# HOW PSYCHOLOGY FITS IN HOMELESSNESS - ADAPTATION AND RECOGNISING COMPLEXITY AND RESILIENCE

In an area with such a significant prevalence of co-occurring mental health, addiction, and complex trauma, the presence of psychology in homelessness has been more absent than one would think. Whilst psychology has contributed to the understanding and development of psychologically informed environments (PIEs) in the homeless sector, the role of psychology beyond consultation has been slower in growth.

There has been a prevailing view that those affected by chronic homelessness, addiction, and mental health difficulties are not able to benefit from psychological support due to a lack of therapeutic readiness or stability (Murphy et al., 2017). This view also appears to have been influenced by this cohort being seen as a hard to access population, as well as the diversity and complexity seen within this cohort. However, the increased understanding of how to engage an individual affected by homelessness at a pre-treatment stage and its efficacy, (Levy, 2015) is contributing to a shift in this view.

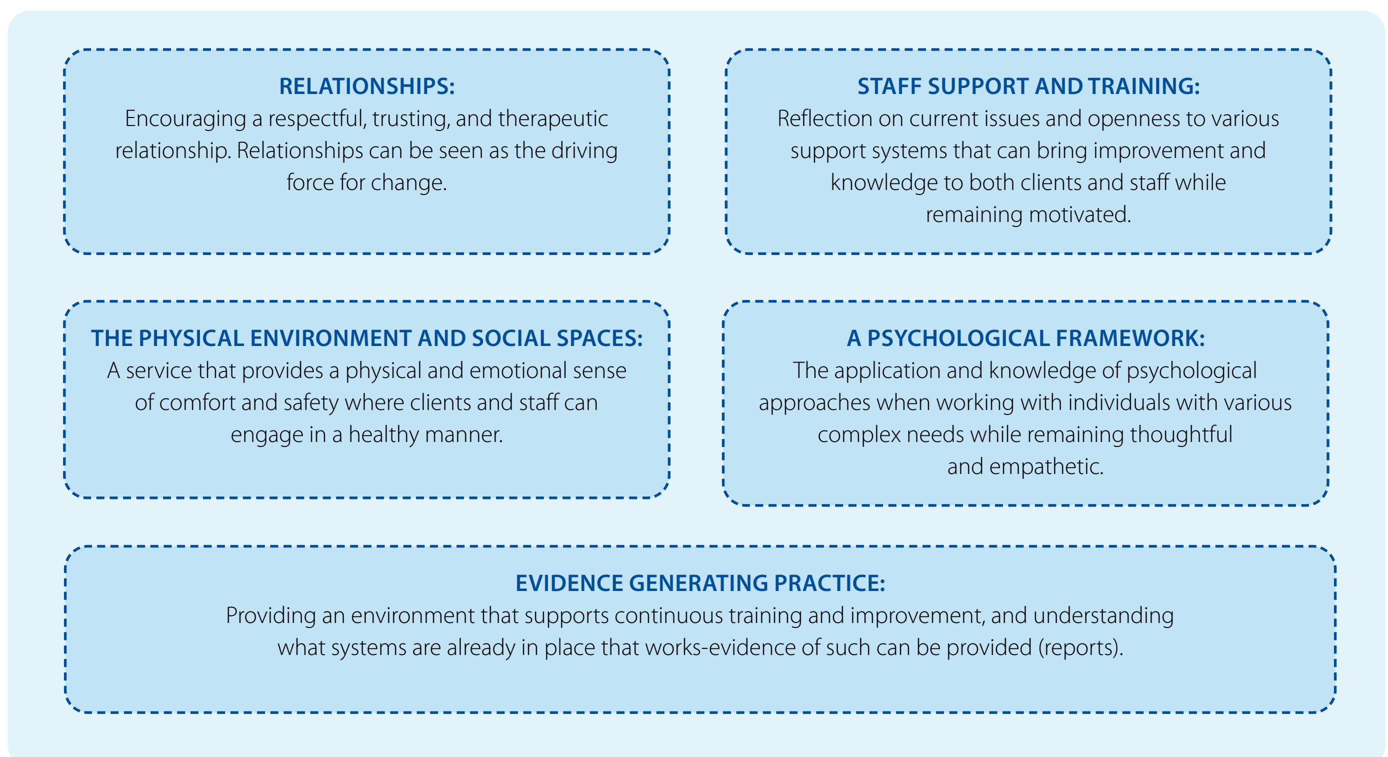
There is no quick or easy step by step guide to create and implement a PIE within the area of homelessness. The importance of recognising the complexity within clients' experiences and difficulties (interpersonal, psycho-social, and personality) and the stressful nature and demands of living and working within homeless services is key. Therefore, core tenets of the PIE as seen in Figure 1 rely upon the provision of support and training for both individuals and staff within homeless services, allowing them to gain a deeper understanding and apply knowledge of how to support and work with clients who experience and endure complex issues.

