Out of the Frying Pan, Into the Fire: Trauma in the Lives of Homeless Youth Prior to and During Homelessness

John Coates

Sue McKenzie-Mohr

Department of Social Work
St. Thomas University

Anecdotal evidence from those who work with homeless youth indicates that trauma permeates these young people's lives. This paper presents the findings from a study of 100 homeless youth regarding the presence of trauma in their lives, both before and during homelessness. Participants living in the Maritime Provinces volunteered to take part in a semi-structured interview lasting one to two hours. The interview questionnaire was conducted by a trained interviewer, and was composed of standardized and adapted survey instruments, as well as questions regarding demographics, experiences prior to becoming homeless, assistance received while dealing with stressors, and current needs. The results indicate that trauma is both a cause and a consequence of youth being homeless, as a large majority of participants experienced a number of types of highly stressful events both preceding and during homelessness, and that trauma in the lives of both male and female homeless youth should be understood as a pervasive reality with serious implications. Implications for service delivery are discussed.

Key words: *trauma, homelessness, youth, abuse, Trauma Symptom Inventory*

Homelessness has gained increasing attention in Canada as structural factors such as poverty, shifts in employment

patterns, lack of affordable housing, gentrification, and violence (Daly, 1989; Farge, 1989; McLaughlin, 1987) have resulted in growing numbers of homeless persons being increasingly both vulnerable and visible (Hewitt, 1994; Hwang, 2001). Homelessness has grown to such import that national and regional initiatives and conferences have been organized in Canada to address this issue (for example, federal initiatives such as the National Homelessness Initiative and Homelessness Partnering Strategy; Growing Home: Housing and Homelessness in Canada Conference, 2009; Alliance to End Homelessness Ottawa, 2005). Homeless youth have been recognized as one of the fastest growing, and particularly vulnerable, sub-groups within the homeless population (Gaetz, Tarasuk, Dachner, & Kirkpatrick, 2006).

Since many homeless youth go on to become homeless adults (McLean, 2005; Simons & Whitbeck, 1991), and because the incidence of psychological distress increases the longer a youth is 'on the street' (Kamieniecki, 2001), efforts to serve homeless youth can have significant long-term benefits for both the youth and society at large. Programs have emerged to serve homeless youth and, while providing protection from the elements remains the primary service, many shelters have established outreach and referral programming in efforts to assist youth to obtain needed services (such as medical, employment, and counselling assistance). Many services target homelessness itself as the core problem, and as a result provide interventions that focus primarily on accessing housing, readmission to school, and securing employment training or actual employment. However, as severe and serious as homelessness is, for many youth being homeless is symptomatic of longer-term and deep-seated social and personal realities. For example, Tyler and Cauce (2002) report that 75% of homeless adolescents' reports of abuse have been met with a lack of concern, and homelessness for many youth begins in a search for a better life, as they leave home to escape abuse and neglect (Janus, Archambault, Brown, & Welsh, 1995; Kurtz, Kurtz, & Jarvis, 1991; Schneir et al., 2007; Tyler & Cauce, 2002). Homeless youth are "not simply in need of temporary shelter and short-term counselling, but ... ongoing help (is) needed to help them resolve, or at least cope with, the burden of

long-standing family, school, and personal problems" (Kurtz et al., 1991, p. 547).

The remainder of this paper describes the research project that was undertaken to explore the presence and impact of stressful events in the lives of homeless youth both before and during homelessness; presents the results of this study; and considers implications for both service delivery and future research.

Literature Review

While the presence of trauma has been found to be correlated with adult homelessness (North & Smith, 1992), and with young offenders (see for example, Greenwald, 2002; Sawdon, Reid-MacNevin, & Kappel, 2003), few studies on the prevalence or impact of trauma in the lives of homeless youth have been carried out. Anecdotal evidence from shelter staff in New Brunswick indicates that many youth have experienced trauma as a contributor to the onset of homelessness and/or as a consequence of being homeless. However, efforts to study the role of trauma in the lives of homeless youth are made more difficult by the reluctance of many homeless youth to trust service providers and professionals (Kidd, 2003; Schneir et al., 2007), and by the life circumstances experienced by the majority of homeless youth. Life conditions include chronic poverty, family instability, parental substance abuse, mental illness and social isolation (Koegel, Melamid, & Burnam, 1995; Masten, Miliotis, Graham-Bermann, Ramirez, & Neeman, 1993; Ziesemer, Marcoux, & Marwell, 1994). The instability of their life conditions renders potential participants difficult to track.

Despite these methodological challenges, considerable research (Ayerst, 1999; Simons & Whitbeck, 1991) provides strong evidence to explain that large numbers of homeless youth, both male and female, fled their parental homes to escape physical and/or sexual abuse. For example, Farber, McCord, Knast, and Baum-Faulkner (1984) and Powers, Eckenrode and Jaklitsch (1990) reveal rates of physical abuse within families of homeless youth of 78% and 60%, respectively. These American studies are supported by Canadian data (Janus et al., 1995; Janus, McCormack, Burgess, & Hartman, 1987) that indicate

78% and 43%, respectively, of runaways experienced abuse in their homes. Similar experiences are also found among young offenders (see Greenwald, 2002; Sawdon et al., 2003), as the abuse often does not come to public attention (i.e., not referred to child welfare authorities) until a youth's disruptive behavior (criminal offence, school expulsion, homelessness, etc.) draws attention. As Karabanow (2004a) notes, drawing upon his research findings of the experiences of homeless youth in Halifax, "If 'home' is defined as a safe haven, with people who love and care for you, most of these youth were homeless long before they left for the streets" (p. 22).

The well-being of homeless youth is further compromised as many face violence after they become homeless. Janus and colleagues (1995) report that while the "allure of the streets" is safer than being at home, homeless youth are "not able to protect themselves from physical risk" (p. 443). Thus, while exposure to highly stressful experiences frequently occurs prior to a youth becoming homeless, traumatic experiences also occur as a consequence of being homeless (Gwadz, Nish, Leonard, & Strauss, 2007; Kamieniecki, 2001; Karabanow, 2004a; McCormick, 2004; Stewart et al., 2004). Goodman, Saxe, and Harvey (1991) extend this point, arguing that homelessness itself can be understood as a form of psychological trauma. For youth on the street, the common experience of violence and rejection has repercussions that can lead to or exacerbate negative effects of trauma.

Schneir and colleagues (2007), working for the National Child Traumatic Stress Network, cite studies (Robertson & Toro, 1999; Ryan, Kilmer, Cauce, & Hoyt, 2000) that support the findings of other researchers (Karger & Stoesz, 1998; Page & Nooe, 1999; Van Wormer, 2003) who indicate that homeless youth have developed a variety of mental health problems that constrain their ability to cope effectively with life's challenges. Several studies indicate that for many homeless youth, mental health concerns appeared before homelessness (Kamieniecki, 2001; Morrell-Bellai, Goering, & Boydell, 2000), and are manifested in studies of youth who are homeless (Page & Nooe, 1999; Powers et al., 1990; Safyer, Thompson, Maccio, Zittel-Palamara, & Forehand, 2004). Mental health concerns experienced by youth before becoming homeless can be exacerbated

by the trauma of street life. Further, Kamieniecki (2001) found a high rate of psychiatric disorders among homeless youth and this rate tended to increase the longer one was homeless. This is consistent with a number of other studies of homeless adults, which found a high prevalence of abuse and mental health problems that began in childhood (Coates & Neate, 2000; Herman, Susser, Struening, & Link, 1997; Koegel et al., 1995; Morrell-Bellai et al., 2000).

