicum taught me and how it better informed my understanding of working with this vulnerable population within the context of social work values and ethics.
Seeing the Trauma of Homeless Women

Chapter 2: Theoretical Perspectives

2.1 Introduction

In this chapter I discuss three theoretical perspectives, ecological systems framework, trauma theory, and the recovery process model; to provide an epistemological background and guidance for this report. First, I use Bronfenbrenner’s (1989) ecological systems theory to understand the structural barriers in homeless women’s environments. Most homeless women struggle with their traumatic experiences in the context of their environment. Second, in order to understand the impact of trauma, I use trauma theory, with a focus on PTSD and complex PTSD, to understand how individuals experience and react to different traumatic experiences that range from varying forms of violence to life losses (e.g., death of a loved one; Hunter, 2016). Finally, the use of the recovery process model helps me explore potential solutions to client challenges (Hunter, 2016). I discuss each of these theoretical perspectives below.

2.2 Ecological Systems Theory

Burns, Warmbold-Brann, and Zaslofsky (2015) claim that to understand an individual, we cannot avoid considering his or her multi-tiered environment. Therefore, the person-in-environment perspective is one of the central frameworks that guides social work practice (Sawssan, Amer, & Killawi, 2017). The ecological systems theory provides social workers with a broad understanding of clients’ issues (Coady & Lehmann, 2008). The complex relationship between social, economic, and political structures impacts families differently and unevenly. As a result, an ecological analysis that emphasizes an examination of social reality, injustice, and the oppressive environment (Coady & Lehmann, 2008) is beneficial in social work practice. As social workers, we must understand the impact of homeless women’s
Seeing the Trauma of Homeless Women
cultural environments and the societal barriers they face, and the crises that they can precipitate for homeless women in Canada and around the globe.

Coady and Lehmann (2008) describe how the ecological systems theory integrates ecological theory and systems theory, which highlights the interaction between individual and social systems, such as the school system, community, and work placement. Ecological theory focuses on the “goodness of fit,” which means the adaptation of the individual to their social environment (Coady & Lehmann, 2008, p. 98). However, our environment and society change rapidly. Therefore, social work is dedicated to maintaining an adaptive balance for clients in this changing environment (Horejsi, Horejsi, & Sheafor, 2010). Gitterman and Germain (2008), in their discussion of the central concepts of the ecological systems theory, argue that there is a dynamic balance between environmental resources and people’s needs. In an attempt to find the balance between the individual and their environment, there is a constant search for adaptive behavior and social exchanges. In the event of an imbalance between an individual and their environment, groups of people, families, and communities are likely to experience marginalization and powerlessness, as is the case for homeless women (Horejsi et al., 2010).

Bronfenbrenner’s (1989) ecological systems theory focuses on “a scientific approach emphasizing the interrelationship of different process and the contextual variation” (Darling, 2007, p. 203), which is helpful in order to identify the issues. He proposes a series of concentric circles to identify holistic social systems: the microsystem, mesosystem, exosystem, and macrosystem (Sawssan et al., 2017; Johnson, 2008). For example, Johnson (2008) uses Bronfenbrenner’s model to show how negative interactions in the microsystem—the environment in which an individual has the greatest and most direct contact with parents, partners, and
Seeing the Trauma of Homeless Women

family—have the greatest impact on the potential for homelessness. Within the microsystem, major risk factors such as domestic violence, mental illness, and substance abuse predispose women to homelessness, as will be demonstrated in chapter 3 of this document.

The consequences of being subject to negative micro-factors in an environment creates what Bronfenbrenner refers to as a mesosystem environment. For example, once low-income women separate from their intimate partner, obtain a divorce, or lose custody of minor children, they lose their major income sources (McLaughlin, 2009). Without stable and sufficient income resources, it is even harder for women who live at the edge of poverty to afford rent or a house mortgage. Therefore, they often lose their accommodation through eviction (McLaughlin, 2009). Records from YWCA Regina–My Aunt’s Place (2017) show that almost 10% of homeless women in the shelter have experienced eviction.

Speedlin (2015) claims that women who become homeless are at a high risk of being abused, for example, they are often sexually assaulted, whether by someone they know or by a stranger. McLaughlin (2009) reports that 44% of his homeless study participants had been raped or sexually assaulted after becoming homeless. Many scholars assert that homeless women often become involved in gang activity or sex work in exchange for temporary accommodation (Lankenau, Clatts, Welle, Godsamt, & Gwadz, 2005). The trauma sustained by homeless women is doubly compounded by concomitant traumas. During my practicum, I met several women who had been victimized by gangs after experiencing trauma. This gang involvement further stigmatizes homeless women and creates the societal impression that they are undesirable because of their criminal activities.

Bronfenbrenner (1989) describes the exosystem as a large social system that
Seeing the Trauma of Homeless Women

indirectly impacts the individual. For example, local economic and governmental policies can impact the lives of homeless women. In chapter 3 of this document I discuss the housing shortage in Saskatchewan, which is connected to the Saskatchewan Ministry social housing policy and rental supplement. Homeless women also lack of resources owing to social marginalization.

Bronfenbrenner (1989) defines the macrosystem as the overarching framework for all systems, including the micro-, meso-, and exosystem, which is more related to a broad social context, culture, value system, etc. For example, gender and ethnicity also have a broad influence on homelessness. In Canada, the majority of homeless services are directed at men, owing to a higher population of homeless men. However, homeless women experience more trauma and abuse than men (Duchesne, 2015). In the next chapter of this document, I focus on the feminization of poverty and patriarchy to illustrate how gender can impact upon homelessness.

In Canada, 34% of homeless people are identified as Indigenous (Gaetz, Dej, Redman, & Richter, 2016). Some scholars argue that there is a direct relationship between ethnicity and homelessness (Urban Society for Aboriginal Youth, 2012). In the next chapter 3, I discuss this subject further.

2.3 Trauma Theory and Homeless Women

In his application of trauma theory, Herman (2015) contends that traumatic events can refer to any incidents that overwhelm a person and make them feel powerless and helpless. In his book Kaplan and Sadock's comprehensive textbook of psychiatry, Hodo (2006) gives some examples; he states that the feelings of psychological trauma are “intense fear, helplessness, loss of control, and threat of annihilation” (p. 918). The American Psychiatric Association’s (2013) DSM-V also identifies trauma as a psychological illness, labeling it post-traumatic stress disorder
Seeing the Trauma of Homeless Women

(PTSD). Herman (2015) adds complex PTSD to this (I discuss this in the next section). Ford (2013) explains that an individual with PTSD will radically change their brain’s and body’s self-regulation to a continuing state of alarm because they are dealing with terror and helplessness. Homeless women not only experience a single or certain traumatic event, but multiple traumas. Or they remain in a terrifying and abusive environment for a long time, which is akin to complex PTSD. The National Health Care for the Homeless Clinicians’ Network (1999) indicates that 34% of homeless women have been diagnosed with PTSD, while 47% of them suffer from depression and other emotional symptoms.

2.3.1. Post-Traumatic Stress Disorder (PTSD)

In this subsection and the next, I introduce the symptoms of PTSD and complex PTSD and discuss how they impact the individual. The American Psychiatric Association’s (2013) DSM-V defines PTSD as a psychological disease triggered by a traumatic event that causes anxiety. Herman (2015) classifies PTSD symptoms into three categories: 1) hyperarousal—how the individual reacts to expected danger on an ongoing basis; 2) intrusion—the imprint of the traumatic moment on the individual’s memory that can interrupt the individual’s life, and 3) constriction—the numbing response of surrender owing to dysfunctional self-defense. Responding continually to negative events can cause people’s brains to become highly active all the time, causing insomnia, difficulty controlling emotions, difficulty concentrating, and feelings of being unsafe. With PTSD, individuals become easily startled and may re-experience trauma as a flashback at any time (Herman, 2015; Tull, 2018). Further, an individual experiencing PTSD may have negative thoughts and beliefs, feel distant from others; and avoid feeling, discussing, and mentioning the traumatic events (Tull, 2018).
Seeing the Trauma of Homeless Women

2.3.2 Complex Post-Traumatic Stress Disorder (Complex PTSD)

The symptoms of PTSD do not include those of people who have been in a trauma environment for a long time and/or suffer multiple traumas. Therefore, Herman (2015) has categorized those separately as complex PTSD. Complex trauma involves a recurrence of traumatic experiences, also called “chronic traumas” (e.g., ongoing domestic violence, neglect and physical/sexual abuse in childhood, repeated sexual exploitation, etc.). Some homeless women often stay in an abusive and violent environment for a long period or have experienced domestic violence or abuse since childhood (National Health Care for the Homeless Clinicians’ Network, 1999).

