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Trauma in Plain Sight

Photo illustration by Slate. Photos by Getty Images Plus.

by Lori Teresa Yearwood

The psychiatrist in the windowless room on the second floor of the rehabilitation center in Utah didn't say much. He asked a handful of questions, scribbled a few notes on a piece of paper and then, Millie Davidson says, he told her that she needed to take antipsychotics. Given the severity of her diagnosis, she should also sign up for permanent disability benefits, she remembers him saying.

Davidson declined the offer even when she saw the doctor's paperwork, detailing her all-you-can-eat buffet of serious mental health diagnoses, which included schizoaffective disorder and bipolar disorder.

"Deep down, I thought, 'That couldn't possibly be me,' " says Davidson, who had just emerged from two years of living on the streets. "But I was weak from everything I had gone through and I was just so lost that I also thought, 'Maybe that *could* be me.' If a doctor was telling me this, then maybe he was right."

Turns out he was wrong. Eight years later, in the spring of 2019, in the midst of healing from her collapse into homelessness and the substance abuse that she fell into during that time, Davidson received a drastically different mental health assessment. This one was given by a team of university researchers and doctors, who concluded that Davidson—now a full-time youth leader at an all-girl's school, a homeowner, and a college student slated to earn her bachelor's degree this year—has posttraumatic stress disorder. Not schizoaffective disorder and not bipolar disorder.

"In short," the diagnosis stated, "Ms. Davidson presented a psychological profile that matches her life story."

That life story, like those of many homeless people, included an extreme amount of trauma. But the role of trauma and the resulting mental health diagnosis of PTSD is widely ignored in the homeless population, mental health experts say. The result is a debilitating, even life-threatening situations in which homeless people experience or witness traumatic events, yet the effects of those experiences go unacknowledged, undiagnosed, or misdiagnosed.

"Chronic homelessness is chronic exposure to stress and chronic exposure to trauma that could lead to PTSD," G. Robert "Bobby" Watts, chief executive officer of the National Health Care for the Homeless Council in Nashville, Tennessee, told me. "But not all organizations are trauma-informed enough to be able to make the accurate diagnosis." As a consequence, post-traumatic stress is often overlooked or

misdiagnosed as some other psychiatric condition. The people to whom this happens are re-traumatized to such an extent, Watts said, “that the trauma that already existed is exacerbated.”

Exacerbated trauma can look like a lot of things. In the realm of PTSD, it can look like going into “flight,” “fright,” or “freeze” mode. This brings up a whole other layer of causation, one in which the question naturally arises: Can untreated PTSD be so detrimental that it renders a homeless person unable to gather their wits to the point where they can escape homelessness?

As a formerly homeless woman who “froze” for nearly two years, my answer is a resounding “yes.”

There are no national statistics on the prevalence of post-traumatic stress disorder among homeless people. Even the estimates of how many people suffer from the disorder in mainstream America vary greatly—from 5 million to 24 million.

But in researching the subject, I found studies that deal with the trauma inherent in homelessness, especially for women.

Here, mental health professionals and advocates for the homeless speak about the unrelentingly and often inescapable dangerous conditions of homelessness—the rampant sexual assaults committed against women and the continual threats made on men as well as women’s lives. The numbers of the traumatized are astronomical, experts say.

Jaime Bustamante, behavioral health director at the Fourth Street Clinic, a Salt Lake City health care organization dedicated to helping the homeless, estimates that 90 percent of the clients she sees qualify for a PTSD diagnosis.

Much of the time, Bustamante said, PTSD is misdiagnosed as bipolar disorder, or borderline personality disorder, simply because no one has asked the client about trauma. “Trauma-informed care is about asking what happened to you versus what’s wrong with you,” she said. “When

I hear someone has been diagnosed with bipolar disorder," she said, "I immediately assess for PTSD." Signs of the disorder— dissociation, aggressive behavior, verbal or physical outbursts—are often flight-or-fight responses, she explained. "It may look like a person is totally insane," she said. "But in reality, they are reacting to a world of pain."

The term "post-traumatic stress disorder" was added to the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders in 1980. It emerged in large part from the study and treatment of Vietnam War veterans in the '70s. The significance of the diagnosis: It stipulated that the cause of the mental disorder was an event outside the individual, rather than any organic internal condition.

