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ABSTRACT
Jacqueline N. Rion

Child Sexual and Physical Abuse as Precursors for Homelessness in Adolescence
(Under the direction of Monica Swahn, Faculty Member)

Introduction: Homelessness is a living condition associated with a number of adverse health outcomes. Unaccompanied homeless youth are at risk for many of the same health outcomes as other homeless persons, but these youth are especially vulnerable because they are young and without the protection or support of an adult caregiver.

Aim: The purpose of this capstone project is to present a basic overview of the topic as well as to highlight what more needs to be done to address this issue.

Methods: This project involved a review of the literature related to homeless youth, child sexual or physical abuse, and mental health issues associated abused and/or homeless youth, focusing on United States information, for the years 1995 to present.

Discussion: to discuss current prevention and intervention efforts, and to discuss needs for future research and intervention

INDEX WORDS: sexual abuse; physical abuse; adolescence; homelessness; homeless youth; adverse childhood experience

CHILD SEXUAL AND PHYSICAL ABUSE AS PRECURSORS FOR HOMELESSNESS IN ADOLESCENCE

by

JACQUELINE N. RION

B.A., GEORGIA STATE UNIVERSITY

A Capstone Project Submitted to the Graduate Faculty

of Georgia State University in Partial Fulfillment

of the Requirements for the Degree

MASTER OF PUBLIC HEALTH
ATLANTA, GA, 30303

CHILD SEXUAL AND PHYSICAL ABUSE AS PRECURSORS FOR

HOMELESSNESS IN ADOLESCENCE

by

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Jacqueline N. Rion

Signature of Author

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EXECUTIVE SUMMARY

An estimated 2.3 to 3.5 million people are homeless in the United States at some point in a typical year; about a third of them are children and youth (Vissing & Hudson, 2008). Homeless life is dangerous and can have deleterious health consequences on all ages, but it can be even more difficult for unaccompanied youth. Youth are more vulnerable due to their age, developmental immaturity, and lack of responsible and caring guardians or caregivers. Unaccompanied youth rarely have the education or skills or may be too young to obtain legitimate employment, and end up homeless, often resorting to staying in shelters, in cars, or sleeping on the streets.

Homelessness puts youth at risk for most of the health dangers suffered by homeless adults. Homelessness is associated with multiple health conditions, both acute and chronic, which can deleteriously impact an individual's quality of life. It is also associated with greater risk of violent victimization and suicide. Further, the harsh conditions of homelessness, such as exposure to inclement weather and general poor nutrition and food insecurity, can exacerbate existing conditions and make individuals more susceptible to new infections and health problems. There are greater barriers to health care for the homeless than for housed persons, and health care needs are often neglected because food and shelter take immediate importance and must be provided for first. At especially high risk for negative health outcomes are abused youth who are homeless. They tend to have higher rates of various mental health issues and a greater reliance on risky deviant subsistence strategies such as unprotected sex, drug use, and

survival sex, which further increase their vulnerability in the absence of a responsible caregiver (Martinez, 2006).

Youth who have been abused are more likely to become homeless compared to their peers. Although all forms of child maltreatment put youth at higher risk for homelessness, sexual abuse and physical abuse are particularly strongly linked with homelessness. Adolescents are more likely to leave home when they experience serious family dysfunction and conflict, and abuse is frequently among the primary reasons homeless adolescents give for becoming homeless (Smollar, 1999). There are four types of child maltreatment: physical abuse, sexual abuse, emotional abuse, and neglect, which can be physical and/or emotional; all of which are associated with negative outcomes. However, youth who are sexually or physically abused have higher rates of a number of negative outcomes. In addition, persons who have experienced both sexual and physical abuse often show still worse dysfunction than persons who experienced sexual abuse or physical abuse alone. Sexual abuse and physical abuse are the most widely studied types of child maltreatment.

Researchers have begun to use the life course model and perspective to understand the complexities of health outcomes and to try to create a more comprehensive approach to health and wellness across developmental stages. The life course model theorizes that health is influenced by the complex interaction between protective and risk factors such as various biological, psychological, and social responses and personal behaviors. According to the life course model, risk factors that recur early in life can have a lifelong, negative impact on a person's health. Examples of adverse childhood experiences, also known as ACE's, include child maltreatment, such as sexual

abuse and physical abuse. These are early life events that can affect a child's normal development and have a lasting effect on his or her health and well-being as an adult (Middlebrooks & Audage, 2008).

Although various risk and protective factors can occur at any time in one's life and affect health outcomes, the life course model theorizes that there are several periods when factors or events may have a more profound effect. Developmental periods during early childhood and adolescence are life stages when these protective or risk factors may have greater impact on health outcomes. Examples of risk and protective factors include socioeconomic status, nutrition, stress, race, health care, and adverse childhood experiences (Middlebrooks & Audage, 2008). Advocates of the life course model suggest that, because of this important and continuing impact of early life factors on one's health, public policy should invest greater resources in improving the health and social conditions of families and children to promote health and decrease health disparities.

Despite the bleak outlook for homeless youth, homelessness can be prevented, and so can many of the risk factors for homelessness and associated negative outcomes. Because the homeless condition has such far reaching impact on a person's health and well-being, and because that condition is preventable, the problem of homelessness is one which the public health community can and must help address. Continuing research into the psychological effects of child abuse is needed, as well a greater understanding of homeless youth and abused homeless youth, and how to effectively target this vulnerable and often untrusting group.

The major research questions which guided this review are as follows. What is the public health importance of homelessness among youth? What are the risk factors and causes of homelessness? How are child abuse, mental health issues, and youth homelessness interrelated? The purpose of this project was to write a review of the literature and consider implications for future research and interventions in order to provide a general overview for the reader.

CHAPTER I

INTRODUCTION

Since the economic crisis of 2008 in the United States, the numbers of people unemployed, the numbers of homes that have been foreclosed and the number of individuals and businesses that have declared bankruptcy have increased dramatically (Vissing & Hudson, 2008). These events have resulted in a significant increase in the number of homeless individuals and families across the country. Roughly 3.5 million people, including approximately 1.35 million children, are likely to experience homelessness in a given year according to a study conducted by the National Law Center on Homelessness and Poverty (National Coalition for the Homeless, 2008a). This year, during the economic crisis, these numbers are estimated to be much greater. School districts across the United States are reporting more homeless children and youth in their schools, along with associated challenges such as school attendance and behavioral problems. Many school districts reported identifying more homeless students in the first few months of the school year than they had identified the entire previous school year (Duffield & Lovell, 2008).

Homelessness has been increasing over the past 25 years, largely due to a growing shortage of affordable rental housing and an increase in poverty (National Coalition for the Homeless, 2008b). Research shows that renting a one- or two- bedroom apartment at Fair Market Rent requires more than the minimum wage in every state (National Coalition for the Homeless, 2008b). Other economic factors, such as inadequate minimum wage, unemployment, and underemployment have also affected homelessness

rates. Consequently, many people are more vulnerable to losing housing, co-habitating with friends and families in their dwellings, entering emergency shelter, or living in cars or on the streets. Obtaining even temporary shelter during financially difficult times can be very challenging. Families leaving welfare struggle to get medical care, food, and housing, and may be more vulnerable to becoming homeless (National Coalition for the Homeless, 2008b).

