NCTSN The National Child Traumatic Stress Network

Culture and Trauma Brief
V2 n1 2007

Trauma Among Homeless Youth

Joe is a 17-year-old who has been living on the streets for three months. Joe was removed from his home when he was about five years old because his mother had a significant substance abuse problem and he had been physically abused by several of her boyfriends. Joe has lived in various foster care settings and group homes, but he got into fights with his peers and transferred frequently due to anger management problems. He ran away from the most recent group home because he said he didn't want to continue living with people who didn't really care about him. He thinks he has completed school up to the ninth grade, but it is hard to know, since he changed schools so often due to his various placements. He currently lives in a "squat"—an abandoned building—with a group of other homeless youth he calls his family. Joe panhandles for money and admits to shoplifting to get food. He drinks alcohol and uses drugs whenever he has the opportunity, but he doesn't think that he has a substance abuse problem. Joe knows that there are programs for homeless youth in his area, but he's reluctant to get services because he is afraid of being returned to a group home. He has gone to a drop-in center a couple of times for food and clothes and just to hang out; he says that he feels safe there because "the staff are cool and don't ask too many questions." Although Joe hasn't had any contact with his mom in years, he dreams of finding her and returning to live with her.

(Note: "Joe" was created by the authors to illustrate issues observed over many years.)

The Culture and Trauma Briefs series serves to support the NCTSN commitment to raising the standard of care for traumatized children, their families, and their communities by highlighting the diversity of needs and experiences of those children, families, and communities.

Introduction

Homeless street youth have become a common presence in most large American cities. The prevalence of homeless youth is difficult to determine, but researchers estimate that 1 million to 1.6 million youth per year experience homelessness (National Alliance to End Homelessness, 2006). Not surprisingly, homeless youth have significant mental health problems, including depression, anxiety disorders, posttraumatic stress disorder (PTSD), suicidal ideation, and substance abuse disorders (Cochran, Stewart, Ginzler & Cauce, 2002). Most of these youth experienced potentially traumatic events before they left home, and many of them are retraumatized once they arrive on the street (Stewart, Steiman, Cauce, Cochran, Whitbeck, & Hoyt, 2004). These youth struggle to recover from both previous and new traumatic experiences while trying to survive in a hostile street environment.

Attempting to accurately describe the characteristics of this ethnically and racially diverse population is very difficult, partly because homeless youth don't necessarily interact with service providers. Studies conducted in the youths' locale often document that homeless youth generally reflect the racial and ethnic makeup of their community. However, overrepresentation of racial and ethnic minorities is common (Robertson & Toro, 1999). The proportion of homeless youth who are gay, lesbian, or bisexual also varies across studies, in part due to the types of locations (street, shelter, or clinic) and communities studied: Most report rates of 3 to 10 percent, very similar to the percentage estimated in the youth population at large. Other studies report 25 to 40 percent (Robertson & Toro, 1999). There is some evidence and anecdotal information to suggest that for many street youth, affiliation with a street-based social network is a significant part of their cultural identity (Kipke, Montgomery, Simon, & Palmer, 1997).

Why Do Youth Leave Home?

Studies conducted in the youths' locale often document that homeless youth generally reflect the racial and ethnic makeup of their community. However, overrepresentation of racial and ethnic minorities is common.

There are many reasons why youth leave home, and there are several paradigms used to categorize them. The National Alliance to End Homelessness divides the causes for youth homelessness into two categories: Family Breakdown and System Failure. While these categorizations may not capture all the causes of youth homelessness, they do accurately present the problem as a societal one, and not one caused by the youth themselves.

Among the issues identified in Family Breakdown are parental substance abuse or mental health problems, child abuse and neglect, familial conflict, and family homelessness. The category also includes significant numbers of youth rejected by their parents or caregivers due to their sexual orientation, gender identity, and/or lifestyle.

The System Failure category includes the many youth who become homeless due to the failure of the child welfare, juvenile justice, and/or mental health systems. Each year thousands of youth age out of the foster care system and, without receiving adequate resources or support, are then alone and expected to be independent without adequate resources or support. Many homeless youth are arrested for status offenses—acts that are illegal only for minors, like running away or curfew violations—or for prostitution and other crimes. Without family support and other resources, these youth return to the street when they are released.