## Focus on Primary Need for Engagement

There are many challenges that occur when working with people experiencing homelessness, and in particular long-term homelessness, one of which is engagement with professional services. Indeed, recent National Institute for Health and Care Excellence (NICE) guidance on the provision of health and social care for people experiencing homelessness highlights the need for all clinicians working with this cohort to focus on *supporting engagement, sustaining engagement,* and *supporting re-engagement* (NICE, 2022). Engagement and connection can be viewed as the foundational pillars for the building of a trusting, reciprocal relationship. It is hoped that establishing a positive therapeutic relationship may become the vehicle for increasing self-awareness, trust, authenticity, and potential for change. Often, the primary goal is to try to develop a secure attachment through the therapeutic relationship and relational process.

With the development of this relationship an enhanced connection is created, providing the possibility for the development of epistemic trust, a foundational capacity often injured in these clients (Cockersell, 2018). Epistemic trust is the ability for individuals to have a willingness to trust others and integrate new information from them (Fonagy et al., 2017). With a safe relationship at the foundation, meaningful attainable goals may be then followed, with care plans aimed at alleviating the stressors the individual faces on a day-to-day basis, in turn building self-confidence, self-awareness, and improving quality of life and well-being. However, this is not a straightforward path; many obstacles may arise along the way. These obstacles include, but are not limited

**Figure 1:** *Five foundational elements of PIE (Keats et al., 2012).*



to, relapses, housing issues, access to opportunity/valued roles, legal issues, new experiences that may be positive, but remain unfamiliar to the individual.

The challenges lie in adapting psychological approaches to meet the needs of the individual. In many ways, individuals within this cohort can gain a deeper understanding of the psychological supports available to them. One such approach, is the relationship driven pre-treatment approach (Levy, 2015). With this approach, the value and importance of a positive therapeutic relationship is paramount. Adapting to working with individuals amidst addiction, crisis, and meeting a client 'where they are at' both geographically and psychologically is hugely beneficial. The pre-treatment model is guided by five core principles: relationship formation, developing a common language, cultural and 'ecological' considerations, promotion of safety, and the facilitation of change (Levy, 2015). It allows us to build upon the assertive engagement approach adopted with efficacy across community based mental health crisis teams.

Common language is the tool that is used to navigate and form the connection that can aid in recreating a secure attachment (Levy, 2015). When discussing psychological supports that can be offered to an individual, the way in which we communicate is crucial. Ultimately, explaining complex issues in the person's own words so there are no misunderstandings is key. This may include working on the individual's emotional regulation, positive goal setting, supporting the individual during a crisis, or motivational interviewing strategies. There may be some terms that they do not understand, so these are conveyed in an easy-to-understand language or matched with the language the client uses (Levy, 2015).