Post-traumatic stress disorder (PTSD) is one such mental health construct commonly referenced in the literature as a consequence of highly stressful experiences. Exposure to traumatic events can result in high levels of distress that may lead to the development of PTSD (see Volpicelli, Balaraman, Hahn, Wallace, & Bux, 1999), which has been defined as an often chronic and debilitating psychological disorder characterized by intrusive memories of trauma, increased avoidance and interpersonal difficulties, and increased psychological arousal (American Psychiatric Association, 1994). Critics, however, have cautioned that this psychiatric classification emphasizes pathology and can therefore stigmatize individuals (Burstow, 2003; Morrissette, 1999; Ussher, 1999). This medicalized construction of trauma distracts attention from the potential social and political roots of the problem and experiences of oppression. As such, PTSD has been described as "a grab bag of contextless symptoms, divorced from the complexities of people's lives and the social structures that give rise to them" (Burstow, 2003, p. 1296).

As a result of youth experiencing multiple and prolonged stressors both before and once homeless, the PTSD construct alone may not provide an adequate understanding of the experiences of homeless youth. Some writers have concluded that these conditions have cumulative effects, creating a "pervasive social vulnerability and instability" (Ziesemer et al., 1994, as cited in Page & Nooe, 1999, p. 256). Anglin (2003) highlights this reality most clearly when he states that homeless youth experience "deep and pervasive pain" that is often denied by adults and caregivers. Anglin argues that caregivers and researchers must broaden their focus beyond just "managing behavior" to address the challenge of what he refers to as "pain-based behavior"—behavior that is an externalization of deep-seated pain—

a pain that can be associated with the experience of trauma. Trauma, for example, can violate a youth's basic trust, disrupt attachment, and diminish feelings of self-worth. These factors frequently hinder the development of interpersonal boundaries and reduce socially accepted behaviors. This sensitivity to threat can lead to impaired social competence and intolerable emotions such as intense fear or sadness that may contribute to substance abuse, suicidal ideation, suicide attempts, and other risky behaviors. Trauma can also foster an instant gratification orientation and diminish regard for delayed consequences or future plans (Clarke et al., 1997). Given the complex and tumultuous social realities of this population, it may be more effective to assess these behaviors based on an understanding of homeless youth trauma as cumulative and dimensional rather than categorical (see Davis, 1999).

Not only is our understanding of the phenomenon of trauma in the lives of homeless youth influenced by this more contextualized assessment, but so too is our understanding of the needs and potential solutions for youth. It is important to keep in mind that many factors contribute to trauma, and service providers should be cautious not to reduce the cause of youth homelessness primarily to a personal predisposition or vulnerability. With research indicating that the majority of homeless youth fled or were pushed out of abusive homes, youth homelessness might more correctly be understood as a coping strategy. The subsequent 'life on the street,' however, may result in exposure to additional risk factors (such as poverty, physical and sexual abuse, crime and violence), some of which are likely to be traumatagenic. With greater understanding of the reality of trauma in the lives of homeless youth, shelters and youth services may be able to play a more effective role in enabling youth to recover from trauma, thereby preventing more serious and long-term personal and social difficulties.

Methodology

Participants in this study were youth from the Maritime provinces who had been homeless for at least one day in the previous twelve months, and who volunteered to participate. The parameters of this definition of homelessness are admittedly broad with regard to potential complexity and duration

of youths' experiences of homelessness, because an inclusive range of homeless experiences was sought. The research team had settled upon this definition, anticipating the potential need to compare and contrast findings between those with relatively brief homeless experiences and those whose experiences were more complex and extended. Such a comparison, however, was unnecessary. While there was heterogeneity of youths' degree of street entrenchment and their living situations, almost no participants described a brief and relatively 'straightforward' homeless experience. With regard to participants' experiences needing to have occurred 'in the previous twelve months,' the research team set this parameter in order to focus on recent experiences of homelessness, increasing the likelihood that youths' memories of this time would be quite clear and continuing effects of relevant highly stressful experiences could be assessed.

Youth who participated expressed an interest to participate upon viewing a flyer posted at youth drop-ins or were referred by agencies, such as outreach and residential services that targeted homeless youth. At the time of the interviews, the majority of participants lived in major urban centers in the region, and their participation was complimented by that of a small number of youth who were living in rural areas of New Brunswick and Prince Edward Island.

Each participant took part in a semi-structured interview with a trained interviewer (BSW or MSW graduates). The interview required one to two hours to complete. As several of the instruments were designed to be self-administered, all youth were given the option of completing them on their own or having the interviewer administer the questionnaires orally. Almost all youth preferred to have the questions read to them. Respondents were reimbursed $20 for participating. Ethics approval was received from the Research Ethics Board of St. Thomas University. For comparative purposes, the Trauma Symptom Inventory (TSI) was administered to a sample of first year university psychology students.

The semi-structured interview schedule was developed from a review of the literature on trauma, and homeless and 'at risk' youth. This review revealed the use of various methodologies such as self-report, interview and caregiver reports (see, for example, Meichenbaum, 1994, 2000; Newman, 2002;

Page & Nooe, 1999; Swenson et al., 1996), and risk factors such as poverty, parental addiction, incidence of runaway attempts, physical and sexual abuse, family disengagement, length of time homeless, and experience in foster care (see, for example, Anderson & Imle, 2001; Greenwald, 2002; Janus et al., 1995; Kamieniecki, 2001; Morrell-Bellai et al., 2000; Simons & Whitbeck, 1991; Sullivan & Knutson, 2000; Van Wormer, 2003). The completed interview schedule was reviewed by a small number of experts (frontline workers, youth who had been homeless, and researchers of youth homelessness) to assess the instrument's face validity.

The questionnaire was composed of survey instruments including an adapted version of the Trauma History Questionnaire (THQ) (Green, 1996), and the Trauma Symptom Inventory (TSI) (Briere, 1995), along with questions regarding demographic information and questions regarding youths' experiences prior to becoming homeless (such as foster care, being forced from their home, and couch surfing).

The *Trauma History Questionnaire* (THQ), developed by Green (1996) for a general or clinical population, provides a history of exposure to potentially traumatic events that may meet the stressor criterion for posttraumatic stress disorder. While some standardized self-report measures of trauma exposure (such as the Traumatic Stress Schedule, Norris, 1990) offer more restricted definitions of potentially traumatic events, the THQ uses a broader definition, including a range of both traumatic and stressful life events, and aims to provide comprehensive trauma histories. Green (1996) collected reliability data from 25 female participants, all of whom were tested twice over a two- to three- month interval. Test-retest correlations ranged from .54 to .92. As evidence of the questionnaire's validity, scale means were found to be higher in an outpatient sample than a university sample (see Norris & Hamblen, 2004, for further details).

The original THQ instrument had 24 items addressing the lifetime occurrence of a variety of traumatic events in three categories: crime, general disaster/trauma, and sexual and physical assault experiences. For each event endorsed, respondents of the THQ are asked to document frequency of occurrence of the event and their age at the time of occurrence. As Green

herself notes, the THQ is a "relatively complete" inventory of events (1996). Our research team made the decision to remove two items (e.g., "serving in combat," as this has less relevance in Canada) and to add a small number of events that have also been recognized as potentially traumatic and which are not uncommon amongst youth (e.g., having been bullied by peers) (our adapted THQ had a total of 29 event items). One further adaptation was made for our purposes—the adapted THQ asked participants to indicate whether the event had occurred before and/or since becoming homeless. This addition to the THQ was important to allow the research team to ascertain the range of highly stressful experiences both before and since becoming homeless. A sampling of the experiences addressed in the adapted THQ is listed in Table 3. Participants could also report other events that they considered to be highly stressful.