Some youth do leave home due to situational circumstances—for example, a fight with a parent, fear of punishment for a bad grade, or a curfew infraction—or to seek adventure and/or fame. These youth have generally not experienced complex trauma and are not the focus of this brief. Family counseling can help them, and can assist their parents in figuring out how to set reasonable household rules and expectations while supporting the youth's emerging needs for independence and autonomy.

The majority of youth on the street, however, have decided that the challenges and dangers of living in a street environment are preferable to continuing the life they experienced at home, in foster care, or in a group home. For these youth, family reunification is unlikely, due to the significant challenges facing their parents or caregivers or a history of maltreatment.

Types of Trauma Experienced by Runaway and Homeless Youth

Trauma at home and in the child welfare system: Rates of abuse among homeless youth vary widely across studies, ranging from 17 to 35 percent for sexual abuse and 40 to 60 percent for physical abuse and neglect (Robertson & Toro, 1999; Jenks, 1994). These types of early and often chronic abuse put homeless youth at a higher risk for anxiety disorders, depression, PTSD, suicide, and characterological disorders. Similar problems can be found in youth who were separated from their parents for reasons other than abuse or who may not have had an adult in their life who loves them unconditionally. The early experiences of these youth may interfere with attachment and may lead to difficulty in developing positive relationships with peers and in trusting relationships with other adults. The consequences of these negative experiences can be long-lasting.

***Trauma on the streets*:** Youth on the streets are exposed to community violence and are vulnerable to further victimization by predatory adults, criminals, pimps, and other street youth. As many as 43 percent of homeless adolescent males and 39 percent of adolescent females report being assaulted with a weapon while living on the streets (Whitbeck & Simons, 1990). In order to survive, youth often seek relationships and create social networks among those they meet on the street. Unfortunately, many of these youth end up in new abusive or exploitive relationships. Even when youth have insight into the nature of these relationships, they may be unwilling or unable to leave them for fear of being vulnerable to other dangers on the street.

In order to survive, youth often seek relationships and create social networks among those they meet on the street. Unfortunately, many of these youth end up in new abusive or exploitive relationships.

Consequences of Trauma and Homelessness

Substance abuse: According to various surveys, approximately 75 percent of homeless youth use marijuana or other drugs (Kipke, O'Connor, Palmer, & MacKenzie, 1995; Green, Ennett, & Ringwalt, 1997). Youth sometimes use substances to self-medicate for the trauma and pain they have experienced. Some youth report that they feel they have to be high in order to engage in the types of behaviors that are necessary for survival on the street. Other street youth may become involved in selling drugs in order to pay for food and shelter. Because many youth are not interested in stopping their drug and/or alcohol use unless or until their environment changes, they often will not consider entering treatment programs or services for substance abuse. And the Catch-22 is that many shelters and residential programs require youth to be sober before they enter.

Survival sex: Some homeless youth engage in survival sex: the exchange of sex for food, clothes, money, or drugs. Service providers view survival sex as sexual exploitation of youth, and moreover, are concerned about the increased physical risks associated with it including HIV, sexually transmitted infections, and unintended pregnancies. But youth who either aren't eligible for available shelters or who don't want to enter shelters or other programs may see few other options to support themselves.

Dependence on other street youth: Many street youth create street families in an attempt to find the unconditional love and support that they did not receive from their parents/caregivers. These alliances, particularly with older, more seasoned street youth, can help these youth stay safer on the street but can also accelerate their acculturation to the street environment. Although these relationships offer some immediate benefits, many youth tolerate abusive behavior from their street family or their pimp in exchange for this type of protection.

For a small number of street youth, pregnancy can serve as a catalyst for many positive changes including getting off the street, stopping high-risk behavior and substance use, taking care of their health, and refocusing on a positive future. Other youth, however, are unable to muster the internal or external resources to effect these types of changes.

Parenthood: Street youth often fantasize about returning to their family or creating a new ideal family of their own. Some youth want the opportunity to be the kind of parent that they never had, or want to have a baby so that they will have someone to love who will love them back. For a small number of street youth, pregnancy can serve as a catalyst for many positive changes including getting off the street, stopping high-risk behavior and substance use, taking care of their health, and refocusing on a positive future. Other youth, however, are unable to muster the internal or external resources to effect these types of changes, and often, ultimately, their children are taken away by child protective services, repeating the cycle of separation and trauma.

Lack of independent living and prosocial interpersonal skills: Due to the interruption of their education and normal social development, many street youth lack basic interpersonal and independent living skills. They don't have bank accounts or know how to manage money. Many have difficulty reading social cues and connecting with people.