Persons with extremely low income are at highest risk for becoming homeless. Although not all homeless persons have low income, poverty is a major risk factor for homelessness. People living in poverty have fewer financial resources to handle unforeseen circumstances, such as job loss or death of a financially responsible household member. They often live "paycheck to paycheck" without a safety net in case of unexpected expenses such as an illness resulting in hospital bills and missed work, can force people to choose between paying rent or other necessities, especially if the illness is chronic or results in a disability (National Coalition for the Homeless, 2008b). People from other socioeconomic levels may also become homeless, as can be seen by the rapidly growing number of middle class persons who were forced to live out of their cars or tents following the foreclosure crisis.

Homelessness is usually the result of multiple economic and housing hardships over an extended period of time (Vissing & Hudson, 2008). For this reason, homelessness is sometimes referred to as "a process, not an event." Because becoming homeless is generally a gradual process, it can be difficult to say when a person or family ceases to be at risk for being homeless and actually becomes homeless (Vissing &

Hudson, 2008). For the majority of people, homelessness is a temporary experience rather than chronic or permanent (National Coalition for the Homeless, 2008a).

Social and interpersonal factors are also associated with likelihood of becoming homeless. A person's amount of social capital, such as social, financial, and other practical support from friends and family, often plays an important role in preventing homelessness. When people are at risk of losing their housing, or have first become homeless, most turn to family or friends for social, economic, and other material support. This may include borrowing money for rent and other needs, moving in with a friend or family member, or sleeping on someone else's couch. Those who experience homelessness are likely to have exhausted these resources or to have little social capital to begin with. Further, if a person's social network consists largely of others who themselves have financial difficulties or housing distress, they may not be able to help their friend or loved one when he or she is in need (Congressional Research Service, 2007).

While the condition of homelessness itself is considered a negative outcome, it is also associated with a number of negative health outcomes, such as high rates of comorbidity and chronic conditions, including dermatologic and vascular disorders, drug abuse, and mental illness; high rates of infectious diseases, such as tuberculosis and sexually transmitted diseases (STDs); and early mortality (Rew, 2002). It is also associated with greater risk of violent victimization and suicide. Further, the harsh conditions of homelessness, such as exposure to inclement weather and general poor nutrition and food insecurity, can exacerbate existing conditions.

Homelessness is associated with higher costs of care and worse outcomes, largely due to a heavier reliance on acute care and emergency departments, and the substandard living conditions experienced by many homeless persons which can include exposure to harsh weather, poor nutrition, safety concerns, and crowded quarters which can enable the spread of infectious disease. Homeless persons must devote much of their time and resources to meeting their basic needs of food and shelter, and as a result health needs may go unmet.

Homeless youth are an especially vulnerable subgroup because they are still developing and are without guardians to care for and protect them. The homeless youth population is most broadly defined as adolescents and young adults ages 10 to 24 years, an age group which includes early to late adolescence (Congressional Research Service, 2007). Homeless youth includes those who have left home without their parents' or guardians' consent, also known as "runaways," those who have left home with their parents' consent, also called "throwaways," and those whose parents have forced them to leave homes, or "push-outs". Regardless of the exact nature of their leaving, these youth generally have experienced family conflict at home and are attempting to find a solution to the problem (Vissing & Diament, 1997). Homelessness in adolescence is associated with a number of negative outcomes in adolescence and adulthood, such as violent victimization while homeless, including sexual and physical assault. Further, homeless youth are more likely than housed youth to experience homelessness as adults (Burt, 2001).

The purpose of this review is to present an overview of homelessness among youth and to highlight areas for future research and actions to prevent homelessness and to reduce its many adverse health outcomes. This project involved a review of the literature related to homeless youth. Particular focus was placed on child sexual or physical abuse as a precursor to homelessness and mental health issues associated with abuse and homelessness among youth. The review focuses primarily on information pertinent to the United States, published since 1995, and that are based on youth between the ages of 10 and 24 years. Chapter II will describe the challenges of measuring the magnitude of homelessness. Chapter III will highlight health effects associated with homelessness. Chapter IV will discuss the causes and risk factors associated with homelessness. Chapter V will focus on the role of physical and emotional abuse in becoming homeless and health consequences. Chapter VI will discuss implications and recommend areas for future research and prevention efforts to prevent child abuse, youth homelessness and reduce risk for adverse outcomes associated with these negative events.

CHAPTER II

DOCUMENTING THE PUBLIC HEALTH BURDEN

Estimating the magnitude of the public health burden and describing the characteristics of those who are homeless is important to gaining a better understanding of the problem and to develop prevention and intervention strategies. However, these estimates are difficult to obtain. The challenges include varying definitions and methods of categorizing the homeless and sampling and measurement limitations.

2.1 Defining "Homeless"

Accurately measuring the number of people who experience homelessness is difficult. A significant barrier to obtaining an accurate estimate is the lack of a single, widely used definition. This lack of consensus is evident when considering two of the most widely used definitions, the legal definition provided in the McKinney-Vento Homeless Assistance Act of 2001, and the definition used by the U.S. Department of Housing and Urban Development (HUD). HUD defines a "homeless individual" or "homeless person" as someone who does not have a fixed, regular nighttime residence that is adequate for and designed for sleeping accommodation for humans. This can include persons who stay in shelters, transitional housing or a public or private place not originally intended for regular sleeping accommodation, such as cars, tents, or bridges (U.S. Department of Housing and Urban Development, 2009). However, this definition for homelessness excludes persons who are in "doubled-up" housing, those who co-habitate with others in crowded conditions, or "couch-surf", those who can find only very

temporary shelter with friends or family, sometimes for only a night (Vissing & Hudson, 2008). HUD's definition also emphasizes adults and underestimates families and independent youth because most shelters are not equipped to handle families (Vissing & Hudson, 2008).

The Department of Education (DOE) and many other organizations use the legal definition of homelessness from the McKinney-Vento Homeless Assistance Act of 2001 (Vissing & Hudson, 2008). The McKinney-Vento's definition also includes individuals and families who are able to find accommodations with others, and potentially underestimates the extent of family homelessness (Grant, et al., 2007).

2.2 Categories of Homeless

The homeless population is a heterogeneous group that includes persons of all ages, from children to the elderly. The characteristics and risk factors vary widely, and researchers often divide the homeless population into subgroups when describing them to better account for these differences. These subgroups are typically based on 1) characteristics of the homeless experience, such as number of times homeless; 2) characteristics of the individuals, such as age, family status or military service; or 3) the individual's involvement in the assistance programs or shelter use.

Characteristics of homeless experience

The nature of the person's homelessness may be considered when describing the populations. This is usually described as one of three types: first time homeless, episodically homeless, and chronically homeless. Although definitions may vary slightly, they are generally defined as follows. First time homeless persons have never experienced a homeless episode; episodically homeless persons have been homeless one

or more times before, but have obtained housing between episodes; chronically homeless persons generally have been homeless much or all of the time for an extended period of time, and usually have one or more chronic health conditions that contribute to their difficulty in obtaining and maintaining housing (U.S. Department of Health and Human Services & U.S. Department of Housing and Urban Development, 2007).