The *Trauma Symptom Inventory* (TSI), developed by John Briere (1995), is a widely used assessment tool for use with those who have experienced various forms of trauma. It is a global measure of trauma sequelae. As such, symptom items are not linked to a specific event (Briere, 1996). The TSI assesses trauma related symptoms through 100 questions that provide 10 clinical scales (Anxious Arousal, Depression, Anger/Irritability, Intrusive Experiences, Defensive Avoidance, Dissociation, Sexual Concerns, Dysfunctional Sexual Behavior, Impaired Self-Reference and Tension Reduction Behavior). Each scale is scored by adding the responses to 8-9 questions; the response to each question is in a Likert format (0-3: never-often).

The TSI has consistently demonstrated acceptable internal consistency (alpha .74-.91) and has been standardized across several populations (see Runtz & Roche, 1999). Raw scores can be converted to standard (T-Scores) with a mean of 50 and a standard deviation of 10. Briere (1995) argues that individuals with a standardized score above 65 are showing negative effects of trauma.

The analysis was quantitative and included descriptive statistics to report demographic information and the frequency of responses on the THQ. T-tests (independent samples) were used to compare the total number of stressful experiences (THQ) before and since first becoming homeless, and to compare the scores on the TSI scales of homeless youth and

university youth. An ANOVA was used to compare the low, moderate and high scale scores on the TSI when scores were standardized (see Briere, 1995).

Findings

Demographics

One hundred and three youth responded to the survey, of which 102 interviews were usable for the purposes of this study. Table 1 presents relevant demographic information. The participants revealed various ages when they first became homeless (7% first experiencing homelessness at the age of 12-13, although the mean age was 16 years).

While 90% of the respondents were from the Maritime provinces, the majority of the respondents were not from the city where they were interviewed. For example, 45 youth lived in Moncton, 25 in Halifax and 11 in Fredericton, but only 17, 8 and 6 respectively, were originally from those cities. Consistent with anecdotal information from service agencies, the data indicates that youth move to larger urban centers where some services are available.

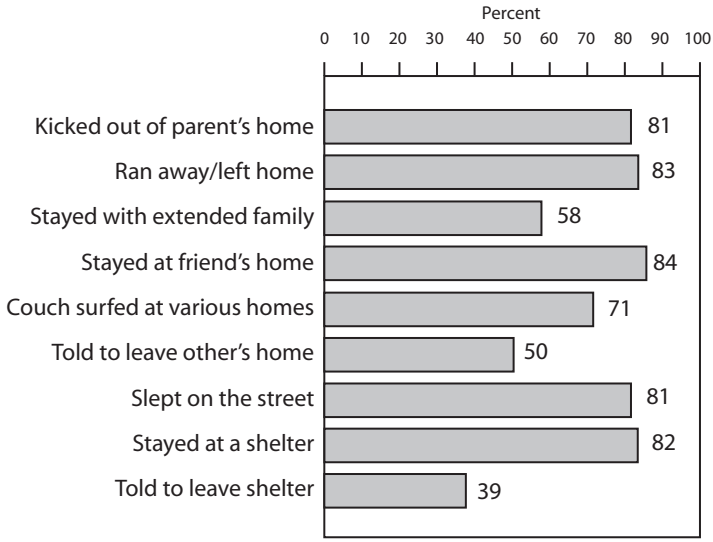
Experiences with Living Arrangements

For the majority of homeless youth in this study, their journey into homelessness was marked by a series of varied and unstable living arrangements (see Figure 1). Youth frequently experienced a "back-and-forth movement" among various family members and friends on their way toward more long-term experiences of homelessness. While the data does not enable us to report any particular sequence, the data does indicate that for the large majority of the youth, homelessness was not the product of a single event, nor did it lead immediately to the streets. Rather, homelessness for most of the youth resulted in a number of different living arrangements that reflected the use, and perhaps even the "burning out," of their available social networks. On average, a youth experienced 6 of the 9 living arrangements listed, reflecting a pattern of unstable and diminishing options.

Table 1. Demographic Information (N=102)

	Male	Female	Total
Gender	66	36	102
Age range	16-24	16-24	
From Maritimes	58	30	88 (88%)
Completed High School	8	11	19 (19%)
Had difficulty with law	46	16	62 (60%)
Been in foster care	30	11	41 (40%)
Been in sex trade	8	8	16 (16%)
Currently employed in some capacity	19	9	28 (27%)
See self as currently homeless	33	15	48 (45%)
First experience of homelessness before or during their 16th year of age	39	24	63 (62%)

Figure 1. Have you experienced any of the following? (N=102)



Two excerpts from interviews typify the erratic nature of living arrangements that were articulated by most participants:

> I never knew my dad, I just know his name. I was removed from my mom's care when I was 2, and went into foster care until I was 12. I went from group home to group home. I learned a lot of street smarts—how to survive. My last place was living on my own, I had a 2-bedroom apartment. I partied too much, and got evicted. I had the apartment for 5 months. I'm not in touch with any family. I'm trying to get a job. ('Jim,' age 23)

> I grew up in (rural community). When I was 17, my mom brought me to a shelter. She couldn't afford to keep me. I stayed at the shelter, and then back home for a while. Then back to Halifax again, spent a week on the street, went to (shelter) for one night, got into a place to stay. I was kicked out for smoking in my room. I came back to the shelter, then went back to my mom's place until recently. I came back to the shelter because I want to be back in the city. ('Mike,' age 19)

Stressful Events

Responding to the Trauma History Questionnaire (adapted), youth reported having experienced numerous and varied highly stressful events during their lives. Table 2 indicates the proportion of respondents who reported having encountered each of the highly stressful experiences.

Of particular note is the very high incidence of being bullied (78%), facing isolation (63%), being assaulted (61%), and fearing being killed or injured (61%). The experience of, and witnessing of, physical abuse within the family is also very high (58% and 55% respectively). In addition to these 'high incidence' events, it is important to emphasize that a large proportion of the youth faced very severe situations—almost half had been assaulted with a weapon, 40% faced serious injury, one-third had been sexually abused, over 30% had been mugged, and almost one quarter had been raped.