Impulsivity and poor decision-making: It has been demonstrated that serious traumatic experiences change brain chemistry. As a result of trauma and the demands of the street, many street youth become hypervigilant, impulsive, and have difficulty making appropriate choices when they have the opportunity. They also often cannot determine who to trust and who not to trust.

Depression and PTSD: For street youth, the mental health consequences of trauma, including depression and PTSD, make their struggle for stability even more difficult. Rates of serious disorders among homeless youth, assessed with standardized instruments and diagnostic criteria, range from 19 to 50 percent (Robertson & Toro, 1999). Runaway and homeless youth with previous histories of both physical and sexual abuse have been found to have the most severe psychological symptomatology and to be at greatest risk for revictimization (Ryan, Kilmer, et al., 2000).

Low educational attainment: Many homeless youth have learning problems and low literacy skills, and have not completed their high school education (Rubin, Erickson, San Agustin, Cleary, Allen, & Cohen, 1996). Many do not have the literacy skills or education to function independently. Low educational attainment combined with a lack of independent living and social skills impede their ability to complete a job application, let alone perform basic work tasks or achieve financial self-sufficiency.

Treatment Considerations

Homeless youth may not readily disclose their past traumatic experiences when they seek treatment. It is therefore crucial that the service providers and systems of care be trauma informed: that is, the staff must be able to understand, anticipate, and respond to the special needs of trauma survivors, and provide a safe, supportive, nonthreatening service environment.

In focus groups conducted by Children's Hospital Los Angeles in 1992 and 1999, homeless youth reported that they wanted their mental health providers to:

Homeless youth may not readily disclose their past traumatic experiences when they seek treatment. It is therefore crucial that the service providers and systems of care be trauma informed.

- Be nonjudgmental
- Have a good sense of humor
- Empower rather than enable
- Offer choices instead of advice
- Build trust by being honest regarding confidentiality and the limits of confidentiality
- Be patient and not give up on them
- Match the treatment with the youth instead of matching the youth with the treatment
- Be aware of their own personal problems (e.g., countertransference issues)

These requests indicate that the homeless youth were asking for caring relationships far different from the abusive relationships that they have probably experienced with parents or other adults (Harris & Fallot, 2001). Service providers of all kinds can have a positive impact on runaway and homeless youth and can mitigate the impact of trauma by working to develop supportive relationships with them. Even if a homeless youth never seeks out formal mental health treatment, a strong relationship with an outreach worker, shelter worker, or case manager can make a significant positive difference.

The insight provided by homeless youth themselves informs the treatment considerations. To promote trauma-informed and effective treatment of homeless and runaway youth, service providers should:

- Identify and address agency policies and procedures that could retraumatize homeless youths by inadvertently having them relive their traumatic experiences before they have the knowledge and skills to cope.
- Consider universal trauma screening of homeless youth as part of the intake process in order to identify those who need trauma-specific services.
- Offer assistance with no strings attached. Homeless youth may require access to low-barrier services, such as a meal or a hot shower, while they are developing trust with service providers.
- Consider their behavior in the context of their life experiences including their traumatic life experiences. Many homeless youth can be intentionally provocative and are waiting for service providers to give up on them. Service providers can make themselves available to these youth while still setting reasonable limits.
- Prioritize youths' immediate needs. Youth with unmet primary needs may have difficulty focusing on forming a trusting relationship with service providers.

- During the assessment phase, determine the youths' strengths and talents, rather than focusing only on problems and deficits.
- Allow homeless youth to make their own choices whenever possible. Do not take away their sense of control by "pushing" treatment recommendations or referrals on them.
- Assess the youths' cognitive abilities so that you can use appropriate language to make sure that they understand you.
- Assess the youths' psychosocial needs and refer them to complementary services to augment treatment.
- Offer homeless youth referrals only to agencies that are youth-friendly and that welcome young people.
- Tailor interactions and treatment plans to the individual needs of each youth.
- Be aware that the use of trauma-exposure therapies is discouraged because many youth have comorbid substance abuse disorders and generally lack adequate support and basic safety (Thompson, McManus, & Voss, 2006).
- Recognize that youth may have co-occurring disorders and other mental health problems that need to be addressed.
- Ask youth about their current sleeping situation—where they slept the night before and where they plan to sleep tonight—at each treatment session and pace interventions accordingly. Homeless youths' willingness to open up to a mental health provider is often directly correlated to how safe they feel when leaving the service provider's office.
- Remember that most homeless youth have experienced multiple types of trauma over an extended period of time, and have acculturated to the street environment and culture. Engaging and retaining these youth in treatment is challenging, even for the most skilled clinicians.
- Remember that change is slow and that homeless youth may take many small positive steps instead of one large one. A harm reduction model can provide a good framework for appreciating small steps to positive change.