Characteristics of Individuals who are Homeless

Homeless individuals are more likely to be male, to be chronically homeless, and to have more chronic health problems. As a result, chronically homeless individuals make up a disproportionate amount of the public health burden of the homeless population. Although chronically homeless people make up only 10 percent of the homeless population, they consume as much as 50 percent of the shelter system's resources (NGA Center for Best Practices, 2007). Veterans experience relatively high rates of homelessness, and homeless veterans are frequently categorized as chronically homeless individuals. An estimated 271,000 veterans are homeless on any given night (National Coalition for the Homeless, 2007). Forty percent of homeless men are veterans compared to 34% of the general adult male population (National Coalition for the Homeless, 2007). Among this population about 46% are white and 56% are African-American or Latino (National Coalition for the Homeless, 2009). Homeless veterans are a subset of the chronically homeless individual population that experiences a disproportionately high number of chronic health problems, especially combat-related outcomes such as post-traumatic stress disorder, alcoholism, and physical disability. Although the Veteran's Administration has programs that address homelessness in

veterans, this population continues to grow and to experience a high rate of negative outcomes.

Homeless Families with Children

Families with children are the largest subgroup of the homeless population (National Coalition for the Homeless, 2008a), and they are also one of the fastest growing subgroups (National Coalition for the Homeless, 2007). Most of them become homeless, not because they had mental health or substance abuse problems, but because they either could not find affordable, available housing or they lost their financial ability to pay for all the things their families require (Vissing & Hudson, 2008). Homeless families are very similar to other low income families, but homeless families are more likely to have extremely low incomes and to lack strong social networks (National Alliance to End Homelessness, 2007). Without strong social networks, families are less likely to have a support network to rely on for temporary housing when they lose their own (Grant, et al., 2007). These families may "double up" with friends or family, but this is frequently only a temporary solution, as overcrowded conditions may force the homeless family to find other alternatives, including literal homelessness and emergency shelter (Grant, et al., 2007).

Homeless Families tend to be single-parent households, usually headed by a young parent and with young children (National Alliance to End Homelessness, 2007). One 1999 national survey found that 95% of homeless families were headed by single females and 79% were unemployed. About half of these families had children younger than 5 years of age (47%), or 5 to 17 years (53%) (Grant, et al., 2007). Homeless families tend to have poor housing histories or move frequently (National Alliance to End

Homelessness, 2007). For example, a 1998 study estimated that 2 million single parent households in the United States were living in doubled-up housing; a condition which places them at risk for becoming homeless (Grant, et al., 2007). Homeless families are more likely to be first-time homeless or episodically homeless than are homeless individuals. Children with families are more likely to be placed in foster care or other out of home services, and are more at risk for a number of negative outcomes.

2.3 Measures

There are two basic ways that researchers generate estimates of homelessness: "period prevalence counts" and "point in time counts". Period prevalence counts estimate the number of homeless persons over a given period of time. A point in time count tabulates all the homeless people on a given day or given week. Point in time counts are often easier and more affordable than period prevalence counts. Because homelessness tends to be a temporary experience, point in time counts tend to over represent chronic homeless persons, who are more likely to be homeless at any given time than episodic- or recurrent- homeless persons. At the same time, non-chronic homeless persons, such as homeless families with children or homeless females, are underrepresented. Because different homeless subpopulations have very different characteristics and needs, it is important to have an accurate estimate and description of the homeless population, in order to better understand the problem and to address it effectively. For this reason, period prevalence counts are often preferred. This tends to give a more accurate overview of the homeless population (National Coalition for the Homeless, 2008a).

2.4 Sampling

The homeless population is transient and temporary, moving from one location to another, moving into homelessness then back to housing, potentially to return again to homelessness at a later time. Researchers typically use a number of different sampling methods when considering this issue. Nationally representative, cross-sectional surveys of households often conducted over the phone are one way that researchers address issues of homelessness. Such surveys ask questions regarding former homeless episodes among the housed sample. However, this type of retrospective design has limitations because of possible recall error, and also because some subjects may not report episodes due to perceived stigma.

Some studies sample homeless persons in shelters. Shelter persons are easier to find than unsheltered homeless persons. The major limitation to this technique is that the homeless who utilize shelter services can be very different than those persons who do not utilize such services, and researchers cannot generalize findings on sheltered homeless to the general homeless population. Accordingly, researchers miss a number of homeless persons during any given count because they are in places that are more difficult for researchers to find or approach. These people, the “unsheltered” or “hidden” homeless may sleep in cars, under bridges, or may double up in housing. For instance, a 1995 study of formerly homeless people found that 59.2% had lived out of automobiles while homeless (National Coalition for the Homeless, 2008). Thus, any available estimate of the number of homeless youth represents a significant underestimate which should also be considered in future planning.

CHAPTER III

HOMELESS YOUTH

Youth may be the single age group most at risk of becoming homeless (Toro, Dworsky, & Fowler, 2007). Homeless youth may be with their families or on their own. One study estimated that each year about 500,000 youths are homeless with their families, another 500,000 have been "thrown away" by their families, and about 1,000,000 have run away from home (Rew, 2002). Unlike runaways, who choose to leave home, throwaways leave their homes because their parents force them to leave (Toro, et al., 2007). Another study estimated that 750,000 to 2 million 18 to 24 year old young adults experience homelessness each year; this group constitutes 13% of the adult homeless population and 26% of the homeless family population (Ammerman, et al., 2004). In addition, it is estimated that there are over 1.6 million unaccompanied and homeless youth ages 12 to 17 years annually (Vissing & Hudson, 2008). Another study estimated that 1.7 million youth had at least one runaway or throwaway episode in 1999 alone (Vissing & Hudson, 2008).

It is extremely difficult to estimate how many youth are affected by homelessness. Many of the difficulties in studying homeless youth are similar to other homeless populations. Homeless youth tend to be more hidden than chronically homeless adults, making them more difficult to find and identify. Many homeless adolescents return to their family of origin fairly soon after leaving (Toro, et al., 2007), making point in time counts less useful. Many shelters legally require minors to have a parent or guardian to sign on their behalf in order to admit minors. Because they are homeless without parental

support, these youth are rarely able to meet this requirement, and cannot access shelter services (Vissing & Hudson, 2008). This makes shelter-based estimates of homeless youth impractical. Because youth homelessness is generally temporary, it is more practical to do cross-sectional than longitudinal designs.

3.1 Homeless Patterns Among Youth

Youth tend to be first time or episodically-homeless rather than chronically homeless and they are considered a "mobile and changing population." Such episodes may involve: 1) staying with extended family, friends, or family of friends, or other non-relatives, often moving frequently from one household to the next when needed, i.e., "couch surfing"; 2) "squatting" in abandoned building; 3) sleeping in cars, parks, or public spaces; 4) traveling alone with a friend or friends; 5) using service programs like emergency shelters or soup kitchens; 6) sleeping on the street; and 7) exchanging sex or engaging in other illegal activities for necessities such as a place to stay and food, or drugs (Toro, et al., 2007).

Youth and young adults become homeless for a number of different reasons, and are often categorized by their reason for leaving home. The most commonly used terms are "runaway", "throwaway", and "systems youth". Runaways are youth who leave their homes without parental permission (Toro, et al., 2007). This is the oldest and most commonly used categorization of homeless youth, and is the most researched subgroup of homeless youth. In a sample of 16 to 19 year old homeless youth, the average age when they first ran away from home was 13.4 years old (Yoder, Longley, Whitbeck, & Hoyt, 2008). In a nationally-representative study of adult clients of public assistance programs, one-third of all adult homeless clients reported having run away from home for more than

24 hours before reaching 18 years of age (Burt, 2001). Youth often run impulsively with no forethought to their personal safety or where they will go, and usually run following a negative event (Martinez, 2006). Despite the hardships that homelessness may bring, many runaways do not feel that life while homeless is any worse than life at home (Martinez, 2006). This perception may make runaways less likely to return home, or more likely to run away again in the future. Suicidal ideation and attempts are considered two effective independent predictors of running away (Martinez, 2006; Thompson, Zittel-Palamara, & Maccio, 2004). Some youth use running away as a problem-solving solving tool (Martinez, 2006). They may use running as a way to find out if their parents really love and value them, or if the abuse or other family conflict they experienced prior to running will stop when the youth returns home. These beliefs are rarely if ever realized, or only short-term changes are made.