Table 2. Proportion of Youth Who Reported Stressful Experiences (*N=102*)

	Male *n=66*	Female *n=36*	Total *N=102*
Bullied	49 (74%)	31 (86%)	80 (78%)
You or someone close to you experienced a life-threatening event	49 (74%)	31 (86%)	80 (78%)
Stressful isolation	40 (61%)	24 (67%)	64 (63%)
Been assaulted without a weapon	42 (64%)	20 (56%)	62 (61%)
Feared being injured or killed	41 (62%	21 (58%)	62 (61%)
Been physically abused by a family member	39 (59%)	20 (56%)	59 (58%)
Witnessed physical abuse by a family member	33 (50%)	23 (64%)	56 (55%)
Witnessed death or injury	35 (53%)	19 (53%)	54 (53%)
Serious accident	35 (53%)	13 (36%)	48 (47%)
Been assaulted with a weapon	36 (55%)	11 (31%)	47 (46%)
Stressful school experience	32 (49%)	14 (39%)	46 (45%)
Family member or close friend killed or injured	30 (46%)	13 (36%)	43 (42%)
Serious injury	31 (47%)	10 (28%)	41 (40%)
Robbed	31 (47%	5 (14%)	36 (35%)
Sexually abused by someone outside the family	14 (21%)	20 (56%)	34 (33%)
Mugged	28 (42%)	4 (11%)	32 (31%)
Trouble with the law	27 (41%)	9 (25%)	36 (35%)
Forced to touch another sexually	11 (17%)	21 (58%)	32 (31%)
Experienced abortion or miscarriage	13 (20%)	17 (47%)	30 (29%)
Home broken into	19 (29%)	11 (31%)	30 (29%)
Forced to have sex	4 (6%)	20 (56%)	24 (24%)
Felt high stress as a perpetrator	17 (26%)	6 (17%)	23 (23%)
Human disaster	19 (29%	4 (11%)	23 (23%)
Serious illness	14 (21%)	7 (19%)	21 (21%)
Forced into other unwanted sexual acts	6 (9%)	15 (42%)	21 (21%)
Natural disaster	13 (20%)	5 (14%)	18 (17%)
Handled dead bodies	15 (23%)	2 (6%)	17 (17%)
Sexually abused by a family member	8 (12%)	9 (9%)	17 (17%)
Another stressful event	19 (29%)	16 (44%)	35 (34%)

Thirty-four youth responded to the 'other stressful experience' question—the majority of responses to this question reflected more pervasive stressful realities—such as their

children being taken into care, missing family, life on the street, life with parents, addiction, and one's "whole life (as) hell." The small number of specific stressful events reported appear to be those that continue to be emotionally bothersome—for example, gang rape, assault, injury, death of a loved one.

Stressful Events—Before and After First-Time Homeless

For both males and females, the numbers of stressful experiences were high (13.5 on average), and similar in their prevalence: 13.8 (males) and 13.3 (females) overall. As well, the number of stressful experiences before becoming homeless was similar to the number of stressful events that were experienced after becoming homeless: 7.0 and 6.4 respectively (see Table 3). Table 3 also reveals no significant differences between males and females regarding the overall incidence of stressful experiences before and since becoming homeless.

Table 3. Mean Number of Stressful Events Before and After First Time Homeless (*N=102*)

	Male *n=36*	Female *n=66*	df	T-value **ns*
Before homeless	7.1	7.0	100	.161*
SD	4.227	3.794		
Since homeless	6.2	6.8	100	-.650*
SD	3.849	4.251		
Total	13.3	13.8	100	-.302*
SD	6.571	6.133		

Despite the fact that many youth left home to escape stressful events, the street held its own significant stressors—almost equal in number. However, as Table 4 reveals, the nature of the trauma-inducing events shifted considerably once youth became homeless.

Table 4 reveals several of the stressful events reported by youth. The extremely high incidence of bullying that was encountered by both female and male participants was most common before becoming homeless. Many forms of sexual and physical violence, reflected in most of the first seven items, decreased overall after becoming homeless. The exception to this trend, however, involved the high prevalence of females'

experiences of varied forms of sexual violence by non-family members (rape; sexual abuse by a non-family member; forced sexual touching), which continued after they became homeless. As well, experiences of physical assault continued to be very prevalent in both men's and women's experiences after

Table 4. Stressful Experiences Before and After First Becoming Homeless

Trauma Event	Before Homelessness		Since First Being Homeless	
	Males	Females	Males	Females
Rape	4	12	0	11
Family/Close friend killed or injured	21	7	11	6
Sex abuse by family	8	8	0	3
Sex abuse, non-family	11	12	2	11
Forced sexual touching	10	15	1	12
Physically abused by family	38	19	8	5
Bullied	49	30	12	9
Serious accident	22	15	8	6
Mugged	10	1	22	3
Break-in	7	0	26	5
Assaulted with and without a weapon	43	35	38	26
Abortion/Miscarriage	1	2	12	16
Feared being killed	17	8	33	17

becoming homeless. The incidence of other forms of violence and threats of violence (muggings, break-ins, fears of being killed) was considerably higher after becoming homeless, particularly for male participants. Overall, the data indicates

that homelessness brought a shift as family violence was replaced by street violence. One other highly stressful event noted by participants, the increase in abortion after becoming homeless, seems to be reflective of a shift in living arrangements. It is also worth noting that a number of males identified experiencing their girlfriend having an abortion as a personally traumatic event.

Current Negative Effects of Trauma

The Trauma Symptom Inventory (TSI) was administered in the interviews, as it is a widely accepted and administered indicator of the negative effects of trauma. The raw scores for each of the 10 scales range between 0-27, with higher scores suggesting progressively more severe current negative effects.

Table 5. Comparison of Negative Effects Scale Scores

TSI Scales	University Youth-1999* *N=770*	Physically Maltreated as a child *N=152	Homeless Youth *N=101*
Anxious arousal	9.8	11.4	13.8
Depression	8.6	10.5	13.2
Anger/Irritability	10.3	11.5	16.5
Intrusive exp.	6.8	9.0	13.4
Defensive avoidance	8.4	11.0	15.2
Dissociation	8.4	10.4	13.0
Sexual concerns	5.6	7.4	7.1
Prob. sexual bhvr.	4.2	5.5	7.6
Impaired self-reference	10.9	12.9	13.9
Tension reduction bhvr.	4.4	5.3	8.3

* Reported in Runtz and Roche, 1999.

Table 5 compares the raw scores of a sample of female University students and a sample of female University students who reported having been physically maltreated as

children (both reported by Runtz & Roche, 1999), and the homeless youth participants of this study. The sample of homeless youth scored substantially higher than the other two groups on all TSI scales, even higher than the sample who reported having experienced physical maltreatment as children.

Table 6. Mean of Scale Scores of Current Negative Effects

TSI Scales	Homeless Youth *N=101*	University Youth 2008 *n=104*	df	T-value
Anxious arousal	13.8	8.6	190	-6.8*
SD	6.1	4.8		
Depression	13.2	6.4	182	-8.2*
SD	6.8	4.9		
Anger/Irritability	16.5	8.9	198	-8.371*
SD	7.0	6.1		
Intrusive exp.	13.4	5.6	174	-10.493*
SD	6.4	4.3		
Defensive avoidance	15.2	7.4	205**	-10.764*
SD	5.3	5.3		
Dissociation	13.0	6.9	185	-7.438*
SD	6.9	5.0		
Sexual concerns	7.1	3.4	139	-5.311*
SD	6.6	3.1		
Prob. sexual bhvr.	7.6	3.4	164	-5.223*
SD	7.1	4.4		
Impaired self-reference	13.9	8.4	192	-6.522*
SD	6.6	5.4		
Tension reduction bhvr,	8.3	3.4	155	-7.731*
SD	5.6	3.2		

Note: **equal variances, *p<.001

Table 6 compares the TSI scores of the homeless youth in this study to a mixed-gender group of first-year undergraduate university students (conducted by the authors in 2008). The differences in scale scores were even larger than those reported in Table 5, and all differences were statistically significant ($p < .001$). The severity of the negative effects may be due to high levels of physical and sexual abuse experienced by youth in

the current sample, as a study by Kurtz and colleagues (1991) revealed that youth who had been maltreated experienced more personal and social problems than youth who had not been maltreated.