Tseris (2013) describes the close connection between gender and trauma, arguing that girls are more vulnerable to childhood abuse and sexual violence than boys (see also Brand, 2003). Therefore, for women, the consequences of trauma can extend from childhood to adulthood (Hunter, 2016). Although survivors of childhood trauma develop unique strategies in their childhood to cope with their trauma, these strategies can cause long-term psychological and psychosocial damage in adulthood (Hunter, 2016). According to Herman (2016), prolonged trauma manifests itself in six areas, with symptoms ranging from severe to extremely severe (p. 121):

1. Affect regulation—chronic suicidal thoughts, persistent dysphoria, self-injury, extremely negative emotional expressions;
2. Consciousness—panic attacks (depersonalization/derealization), loss of the memory of traumatic events, amnesia or hypermnesia regarding traumatic events, reliving the traumatic experiences;
3. Self-perception—low self-esteem owing to self-blame, stigma, helplessness, and feeling different from others;
4. The perception of the perpetrator—rationalization of the perpetrator’s behaviors, idealization, or paradoxical gratitude or revenge;

5. Relationship with others—a distrust of people, isolation, withdrawal;

6. The system of meaning—a sense of helplessness, despair, lost faith.

When individuals experience complex trauma, their perception of the world is affected. They always feel unsafe and distrustful of their surroundings. People affected by PTSD or complex PTSD also experience fatigue and have intense distress due to triggering factors in their immediate environment. As a result, they use different coping mechanisms to escape from reality and painful memories, such as illegal drugs, alcohol, and even self-harm (Tull, 2018). Torchalla, Strehlau, Li, and Krausz’s (2011) survey shows that 82% of homeless women in Canada have a substance use disorder and depend on alcohol and drugs. Hunter (2016) sees a strong relationship between trauma and substance abuse. However, negative consequences of trauma and resilience can also co-exist, where individuals function well in some environments but demonstrate poor coping ability in other social settings.

2.4 Recovery Process Model

Trauma can be mitigated by a combination of individual strengths and social factors. Herman (2015) claims that there are three stages of traumatic disorder recovery for individuals: 1) safety, 2) remembrance and mourning, and 3) reconnection (p. 156). It is not necessary for women to go through all three phases. Some people may choose only to complete the first stage of healing. Later, I discuss how a therapist can help survivors heal from their trauma through these three phases.

2.4.1. Stage 1: Safety

In the first stage of recovery, the central task is to build a safe physical and psychological environment for clients (Herman, 2015). This is the most important
Seeing the Trauma of Homeless Women

phase of healing from trauma. In this stage, the therapist deals with the most acute reactions and symptoms to help stabilize the client’s life. Herman (2015) asserts that in the first stage of healing, we need to bring back the client’s control ability, such as her ability to fall asleep, manage post-traumatic symptoms, and control unhealthy adaptation or behaviors. Furthermore, it is also necessary for women to keep themselves safe at the beginning of treatment. Trauma may cause them to view the world as unsafe (Herman, 2015). Staying in an abusive environment for a long time can result in women believing that safety is unimportant (Thera, 2016), which can cause a client to continue putting herself in an unsafe environment or to stay with an abuser. Therefore, exploring the reasons why the client stays in an unsafe place and creating a safety plan with her is paramount during social work interventions (Thera, 2016). Courtois (2004) concludes that establishing safety includes building a safe therapeutic alliance, promoting health affect regulation, providing enough support and knowledge to ensure safety, and providing education.

2.4.2. Stage 2: Remembrance and Mourning

The second stage of recovery focuses on continued empowerment through the action of storytelling by clients (Herman, 2015). In the second stage of recovery, we need to use narrative-based techniques to reconstruct the survivor’s traumatic story (Courtois, 2004). In this stage, survivors confront the post-traumatic memory and integrate the ability to learn from the first stage of recovery. Through understanding past traumatic events, survivors become aware of the impact caused by trauma (Courtois, 2004). During the process of storytelling, the therapist can also explore the survivor’s strengths by transforming the traumatic memory to continue empowering them (Herman, 2015).
Seeing the Trauma of Homeless Women

2.4.3. Stage 3: Reconnection

The third phase of healing emphasizes the client’s future (Herman, 2015). Courtois (2004) asserts that stage 3 is about the accumulation of previous skills and the development of oneself. In this stage, survivors continue to seek reconnection with others through relationship building, learning to trust, and maintaining appropriate boundaries (Herman, 2015; Thera, 2016).

2.5 Summary

As shown in this chapter, Bronfenbrenner’s (1989) ecological systems theory addresses everything from the individual to the entire social structure. I also focused on the impact of traumatic experiences, which may result in overwhelming physical and mental health crises. Finally, using the recovery process model, I explored possible solutions to homelessness as experienced by women.
Chapter 3: Homeless Women’s Environments and Experiences in Canada

3.1 Introduction

In this chapter I review the literature on the issues and barriers faced by homeless women in Canada. Housing shortages, feminization of poverty, patriarchy, gender, and ethnic identity are some of the factors discussed as contributing to women’s homelessness. I also explore issues of domestic violence and its relationship to women’s experiences of homelessness. I conclude this chapter by reviewing the available resources for homeless women.

3.2 Housing Shortages

Since 2008, the global financial crisis combined with housing shortages and rental cost increases has exacerbated the homeless crisis in Canada (Zwack, 2015), and the problem may be worse in Saskatchewan than in the other provinces. The Canadian Centre for Policy Alternatives (CCPA, 2010) claims that housing in Saskatchewan is more critical than it is in other provinces, which means that Saskatchewanians are more at risk of being homeless. The Saskatchewan Ministry of Social Services (2011) suggests that increased rental costs and a scarcity of affordable housing are to blame. The Ministry adds that these conditions have been made worse because of a decrease in federal funding for affordable housing and housing market shifts at the lower end of the housing scale. The Ministry also cites the rapid population growth of Saskatchewan since 2006 as contributing to the housing shortage, increased costs, and higher rental rates. For example, the typical rent for a two-bedroom apartment in the province rose from $500 to $800 between 2006 and 2010 (Saskatchewan Ministry of Social Services, 2011). This makes it difficult for a low-income family to find an affordable living space, and it places them at risk for homelessness.
Seeing the Trauma of Homeless Women

In 1996, the management of social housing was transferred from the federal government to provincial governments (Westhues & Wharf, 2013). However, due to fixed budgets, the Saskatchewan government has had difficulty making up this federal shortfall of funding for affordable housing (Saskatchewan Ministry of Social Services, 2011). Owing to this shortage in social housing funding and increases in the cost of Saskatchewan housing, residents of the province, especially those who live in poverty, are at a higher risk of becoming homeless. Unfortunately, beginning in 2018, the Saskatchewan government no longer provides a rental housing supplement (CBC News, 2018), which makes homeless women’s situations even worse.

3.3 Feminization of Poverty

The CCPA (2010) claims that poverty is the major factor causing homelessness. It also reports that one in five people in Saskatchewan experiences homelessness or is at risk of being homeless. Canada’s social structure and value system do not support women in becoming economically independent (Townson, 2009). Without economic independence, people have a higher risk of falling into poverty. Townson (2009) posits that women are economically disadvantaged in the labor market and face further limitations because of their care-giving role. Many feminists argue that women in Canada face more barriers to obtaining well-paid and stable employment (Westhues & Wharf, 2013). Townson (2009) cites Canadian statistics showing that women employed full-time between the ages of 25 and 44 earned only 65.7% of men’s average salary in 2008, which also indicates that the gap between women and men’s salaries is the same as it was 10 years ago. To compound the problem, 40% of women work as non-standard and low-wage workers in part-time or casual jobs, which means they are less financially secure and are often denied basic health and insurance benefits (Townson, 2009).
Seeing the Trauma of Homeless Women

One of the reasons for women’s precarious economic situation is that women in Canada still have more responsibility for childcare, which makes it hard for them to devote themselves to a job and narrows their choice of employment (Townson, 2009). According to Townson (2009) and Westhues and Wharf (2013), the primary barrier to women’s employability or sustainable employment is a lack of affordable child care services. Statistics Canada (2015) has shown that more than 50% of families spend at least $600 CAD every month on child care services; only 12.5% of parents incur no direct cost for child care in Canada only because they cannot afford it. According to the Government of Saskatchewan (2018), parents receive approximately $400 CAD per month of child care subsidy per child. This discourages women from low-income families. To compound the problem, women who leave their workplace for a long period to look after their children find it difficult to return to the workforce or to make up for lost time away from the labor market. If these women leave their partner or family, they have a higher possibility of falling below the poverty line. In Canada, 81% of lone-parent families are single mothers, and approximately 23% of these live in poverty with an annual income $7,500 below the poverty line (Statistics Canada, 2015; Townson, 2009). The YWCA Regina–My Aunt’s Place (2017) internal survey notes that 25% of homeless women are single female heads of the family and that 137 children came to the shelter with their mothers in 2017.