Recognising and responding to trauma and its impact is at the fore of providing psychologically informed care in working with those experiencing homelessness and brings our awareness to the core need for supporting many in seeking safety, security, and trust, and reconnection with self (Mate, 2018). Addiction and substance use are often primary means of responding to the impact of trauma and become the solution for managing emotional pain and distress that ensues (Najavits, 2002).

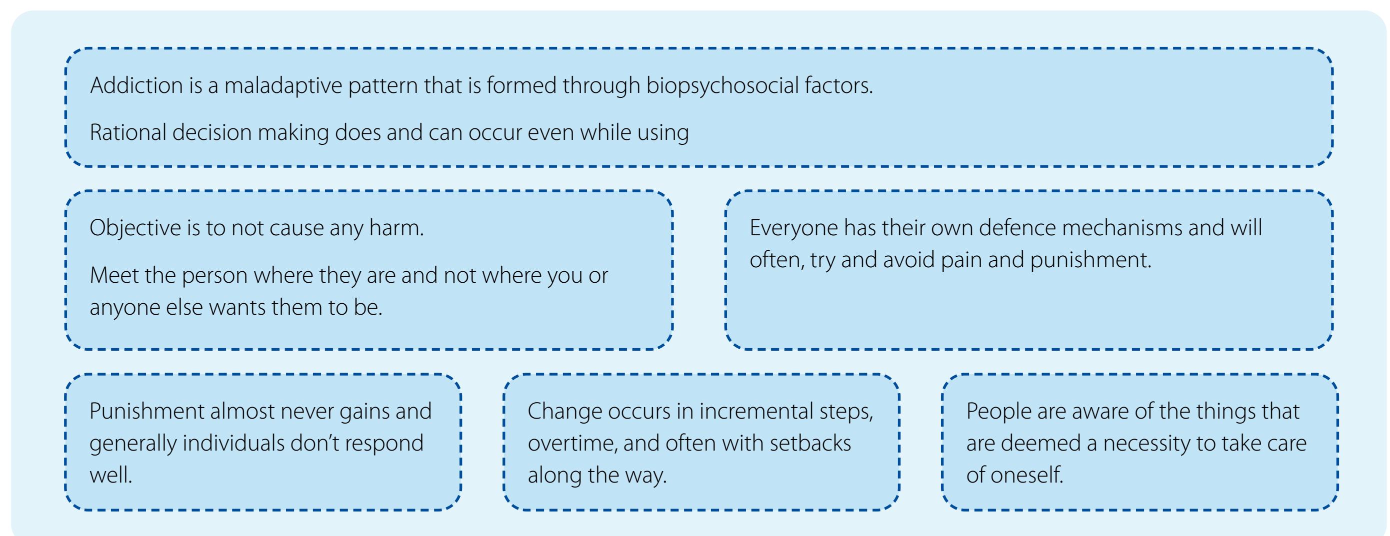
## Harm Reduction Response as a Pragmatic Therapeutic Approach

Approaches like harm-reduction psychotherapy (Tatarsky, 2002) can improve and focus the individual on the positive steps that can be achieved while striving for change, such as lowering the volume of alcohol intake the individual has in a day. Many individuals with problematic substance use, due to various reasons that have developed throughout their lives, are either unable or unwilling to strive for abstinence. Harm reduction enables such individuals to take incremental positive steps towards reducing the harm being caused to them. The harm-reduction approach provides reassurance to those caught in the cycle of addiction that they are not failures and that incremental steps (such as lowering alcohol intake or attending to physical health needs while still using substances at the same level) can be taken to find recovery (Tatarsky, 2002). This person-centred approach includes abstinence as a goal but denies that abstinence is best, or the only goal. Some of the harm reduction strategies that have been seen to enable an individual to reduce the use of substances are psychodynamic, cognitive, and behavioural based.