Raw scores on TSI Scales, as explained previously, range from 0 to 27, and the standardized scores on each scale have a mean of 50 and a standard deviation (*SD*) of 10. Following the methodology outlined by Briere (1995), the standardization has produced three zones with the low and high score groups each 1.5 *SD* above or below the mean (1.5 *SD* -/+ X). A 'low' group is made up of participants with a mean of 0-34, a 'moderate' group includes those with means between 35 and 64, and a 'high' group includes those with means of 65 and above. According to Briere (1995), respondents who score 65 or above are "clinically significant" and "indicate greater degrees of symptomatology" (p. 11). Briere points out that a T-score of 70 indicates that an individual's score is higher than 98% of the standardization sample. Table 7 presents the raw scores of the homeless youth after they have been separated into the standardized scores for the TSI scales. It offers the results of an ANOVA and indicates significant differences ($p < .001$) across the groups. Each column reports the mean (x) and the number of youth (n) in each group. Most relevant to our study, for the majority of the scales, approximately half or more of our homeless youth participants scored in the high or "clinically significant" group. Sexual concerns and problematic sexual behavior did not score as high for a majority of these youth.

It is important to note that in Table 7 there was no statistically significant difference in scale scores for youth within the current study based on: having experienced foster care; duration of time in foster care; or the number of foster homes. However there are small negative correlations with half of the TSI scales and 'age when a youth was first homeless,' indicating that there tend to be higher TSI scale scores, the younger a participant was when first becoming homeless (AA -.27, D -.23, AI -.20, ISR -.25, TRB -.22) ($p < .01$, N=101) . Similarly, a small negative correlation (-.17, $p < .05$) was found between age when first homeless and number of highly stressful events experienced.

Discussion

Stressful or traumatic experiences were pervasive in the lives of youth participants both before and after becoming

Table 7. Frequency and Means of Standardized TSI Scores for three groups (n=101)

TSI Scales	Overall Mean	Low 0-34 x n	Moderate 35-64 x n	High 65-100 x n	ANOVA F
Anxious arousal	14	4 / 13	11 / 41	19 / 47	195.4
Depression	13	3 / 14	10 / 42	19 / 45	212.7
Anger/Irritability	17	5 / 16	13 / 31	22 / 54	343.7
Intrusive exp.	13	2 / 9	9 / 39	19 / 53	170.5
Defensive avoidance	15	4 / 8	12 / 41	19 / 52	201.7
Dissociation	13	2 / 12	9 / 34	18 / 55	132.0
Sexual concerns	7	1 / 40	8 / 38	22 / 17	251.6
Prob. sexual bhvr.	8	.5 / 34	6 / 23	14 / 43	133.4
Impaired self-reference	14	2 / 9	10 / 39	19 / 53	157.3
Tension reduction bhvr.	8	1 / 18	5 / 28	13 / 54	152.0

Note: Sig. for all = p<.001

homeless. While this finding corroborates results of previous studies (Gwadz et al., 2007; Stewart et al., 2004; Whitbeck, Hoyt, & Ackley, 1997; Wolfe, Toro, & McCaskill, 1999), the current research extends our understanding of the breadth and impact of these stressful experiences in their lives. The stressful experiences faced by these youth are numerous, wide-ranging and severe. Youth were confronted with, on average, 11-12 different forms of potentially traumatic events, approximately half of them before, and the other half after, becoming homeless. Youth left or were forced out of homes where most had experienced extensive trauma, only to find themselves experiencing severe and multiple forms of trauma 'on the street.' Sadly, the National Child Traumatic Stress Network (Schneir et al., 2007)

notes that the struggles of the street are, for many youth, better than the negative treatment they had experienced at home, or in the child welfare and justice systems.

Supporting previous findings (Gwadz et al., 2007; Powers et al., 1990), the current study concluded that both male and female homeless youth experienced highly stressful events at very high rates. As well, the findings from the current study were similar to previous research indicating that homeless youth experienced high rates of physical violence (Janus et al., 1995). However, in the current study, male homeless youth were found to have experienced more physical types of violence (abuse, assault, muggings, etc.), while females more often experienced violence that was sexual in nature (rape, sexual abuse, unwanted touching, etc.). It is important to point out that while sexual victimization was more prevalent among female youth both before and after becoming homeless, several male youth experienced sexual assault in their homes. The flight from their homes served to shift the types of stressful events that youth experienced; some types decreased after becoming homeless, only to be replaced by other forms of traumatic events. The types of experiences that decreased upon leaving home tended to be forms of sexual and physical abuse, and the extremely high incidence of being bullied. Significantly diminished experiences of being bullied after becoming homeless may be related to the high drop-out rates from high school (78%) that accompanied this (as reflected in Table 1). Youth may be fleeing violence that is occurring in both their homes and schools.

The incidence of physical violence (excluding forms of family violence) remained consistent for male youth and increased for females after becoming homeless. The incidence of sexual violence was consistent both before and after becoming homeless for female youth but all forms of sexual violence decreased for males upon becoming homeless. The increase in other forms of violence (muggings, break-ins, and fears of being killed) was considerably higher for male than for female participants.

A large proportion of homeless youth in this study scored very high on the TSI scales. This is consistent with other studies (Hicks-Coolick, Burnside-Eaton, & Peters, 2003; Kamieniecki,

2001) that reported higher rates of mental illness among homeless youth. Over 50% of the youth scored in the 'severe' group on six of ten scales, and over 43% on all scales but one (sexual concerns). The cumulative impact of the various highly stressful events appears to have contributed to the large number of youth with very high clinically significant TSI scores. Over 50% of homeless youth were currently experiencing severe negative effects of trauma. The impact of the pervasiveness and continuity of stressful experiences is consistent with the findings of Davis (1999), whose research emphasized the importance of considering 'continuously experienced trauma.' Efforts by the youth to escape trauma experienced in their homes and home communities have mixed results. While some types of stress (bullying and various forms of family violence) decreased dramatically, it appears that the source of violence and stress had shifted from home to the street. After becoming homeless, youth continued to face highly stressful events, and the continued negative repercussions were revealed in their high scores on the TSI scales.

Implications

While the focus of this investigation did not involve a direct assessment of current services or approaches available to homeless youth or those at high risk of becoming homeless, findings regarding both the trauma histories and effects of these experiences in the lives of youth who have experienced homelessness offer us a place from which to reflect on practice and policy implications.

In considering potential implications of this research, the need for effective trauma-informed service stands out. With regard to considerations for trauma-informed service, we highlight implications in three areas: therapeutic; programming and organizational practice; and policy/social change. Before exploring implications across these three areas, it is important to return to our conceptualization of trauma.

The study of trauma has been strongly influenced by the domains of psychiatry and psychology, and within these realms the concept has most often been individualized, medicalized, universalized and de-contextualized. As long as the construction of trauma is understood merely as an individual

phenomenon, attention is not paid to potential social and political roots of a problem, forms of oppression, and experiences of families and communities (Brown, 1995; Burstow, 2003; Davis, 1999). Solutions remain limited to the medical and psychological realms, working toward individual recovery rather than addressing individual growth and emancipatory goals toward social change. We require instead a "radical understanding of trauma and trauma work" (Burstow, 2003, p. 1293), one that offers "a more inclusive, critical theory and practice, appreciating the full variety of traumatic reactions, and responses, as well as of contexts within which they are derived" (Davis, 1999, p. 771). It is this latter conceptualization of trauma upon which we base our discussion of needed trauma-informed service.