Indigenous women in particular are at greater risk of living below the poverty line and have a greater chance of being homeless. Homelessness is identified as one of the most serious social problems in North America. Fitzpatrick, LaGory, and Ritchey (1999) state that “homelessness deprives individuals of . . . basic needs, exposing them to risky, unpredictable
Seeing the Trauma of Homeless Women

environments” (p. 439). Guirguis-Younger, Hwang, and McNeil (2014) describe how to recognize homelessness:

1) Living outside or in places not fit for human habitation; 2) staying in the temporary or emergency accommodation (e.g., emergency and transitional shelters); 3) living in the accommodation without security of tenure (e.g., “couch surfing” or staying with friends or acquaintances); 4) living at risk of homelessness due to lack of financial security or other factors (e.g., intimate partner violence, separation, or divorce) that may compromise housing. (p. 2)

Homelessness is a devastating situation for anyone who faces it, and women are at a higher risk of poverty and homelessness (Tutty et al., 2013). They are also a more vulnerable segment of the homeless population and are more likely than men to experience sexism, emotional and physical abuse, poverty, and discrimination.

3.4 Patriarchy

Tied to the issue of the feminization of poverty is the patriarchal dominance and oppression of women. Historically, women have been the primary caregivers and have been economically disadvantaged in the workplace (Townson, 2009). Patriarchal norms and expectations have fostered an environment where women’s economic contributions in the private space have been exploited and their role as caregivers undervalued. These factors have contributed to a high incidence of single women with children ending up homeless. Without stable and independent economic resources, such women must rely on their family's or partner’s economic support. Often this economic dependency forces women to stay in an abusive environment so that they and their children remain supported (Duchesne, 2015).
Seeing the Trauma of Homeless Women

3.5 Gender and Ethnic Identity

I cannot discuss patriarchy without considering gender and ethnic identity and their impact on women’s homelessness. The situation faced by Indigenous women is even more dire owing to generations of institutionalized racism and discrimination, years of abuse in residential schools, and the destruction of families and communities stripped of their economic base and ways of life (Patrick, 2014). These societal traumas have undermined the physical, emotional, and economic well-being of Indigenous people—Indigenous women in particular—placing them at greater risk for homelessness with all its attendant problems.

Patrick (2014) asserts that colonialism has led to most Indigenous women suffering trauma and carrying a disproportionate burden owing to their gender and ethnicity. Canada, the United States, and Australia are typical settler colonial states (Pulido, 2018). Pulido (2018) indicates that the major purpose of settler colonial states is building a country in this place, which means they typically displaced Indigenous people to occupy the land. In order to occupy the land, the settlers used violence to force the Indigenous population to surrender. Pulido (2018) alleges that for the “conquerors” to rationalize their colonial actions, they carried out a series of brainwashing policies aimed at the Indigenous people by forcibly relocating their children to residential schools. Patrick (2014) reports that from 1857 to 1996, most Indigenous children were sent to residential schools until they reached adulthood. Furthermore, from the 1960s to the 1980s in the “Sixties Scoop,” child welfare workers removed many Indigenous children from their homes and housed them in a non-Indigenous care system (McKenzie, Varcoe, Browne, & Day, 2016). To compound the problem, most Indigenous children in residential schools suffered physical, sexual, and/or emotional abuse (Patrick, 2014). Owing to these historical
Seeing the Trauma of Homeless Women

events, many Indigenous adults lack the experience of living with their parents or forming an attachment to their own children. Therefore, they lack the experience of taking responsibility for child-rearing (Patrick, 2014). Consequently, many Indigenous children today are apprehended by the government because they live in a dysfunctional family system. Oelke, Thurston, and Turner (2016) state that, in 2011, 48% of children in foster homes were Indigenous children.

Ruttan, LaBoucane-Benson, and Munro (2008) researched the connection between young Indigenous homeless women and intergenerational abuse and found that most of the women had negative narratives of self-identity. Patrick (2014) asserts that Indigenous women suffer the trauma of colonization, economic deprivation, family fragmentation, and the lack of positive self-identity, all of which contribute to homelessness. According to Patrick (2014), this cultural genocide has crushed the women’s individual spirits, physical well-being, cultural identity, and mental health, resulting in many multi-generational problems. Thus, the traumas that affect Indigenous people in Canada, especially women, place them in a low social-economic status and at a high risk of being homeless (Urban Society for Aboriginal Youth, 2012).

According to Gaetz et al. (2016), 235,000 people have experienced homelessness in Canada in 2016. Of these, 27.3% are women. In the YWCA–My Aunt’s Place (2017) internal survey, more than 65% of homeless women identified themselves as Indigenous/Metis.

Furthermore, once women become homeless, they are at greater risk to become involved in the underground street economy, whether in the sex trade, dealing drugs, or drug use (Lankenau et al., 2005). These traumatic experiences can lead to mental illnesses such as complex PTSD, bipolar disorder, and schizophrenia, which prevent
Seeing the Trauma of Homeless Women

women from achieving stability in their lives or breaking the cycle of homelessness.

### 3.6 Domestic Violence

Domestic violence and escaping from an abusive environment are two of the major factors impacting women’s homelessness. There is a close connection between domestic violence and homelessness (McLaughlin, 2009; Speedlin, 2015). Beattie and Hutchins (2015) indicate that more than 50% of women in Canada use shelter services because of various abusive circumstances, such as emotional abuse, physical abuse, and sexual abuse. In addition, 15% of women sought shelter services to protect their children from violence in their environment. Statistics Canada (2014) indicates that more than 69% of women in shelters are escaping from their current intimate partner and 17% are escaping from their former intimate partner. In fact, the YWCA Regina–My Aunt’s Place (2017) internal survey shows that 31.76% of the women who come to the homeless shelter do so because of a family/relationship breakdown, and 16.69% of the women fear for their safety because of violence. Most homeless women suffer abuse at the hands of an intimate partner in their immediate environment.

### 3.7 Mental Illness

There is also a high correlation between mental illness and homelessness. Clearly, domestic violence and abuse contribute to mental illness (Duchesne, 2015). According to Mueser et al. (1998), an estimated 51–98% of public mental health illnesses are related to a traumatic history. Most homeless women suffer various mental illnesses such as schizophrenia and personality disorder, depression disorder, PTSD, complex PTSD, and bipolar disorder (Canadian Institute for Health Information and Canadian Population Health Initiative, 2007; McLaughlin, 2009). According to Duchesne (2015), there are barriers to homeless women seeking treatment for mental illness owing to a lack of information about existing resources.
Seeing the Trauma of Homeless Women

and their embarrassment about their illness. Untreated mental illness worsens an already challenging situation and contributes to the women’s homeless problem (Duchesne, 2015).

3.8 Substance Abuse

Similarly, McLaughlin (2009), Duchesne (2015), and the Canadian Institute for Health Information and Canadian Population Health Initiative (2007) agree that substance abuse is a major cause of homelessness. A survey by Torchalla et al. (2011) showed that 82% of homeless women in Canada had a substance use disorder and depended on alcohol and drugs. In their attempt to cope with trauma symptoms, homeless women often use drugs to ease their painful feelings (Tull, 2018). However, sustained drug use can also contribute to the development of mental illness for some people, which stigmatizes them even further (Torchalla et al., 2011). Co-occurring mental illness and substance abuse is a major reason why homeless women are stigmatized (Duchesne, 2015).

3.9 Resources for Homeless Women

In general, homeless women lack social resources and social supports. Tutty et al. (2013) claim that one of the major reasons homeless shelters are lacking in Canada is because people consider homeless women undeserving of help. This perception stems from the fact that many homeless women engage in criminal activity (Tutty et al., 2013).

In Canada, the major strategy of dealing with homelessness is “housing first” (Maki, 2017). The assessment of housing as the first priority is based on the score of the Service Prioritization Decision Assistance Tool (SPDAT), a questionnaire designed to identify a client’s background and issues, such as substance abuse history, experience of abuse, and risk of harm to self or others. However, in order to keep
Seeing the Trauma of Homeless Women
custody of their children, and for many other reasons, many women hide the truth
during the SPDAT assessment, which means that they do not get into the housing first
system. Many women who have experienced domestic violence may be prevented
from accessing social housing because of fear and negative interactions with various
systems, such as child welfare agencies, social assistance, family court, etc. (Maki,
2017). As a result, women sometimes must choose between returning to their abusive
partner, or living on the street.