While runaways leave home without parental consent, throwaways are asked or forced to leave by their parents. Some parents ask their children to leave because they can no longer financially support them. Others force their children to leave because of family conflict or dysfunction, sometimes relating to a child's behavior problems, and sometimes due to conflict between the child and a parent, a stepparent, or other member of the household (Toro, et al., 2007). Systems youth are those who have been discharged from state or institutional care and cannot return home or have no home to return to, and as a result have nowhere to go and have few or no resources. These youth end up on the streets after being discharged from institutions such as foster care, psychiatric hospitals, juvenile detention centers, and residential schools (Rew, 2002). This often happens when

eighteen year olds "age out" of such services, and when youth are released from juvenile detention when they lose minority status or finish their sentence.

Although these definitions are helpful, there is often some overlap with youth who may fit in more than one category. Because of this overlap, and for general simplicity, some researchers refer to all subcategories of homeless youth as "homeless youth". In addition, some researchers feel that using the term "housing distress" may be more useful because it is a more inclusive concept than literal "homelessness," and can capture a number of youth who are not literally homeless but nonetheless experience significant problems relating to housing instability. For consistency in this paper the term homeless youth refers to all homeless youth subgroups, unless the distinction is important.

3.2 Characteristics of homeless youth

Homeless youth as a group tend to be heterogeneous and demographically diverse. They are both male and female, represent all races, ethnicities and sexual orientations, and may come from rich, poor, and middle income backgrounds. Although low income youth are more vulnerable to becoming homeless than their wealthier peers, youth homelessness occurs across all socioeconomic levels. Youth who are homeless with their family, on the other hand, are more likely to be low income (Rew, 2002). Unaccompanied homeless adolescents come from urban, suburban, and rural areas, and can be found in all these areas, although some may travel in search of better opportunities and services (Rew, 2002).

<u>Ethnicity & Geography</u>

In 2007, nearly half of the homeless population was African-American (47%) even though African-Americans made up only 12% of the U.S. adult population. (National Coalition for the Homeless, 2009). However, the relationship between race and ethnicity and risk of homelessness is complex. Persons living in poverty are at greater risk for experiencing homelessness, thus demographic groups that are disproportionately low income are also more likely to become homeless. In other words, African Americans are more likely to become homeless than Whites or Asian Americans, in part because African Americans are more likely to live in poverty (National Coalition for the Homeless, 2007), and poverty is a significant risk factor for homelessness.

The racial and ethnic makeup of homeless populations also varies by geographic area (National Coalition for the Homeless, 2007), with the demographics generally being similar to that of the general population in that area. Homeless populations in large metropolitan areas tend to have more racial and ethnic minorities than in rural areas, while rural areas tend to have more white Americans. In 2004, the urban homeless population was estimated to be 42% African-American, 39% white, 13% Latino, four percent Native American and two percent Asian. The rural homeless are more likely to be white, female, married, and employed. They tend to be homeless for the first time, and to be homeless for a shorter period of time than their urban counterparts (National Coalition for the Homeless, 2009). An estimated 9% of the residents in rural communities are homelessness according to the Council for Affordable and Rural Housing (Vissing & Hudson, 2008).

Education

Homeless youth are more likely to have educational difficulties such as truancy, poor or failing grades, and a high drop-out rate. Life while homeless is harsh and survival needs often overshadow educational needs (Thompson, et al., 2004). Because level of educational attainment is important to successful employment and impact wages, educational difficulties, especially failure to obtain at least a high school degree, are associated with lower wages and higher rates of unemployment. It can be more difficult for homeless persons to achieve gainful, legal employment, especially for homeless minors. Many adolescents have not completed high school and do not possess the skills needed for a job with wages sufficient to support themselves (Wolfe, et al., 1999). Underage youth who have inadequate or no assistance to meet their basic needs may resort to subsistence strategies, such as prostitution, in this case often referred to as "survival sex," drug dealing, theft, or other criminal activities.

Homeless youth who do not finish their education are less likely to acquire the skills for jobs with adequate wages, making them more likely to live in poverty as adults. As low income adults, they are more at risk of homelessness again as adults (National Coalition for the Homeless, 2007). Unfortunately, a number of homeless youth may not be able to enroll in school because they cannot obtain required documentation such as immunization records as well as residency requirements and lack of transportation. Those that are enrolled often do not attend school regularly (National Coalition for the Homeless, 2007), often due to barriers like transportation issues. Homeless parents move their families frequently. Many shelters limit the length of stays, mothers may move their families to escape abusive intimate partners, or parents may move their families to look for employment and/or housing (National Coalition for the Homeless, 2007). Relocation

is common among homeless children, with one study of homeless children finding that 42% of the sample transferred schools at least once while homeless (National Coalition for the Homeless, 2007). Changing schools is disruptive to a child's education, and a child may lose an estimated 3-6 months of education every time he or she moves.

Attending school also helps youth maintain connections to social networks. Youth who are not working or attending schools do not have strong social networks that can provide financial and/or practical assistance, such as employment connections, health insurance coverage, or housing (Congressional Research Service, 2007). These individuals are referred to as socially disconnected youth. When an individual chooses or is forced to leave one's home, generally he or she tries to find a friend or other family member to stay with. This is true of adults as well as adolescents. Homelessness is the result of having no one to turn to for assistance. Youth may exhaust their social ties after frequent runaway episodes, or from problem behavior. They may simply have few or no persons in their social network that they can turn to for help. Youth who are socially disconnected are at greater risk for homelessness and for living on the street when they are homeless, because they have fewer people to help them. Strong social supports are necessary to preventing homelessness and aiding in the transition to stability following a homeless episode (Ammerman, et al., 2004).

3.3 Vulnerable Youth

Because homelessness in adolescence is associated with a number of adverse outcomes, homeless youth are part of a larger category of at-risk youth, known as vulnerable youth. Vulnerable youth are at risk for developing potentially harmful behaviors and outcomes that may harm the individuals and/or their community, due to

certain characteristics or experiences of the youth (Congressional Research Service, 2007). Examples of vulnerable youth include: youth emancipating from, or "aging out of," foster care; runaway and homeless youth; youth recently released from the juvenile justice system; youth with physical or mental disabilities; and youth with mental disorders (Congressional Research Service, 2007). Homeless youth may fit into more than one of these categories.

Mental Health and Behavioral problems

Mental illnesses are more common among homeless than housed youth. Mental health problems can be risk factors as well as outcomes. Homeless youth frequently present with multiple psychological and behavioral problems prior to becoming homeless, problems such as general mental health issues, depression, substance abuse, history of institutionalization in the juvenile justice system, child protective services or psychiatric hospitals, school problems, and poor coping skills (Smollar, 1999). In addition, alcohol and illicit substance use behaviors used to cope with the difficult life of homelessness may exacerbate existing mental illness.