Therapeutic implications. Many homeless youth experience multiple forms of trauma in the context of negative living conditions (e.g., poverty, social marginalization, dangerous environments, and deprivation), both preceding and during homelessness. The results of having experienced multiple forms of trauma in one's childhood and youth (coined 'complex trauma') have been found to be diverse and serious (Briere, Kaltman, & Green, 2008; Briere & Lanktree, 2008; Briere & Spinazzola, 2005). Research findings link trauma experiences to challenges observed frequently in homeless youth populations. These include addictions, heightened suicide risk, mental health difficulties, lack of trust in relationships, and difficulty creating stable conditions (such as the ability to concentrate in school, or to show up reliably for employment). Linking such challenges to trauma histories allows new attributions to be considered and solutions sought. For example, drug use by homeless youth may be understood as a form of self-medicating in order to manage the distressing effects of trauma (such as anxious arousal) (Kidd & Davidson, 2007; Stuart, Capostinsky, Joyce, Lucier, & Healy, 2006).

The marginalized location of those who have faced multiple traumas in their youth is correlated with difficulties in accessing appropriate services to respond to the effects of trauma. Accessible counselling services staffed by professionals with knowledge and training in responding to youths' experiences of complex trauma (including advocacy and interventions at the system level) is necessary (see Briere and

Lanktree's [2008] guide for the treatment of multiply-traumatized youth). Assisting youth to transition away from coping strategies that heighten health risks and to develop abilities in coping strategies that reduce risk is one important aspect of this work (Briere & Lanktree, 2008; Kidd & Carroll, 2007). Addressing the ways that youth have made meaning of their trauma experiences may also be an important element of this work. One's meaning making after trauma can have powerful effects on identity, sense of self-worth, life course, and relationships. Given common experiences of social stigma and marginalization, homeless youth may need to find ways to "replace internalized messages of guilt and shame with a more empowering understanding of the various factors underlying stigma and systemic discrimination" (Kidd, 2007, p. 298). Therapeutic rewritings of the life narrative may be one adaptive meaning-making process, assisting youth in establishing new understandings of self, relationships and beliefs that create hope and possibility (Kidd & Davidson, 2007). Approaches such as this may assist in transforming dominant blaming discourses in their explanation of youth homelessness. This process of rewriting the life narrative may be a liberating experience that could be incorporated into experiential forms of therapy such as performing theater or completing creative writing exercises. As Karabanow and Clement (2004) note in their review of service delivery approaches that have been provided to homeless youth, forms of experiential therapy can be motivating and recognize youths' potential.

Programming and organizational implications. Responding to the negative effects of trauma in the lives of homeless youth is infrequently a focus of programming. Those creating services for this population must become more versatile, so that interventions can be "tailored to an individual youth's circumstances" and needs (Kidd, Miner, Walker, & Davidson, 2007). While not all homeless youth are coping with distressing effects of trauma, many are. Effects of complex trauma are often severe and can undermine other efforts that youth may be undertaking to bring stability and security to their lives. Programming has not adequately targeted this need of many homeless youth, and without greater investment in such programs, other programming efforts are less apt to succeed.

Common barriers to moving off the street (such as drug use, mental health issues, and challenges in readjusting to a routinized lifestyle) (Karabanow, 2004a), can be linked to trauma effects. These understandings can be helpful in shaping organizational policies. For example, most shelters do not promote a harm reduction model. If a youth is using drugs to manage severe negative effects of trauma, it often takes time and the assistance of a counsellor to replace this coping strategy with more effective alternatives. In the meantime, the youth requires safe and secure shelter, and a harm reduction policy would be more inclusive and responsive to her/his needs.

Communities also need to offer longer-term safe and supportive programs (such as second stage housing) that create space for youth to establish stability in their lives as they address the effects of trauma. Such programming will, in turn, support youth to improve various elements in their lives (such as schooling, employment, and relationship issues). Karabanow (2004b) notes Toronto's Covenant House and Phoenix Youth Services in Halifax as progressive programs, both of which offer partially-independent supportive housing.

Preventive care options as part of child welfare services must be made a priority. Earlier interventions to assist families, and support and care programming for those youth who are exiting group homes or the foster care system are needed to minimize risks that these youth will become homeless. In November 2008, New Brunswick's Child and Youth Advocate Report Card offered the grade of C+ to the province's response to child welfare, highlighting the dearth of youth transition homes and services for 16- to 18-year-olds, and calling for much greater effort in this area.

Overall, agencies that are offering services to homeless youth or youth at-risk of becoming homeless must work to become effective "trauma-informed agencies" (Prescott, Soares, Konnath, & Bassuk, 2008). In their guide for creating trauma-informed services for those experiencing homelessness, Prescott and her colleagues (2008) recommend the adoption of organizational guidelines, such as: creating physical environments that are safe; developing policies and procedures based on the assumption that some service users will be managing the effects of trauma and working to minimize related

barriers to service; reviewing current policies and practices to ensure that they do not re-traumatize service users; establishing services that offer caring, long-term relationships and ongoing crisis prevention activities; and providing training on trauma-informed care.

Policy and social change implications. Of course, therapeutic and programming recommendations noted in the previous two sections are only possible with adequate funding, and public and structural supports. Currently, numerous structural factors limit youths' choices, and thus trauma-informed interventions must include assessment of political and social roots of the problem, advocacy work, and empowerment and social change strategies. Funding cutbacks have depleted services for homeless youth, and with meager resources available, most programming is limited to responding to youths' basic needs. There are urgent calls for "a more comprehensive service response based on a better understanding of the complex problems associated with life on the street," with an emphasis on "continuity in the delivery of consistent, caring and long-term support" (Kelly & Caputo, 2007, pp. 734-735). Such continuity of service is only possible with adequate and stable funding.

Serious gaps in the social service delivery system play a role in youths' trauma experiences. Rather than investing in proactive, collective interventions aimed at primary prevention of family difficulties to assist in diminishing early trauma experiences for youth, programs are mainly reactive, deficits-based and professional-driven. Gaps in services to youth aged 16-18 also contribute to instability and homelessness in youths' lives, which heightens their risk of further trauma. Alternatives must be explored, as our system is failing many youth. Responding to the significant gaps in the current social service delivery system, Prilleltensky and Prilleltensky (2006) highlight the value of developing programs that are strengths-based, and are committed to primary prevention, empowerment, and community conditions. Karabanow (2004b) also articulates and recommends a number of characteristics of anti-oppressive organizations to best serve homeless youth, which include elements of: a structural definition of the situation; consciousness-raising; locality development; social development; and social action. These elements highlight the

need for a re-storying of the causes of youth homelessness and the active involvement of youth in working for structural changes.

Implications for future research. In considering useful directions for future research, we suggest several areas worth pursuing. Exploring means for earlier identification of youth with needs related to trauma in their lives would be of value. As well, we have the potential to further develop and strengthen our current initiatives by evaluating the effectiveness of existing longer-term, supportive services that focus on mental health and social stability with homeless youth or those at risk of becoming homeless.

Our research design drew heavily upon standardized measures, and while helpful for our purposes, we would benefit by listening intently to youths' stories and their ideas regarding how we can best address the effects of trauma in their lives. The exploration of youths' changing meanings and ideas surrounding survival and resilience before and while homeless would assist scholars and practitioners in considering strategies to help overcome dominant discourses that blame homeless youth for their circumstances. A client-driven approach that invites youths' active involvement in planning services and interventions is imperative, and will assist professionals in overcoming or minimizing barriers for youth in accessing these services.