3.10 Summary

In this chapter I have discussed some of the structural issues faced by
homeless women in Canada: housing shortages, feminization of poverty, mental
illness, substance abuse, abusive experiences, the marginalization of the community
and social system, and the intergenerational trauma and patriarchal society. Issues of
ethnicity in connection with Indigenous women and the experiences of homelessness
were also examined. As discussed, colonialism has resulted in traumatic experiences
for Indigenous people, which in turn, have affected women’s ability and capacity to
live independently in safe and stable homes. At My Aunt’s Place, more than 60% of
homeless women identify as Indigenous (YWCA Regina–My Aunt’s Place, 2017). In
Chapter 4, I focus on two interventions adopted by My Aunt’s Place to help address
concerns of homelessness: trauma-informed practice (TIP) and crisis intervention
Chapter 4: Service Interventions and Models at My Aunt’s Place

4.1 Introduction

It is widely understood that most homeless women have experienced trauma during childhood, whether domestic violence, criminal activity, and sexual and/or physical abuse. Understanding the nature of this trauma is a priority when working with such women. This knowledge assists frontline workers to engage in appropriate interventions that minimize the re-traumatization of clients. Trauma-informed practice not only builds client awareness and strength, but also integrates trauma and recovery theory concepts (Poole, Urquhart, Jasiura, Smylie, & Schmidt, 2013). It is an approach that helps frontline workers and human service providers model appropriate attitudes and identify useful services to assist homeless women. Two important goals of shelter frontline workers are: 1) to avoid re-traumatization during interventions with clients and 2) to facilitate opportunities for the women to make better, life-changing choices for themselves and their children.

Most homeless women come to a homeless shelter after a crisis. Hoff (1995) asserts that crisis intervention focuses on using the individual’s social and environmental resources to solve issues and concerns. As the only emergency homeless shelter for women in Regina, crisis intervention at My Aunt’s Place is implemented to quickly identify issues and connect the resident with suitable services to match her needs. Trauma-informed practice and crisis intervention are the main practice methods used in the shelter. These two interventions enable staff to not only respond to complex crises, but also to help heal the residents’ long-term traumatic experiences.

During my practicum at My Aunt’s Place, I spent more than 200 hours observing how frontline workers used trauma-informed practice to interact with homeless
Seeing the Trauma of Homeless Women

women. I also worked with residents to develop their case plans. I noted, however, that we faced some challenges when we implemented trauma-informed practice and crisis intervention. This rest of this chapter identifies some of these challenges that I observed when these two practice interventions were employed with the clients. Below is a description of how frontline workers engage trauma-informed practice principles when working with residents and the challenges they face when using this approach.

4.2 Trauma-Informed Practice (TIP)

When employing trauma-informed practice (TIP), it is important to be aware of and understand the client’s traumatic experiences and to avoid potential re-traumatization (Hopper, Bassuk, & Olivet, 2010). To this end, staff at My Aunt’s Place embrace TIP’s five guiding principles to frame their interactions with the clients: 1) patient empowerment, 2) choice, 3) collaboration, 4) safety, and 5) trustworthiness (Menschner & Maul, 2016). These principles are adopted at the macro-level of an organization’s philosophy, which then influence micro-level clinical practice (Menschner & Maul, 2016). Based on the five principles, Hopper et al. (2010) identify four themes to guide TIP practice in a homeless shelter: 1) trauma awareness; 2) emphasis on safety; 3) opportunities to rebuild control; and 4) strengths-based approach. I used these four TIP principles as the yardstick to measure my own practicum experiences with clients at My Aunt’s Place and to better inform my observations of other staff members.

4.2.1 The Practice of Building Trauma Awareness

Trauma awareness is one of the key components of an the effective use of TIP in human services. Only with fulsome understanding of homeless womens’ traumatic experiences can frontline workers shift their own perspectives on how they view their
Seeing the Trauma of Homeless Women

clients. Additionally, when clients become aware of the effects of trauma on their lives, they can begin to change the way that they view themselves. Clearly, workers have a great responsibility and face challenges when applying TIP principles to raise both their understanding and their client’s awareness of the impact of trauma.

4.2.1.1 Systematic TIP Training

Both organizations and frontline workers need to understand why they use TIP in their work settings and the need to integrate the ideals of TIP in agencies’ philosophies and missions (Hopper et al., 2010). TIP changes the way we see our clients and the way we treat them, and it affects every action and decision. Therefore, to residents of a homeless shelter with quality treatment, it is important to provide systematic training in TIP to frontline workers. Hopper et al. (2010) list staff education, training, and consultation as the major methods to build trauma awareness for frontline workers.

YWCA Regina holds regular staff meetings for shelter and department staff (including staff from My Aunt’s Place, Isabel Johnson Shelter, and YWCA Outreach) every six months to reinforce the Agency’s philosophy and mission, including TIP. My Aunt’s Place also holds staff meetings every month to review the behaviours and symptoms of women impacted by traumatic experiences, such as substance use, aggressive behaviours, insomnia, and mental illness, in the shelter. During these staff meetings, workers’ reactions to residents’ trauma are discussed, using role playing. Staff discuss real situations and issues they have faced in the workplace and the staff and managers discuss how to best address these issues based on TIP principles. For example, when a woman uses illegal drugs in the shelter, which is contrary to shelter rules, a safe drug use plan is discussed during role playing. Recognizing that substance use is a common strategy to deal with pain caused by trauma, the focus is
Seeing the Trauma of Homeless Women

on safe drug use as opposed to judgment of the woman’s behavior. Appropriate use of language and the appropriate way to respond to a woman’s behavior based on the TIP model of client interaction are also discussed by managers at the regular staff meetings.

Unfortunately, high staff turnover rates impact the continuity and quality of those worker/client interactions and interventions. The high staff turnover is also part of the reason for regularized TIP training. The workforce attrition also limits practicum students’ exposure to role playing with skilled staff. As a result, during my practicum at My Aunt’s Place, I did not have a chance to witness role-play training at the shelter. Many casual workers who joined the staff while I was there had never experienced role-playing sessions or received TIP training. This results in inconsistent interventions with residents as different frontline workers implement different rules and boundaries based on their former experiences and training. Unfortunately, this lack of timely training places new workers in challenging positions when asked to implement TIP in their daily work. For example, inexperienced frontline workers were often uncertain about how to respond appropriately and safely using TIP principles when they were confronted with volatile situations including intoxicated, abusive, and/or threatening clients.

4.2.1.2 Trauma Awareness for the Residents

Poole et al. (2013) stress the importance of both workers and residents building their knowledge of trauma awareness and adaptations, after which residents can be more self-aware and engage in less maladaptive behavior. When residents feel inadequate, they are more prone to impulsive behaviors that result in fights, panic attacks, and depression (Poole et al., 2013). At My Aunt’s Place, frontline workers lead educational group sessions to raise residents’ awareness of trauma and its impact
Seeing the Trauma of Homeless Women

on their lives. They discuss the physical and emotional adaptations to trauma such as anxiety, panic, and fear, which are connected with the brain’s reaction to trauma. They also help residents cope with these adaptations. Residents are encouraged to share their experiences and feelings with the group. Interestingly, after residents leave an abusive environment and move into a safe setting, they are more willing to share their feelings and experiences with others.

Herman (2015) illustrates that the first stage of recovery is to name the problem(s), which means we need to separate the behavior from the person. Therefore, enhancing trauma awareness can be a beneficial exercise in assisting residents to identify symptoms caused by trauma and to stop blaming themselves for the undesirable behavior. The goal is to help homeless women recover from traumatic experiences through their awareness of their natural responses to trauma.

4.2.2 The Practice of Emphasizing Safety

In the previous discussion about trauma recovery, I noted that the first element of recovery is "safety." Without a safe environment, healing cannot be achieved. Survivors who have experienced trauma sense the world differently. They feel their surroundings are unsafe all of the time (Herman, 2015). The goal is to provide a safe place for them to stay and shed the stress of being homeless. Therefore, maintaining the clients’ physical, emotional, and cultural safety is of major importance in using trauma-informed practice (Poole et al., 2013).

There are four principles in establishing a safe environment for homeless women ranging from the physical to the psychological: “1) physical and emotional safety; 2) relationships: authentic, respectful, clear boundary; 3) avoid re-traumatization; 4) acceptance of and respect for diversity” (Hopper et al., 2010, pp. 83–84). However, creating a safe, respectful, and acceptable environment is not easy,
Seeing the Trauma of Homeless Women especially in a homeless shelter where there are multiple social issues present. It requires intentional effort on the part of both the organization and professionals to create such an environment.

4.2.2.1 A Safe Physical Environment

Menschner and Maul (2016) illustrate some of the criteria to build a safe physical shelter for residents, such as monitoring people coming in and out of the shelter and keeping a low noise level in the office and waiting rooms. People who have experienced trauma may be more sensitive to their surroundings, including noise and commotion. There is also the fear of offenders and perpetrators of violence following residents to shelters with the intent of harming them. Therefore, it is the organization’s responsibility to build and maintain a safe physical shelter for both frontline workers and residents.

At My Aunt’s Place, shelter staff are trained to monitor and keep confidential record of residents. Residents’ safety also has meant that shelter staff are well trained and prepared to address issues like panic attacks of residents. At My Aunt’s Place’s safety measures also require that needs such as food, clothing, and medications are provided. Their availability address the immediate needs of homeless women who often arrive at the shelter with little more than the clothing that they are wearing.