The traditional mindset towards addiction, which focuses on the idea of "tough love", "alienation", or the mentality that "they must hit rock bottom before they change" as the only possible way for escaping the clutches of addiction, is now shown to be outdated and ineffective. Denning (2010) outlines how it is not only highly unlikely for someone to complete a singular 28-day programme and be fully "cured" from addiction, but also how it is potentially psychologically harmful since it can lead toward re-traumatisation, shaming, disappointment (where relapse occurs, despite it being known that relapse is a normal part of recovery), loss of hope, and anger. These negative consequences can affect both the substance user themselves, their families and friends, and anyone else trying to support the individual on their road to recovery.

By contrast, an approach based on Denning' s (2010) harm-reduction principles (Figure 2) can contribute to the recovery process both for people who have substance use problems and their loved ones, by providing them with tools to help them in their healing process.

**Figure 2:** *Core principles of harm reduction psychotherapy (Denning, 2010).*



For psychological practitioners working in the field of substance use/ addiction and related areas such as homelessness/multiple exclusion, the operationalisation and clarification of theoretical and evidence-based models of psychological support is exciting. It allows creativity, flexibility, and spontaneity within the work, with the reassurance of operating within, and being able to measure against, an established framework. It also offers exciting training opportunities for psychology doctorate trainees and assistant psychologist roles, creating a pathway for those with an interest in the area.

With the newly expanding presence and ever-growing need for psychological knowledge, support, and intervention within the homeless sector, it is pertinent to stress this role is not attempting to substitute or replace other adult mental health services that are in place which have been progressive in working with individuals who have found themselves in homelessness. Psychologists can respond to and assess the client's needs and guide them into mainstream services if needed or provide psychological support in the absence of community multi-disciplinary mental health teams.

The multi-faceted approach that clinician psychologists can offer, informed by the theory and evidence in this area, is an exciting and innovative future for psychology. It is also an opportunity for psychology to become embedded in the development of robust trauma informed care within the homeless services, and to provide much-needed psychological support to a resilient yet vulnerable cohort.

---

Peter Browne, Joanne Rolfe, & Eilish Burke
The authors are psychology practitioners currently working in the homelessness services in Galway and Cork

---

## References

Cockersell, P. (2018). *Social exclusion, compound trauma and recovery: Applying psychology, psychotherapy and PIE to homelessness and complex needs.* Jessica Kingsley.

Denning, P. (2010). Harm reduction therapy with families and friends of people with drug problems. *Journal of Clinical Psychology, 66*(2), 164-174.

Fonagy, P., Luyten, P., Allison, E., & Campbell, C. (2017). What we have changed our minds about: Part 2. Borderline personality disorder, epistemic trust, and the developmental significance of social communication. *Borderline Personality Disorder and Emotion Dysregulation, 4*, 9.

Keats, H., Maguire, N.J., Johnson, R. & Cockersell, P. (2012). *Psychologically informed services for homeless people: Good practice guide.* Department of Communities and Local Government. Available at: www.southampton.ac.uk/assets/imported/transforms/peripheralblock/UsefulDownloads. http://pielink.net/pies-2-0/.

Levy, J. S. (2015). *Pre-treatment in Action: Interactive exploration from homelessness to housing stabilization.* Loving Healing Press.

Mate, G. (2018). *In the realm of hungry ghosts; close encounters with addiction.* Vermillion Press.

Murphy, R., Mitchell, K., & McDaid, S. (2017). *Homelessness and mental health: Voices of experience.* Mental Health Reform, Simon Community and St Stephens Green Trust.

Najavits, L.M. (2002). *Seeking safety; A treatment manual for PTSD and substance abuse.* Guildford Publications.

National Institute for Health and Care Excellence. (2022). *Integrated health & social care for people experiencing homelessness.* Available from https://www.nice.org.uk/guidance/ng214.

Tatarsky, A. (2002). Harm reduction psychotherapy: Extending the reach of traditional substance use treatment. *Journal of Substance Abuse Treatment, 25*(4), 249-256.