Today, the difference between a correct or incorrect diagnosis can mean the difference between receiving appropriate or inappropriate treatment. It can also dictate whether a patient is cast into the category of an intractable lifelong mental illness—or that of PTSD, a condition that is often resolved with cutting-edge alternative therapies and holistic activities that include talk therapy, yoga, meditation, and horseback riding.

Earlier this year, a study in the Journal of Child Psychology and Psychiatry at the University of East Anglia backed up the importance of appropriate treatment of PTSD, concluding that the risk of persistent post-traumatic stress disorder among the 200 children and teens studied was higher if the subjects believed their response to a traumatic event was abnormal.

Still, some psychiatrists suggest extreme caution when it comes to any conclusions about the mental health of the homeless. "You have a situation where being homeless makes you vulnerable to adversity," said Rachel Yehuda, director of the traumatic stress studies division at the Icahn School of Medicine at Mount Sinai in New York. "And so you don't have to go any further than that."

One thing is sure: Chronic, severe mental illness plays a vital role in the public's understanding—or misunderstanding—of homelessness. Homelessness did rise with the wave of deinstitutionalization of people with mental illness that began in the late 1960s. This led to the widespread perception that people who live on the streets are doing so because of a serious, preexisting mental illness that precludes them from being able to be employed or house themselves.

But the perception is inaccurate. The true cause of the surge in homelessness, according to Martha R. Burt, author of *Over The Edge* and a social researcher at the Urban Institute, is the housing crisis in this country, which also began in the 1960s with the elimination of inexpensive urban housing. That gave people, including those who were deinstitutionalized, no other option but to live on the streets. This was accompanied by the dissolution of social and economic structures that had sustained low-income people, says Burt, who has been studying the homeless for more than 40 years.

There is far too much emphasis placed on the personal pathology of homeless people, Burt says, with far too little attention on the issues in the U.S. economy that are the actual root causes of homelessness. For example, we have to acknowledge the reality that the lowest two echelons of working-class Americans have experienced a freeze in wage increases—while their housing costs have at least doubled, thus "making everyone who isn't a millionaire housing insecure," Burt said.

"We're still assuming homeless people are 'crazy' because it's a way to write them off, and it's easier than looking at the structural housing crisis," she said.

Lori Teresa Yearwood
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The events that led up to my homelessness were traumatic in their own right, and the trauma accumulated in the span of less than a year. There was the house fire, in which I ran into the flames to yank my landlord out and which destroyed everything I had in the building. There was my mother's death from cancer, my dog's death from cancer, a vengeful family battle over an inheritance, and then, finally, the loss of my business and all my animals because I did not have the money to care for them.

For the first year of my homelessness, I lived on the streets. During that time, I was continually stalked, beaten, and sexually assaulted by a man who initially worked at a homeless outreach center and then at a construction company.

Yet when the police officers found me, in my confusion and shock, lying naked on the side of the street in downtown Salt Lake City, and the psychiatrists evaluated me for my repeated acts of public disrobing, no one ever asked me one incredibly important, treatment-altering question: What happened to you?

I spent the majority of the second year of homelessness in psych wards: locked in white rooms with white tiled floors, injected with court-ordered medications, and put on the waiting list for the Utah state mental hospital. At the age of 50, I had never been diagnosed with a major mental illness. I felt mentally invisible to my professional caretakers, who spent their time analyzing my vital signs and behavior and repeatedly testing me for drug addiction, though I always tested clean.

No longer believing that anyone could possibly have my best interests at heart, I—a former businesswoman, homeowner, and journalist—stopped talking and refused to answer any of the doctors' questions. The notes from one of my psych ward records acknowledge the fire and my mother's death. But on the next page, those same records state that there was "no sign of PTSD."

My behavior was labeled as "bizarre," and I was diagnosed with a smorgasbord of mental illnesses: schizoaffective, bipolar, mania, and paranoia. Then, like Amelia Davidson, I was urged to sign up for disability, which I refused.

One of the factors I have considered is the role that the color of my skin may have played in my treatment, or lack thereof. The daughter of a Panamanian immigrant and a Caucasian woman from South Dakota, I was presumed by my caretakers to be African American.