The most useful discussion between workers and residents involves developing their own safety plan. The safety plan is one of the most important steps for the worker to discuss with residents because it addresses important security issues. The safety plan naturally evolves as the residents disclose their concerns, such as domestic violence, at-risk children, substance abuse, or gang involvement. Skilled frontline workers neutralize the discussion without passing judgment through words, facial expressions, and actions. During the decision-making process, the residents’ choices
Seeing the Trauma of Homeless Women

are not judged, even if they choose to go back to an abusive environment.

Nevertheless, based on their decision, tools to maintain their safety are discussed, such as how to identify the offender’s behavior patterns, the need to prepare an escape route, and the importance of keeping important possessions beside the door.

Additional support amenities are put in place, such as cell phones and escape plans. In the end, the residents need to recognize their own strengths and strategies for dealing with their issues and the availability of the staff to support them as needed. This empowering knowledge can instill feelings of confidence and emotional security in the residents.

4.2.2.2 A Safe Social-Emotional Environment

Menschner and Maul (2016) discuss methods for creating a safe emotional environment, which is based on the social worker’s competency in TIP. However, in clinical practice, several challenges arise when workers try to build a safe and accepting social-emotional atmosphere for all residents.

Hopper et al. (2010) suggest that building a mutual, authentic, and respectful relationship is one of the main ways to establish an emotionally safe environment for residents. A trusting relationship can make the residents feel welcome, respected, and supported in the shelter (Menschner & Maul, 2016). From my experience at My Aunt’s Place, it is an effective way to build an initial relationship with clients when we assist the client to connect resources and advocate for them. During this process, the residents can understand that staff members are supporting them. However, on every shift, there is only one frontline worker at the shelter to attend to almost 28 residents. This means they are too busy to build a meaningful relationship with each resident. For example, during a typical shift, the caseworker monitors the front door, builds a case plan with every resident, communicates with different agencies, answers
Seeing the Trauma of Homeless Women

nonstop phone calls, and deals with conflicts. This highly stressful workload contributes to high staff turnover and burnout. Without stable and long-term frontline workers, it is even harder to build trust relationships.

Frontline workers have identified safety concerns as important, especially on the evening shift when there is only one staff person on duty. Certainly more shelter workers on the evening shift would increase security and foster greater communication with the residents. It would also provide staff with more time to build relationships with residents, using TIP practices. Unfortunately, funding is not available to support such an enhanced level of staffing.

4.2.2.3 A Safe Cultural Environment

The final principle in emphasizing safety is to accept and respect residents’ diversity (Hopper et al., 2010). Menschner and Maul (2016) state that service providers should be aware of how culture affects an individual’s trauma and that staff must perceive client safety within the cultural norms regarding race and gender. YWCA Regina–My Aunt’s Place (2017) statistics reveal that almost 65% of homeless women are Indigenous. Mindful of that reality, the shelter offers an Aboriginal spirit room.

Sensitivity to gender is also considered during intake when residents are asked what their preferred gender identity is and how they wish to be addressed. Furthermore, owing to intergenerational and historical trauma, many Indigenous people have difficulty voicing their thoughts and feelings to social service workers or to the government. Thus, staff often act as advocates for the clients when dealing with government and community agencies.

In order to build on the discussion of physical, emotional, and cultural safety for shelter residents, Menschner and Maul’s (2016) provide some methods of how to
Seeing the Trauma of Homeless Women

build a safe environment, such as providing clear schedules and procedures in the homeless shelter, maintaining boundaries and dealing with conflicts with residents, having consistent, respectful and empathic communication with residents. I used Menschner and Maul’s (2016) methods as the yardstick to measure my own practicum experiences with clients at My Aunt’s Place.

1) Clear schedules and procedures

Menschner and Maul (2016) report that residents do better when shelter schedules and procedures are clearly outlined for them. Hopper et al. (2010) explain that trauma-informed practice should provide clear roles and boundaries because interpersonal trauma is escalated by boundary violations and the abuse of power. As a shelter, My Aunt’s Place provides guidelines and rules to be followed by residents before they move into the facility. These guidelines include safety measures, confidentiality, and rules governing the residents’ plan to come in and go out of the shelter. However, during my practicum, I found that the procedures were not clear enough for the workers and the residents to follow. In the past, there were many daily procedures in the shelter for the residents and workers to follow. However, in order to provide a flexible and relaxing environment at My Aunt’s Place, some procedures are no longer feasible. In addition, due to the high staff turnover, many new frontline workers were not familiar with these procedures and rules. Without a checklist of clear procedures and boundaries, the atmosphere in the shelter appeared chaotic and confusing at times.

2) Maintaining boundaries and dealing with conflicts

Available literature makes it clear that shelters need to ensure that frontline workers manage residents’ conflicts and maintain professional boundaries (Menschner & Maul, 2016). Herman (2015) shows that the brain of an individual
Seeing the Trauma of Homeless Women

who has experienced trauma is in a state of hyper-arousal, which means that they sense threats easily. Once a person in this situation senses a threat, his or her brain automatically reacts with a fight-and-flight or a frozen response (Herman, 2015). Therefore, it is easy for individuals who have experienced trauma to get into a conflict with others.

Hence, in the shelter, a conflict protocol guides frontline workers in dealing with conflict and prepares them to assist residents experiencing panic attacks. Maintaining boundaries with the residents is the most challenging, because for workers, it is difficult to strike a balance between enforcing rules without overpowering the residents. Every rule must have a clear rationale that increases safety and allows for TIP principles to be enacted. One tenet of building safety and trustworthiness is to provide clearly outlined program and treatment expectations (Poole et al., 2013). Based on my experience, consensus building occurs when respectful conversations with residents take place that outline the rules or treatment expectations and in which solutions to satisfy everyone’s needs are discussed.

3) Consistent, respectful, and empathic communication

Hopper et al. (2010) assert that a main purpose of TIP is to prevent re-traumatization of residents in the shelter or at least to minimize re-traumatization. These goals are served by increasing shelter safety for everyone. To this end, workers must communicate in a consistent, open, respectful, and empathetic manner (Menschner & Maul, 2016). Building alliances with residents is necessary to increase their comfort about disclosing traumatic events and setting up boundaries with them. Poole et al. (2013) explain that people feel unsafe and disconnected when service providers bombard them with too many questions.

During the intake process at My Aunt’s Place, residents are reassured that they
Seeing the Trauma of Homeless Women

do not have to disclose their reasons for being there if doing so makes them uncomfortable. Additionally, caution is required when asking homeless women to disclose their history of trauma because it can cause them to experience a flashback and be re-traumatized. Poole et al. (2013) provide guidelines regarding relationship building skills, such as rational and normalizing questions (e.g., we can connect the participants’ past experiences and their current functions and health), choice explicit (i.e., during our conversation, the participants’ have the right not to answer the question if they feel uncomfortable), questioning informally (i.e., we shall make the questions easy to understand and relate to their experiences), eliciting strengths (i.e., we help them to draw out their strength, strategy, goals).

4.2.3 Rebuilding Residents’ Competency and Control

A traumatic circumstance deprives an individual of control and power (Hopper et al., 2001). Typically, the perpetrator uses coercion to accomplish this (Herman, 2015). Individuals who are subjected to sustained trauma develop “learned helplessness” behaviors. Herman (2015) identifies this “captivity” syndrome as one that renders the victim powerless and vulnerable to the offender. Thus, in using trauma-informed practice, workers strive to restore a woman’s sense of control and power. Collaboration is the key to restoring the residents’ power and control, because when staff involve residents in the process, these important feelings return to the clients (Poole et al., 2013).

Poole et al. (2013) identify collaborative strategies that workers should employ with clients that allow them to make their own choices. These skills are highly valued in a crisis intervention situation, which is the second model adopted by My Aunt’s Place and is discussed in section 4.3. Here I focus on some of the collaborative strategies that shelter workers can apply when working with clients. Specifically,
Seeing the Trauma of Homeless Women
these include accompaniment, problem identification, provision of well-rounded
information, using a self-determination strength-based approach, and working towards
and emphasizing successes. Each of these strategies are discussed below, starting with
accompaniment.

4.2.3.1 Accompaniment

Frontline workers should work with residents through every step, including
accompanying them to meetings or appointments (Poole et al., 2013). At My Aunt’s
Place, the case worker accompanies residents to appointments with social services or
other agencies. Sometimes, they also communicate with other agencies for their
clients through telephone. Thus, the case worker often serves as a client advocate.
This worker support often defuses conflict and reduces miscommunication between
the worker and the client.