Substance abuse

Alcohol or other drug (AOD) use is associated with adolescent homelessness because AOD use makes adolescents more likely to become homeless, and because adolescents may use AOD to help them cope with the homeless condition (Rew, 2002). In one study of homeless youth in San Francisco, New York City, and Denver, 97% reported use of alcohol or other drugs (Rew, 2002). Youth may use drugs or alcohol as a means to cope with the harsh life of homelessness, particularly those who engage in survival strategies such as prostitution. One sample of runaway youth reported an

increase of marijuana use from 24% before leaving home to 39% after leaving home, and an increase of hallucinogen use from 5% to 11%. The youth claimed the increased drug use was "their attempts to forget or escape their problems" (Thompson, et al., 2004).

3.4 Family Factors

A number of family environment factors, such as family conflict, family dysfunction or family breakdown are associated with an increased likelihood of youth homelessness (National Alliance to End Homelessness, 2007b). Family conflict or dysfunction is often the primary reason for youth homelessness (Toro, et al., 2007; Ryan, et al., 2000; Smollar, 1999). Other negative family factors that can contribute to homelessness include domestic abuse or family violence, child maltreatment, family homelessness, parental mental illness and/or substance abuse. Parental mental illness places children at greater genetic risk for developing mental illness themselves. It can also negatively affect children if the parent's mental illness results in or contributes to an inconsistent and dysfunctional family environment.

Homeless and runaway youth commonly report having grown up in families with parents who abused alcohol and other drugs. In a study of 19 to 21 year old homeless young adults in four Midwestern states, alcohol use and/or drug use characterized the majority of their households (Tyler, 2006). Parental substance abuse is associated with higher rates of child abuse, as intoxicated parents may be more likely to abuse their children than parents who are not under the influence of AOD. Intoxicated parents are also less likely to be capable of or willing to stop other persons from abusing their children (Tyler, 2006). Some youth leave home as a result of the abuse they experience while their parents are intoxicated (Rew, 2002).

Homeless compared to housed youth more often come from single-parent households or "blended" families, such as stepfamilies. Families of homeless youth often experience more residential moves than their housed peers. (Toro, et al., 2007). Young mothers are more likely to become homeless than their older counterparts. Although the reasons may differ, homeless adolescents as a whole report low levels of care and acceptance from their caregivers (Wolfe, Toro, & McCaskill, 1999).

Family violence

Intimate partner violence or domestic violence is a major reason for homelessness among families. According to a study by the US Conference of Mayors, in 2007 39% of cities surveyed identified domestic violence as the primary cause of family homelessness. Poor mothers in abusive relationships must sometimes choose between staying in an environment that is unsafe for them and their children, or leaving the relationship and becoming homeless (National Alliance to End Homelessness, 2007c). Unfortunately, both choices can be dangerous and may result in trauma or other adverse outcomes for the children.

Between one half and three quarters of homeless youth report a history of child abuse, including physical abuse, sexual abuse, or both (Ryan, et al., 2000). In a study of 19 to 21 year old homeless young adults in four Midwestern states, a majority of youth reported having experienced and/or witnessed physical abuse. These youth reported that some of their mothers who were victims of domestic violence felt helpless and were unable to protect their children (Tyler, 2006). Physical abuse was the most common form of maltreatment they reported (Tyler, 2006).

Foster Care

Out of home placement such as foster care is associated with greater risk for homeless episodes among youth. This is not surprising, as out of home placement is a sign of serious family dysfunction, and such placement may be associated with one or more of the above negative family environment factors. Foster care youth also tend to have less social capital and a smaller social network than other youth, making them more vulnerable to homelessness (Congressional Research Service, 2007). Young adults who "age out" of foster care, who are discharged from it because they have reached a certain age, as well as youth who are discharged from juvenile corrections, are at higher risk for homelessness because they often have nowhere to go and often do not have the social or financial resources to obtain housing of their own (National Alliance to End Homelessness, 2007b).

3.5 Especially Vulnerable, High Risk Subpopulations

Although homeless youth are at greater risk than their housed peers to suffer from a number of adverse outcomes, some subpopulations of homeless youth are at even greater risk for some of these outcomes than the rest of their homeless peers. Street youth, Gay, Lesbian, and Bisexual (GLB) youth, and youth who have been sexually abused are all more likely to engage in a number of high-risk behaviors, particularly deviant subsistence strategies like survival sex, that increase the likelihood of adverse outcomes such as street victimization, unintended pregnancy, STDs, HIV/AIDS, and blood borne diseases like Hepatitis.

Street Youth

Street youth are homeless youth who spend more time on the streets, and many are less likely to utilize available assistance programs and services. Homeless youth find

a number of different places to sleep and many spend at least some time on the streets during their homeless episode. In a study of homeless youth aged 16 to 19 years from several small- and moderate-sized Midwestern cities, 61% of male respondents and 39% of females had spent at least one night directly on the streets (Whitbeck, Johnson, Hoyt, & Cauce, 2004). Street youth tend to have experienced more stressful events and to exhibit more psychological symptoms than homeless youth who have not spent time on the streets (Toro, et al., 2007). Although all unaccompanied homeless youth are at increased risk of mental health problems compared to housed youth, street youth are at particularly high risk for mental health problems. Furthermore, the longer an adolescent spends on the street, the more likely they are to adopt street values, which encourage health-risk behaviors such as deviant subsistence strategies and drug use (Rew, 2002).

Gay/lesbian/bisexual (GLB) sexual orientation

Compared to the general adolescent population, homeless adolescents report a higher percentage of gay/lesbian/bisexual (GLB) sexual orientation (National Coalition for the homeless, 2009). Many GLB youth chose to leave or are forced to leave their family because of family conflict concerning their sexual orientation (Rew, 2002). GLB youth who are homeless are more likely than heterosexual homeless youth to run away from home at an earlier age, initiate sexual activity at an earlier age, and have an earlier onset of heroin use (Rew, 2002).

Abused Youth

Abused youth are a vulnerable subpopulation, due largely to higher rates of various mental health issues and a greater reliance on risky deviant subsistence strategies. Abused youth are also more likely to become homeless compared to their nonabused

peers. Although all forms of child maltreatment put youth at higher risk for homelessness, sexual abuse and physical abuse are particularly strongly linked with homelessness. Adolescents are more likely to leave home when their family shows serious dysfunction and conflict, and abuse is frequently among the primary reasons homeless adolescents give for becoming homeless.

CHAPTER IV

HEALTH AMONG HOMELESS YOUTH

4.1 Overview

Although much of the literature regarding homelessness and health concerns homeless adults, often the chronically homeless, there is also a growing body of research devoted to the impact of homelessness on the health of children and youth. Many of the childhood health problems associated with homelessness are those associated with very low income children in general. Problems such as malnutrition and nutritional deficiencies, interruption of regular pediatric care, or lack of such basic preventative care as immunizations and regular check ups are common problems for homeless children and can lead to or exacerbate such serious pediatric problems as obesity, asthma, high blood pressure and iron-deficiency anemia (Grant, et al., 2007).

Although homelessness is usually only a temporary experience with most families returning to housing within a few months, the health effects of homelessness can last long after the homeless episode has ended. The lasting impact of homelessness on health can be especially significant for children, whose minds and bodies are still developing and are more vulnerable to the negative effects of homelessness. Homeless children lack a permanent place for shelter and social support, which are important to healthy growth and development (Rew, 2002), and homeless families with children frequently experience food insecurity. Food insecurity is associated with a number of negative outcomes in young children, such as experiencing psychological stress and anxiety, and being in fair or poor health and increased likelihood of hospitalization (Grant, et al., 2007).