Conclusion

While much of the research conducted on youth homelessness in Canada has occurred in large urban centers in central and western Canada, the undertaking of research in the Atlantic provinces in more recent years is beginning to shed light on the experiences of homeless youth in this region (see, for example, Asher, 2007; Coates & Neate, 2000; Karabanow, 2004a). The current study contributes to this emerging regional knowledge base, as we attempt to better understand the experiences and potential needs of homeless youth. With a concern based not only on the individual but also on the social, the current study is politically grounded in its desire to deconstruct relations of power and in its attempt to inform the continuing efforts for

improved services for youth who are homeless or at risk of becoming homeless. This study supports the growing body of research that indicates that trauma is pervasive in the lives of youth, both prior to and during homelessness. Most importantly, this study reveals that the consequences of such trauma are both serious and ongoing. These findings direct us to look beyond the short-term services that focus on shelter, training and employment which, while helpful for some youth, are inadequate for most. To be effective, shelters and services must be structured to enable youth to address trauma-induced issues.

References

Alliance to End Homelessness Ottawa. (2005). *Homelessness report card*. Retrieved from http://intraspec.ca/Report_Card_on_Homelessness_in_Ottawa_2004.pdf.

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

Anderson, D., & Imle, M. (2001). Families of origin of homeless and never-homeless women. *Western Journal of Nursing Research, 23*, 394-413.

Anglin, J. (2003). A comment on working with homeless children and youth: Dealing with the "inside" of "acting out." *Child and Youth Care Forum, 32*, 245-247.

Asher, K. (2007). *Youth homelessness in Saint John.* Unpublished manuscript.

Ayerst, S. L. (1999). Depression and stress in street youth. *Adolescence, 34*, 567-576.

Briere, J. (1995). *Trauma symptom inventory: Professional manual.* Lutz, FL:Psychological Assessment Resources, Inc.

Briere, J. (1996). Psychometric review of Trauma Symptom Inventory (TSI). In B. H. Stamm (Ed.), *Measurement of stress, trauma, and adaptation* (pp. 381-383). Lutherville, MD: Sidran Press.

Briere, J., Kaltman, S., & Green, B. (2008). Accumulated childhood trauma and symptom complexity. *Journal of Traumatic Stress, 21*, 223-226.

Briere, J., & Lanktree, C. (2008). *Integrative treatment of complex trauma for adolescents (ITCT-A): A guide for the treatment of multiply-traumatized youth*. Retrieved from http://www.johnbriere.com/Adol%20Trauma%20Tx%20Manual%20-%20Final%208_25_08.pdf.

Briere, J., & Spinazzola, J. (2005). Phenomenology and psychological assessment of complex posttraumatic states. *Journal of Traumatic Stress, 18*, 401-412.

Brown, L. (1995). Not outside the range: One feminist perspective on psychic trauma. In C. Caruth (Ed.), *Trauma: Explorations in memory* (pp. 100-112). Baltimore: The John Hopkins University Press.

Burstow, B. (2003). Toward a radical understanding of trauma and trauma work. *Violence Against Women, 9*, 1293-1317.

Clarke, D., Pollock, N., Bukstein, O., Mezzich, A., Bromberger, J., & Donovan, J. (1997). Gender and comorbid psychopathology in adolescents with alcohol dependence. *Journal of the American Academy of Child Psychiatry, 36*, 1195-1203.

Coates, J., & Neate, D. (2000). *No place at the table: A study of homelessness in Fredericton*. Fredericton, NB: Ministry of Human Resource Development.

Daly, G. (1989). Homelessness and health: A comparison of British, Canadian and U.S. cities. *Cities, 6*(1), 22-38.

Davis, H. (1999). The psychiatrization [sic] of post-traumatic distress: Issues for social workers. *British Journal of Social Work, 29*, 755-777.

Farber, E., McCord, D., Knast, C., & Baum-Faulkner, D. (1984). Violence in families of adolescent runaways. *Child Abuse and Neglect, 8*, 295–299.

Farge, B. (1989). Homeless women and freedom of choice. *Canadian Journal of Community Mental Health, 8*(1), 135-145.

Gaetz, S., Tarasuk, V., Dachner, N., & Kirkpatrick, N. (2006). "Managing" homeless youth in Toronto: Mismanaging food access and nutritional well-being. *Canadian Review of Social Policy, 58*, 43-61.

Goodman, L., Saxe, L., & Harvey, M. (1991). Homelessness as psychological trauma: Broadening perspectives. *American Psychologist, 46*, 1219-1225.

Green, B. (1996). Psychometric review of Trauma History Questionnaire. In B. H. Stamm & E. M. Varra (Eds.), *Measurement of stress, trauma and adaptation* (pp. 366-369). Lutherville, MD: Sidran.

Greenwald, R. (2002). *Trauma and juvenile delinquency: Theory, research, and interventions*. Binghamton, NY: Haworth Press. Co-published simultaneously as *Journal of Aggression, Maltreatment and Trauma, 6*(11).

Growing Home: Housing and homelessness in Canada Conference (2009). Retrieved from http://www.nhc2009.ca/.

Gwadz, M., Nish, D., Leonard, N., & Strauss, S. (2007). Gender differences in traumatic events and rates of post-traumatic stress disorder among homeless youth. *Journal of Adolescence, 30*, 117-129.

Herman, D., Susser, E., Struening, E., & Link, B. (1997). Adverse childhood experiences: Are they risk factors for adult homelessness? *American Journal of Public Health*, *87*, 249-255.

Hewitt, J. (1994). *Homelessness and the criminal justice system in Canada: A literature review*. Ottawa, ON: Department of Justice Canada.

Hicks-Coolick, A., Burnside-Eaton, P., & Peters, A. (2003). Homeless children: Needs and services. *Child and Youth Care Forum, 32*, 197-210.

Hwang, S. (2001). Homelessness and health. *Canadian Medical Association Journal, 164*, 229-234.

Janus, M., Archambault, F., Brown, S., & Welsh, L. (1995). Physical abuse in Canadian runaway adolescents. *Child Abuse and Neglect, 19*, 433-447.

Janus, M., McCormack, A., Burgess, A., & Hartman, C. (1987). *Adolescent runaways: Causes and consequences*. Lexington, MA: Lexington Books.

Kamieniecki, G. (2001). Prevalence of psychological distress and psychiatric disorders among homeless youth in Australia: A comparative review. *Australian and New Zealand Journal of Psychiatry, 35,* 352-358.

Karabanow, J. (2004a). *Exploring salient issues of youth homelessness in Halifax, Nova Scotia*. Unpublished manuscript.

Karabanow, J. (2004b). Making organization work: Exploring characteristics of anti-oppressive organizational structures in street youth shelters. *Journal of Social Work, 4*, 47-60.

Karabanow, J., & Clement, P. (2004). Interventions with street youth: A commentary on the practice-based research literature. *Brief Treatment and Crisis Intervention, 4*, 93-108.

Karger, H., & Stoesz, D. (1998). *American social welfare policy: A pluralist approach* (3rd ed.). New York, NY: Longman.

Kelly, K., & Caputo, T. (2007). Health and street/homeless youth. *Journal of Health Psychology, 12*, 726-736.

Kidd, S. (2003). Street youth: Coping and interventions. *Child and Adolescent Social Work Journal, 20,* 235-261.

Kidd, S. (2007). Youth homelessness and social stigma. *Journal of Youth Adolescence, 36*, 291-299.