4.2.3.2 Problem Identification and Provision of Well-Rounded Information

Brainstorming with clients allows for problem identification and the exploration
of possible solutions with a view to expanding residents’ internal locus of control over
their lives (Poole et al., 2013). In the shelter, frontline workers brainstorm with
residents about their safety plan and their decisions. Discussions centre around the
best way to meet the clients’ needs. During the discussion, frontline workers need to
provide full information to help the residents make decisions about service
interventions.

4.2.3.3 Self-Determination

Frontline workers need to confirm an individual’s priorities and hopes (Poole et
al., 2013). Sometimes there is a difference between the worker’s and client’s treatment
priorities. In all cases, the residents’ decisions and choices must be respected.
Collaboration and self-determination provide homeless women with the opportunity
Seeing the Trauma of Homeless Women
to control their lives. They need to make their own decisions because only they know
what they want and where they are at in their journey of reaching their goals.

4.2.4 Strengths-Based Approach

Service providers should highlight the client’s strengths, ability to adapt, and
resiliency (Hopper et al., 2010). Coming to the shelter is not an easy journey for many
homeless women who have experienced trauma. Social workers need to emphasize
the residents’ strengths and empower them to heal from their trauma.

The use of appropriate language and trauma-informed practice techniques helps
clients feel positive and comfortable when they disclose their traumatic experiences to
staff (Poole et al., 2013). When taking the view of the client into account, staff begin
to understand how difficult it is for homeless women to overcome barriers and muster
the strength to leave an environment they know, even though it is abusive and unsafe.
Divulging their trauma and weaknesses to staff can be very threatening and
intimidating and can subject them to judgment and re-traumatization. At My Aunt’s
Place, a shift in language along the lines of TIP guidelines has had positive results.

My experience at the shelter demonstrates how powerful words can be. As one
example, some women identified symptoms caused by trauma (substance use,
addiction problems, suicide, and mental illness) that had made their life situation
unstable after leaving abusive environments. When the women disclosed their
behaviors to staff, staff explained that these were typical adaptation behaviors for
someone who has been subjected to abuse and that they were not personal failings.
Once residents understood the cause of these behaviors, they felt less judged and more
willing to share their experiences and feelings, especially when strengths-based
language was employed. When such language is used, clients begin to understand that
the staff is on their side and aware of the reasons for the adaptations without judging.
Seeing the Trauma of Homeless Women

(For this discussion, I have included Table 1 to illustrate changes in language from a deficit perspective to TIP and a strengths-based practice.)

**Table 1. Guidelines for using positive language in TIP**

<table>
<thead>
<tr>
<th>Deficit Perspective</th>
<th>Trauma-Informed and Strengths-Based Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is Wrong?</td>
<td>What has Happened?</td>
</tr>
<tr>
<td>Symptoms</td>
<td>Adaptations</td>
</tr>
<tr>
<td>Disorder</td>
<td>Response</td>
</tr>
<tr>
<td>Attention seeking</td>
<td>The individual is trying to connect in the best way he or she knows how.</td>
</tr>
<tr>
<td>Borderline</td>
<td>The individual is doing the best he or she can considering his or her early experiences.</td>
</tr>
<tr>
<td>Controlling</td>
<td>The individual seems to be trying to assert his or her power.</td>
</tr>
<tr>
<td>Manipulative</td>
<td>The individual has difficulty asking directly for what he or she wants.</td>
</tr>
<tr>
<td>Malingering</td>
<td>The individual is seeking help in a way that feels safer.</td>
</tr>
</tbody>
</table>


During counselling, many residents used negative words to describe themselves such as “chicken” or “coward.” Emphasis must be placed on reversing such negative self-descriptions (Poole et al., 2013). This can only occur when women begin to understand the causes of their maladaptive behaviors. For example, in a domestic violence case, the client’s strengths in removing herself from a dangerous situation can be recognized and applauded. This may be the first time that she has ever received affirmation for her actions. Only when women recognize their strengths can they begin to rebuild their self-identity and express themselves in a more positive manner.

**4.2.4.1 Building and Emphasizing Successful Experiences**

Lastly, a homeless shelter is an appropriate place to create successful experiences for homeless women because frontline workers can help shape positive daily life changes while reinforcing positive behaviors through recognition and
Seeing the Trauma of Homeless Women

affirmation. Many homeless women repeatedly return to the shelter, and the staff uses this opportunity to acknowledge improvements they have made since their last stay. The recidivism is never viewed as a weakness but, rather, as an opportunity for further improvement. For example, a resident may have had serious arguments and conflicts with other residents during her first stay at the shelter. However, on a repeat visit, she may demonstrate improvement by discussing her problems with staff instead of lashing out at other residents. The worker acknowledges the resident’s growth in dealing with conflict as a positive and important behavioral change.

In another example, a resident may refuse to go to a detox center during her first two stays at the shelter. However, by the time of her third admission, the resident decides that she wants to quit her addictive behavior and asks to go to a detox center. Again, this is recognized as positive change and a sign of strength. Hopper et al. (2010) maintain that TIP can increase residential stability for homeless women and decrease substance use and psychiatric symptoms.

Now I will discuss crisis intervention, a practice model that has been adopted by My Aunt’s Place in its work with homeless women.

4.3 Crisis Intervention

The second practice method used at My Aunt’s Place is crisis intervention. It may take a long time for people to recover and heal from trauma and stabilize their lives. Unfortunately, as an emergency shelter, My Aunt’s Place cannot support its clients as long as is necessary. Most women search for homeless shelters when they go through a crisis with which they cannot cope. Therefore, in an emergency homeless women’s shelter like My Aunt’s Place, the main goals are for the frontline workers to assist the residents to overcome their crisis in the short term, stabilize their current situation, and protect them from any potential immediate danger.
Seeing the Trauma of Homeless Women

Crisis can be considered a type of traumatic experience, since the symptoms and behavioral patterns, such as anxiety, panic, and PTSD, are similar. A crisis is a life event that overwhelsms a person’s ability to deal with it by using typical problem-solving techniques (Registered Nurses’ Association of Ontario, 2017). Trauma-informed practice underscores the importance for the worker to see the trauma from the client’s perspective, which facilitates the therapeutic intervention.

Crisis intervention is an immediate problem-solving strategy that assists workers when responding to crises (Hoff, 1995). Therefore, it is appropriate for social workers to use crisis intervention in the emergency shelter to address and solve the residents’ crises and any problems arising from them. This document illustrates how crisis intervention based on TIP philosophy is used to collaboratively build the client case and safety plans. The types of crises encountered at the shelter and the seven steps used to address them are discussed below. The barriers and struggles women face during crisis intervention will also be addressed.

4.3.1 Types of Crises

Staff at homeless shelters see clients who are encountering a variety of crises. All of these crises can be categorized into three major types: 1) developmental or maturation crisis; 2) situational crisis and; 3) disaster or adventitious crisis (RNAO, 2017).

1) Developmental or maturation crisis

These crises include pregnancy, the birth of a baby, and marriage (RNAO, 2017). At the shelter, crises are often precipitated following marriage (e.g., domestic violence, pregnancy, or child caregiving). In an abusive environment, when women face the situations, such as pregnancy or raising children, they may lead to the need to leave violent relationships that they had previously been
Seeing the Trauma of Homeless Women

endured. Leaving violent relationships may lead to homelessness. As a result, women may turn to prostitution in exchange for housing or money. At this point, they may reach out to a shelter as a safe place to get help.

2) Situational crisis

External and unanticipated events can also cause crises, such as the loss of a job, financial trouble, or sudden illness (RNAO, 2017). Most of the residents at My Aunt’s Place have financial issues and have trouble finding a stable job. Life stressors may also cause women to become overwhelmed, leading some of them to become homeless because of depleted resources.

3) Disaster or adventitious crisis

Lastly, according to the RNAO (2017), unpredictable events such as a natural disaster, violent crime, and random and unexpected events can be crises that overwhelm or threaten an individual’s life. Given Saskatchewan’s long and brutally cold winters, many homeless women face the risk of freezing to death. Additionally, many residents become involved with gangs, which places them in dangerous or life-threatening circumstances. Therefore, the emergency shelter is the safest place for them to escape from such danger.

4.3.2 Implementing Crisis Intervention

After identifying the type of crisis that a homeless woman experiences, frontline workers implement a crisis intervention plan. Roberts and Ottens (2005) outline a seven-step crisis intervention model. At My Aunt’s Place, trauma-informed practice principles are used in concert with Roberts and Ottens’s seven steps. There are many similarities between the two approaches.