One study found that homeless children were two to three times more likely to use emergency department care than the general pediatric population (Grant, et al., 2007). Compared to their low-income housed peers, homeless children had higher rates of both acute illness like ear infection and chronic conditions such as asthma and obesity (Grant, et al., 2007). Homeless children exhibit high rates of unintentional injuries, elevated lead levels, and speech-language delay (Grant, et al., 2007). One 1990 Los Angeles study of homeless and low-income housed children found that homeless children had higher rates of developmental delay, school failure, and behavioral problems, and obesity (Grant, et al., 2007).

Homeless youth are at greater risk of physical illness, both due to their greater exposure to the elements and because the barriers to health care are greater for homeless youth than for housed youth. Homeless persons must devote more of their resources to the primary need of housing, and meeting basic needs such as for food and healthcare often suffers as a result. Cost and lack of health insurance are not the only obstacles homeless youth face in getting health care. Transportation issues, distrust of care providers, fear of a diagnosis, little or no knowledge of where to go for health care services, and being embarrassed to ask for help are all obstacles homeless youth may encounter in accessing care (Rew, 2002).

4.2 HIV/AIDS and STDs

Survival sex is associated with higher rates of unwanted pregnancy, and STDs including human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS). In addition to the physical health problems associated with HIV infection or AIDS, there are also higher rates of suicidal ideation, attempts, and suicide.

Compared with children in homeless families, unaccompanied youth are more likely to have HIV and STD infection. They are also more likely to suffer from a number of negative psychiatric outcomes, trauma, and to be involved in survival sex (Ringwalt, et al., 1998). STDs, HIV/AIDS are also highly associated with alcohol and other drug abuse in homeless youth (Rew, 2002).

4.3 Unintended Pregnancy

Studies exploring pregnancy and parenthood among homeless youth find high rates of pregnancy and parenting among this population. One study of street and shelter youth found that 48% of street youth and 33% of shelter youth had ever been pregnant or impregnated someone, compared with 10% of nationally representative sample of housed youth. Some studies have reported that roughly 10% of homeless female youth were currently pregnant at the time of the studies (Toro, et al., 2007). Although these rates are high, they are not surprising when considering that homeless youth are more likely to engage in high risk sex behaviors than their housed peers. Evidence suggests that homeless youth with a history of abuse are especially likely to have been involved in an unplanned pregnancy. Women reporting 4 or more types of child abuse are more likely to have an unintended pregnancy at or before the age of twenty (Middlebrooks & Audage, 2008). A history of frequent physical or sexual abuse is associated with a greater risk of a male being involved in a teenage pregnancy (Middlebrooks & Audage, 2008).

Although this project attempts to address homeless youth as a population of homeless individuals, homeless young parents, usually young females, make up part of the homeless families population. Unaccompanied homeless youth with children share a number of characteristics and risk factors with unaccompanied homeless youth, but they

also have a number of unique needs and risk factors that unaccompanied youth do not, such as the need to provide for their children's basic needs and protection in addition to their own. Further, homeless youth with children are generally studied with the rest of the homeless family or homeless female with children population, rather than as homeless young parents. For these reasons, homeless youth with children will not be addressed further here.

4.4 Victimization

Homeless youth report higher rates of physical and sexual victimization than their housed peers (Gwadz, Nish, Leonard, & Strauss, 2007). Homeless youth are more vulnerable to victimization because they typically are without adult supervision and protection. In addition, lack of shelter leaves homeless youth vulnerable to violent victimization and exploitation by adults and other youth. Many homeless youth are victimized repeatedly while homeless (Toro, et al., 2007). Females are more likely to experience physical assault while homeless, both by acquaintances and strangers (Gwadz, et al., 2007). Abused homeless youth are frequently re-victimized while homeless (Martinez, 2006). Survival sex, drug dealing, theft, or other criminal activities put the youth in dangerous situations where they are more likely to be sexually or physically assaulted. Youth engaging in such high risk behaviors are at a greater risk for victimization by known and unknown assailants (Martinez, 2006).

4.5 Mental health

One study of homeless youth found that 89% of their sample met criteria for one or more of five psychiatric disorders; and 67.3% met criteria for two or more disorders (Whitbeck, et al., 2004). Age, having been victimized since being on the street and

participating in deviant subsistence strategies has been associated with meeting lifetime criteria for mental disorder even after controlling for the influence of gender, sexual minority status, number of runs, ever on the street, and caretaker abuse (Whitbeck, et al., 2004).

Mental health issues are sometimes divided into two categories, internalizing versus externalizing. Internalizing problems include depression, anxiety, post traumatic stress disorder (PTSD), dissociative disorders, and suicidal ideation and attempts. Depression and anxiety symptoms are commonly measured among the homeless youth because depression and anxiety are associated with a number of negative outcomes. Youth who experience depression and/or anxiety are more likely to run away from home by age 18 than peers who experience less or no depression and/or anxiety (Urban Institute, 2009). They are also more likely to engage in high risk behaviors that make them more vulnerable to homelessness, such as higher rates of drug use and theft. Depressed and/or anxious youth are also less likely to obtain educational diplomas and certificates which makes it more difficult for them to obtain jobs with decent wages, thus placing them at even greater risk of homelessness. Youth with depression and/or anxiety are more than twice as likely to leave high school without completing their degree than their peers who experience less or no depression/anxiety, and these vulnerable youth are also less likely than their peers to obtain a degree from a four year college (Urban Institute, 2009). Not surprisingly, then, median annual earnings of 23 year olds is considerably higher for the youth who experienced less or no depression and/or anxiety, $22,875 median income, than for the youth who experienced depression and/or anxiety, who earn an annual median income of $15,506 (Urban Institute, 2009).

Externalizing problems are more related to how an individual interacts with the outside world, and include disorders such as conduct disorder, operational defiant disorder, and include behaviors such as underage drinking and illicit drug use. Because longitudinal and prospective studies of homeless youth are rare, it is difficult to address the direction of the association between mental health issues and homelessness or to determine causality. However, it is generally considered that mental health issues make individuals more vulnerable to experiencing homelessness, and that the homeless experience itself probably exacerbates existing mental health issues (Yoder, et al., 2008).

CHAPTER V

CHILD ABUSE AND HOMELESSNESS

5.1 Overview

Homeless adolescents are more likely to have been abused than housed adolescents. Abused youth are more likely to run away, or to be asked or forced to leave their homes by their caregivers. Forty-nine percent of adolescents reported running away for the first time due to violence at home, physical abuse, and/or sexual abuse (Tyler & Cauce, 2002). The *Federal Child Abuse Prevention and Treatment Act* (CAPTA), as amended by the *Keeping Children and Families Safe Act of 2003*, defines child abuse and neglect as:

> Any recent act or failure to act on the part of a parent or caretaker which result in death, serious physical or emotional harm, sexual abuse or exploitation; or an act or failure to act which presents an imminent risk of serious harm.
>
> (U.S. Department of Health and Human Services, 2009)

Sexual abuse, physical abuse, emotional abuse, and child neglect are forms of child maltreatment (Toro, et al., 2007). In 2007 an estimated 794,000 children were victims of maltreatment and more than 3.5 million children received Child Protective Services investigations or assessments (U.S. Department of Health and Human Services, 2009). Because different forms of maltreatment may have different effects, researchers frequently look at a specific type or types of maltreatment separately to better understand the effects of each type. Sexual is the most widely studied of the 4 major types of maltreatment, followed by physical abuse. Sexual and physical abuse are easier to

measure because there is less gray area as to what does or does not constitute the abuse.