This brief was prepared by:
Arlene Schneir, MPH, Children's Hospital Los Angeles
Nikolaos Stefanidis, PhD, Children's Hospital Los Angeles
Carrie Mounier, LCSW, Children's Hospital Los Angeles
Daniel Ballin, LCSW, Covenant House California
Dylan Gailey, Los Angeles Gay and Lesbian Center
Heather Carmichael, LCSW, My Friend's Place
Tamara Battle, MD, Children's Hospital Los Angeles

References

Cochran, B. N., Stewart, A. J., Ginzler, J. A., & Cauce, A. M. (2002). Challenges faced by homeless sexual minorities: Comparison of gay, lesbian, bisexual, and transgender homeless adolescents with their heterosexual counterparts. *American Journal of Public Health*, 92(5), 773-777.

Green, J. M., Ennett, S. T., & Ringwalt, C. L. (1997). Substance use among runaway and homeless youth in three national samples. *American Journal of Public Health,* 87(2), 229-235.

Harris, M., & Fallot, R. (Eds.). (2001). *Using trauma theory to design service systems*. San Francisco: Jossey Bass.

Jenks, C. (1994). *The homeless*. Cambridge, MA: Harvard University Press.

Kipke, M. D., Montgomery, S. B., Simon, T., & Palmer, R. F. (1997). Homeless youth: Drug use patterns and HIV risk profiles according to peer group affiliation. *AIDS and Behavior,* 1(4), 247-259.

Kipke, M.D., O'Conner, S., Palmer, R., & MacKenzie, R. G. (1995). Street youth in Los Angeles: Profile of a group at high risk for human immunodeficiency virus infection. *Archives of Pediatrics & Adolescent Medicine*, 149, 513-519.

Molnar, B. E., Shade, S. B., Kral, A. H., Booth, R. E., & Watters, J. K. (1998). Suicidal behavior and sexual/physical abuse among street youth. *Child Abuse & Neglect,* 22(3), 213-222.

National Alliance to End Homelessness (2006, May). Youth Homelessness Series, Brief No. 1: *Fundamental issues to prevent and end youth homelessness*. Washington, DC. http://www.endhomelessness.org/files/1058_file_youth_brief_one.pdf

Powers, J. L., Eckenrode, J., & Jaklitsch, B. (1990). Maltreatment among runaway and homeless youth. *Child Abuse & Neglect,* 14(1), 87-98.

Robertson, M. J., & Toro, P. A. (1999). Homeless youth: research, intervention, and policy. In L.B. Fosburg & D. B. Dennis (Eds.), *Practical lessons: The 1998 national symposium on homelessness research*. (pp. 3-1 – 3-32). Washington, DC: U.S. Department of Housing and Urban Development.

Rubin, D. H., Erickson, C. J., San Agustin, M., Cleary, S. D., Allen, J. K., & Cohen, P. (1997). Cognitive and academic functioning of homeless children compared with housed children. *Pediatrics*, 97(3), 289–294.

Ryan, K. D., Kilmer, R., Cauce, A. M., & Hoyt, D. R. (2000). Psychological consequences of child maltreatment in homeless adolescents: Untangling the unique effects of maltreatment and family environment. *Child Abuse & Neglect*, 24(3), 333-352.

Stewart, A. G., Steiman, M., Cauce, A. M., Cochran, B. N., Whitbeck, L. B., & Hoyt, D. R. (2004). Victimization and posttraumatic stress disorder among homeless adolescents. *Child & Adolescent Psychiatry*, 43(3), 325-331.

Thompson, S. J., McManus, H., & Voss, T. (2006). Posttraumatic stress disorder and substance abuse among youth who are homeless: Treatment issues and implications. *Brief Treatment and Crisis Intervention*, 6(3), 206–-217.

Whitbeck, L. B., & Simons, R. L. (1990). Life on the streets: The victimization of runaway and homeless adolescents. *Youth & Society*, 22, 108-125.