A 2019 Rutgers study found that "there has been a tendency for clinicians to overemphasize the relevance of psychotic symptoms and overlook symptoms of major depression in African-Americans compared with other racial or ethnic groups." African Americans represent 13 percent of the general population, but make up more than 40 percent of the homeless population, according to the National Alliance to End Homelessness.

"Somebody who is black is going to have a really hard time," said Ellen Bassuk, a psychiatrist and one of the lead authors of the 2012 article Shelter from the Storm: Trauma-Informed Care in Homelessness Service Settings. The solution, she says: The organizations, the shelters, the

facilities experiencing homeless—need to have more staff of color, and those staff need to be trauma informed.

“If you go to an agency and ask: ‘Are you trauma informed?’ they will say they are,” Bassuk said. “But if you take a close look, they are not. It takes a great deal of work and implies racial equity.”

Watts, the chief executive officer from the National Health Care for the Homeless Council, says that among the barriers to improving the diagnosis and treatment of PTSD for homeless people are standard diagnostic tools commonly used to assess mental health. Simply put, many of the diagnostics were created for middle class people who are housed, Watts says.

Two common diagnostic questions, for example, pertain to changes in sleep and appetite. Those questions fail to consider that a homeless person sleeping on the streets or in a loud shelter usually has no choice but to stay awake, Watts points out. “Understanding the context of someone’s life is critical with coming up with an accurate diagnosis,” Watts said.

Amelia Davidson

Courtesy Lori Teresa Yearwood

Millie Davidson was eight years old when she watched her father stick a rifle into the stomach of another man, pull the trigger “and blow the man’s guts out,” killing him, Davidson recalls.
Fast-forward to 2006, when Davidson, then 27, lost her job as a certified nursing assistant. Then she fell behind on her mortgage payments and ultimately lost her house.
Davidson struggled with heroin addiction, which her then-boyfriend introduced her to while her life was falling apart. Unknown to her at the time, but familiar to trauma-informed mental health experts, was the fact that drugs can provide a means of self-medicating trauma, and PTSD can often lay the groundwork for addiction.

In 2012, Davidson entered a treatment program where she was given her diagnoses of severe mental illness. As I sat with her in her backyard in St. George, Utah, she scanned those old psychiatric evaluations, disbelief flooding her face. Her 6-year-old twins laughed and played nearby.

Now seven years sober, Davidson, 40, has just bought her own condo, has earned her certificate in substance use disorder counseling from Utah Valley University, and is about to graduate from Dixie State University in St. George.

She hadn’t realized it, she says, but her self-confidence had plummeted; she didn’t believe she was good enough to attract a kind and healthy man, or an employer who valued her, she says. But with the PTSD diagnosis, she says, “I am walking with a lot more confidence.”

A week after her new diagnosis, Davidson got a job as a counseling intern at a drug abuse recovery center. Now, she is a youth mentor at Second Chances in LaVerkin, Utah.

When I finally emerged from homelessness in 2017, much of the reason was that Shannon Miller Cox, the founder and executive director of

Journey of Hope, a Salt Lake City nonprofit that provides services for harmed women, had begun speaking to me about the trauma that is inexorably linked to homelessness.

“Nearly every single one of my clients has been sexually assaulted,” she explained to the judge presiding over my public lewdness cases.

All of the criminal charges against me have since been dismissed. The stigma from the psych ward diagnosis, however, proved far more difficult to overcome.
For a few months, I worked with a therapist at a Salt Lake City trauma therapy center. There, when I expressed embarrassment over my behavior on the streets, the counselor helped me understand that I suffered from PTSD and that my behavior, though shocking, was “a normal response to an abnormal circumstance.” The counselor led me through “Rapid Release” pain sessions, which were like hourlong meditations where I was helped to create a safe space in my mind and then feel and release some of the trauma I had endured. All of this work helped to mitigate my substantial anxiety and trauma over that initial diagnosis. The PTSD diagnosis was a huge relief, something that made sense and explained my unraveling—all the way back to the fire.

I have not taken any kind of medication since being released from the psych wards. My elixirs: conversations with a long-distance life coach whom I had worked with before my collapse; CBD oil, though I recently stopped needing it to sleep; yoga and swimming; and the gentle spirit of my tuxedo cat, Iggy, whom the trauma center prescribed as “an emotional pet” to help with the PTSD.

I trust life again.