Neglect and emotional abuse are not as easy to operationally define, and there is more controversy about what level of care or emotional treatment is harmful to a child than what kind of physical punishment or sexual interaction is harmful. Although most people disapprove of any mistreatment of children, sexual abuse and physical abuse are considered far more unacceptable than emotional abuse or neglect. This report focuses on sexual and physical abuse.

There is evidence for significantly higher rates of negative outcomes among youth who are sexually abused or physically abused. Persons who experienced both sexual and physical abuse often show still worse dysfunction than persons who experienced sexual abuse or physical abuse but not both (U.S. Department of Health and Human Services, 2009). Several studies have compared the type or types of abuse experienced with outcomes, specifically physical abuse only, sexual abuse only, both physical abuse and sexual abuse, and sometimes a no abuse variable. Combined physical and sexual abuse are often more severe abuse; more likely to be abused by parents/caregivers and nonrelatives alike; more negative outcomes; as compared to physical or sexual abuse alone. Combined physical and sexual abuse may also be evidence of more severe family dysfunction than other abused children may witness or experience (Martinez, 2006).

A number of negative mental health issues are common among housed persons with a history of child abuse, and a high percentage of homeless youth report history of child abuse and similar mental health issues as abused housed persons. Effects may vary depending on type of maltreatment, as well as its severity, duration, and age and time in child's psychosocial development of onset. Sexual abuse and physical abuse are violent

forms of trauma, and can be especially damaging to children because they are still developing in body and mind (U.S. Department of Health and Human Services, 2009). Abused children and women with a history of child abuse are more likely to have PTSD, as well as a number of other psychological sequelae associated with trauma, such as dissociative disorders, depression, and suicidal ideation and attempts (Gwadz, et al., 2007). These mental health issues, besides being associated with greater psychological distress for the individual, are also associated with greater social interactional and occupational difficulty (Tonmyr, et al., 2005).

Post Traumatic Stress Disorder

Post traumatic Stress Disorder (PTSD) is a disorder that affects some individuals who have experienced a disturbing or frightening event. PTSD generally starts within three months of the event, although sometimes symptoms do not appear until much later. PTSD is a clinical syndrome that can last for years and can cause serious functional impairment. It is characterized by re-experiencing the traumatic event, avoiding trauma-relevant stimuli and/or numbing of general responsiveness, and heightened arousal (Gwadz, et al., 2007). PTSD is a treatable condition, however, treatment and recovery can be complicated by the typical presence of comorbid mental illness, especially depression and anxiety disorders (Gwadz, et al., 2006).

There is strong evidence that girls and women are more likely to develop PTSD in response to trauma than their male peers, although it is not clear why (Gwadz, et al., 2007). One study found no gender differences in sum total of child maltreatment experiences; however, the types of childhood maltreatment experienced were different

for boys and girls (Gwadz, et al., 2007). Gender differences were found among the presence of PTSD symptoms following abuse or trauma. PTSD symptoms were significantly positively associated with physical abuse, sexual abuse, sexual trauma, physical trauma, general trauma, and symptoms of depression/anxiety among girls (Gwadz , et al., 2007). PTSD symptoms were only associated with sexual trauma among boys (Gwadz, et al., 2007).

5.2 Characteristics of victims of childhood abuse

Abused youth tend to be older, female, of an ethnic minority, have a greater number of runaway episodes, and not living with parents at admission or during the previous year (Thompson, et al., 2004). Higher rates of sexual abuse are reported by girls (44%) compared to boys (18%), and sexual minority youth reported higher rates of physical and sexual abuse compared to heterosexual youth (Tyler & Cauce, 2002). Most sexually abused youth were first abused before the age of 12 years (Tyler & Cauce, 2002).

Childhood abuse is associated with high risk sexual behaviors, such as failure to use condoms, sexual activity with riskier partners, and earlier sexual activities, which increases risk for subsequent STDs. While females are more likely to develop internalizing behaviors, male survivors of sexual or physical abuse are more likely to exhibit externalizing behaviors, such as conduct disorder, criminal behavior, and delinquency. Such antisocial behavior can lead to juvenile hall and subsequently jail recidivism.

5.3 Development

The developmental effects of abuse are cumulative. Children are especially vulnerable to the negative effects of adverse life experiences because they can disrupt the normal development process and create lasting problems if not addressed and treated.

Children need a stable, loving environment in which they feel physically safe and have a sense of belonging. When children feel threatened or unloved, they may have more difficulty connecting with others in a socially constructive way. A physically or sexually abusive caregiver can damage a child's psychosocial development. When children feel frequently threatened or unsafe, they may become sensitized to anxiety and react to even small stressors as threats. Evidence suggests that sexually abused children are more likely to experience multiple other forms of trauma in childhood (Middlebrooks & Audage, 2008; Banyard, Williams, & Siegel, 2001), and adulthood (Banyard, et al., 2001). These additional traumatic experiences seem to mediate the relationship between childhood sexual abuse and later adverse mental and physical health outcomes (Banyard, et al., 2001). Children and adults often develop coping strategies to deal with recurrent trauma or a stressful family environment. Although these coping strategies can be very effective in dealing with the adverse situation, they can cause persistent problems throughout the life course in other areas of life, and are very difficult to change.

Child abuse is considered a form of toxic stress because it is negative stress that is harmful to a child's development (Middlebrooks & Audage, 2008). Some other types of stress can be potentially harmful to children but, with proper emotional support from caregivers, can be coped with productively in a way that fosters positive development and growth. Examples of this type of potentially harmful stress include parental divorce and

death of a loved one. Child abuse, however, is considered to be a type of stress that cannot foster this type of positive growth (Middlebrooks & Audage, 2008).

There are three types of stress: positive, tolerable, and toxic. Positive stress results from adverse experiences that are short-lived, like a child's first day of school. Learning to cope with and manage positive stress is a normal part of healthy development. Parents and/or other concerned caregivers can provide the support necessary for children to learn how to respond to stress in a physically and emotionally healthy manner (Middlebrooks & Audage, 2008). Tolerable stress is more intense than positive stress, but can be relatively short lived and can be overcome with adult support. It includes surviving a natural disaster or divorce. Toxic Stress is intensely adverse experiences which may occur over a long period of time. Sexual abuse and physical abuse are considered forms of toxic stress. Toxic stress can have lasting negative effects, because the experiences activate a child's stress response for a prolonged period of time which can permanently affect brain development (Middlebrooks & Audage, 2008).

5.4 Sexual abuse

An estimated 285,400 children were victims of a sexual assault and 35,000 were victims of some other type of sex offense according to a 1999 study. Youth ages 15-17 years were disproportionately represented: they comprise 54 percent of all victims compared to 17 percent of the general population (Finkelhor, Hammer, & Sedlak, 2008). It is difficult to get an accurate estimate of the incidence and prevalence of sexual abuse, and official estimates tend to be artificially low because victims tend to underreport sexual abuse to adults or officials (Finkelhor, et al., 2008). For instance, one national study found that in 70 percent of incidents, the police were not contacted. Police were

not contacted 59 percent of the time because the child did not want the caretaker to find out about the assault or the child did not tell the caretaker until long after assault had occurred (Finkelhor, et al., 2008). Many studies rely on adult retrospective self-reports for child sexual assault data. Although retrospective self-reports are a practical study design, it is prone to a number of errors, such as recall bias and omission due to stigma.