1) Psychosocial and lethality assessment

Robert and Ottens (2005) maintain that the highest priority in a crisis
Seeing the Trauma of Homeless Women

intervention is to determine whether the client is in immediate danger, such as being suicidal or engaging in self-harm. At the same time, based on TIP philosophy, one of the most important principles is the client’s safety (Menschner & Maul, 2016). Therefore, when crisis intervention is implemented, the priority for the social worker is to assess the client’s safety by evaluating the client’s environment and individual circumstances (Robert & Ottens, 2005). According to Eaton and Ertl (2000), the assessment needs to include the client’s outside supports (e.g., community services, family supports, or other official supports) and stressors (e.g., domestic violence, gang involvement, or threats from gangs). Furthermore, it should include their internal needs and weaknesses (e.g., medication, substance abuse, mental illness, and self harm). A psychosocial and lethality assessment provides the frontline worker with a guideline to apprehend each resident’s situation and address her risks.

However, it is challenging for frontline workers to assess homeless women in an emergency shelter particularly when a woman has recently experienced serious trauma. Therefore, it is not easy for her to trust anyone, including the frontline worker. According to the RNAO (2017), creating a safety plan may not be feasible for a woman who still feels anxious and has recently escaped from an abusive environment. Therefore, the intake worker needs to be sensitive to the client’s non-verbal expressions.

During my practicum, I witnessed a woman’s body shaking, her frantic stares, and her inability to state her name during intake. The client was frightened by the unfamiliarity of the people at the shelter, both the staff and residents. The staff sensed that the woman might have immediate serious safety concerns and discussed how we could help her with her current situation and at a minimum, find
Seeing the Trauma of Homeless Women

a safe place for her to sleep. Later, she was connected with various resources including the police, as well as a private and a more protected shelter located away from danger. In this way social workers concern themselves with a resident’s situation and her external environment in order to understand where the resident is at and whether she is ready to deal with the crisis.

Second, homeless women’s circumstances and issues are complex and numerous (e.g., substance abuse, domestic violence, mental illness, child protection, criminal activity; Duchesne, 2015). Every woman’s circumstance is unique and challenges the frontline worker’s professional background knowledge and skills to develop a safety or crisis plan. The plan must be tailored to the individual’s circumstances, employing appropriate counselling skills and therapies to address the crisis at hand (RNAO, 2017).

2) Rapidly establish rapport

Building a trust relationship with clients is the central foundation for social work interventions. The therapeutic alliance is the key element for treatment outcomes (Nichols, 2014). Often the client’s motivation to change is founded on the therapeutic alliance. Robert and Ottens (2005) provide good advice for the kind of counselling required for effective client interactions: non-judgmental conversation, good eye contact, and a positive attitude. However, skillful counselling techniques will not be at the center of building a trust relationship unless clients understand that staff genuinely empathize with them and care about them. As such, it is critical for shelter workers to accept homeless women as valued individuals who have done what they thought was best to cope with their circumstances. To believe otherwise is to cause re-traumatization, an attitude that is unbefitting someone in the social work profession.
3) **Identify the major problems or crisis precipitants**

The major tasks of crisis intervention is to address a client’s current problems. Therefore, the focus is on “why now” (Robert & Ottens, 2005, p. 334). At this initial stage, all problems are identified and prioritized (Robert & Ottens, 2005). During crisis intervention, the client shares problems and past methods for addressing them and explains why her previous coping mechanisms are no longer working. Attempts are then made to remove barriers to successful solutions and identify new ones.

Moving forward from this point, solution-focus therapy techniques provide help to identify clients’ problems. The “miracle question,” such as what it looks like when everything is perfect and what can be done to reach the goal, helps to address problems and set up concrete goals (Nichols, 2014, p. 231). “Scaling questions” assist in problem prioritization and identify where clients are at. For example, with 10 as the perfect situation, the client is asked to indicate where she is now on the scale and how staff can help her to go up one step on the scale (Nichols, 2014). A woman may state that her end goal is to bring her son back to live with her. This leads to a discussion about how best to stabilize her housing arrangements and address financial issues and substance abuse.

However, sometimes the worker and the resident may rank the problems differently, or other times, residents do not want to discuss certain issues. For example, the frontline worker may be concerned about child protection/parenting issues or mental illness, while the woman may focus only on financial supports or temporary housing. Sometimes, residents are not even willing to have further discussions on important issues. Based on the TIP principle of “choice,” sometimes women need to take a break from their overwhelming surroundings and make their
Seeing the Trauma of Homeless Women

own decisions when they are ready. These choices must be respected.

4) **Deal with feelings and emotions**

Staff workers have an important role to play in helping clients to heal by providing them with emotional support (Robert & Ottens, 2005). The women have just escaped from an abusive environment or experienced a dramatic “nightmare.” Therefore, many of them may need to deal with distress and depressed emotions. Some women like to share their emotions and feelings to reduce their stress (Greene, 2016). Frontline workers should employ counselling skills such as paraphrasing, reflecting feelings, and challenging response (Robert & Ottens, 2005). A client can only share her feelings and emotions in a trusting relationship with the worker. When people experience trauma, it is difficult for them to build a trust relationship with others (Herman, 2015). Thus, I appreciated that some women shared their stories and feelings with me. Often, they just needed somebody to listen to their story and comprehend how tired they were. The RNAO (2002) states that emotional support can assist with restoring a client’s mental health. When a resident shares her story and feelings, it means she feels safe and trusting in the shelter. During this step, it is important to verbalize to the client how strong she is by coming through so many difficulties and barriers and how smart she is to have found a safe place to come for help.

5) **Generate and explore alternatives**

Robert and Ottens (2005) explain that therapists and clients should brainstorm together to find out all their official and unofficial resources and possible coping skills. Solution-focused therapy techniques, such as “exploring exception,” provide effective counselling skills to uncover successful strategies from a client’s past experiences (Nichols, 2014, p. 232). Frontline workers can also provide
Seeing the Trauma of Homeless Women

information about a variety of related official resources and provide the client with options from which to choose (Robert & Ottens, 2005). For me, this is the most difficult part of the process, because as an international student, I lacked a thorough knowledge of the community services network in Regina. Although I tried my best to identify government resources during my practicum, I was often unable to be as helpful as I would have liked.

6) Implement an action plan

The sixth step requires clients to follow the agreed-upon plan and implement it (Robert & Ottens, 2005). However, one of the challenges faced at My Aunt’s Place is that residents sometimes retreat and refuse to follow the plan at the last minute. They often use some unpredictable, unbelievable, and unexpected behavior to sabotage the plan. For example, one woman for whom an apartment had been found and paid for, left the shelter on her final day without giving any reason.

Change is never easy, especially for people who have experienced trauma. Change also does not guarantee a better life. Therefore, it is reasonable for residents of the shelter to be afraid of the unknown.

The transtheoretical model of change recognizes the importance for people to retreat from their goal until they collect enough strength to work on it repeatedly and until the new lifestyle becomes habit (McGuire, 2005). The foundation of TIP principles requires staff to respect and accept the clients’ decisions. Thus, even when they have departed from the original plan, they are welcome to start the process again. Robert and Ottens (2005) point out that empowering treatment can be used to encourage clients to change.

7) Follow-up plan and agreement

According to Robert and Ottens (2005), the frontline worker has the
Seeing the Trauma of Homeless Women

responsibility to plan the follow-up schedule for clients, such as continuing the ongoing treatment, assessment of family function, etc. Because My Aunt’s Place is an emergency shelter, staff transfers clients to another department, the YWCA Outreach Program, to continue the follow-up plan. They provide further resources and discussion with residents once they are in the community, which is much more feasible for the clients.

4.4 Summary

Both trauma-informed practice (TIP) and crisis intervention as adopted by My Aunt’s Place are approaches that have provided me with an understanding of how to assist clients in need of healing. Specifically, crisis intervention provides social workers with effective methods with which they can deal with clients’ crises, which is a significant first-step while working towards long-term goals to stabilize clients’ lives and healing. In the next chapter, I will reflect on my practicum learning at My Aunt’s Place, with a focus on social work values and ethics.
Chapter 5: Self-Reflection and Social Work Values and Ethics

5.1 Introduction

Social work values are the fundamental principles that underlie social work practice (Reamer, 2013). As a social work practicum student in Canada, I was expected to follow the Canadian Association of Social Workers (CASW; 2005) Code of Ethics. However, as an international student from Taiwan, I felt disadvantaged because I was unfamiliar with western culture, particularly work styles, communication models, perspectives, values, and even social work techniques. After finishing my practicum, I reflected on my experience and western social work values and ethics and adopted them as a guide for future social work practice.