Kidd, S., & Carroll, M. (2007). Coping and suicidality among homeless youth. *Journal of Adolescence, 30*, 283-296.

Kidd, S., & Davidson, L. (2007). "You have to adapt because you have no other choice": The stories of strength and resilience of 208 homeless youth in New York City and Toronto. *Journal of Community Psychology, 35*, 219-238.

Kidd, S., Miner, S., Walker, D., & Davidson, L. (2007). Stories of working with homeless youth: On being "mind boggling." *Children and Youth Services Review, 29*, 16-34.

Koegel, P., Melamid, E., & Burnam, A. (1995). Childhood risk factors for homelessness among homeless adults. *American Journal of Public Health, 85*, 1642-1649.

Kurtz, P., Kurtz, G., & Jarvis, S. (1991). Problems of maltreated runaway youth. *Adolescence, 26*, 543-555.

Masten, A., Miliotis, D., Graham-Bermann, S., Ramirez, M., & Neeman, J. (1993). Children in homeless families: Risks to mental health and development. *Journal of Consulting and Clinical Psychology, 61*, 335-343.

McCormick, A. (2004). Running for their lives: The impact of family violence on youth homelessness. *BC Institute Against Family Violence, Fall,* 1-9.

McLaughlin, M. (1987). *Homelessness in Canada: Final report of the national enquiry*. Ottawa, ON: Canadian Council on Social Development.

McLean, L. (2005). *Seeking sanctuary: An exploration of the realities of youth homelessness in Calgary.* Calgary, AB: Broadview Applied Research Group, Inc.

Meichenbaum, D. (1994). *A clinical handbook/practical therapist manual for assessing and treating adults with PTSD*. Waterloo, ON: Institute Press.

Meichenbaum, D. (2000). *Treatment of post traumatic stress disorder in adults: A cognitive-behavioral approach*. Waterloo, ON: University of Waterloo.

Morrell-Bellai, T., Goering, P., & Boydell, K. (2000). Becoming and remaining homeless: A qualitative investigation. *Issues in Mental Health Nursing, 21,* 581-604.

Morrissette, P. (1999). Post-traumatic stress disorder in childhood sexual abuse: A synthesis and analysis of theoretical models. *Child and Adolescent Social Work Journal, 16*, 77-97.

New Brunswick Child and Youth Advocate (2008, November). *Child and youth advocate report card* (Report No. 1). Fredericton, NB: Office of the Ombudsman/Child and Youth Advocate.

Newman, E. (2002). Assessment of PTSD and trauma exposure in adolescents. In R. Greenwald (Ed.), *Trauma and juvenile delinquency: Theory, research, and interventions* (pp. 59-78). Binghamton, NY: Haworth Press.

Norris, F. (1990). Screening for traumatic stress: A scale for use in the general population. *Journal of Applied Social Psychology, 20*, 1704-1718.

Norris, F., & Hamblen, J. (2004). Standardized self-report measures of civilian trauma and PTSD. In J. P. Wilson, T. M. Keane, & T. Martin (Eds.), *Assessing psychological trauma and PTSD* (pp. 63-102). New York, NY: Guilford Press.

North, C., & Smith, E. (1992). Post-traumatic stress disorder among homeless men and women. *Hospital and Community Psychiatry, 43*, 1010–1016.

Page, T., & Nooe, R. (1999). Relationships between psychosocial risks and stress in homeless children. *Journal of Social Distress and the Homeless, 8,* 255-267.

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

Prescott, L., Soares, P., Konnath, K., & Bassuk, E. (2008). *A long journey home: A guide for creating trauma-informed services for mothers and children experiencing homelessness*. Rockville, MD: Center for Mental Health Services Administration.

Prilleltensky, I., & Prilleltensky, O. (2006). *Promoting well-being: Linking personal, organizational, and community change*. Hoboken, N.J.: John Wiley & Sons, Inc.

Robertson, M., & Toro, P. (1999). Homeless youth: Research, intervention, and policy. In L. Fosburg & D. 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.

Runtz, M., & Roche, D. (1999). Validation of the trauma symptom inventory in a Canadian sample of university women. *Child Maltreatment, 4*, 69-80.

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

Safyer, A., Thompson, S., Maccio, E., Zittel-Palamara, K., & Forehand, G. (2004). Adolescents' and parents' perceptions of runaway behavior: Problems and solutions. *Child and Adolescent Social Work Journal, 21,* 495-512.

Sawdon, J., Reid-MacNevin, S., & Kappel, B. (2003). *Youth justice in Canada: a resource manual.* Toronto, ON: Canadian Training Institute.

Schneir, A., Stefanidis, N., Mounier, C., Ballin, D., Gailey, D., Carmichael, H., & Battle, T. (2007). Trauma among homeless youth. *Culture and Trauma Brief, 2*(1), 1-7. Los Angeles, CA: National Child Traumatic Stress Network.

Simons, R., & Whitbeck, L. (1991). Running away during adolescence as a precursor to adult homelessness. *Social Service Review, 56*, 224-247.

Stewart, A., Steiman, M., Cauce, A., Cochran, B., Whitbeck, L., & Hoyt, D. (2004). Victimization and posttraumatic stress disorder among homeless adolescents. *Journal of the American Academy of Child and Adolescent Psychiatry, 43*, 325-331.

Stuart, J., Capostinsky, C., Joyce, T., Lucier, S., & Healy, T. (2006). *"A place to call my own": Sexual exploitation in Northern B.C.* Retrieved from http://www.homelesshub.ca/ResourceFiles/Sexual_Exploitation_in_Northen_BC_CASEY.pdf.

Sullivan, P., & Knutson, J. (2000). The prevalence of disabilities and maltreatment among runaway children. *Child Abuse and Neglect, 24,* 1275-1288.

Swenson, C., Saylor, C., Powell, P., Stokes, S., Foster, M., & Belter, R. (1996). Impact of a natural disaster on preschool children: Adjustment 14 months after a hurricane. *American Journal of Orthopsychiatry, 66*, 122-130.

Tyler, K., & Cauce, A. (2002). Perpetrators of early physical and sexual abuse among homeless and runaway adolescents. *Child Abuse and Neglect, 26*, 1261-1274.

Ussher, J. (1999). Feminist approaches to qualitative health research. In M. Murray & K. Chamberlain (Eds.), *Qualitative health psychology theories and methods* (pp. 98-114). Thousand Oaks, CA: Sage.

Van Wormer, R. (2003). Homeless youth seeking assistance: A research-based study from Duluth, Minnesota. *Child and Youth Care Forum, 32*, 89-103.

Volpicelli, J., Balaraman, G., Hahn, J., Wallace, H., & Bux, D. (1999). The role of uncontrollable trauma in the development of PTSD and alcohol addiction. *Alcohol Research and Health, 23*, 256-262.

Whitbeck, L., Hoyt, D., & Ackley, K. (1997). Families of homeless and runaway adolescents: A comparison of parent/caretaker and adolescent perspectives on parenting, family violence, and adolescent conduct. *Child Abuse and Neglect*, *21*, 517–528.

Wolfe, S. M., Toro, P. A., & McCaskill, P. A. (1999). A comparison of homeless and matched housed adolescents on family environment variables. *Journal of Research on Adolescence, 9*, 53–66.

Ziesemer, C., Marcoux, L., & Marwell, B. (1994). Homeless children: Are they different from other low-income children? *Social Work, 39*, 658-668.