5.2 Self-Determination: Cultural Clash Regarding Substance Abuse

The first challenge for me in my practicum was my perspective on substance abuse. In Taiwan, substance abuse is a criminal offense owing to its historical impact. Since the 1840s, during the first Opium War, China was divided and colonialized by various countries (Wikipedia, n.d.). Therefore, in Taiwanese history, it is believed that opium made our people sick and lazy, which led to national weakness (Gou, 2017). According to the current Narcotics Hazard Prevention Act (2017), individuals who obtain, use, or sell illegal drugs are considered criminals. Although in recent years some people have started to discuss drug decriminalization, substance use is still considered criminal behaviour in Taiwan, which means the government can force a drug user to undergo detoxification in jail. In Taiwan, substance use is punished, corrected, or eradicated through education (Narcotics Hazard Prevention Act, 2017). However, when I came to Canada, I found that people have a different perspective on substance abuse. In Canada, the focus is on the reasons why people use illegal drugs. As such, I noted that the staff at My Aunt’s Place focused on the residents’ trauma.
Seeing the Trauma of Homeless Women

instead of their drug use. Substance abuse is viewed not as criminal, but as a client’s adaptive strategy to deal with trauma (Poole et al., 2013). The focus shifts to the client’s toxic environment instead of blaming the individual. Drug use is considered a personal choice and a strategy for dealing with traumatic experiences.

Reamer (2013) argues that it is a social worker’s responsibility to clarify the relationship between their own values and professional practice. During my practicum, I not only struggled with the conflict of personal and professional values, but I also faced challenges related to social and cultural norms. Therefore, I needed to reflect on social work values and ethics. The CASW (2005) Code of Ethics states that one of the core values of social work is “respect for the inherent dignity and worth of persons” (p. 2). The social worker shall maintain the clients’ interests as a priority and respect individual self-determination (CASW, 2005). In other words, substance use is an individual choice that we must respect; the client may or may not be ready or able to overcome their addiction. In such a case, only the safe environment of drug use is discussed. After reflecting on the value conflict within myself, I have a better understanding of self-determination. Self-determination does not mean just providing options for our clients; it also requires waiting for clients’ readiness to change their lifestyles for themselves.

Sometimes during the practicum, I found I was too eager to solve a client’s problem when I discussed her future through crisis intervention. I realized that my over-eagerness could create stress for the client. I forgot that they knew how to survive in their world, but that they needed a place to rest for a while. Based on the value of self-determination, can we allow them to do nothing? Can we allow them to control their own lives even though they do not make the best choices?
Seeing the Trauma of Homeless Women

5.3 Social Work Competence in Consultation Skills

The second difficulty I encountered during my practicum was a lack of consultation competence. In Taiwan, social work responsibilities are divided between the social worker and the psychological consultant. You and Jiang (2017) describe how a psychological consultant focuses on how the environment impacts the individual, while a social worker focuses on how the individual lives in society. Therefore, as a social worker in Taiwan, I did not engage in much consultation with my clients but transferred my cases to the psychological consultant (Wu, Chen, & Wen, 2012). My bachelor of education and work experience in social work in Taiwan did not provide much training or practice in counselling techniques. Most of the time, I focused on basic communication with clients to collect background information and identify the problems they faced. I also connected them with various community support resources.

When I started my practicum in Canada, I discovered that counselling skills were important for social workers. The Saskatchewan Association of Social Workers (SASW; 2012) asserts that one of the necessary competencies for social work is consultation. In Canada, social workers and psychological consultants can share the same work responsibilities. I only learned about “attachment and trauma theories” when I came to Canada. In Taiwan, I thought only psychologists needed to know these theories. I did not know these theories are significantly related to our profession and interventions. Fortunately, as a student, I still had a chance to learn and improve. Although 450 hours were not enough for me to learn and practice counselling successfully, I started to improve my efficacy as a social worker and learned to evaluate my clients better. I appreciated the opportunity to role play, which taught me how to integrate various counselling skills to motivate clients and assist them with the
Seeing the Trauma of Homeless Women
development of safety plans based on TIP intervention principles. I also observed
other caseworkers interacting with clients using appropriate language that avoided re-
traumatization.

5.4 Social Justice: The Faith to Challenge the Unfairness

One important social work value is to pursue social justice for clients (CASW, 2005). Homeless women are often viewed as a group not worthy of being helped(Tutty et al., 2013), and they suffer discrimination from the community and the social
services system. This stigma often arises from their connections with gangs, substance
abuse, sexual work, and other criminal activities (Lankenau et al., 2005).

The most disheartening case that I experienced during my practicum involved
a homeless woman who had been refused financial assistance by social services on
multiple occasions because she lacked the proper paperwork. The woman was
qualified to receive government support but no one clearly told her what kind of
documents she needed to prepare. After being rejected multiple times, it is
understandable that clients lose their confidence and strength to fight for their rights.
Sometimes, a lack of professional knowledge about services and requirements leads
the clients down a dead end to rejection and exasperation. Based on CASW’s (2005)
Code of ethics, the social worker’s responsibility is to advocate for fair and equitable
access to public services and support for clients. However, client advocacy requires
that the professional possesses enough background knowledge to fight for the client.
Therefore, it is important for social workers to be familiar with social rules and
policies.

Many of My Aunt’s Place clients were disappointed and depressed about their
encounter with social services because they had suffered multiple rejections. During
my practicum, I witnessed many women who were afraid to and tired of contacting
Seeing the Trauma of Homeless Women

social services for help and were more willing to suffer cold, poverty, and abuse than to persevere. As social workers, we should be our clients’ voices and fight for them. We also need to make clients aware of their rights and empower them to fight for themselves.

5.5 Summary

When I first learned about trauma-informed practice (TIP), I could relate to this intervention, because it is closely related to social work ethics and values. For example, “choice” can equate to the social work ethic self-determination. They both mean that clients have the right to make their own decisions. “Awareness” corresponds to the social work value pursuing social justice, which means that the social worker has the duty to identify clients’ oppression and advocate for them. I feel like all social workers know how to implement TIP, although they may not be familiar with the term itself. However, coming from a different culture, I faced barriers in trying to understand local values and cultural norms. During my practicum, my confidence as a social worker was shaken owing to these difficulties. However, my practicum journey taught me to understand my clients’ journeys and struggles from their perspectives without imposing my preconceived notions. Through self-reflection on social work values and ethics, I came to recognize how important it is to establish personal boundaries in professional responsibilities. This practicum taught me to leave my preconceived notions at the door and meet my clients at the place in their lives where they were.
Seeing the Trauma of Homeless Women

Chapter 6: Conclusion

Unlike other master of social work students who had set up their learning goals before they entered their practicum, I came to my practicum location to find my learning goals. Everything about Canada was new to me, and I could not identify any learning goals before I entered the field. Therefore, I faced many challenges and barriers. However, although the learning curve has been difficult and steep, I feel confident that I have acquired enough knowledge and experience to continue in a social work career in Canada.

In my bachelor’s degree program, I studied PTSD in a mental illness course, and it seemed to only be related to natural disasters or psychology, which meant it was not commonly used in social work clinical practice. However, after doing my practicum for this degree, I discovered that trauma theory is related to every client. It is not only applied to psychology or mental illness, but to every individual who has experienced trauma in her life. I found that most of the clients at My Aunt’s Place had experienced trauma for a long time, long enough to make them and others believe that their trauma symptoms and adaptive behaviours were part of their personalities or lifestyles, which sometimes placed them in the category of not deserving help. Now that I have learned about trauma theory and the healing process, I believe that as professional social workers we should have the eyes to really see and be aware of our clients’ trauma symptoms and difficulties. It is our duty to pull them out of self-denial and separate the trauma symptoms and behaviors from the individual.

Homeless women are one of the most vulnerable groups to live and survive in abusive and oppressive environments, which subjects them to even more trauma (Fitzpatrick et al., 1999). I have learned a lot from their life experiences. I also discovered that acceptance is an important value and technique when working with
Seeing the Trauma of Homeless Women

homeless women. We need to accept their behaviors without judgment, and we need to accept their decisions without pushing our suggestions onto them. We need to respect who they are by learning about their cultural backgrounds instead of accepting subjective cultural stereotypes. Only when we really accept clients can we help them build their strengths. The role of a social worker working with homeless women is to bring control back to their lives. TIP provided me with the operational guidelines to assist with that process.

When I tried to implement trauma-informed practice and crisis-intervention during my practicum, I faced the most difficulty. I lacked the necessary counselling skills, which made it hard for me to focus on the clients’ problems and have meaningful conversations with them. This experience provided me with an important answer to my question regarding what the skills and competencies required by social workers were and what I was lacking to become an effective professional. In Taiwan, my social work education did not include many courses in counselling skills (You & Jiang, 2017). We establish a clear boundary between social work and counselling. However, language is our tool to work with clients. Without counselling techniques, a conversation between a client and a professional becomes an ineffective conversation and not a therapeutic interaction focused on problem solving and the development of an effective life plan.

My practicum has changed me significantly. It changed the way I see clients and the way I work with them. The theories and ethics I learned have provided me with tools to review my social work perspectives repeatedly. It also changed the way that I see myself and my role as a social worker.
Seeing the Trauma of Homeless Women

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Seeing the Trauma of Homeless Women


Seeing the Trauma of Homeless Women


Seeing the Trauma of Homeless Women


Seeing the Trauma of Homeless Women


Seeing the Trauma of Homeless Women


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