The survey counted victims rather than numbers of assaults, and children who experienced multiple assaults were only counted once. A count based on number of assaults rather than on number of victims could have been even higher (Finkelhor, et al., 2008). In a sample of homeless youth, those who reported being sexually abused also reported a number of adverse health effects including: having trouble walking or sitting (17%); having a pain or itch in their private parts (13%); venereal disease (5%); and bruising and bleeding (13%). Some were severe enough to seek physician outpatient care (16%) or require hospitalization (12%). Both of these outcomes were significantly more likely for females than males (Tyler & Cauce, 2002). Factors such as age at first and last abuse, number of abusers, frequency of abuse, and severity of abuse may mediate negative psychological and emotional outcomes following abuse (Ryan, et al., 2000).

One study found 89% of sexual assault victims were female (Finkelhor, et al., 2008). However, boys are less likely to disclose abuse than girls, as a result of fear of reprisals, stigma against homosexuality, and loss of self-esteem (Valente, 2005). Less research has been done on the effects of sexual abuse on boys. However, existing research on male survivors suggests that they report the same negative responses as female survivors, such as feelings of helplessness, isolation, alienation, guilt, and humiliation (Valente, 2005). Like female survivors, they frequently suffer from anxiety

and feelings of self-loathing, which often leads to self-destructive behavior (Valente, 2005). This self-destructive behavior is thought to be a result of the abused children internalizing their past abuse.

Child sexual abuse victims report greater exposure to other nonsexual traumatic events in both childhood and adulthood and higher mean scores of the composite of other childhood traumas (Banyard, et al., 2001). Childhood sexual abuse and many areas of adult mental health functioning seems to be mediated by a different traumatic events through out life, particularly other childhood trauma and adult sexual assault (Banyard, et al., 2001).

Overall, the perpetrators of sexual abuse are primarily male (53% to 94%), and most identify themselves as heterosexual (Valente, 2005). However, adolescent girls have reported that 96% of their sexual perpetrators were male; whereas among boys, 59% of their perpetrators were male (Tyler & Cauce, 2002). When asked about the perpetrator of the first sexually abusive act they experienced, youth reported strangers/acquaintances as the largest category (58%). Family members such as non-parent relatives and older siblings constituted about 25% of first perpetrators (Tyler & Cauce, 2002). Step/adoptive/foster parents were the least likely to be perpetrators of sexual abuse (7%), followed by biological parents (Tyler & Cauce, 2002).

5.5 Physical abuse

Nearly half of the homeless youth sampled in one study reported being physically abused as a child, and rates were not statistically significant for males (44%) and females (51%) (Tyler & Cauce, 2002). The average duration of physical abuse was 5.4 years (median= 5.0) (Tyler & Cauce, 2002). In a sample of homeless youth, those who reported

being physically abused also reported a number of injuries resulting from the physical abuse. The physically abused youth reported bruises or welts (74%); lacerations (48%); broken bones (12%); and burns (15%) resulting from the physical abuse. The severity of injuries of the physically abused was severe for some: 27% reported needing to see a doctor, and 21% reported needing hospitalized care for their injuries (Tyler & Cauce, 2002). Physically abused youth are more likely to have affective and behavioral difficulties including anxiety, depression, self-destructive behavior, low self-esteem, social detachment, hyperactivity, excessive aggression, and noncompliance by middle childhood, (Ryan, et al., 2000). When asked about the perpetrator of the first physically abusive act, youth reported that more than half of perpetrators of physical abuse were biological parents (69%), with mothers and fathers being equally likely to physically abuse their children (Tyler & Cauce, 2002). Parental use of alcohol in excess is sometimes associated with caretakers being abusive and physically violent (Tyler, 2006).

5.6 Life course model

To understand the complexities of health outcomes and to try to create a more comprehensive approach to health and wellness researchers use the life course model. The life course model, or perspective, views health as a result of the complex interaction between protective and risk factors across the lifespan, such as various biological, psychological, and social responses and personal behaviors. ACEs are examples of risk factors in the life course perspective. ACEs include two types of child maltreatment, sexual abuse and physical abuse. These are early life events that can affect a child's normal development and have a lasting effect on his or her health and well-being as an

adult. A number of factors can delay normal adolescent development, such as substance use and mental health disorders. History of physical or sexual abuse can also delay adolescent development, and can provoke psychological, social, and cognitive regression. (Middlebrooks & Audage, 2008).

Although various risk and protective factors can occur at any time in one's life and affect health outcomes, the life course model theorizes that there are particularly critical periods when factors or events may make an impact. Developmental periods during early childhood and adolescence are life stages where these protective or risk factors can have a profound effect on health outcomes, which may be immediate but may also continue to impact an individual's health throughout their life. Examples of risk and protective factors include socioeconomic status, nutrition, stress, race, health care, and ACEs. (Middlebrooks & Audage, 2008).

The association between ACEs and adult health likely reflects an indirect and complex pathway. Exposure to ACEs can have significant and lasting negative effects on a person's mental health, leading to chronic stress and anxiety or other psychological distress which may continue into adulthood. The effects of ACEs on adult health seem to be mediated by increased risk behaviors, such as alcohol and substance abuse, tobacco use, and obesity. Many survivors of ACEs engage in a greater number of high risk behaviors such as smoking or AOD use in order to cope with their continued psychological distress. Chronic use of such high risk behaviors is often successful in short term relief and management of such problems; however, it can also lead to a number of harmful and even fatal health outcomes, as well as interfere with other aspects

of life, which can impair quality of life (Middlebrooks & Audage, 2008; Felitti, Anda, Nordenberg, Williamson, Spitz, Edwards, et al., 1998)

There are a number of short- and long- term health outcomes associated with ACEs, including a number of mental health issues, such as depression and suicide attempts. Other health outcomes include, but are not limited to: alcohol or other substance abuse; early initiation of smoking; liver disease; multiple sex partners, sexually transmitted diseases; unintended pregnancies; and risk for intimate partner violence Persons who have experienced one ACE are at risk for these outcomes, and the more ACEs a person has experienced, the higher the risk of developing such outcomes (Middlebrooks & Audage, 2008).

Perhaps the most famous study to date that deals with the long-term effects of adverse childhood experiences on adult health outcomes is the Kaiser Permanente ACE Study, a retrospective and prospective study of thousands of Kaiser Health Plan members. The study looks at the relationship between violence-related stressors, including child abuse, and later risky behaviors and health problems using a large adult sample in a primary care setting (Middlebrooks & Audage, 2008; Felitti, et al., 1998). The Life Course Model will be discussed further in the Conclusions and Implications section that follows.

CHAPTER VI

CONCLUSIONS AND IMPLICATIONS

Child abuse and youth homelessness are associated with a number of adverse outcomes which affect a person's health and well-being. Preventing and stopping child abuse and youth homelessness are clearly important, but more work needs to be done in the fields of research and prevention to address these issues. More research is needed in these areas to provide evidence for the most effective prevention strategies and translation research to implement the research in real world settings. This research can be used to inform better primary prevention programs to prevent child abuse and/or homelessness from occurring and intervention programs to reduce harmful outcomes and end the abuse or homeless episode.

6.1 Research Gaps

The life course model can be used to guide research in the causes of abuse and homelessness and the effectiveness of interventions to prevent abuse and homelessness. The life course model theorizes that there are several periods when factors or events may have a more profound effect. More research is needed to understand the most vulnerable periods and how to effectively intervene to prevent youth from becoming homeless as well as how to protect youth once they become homeless. Three main areas need further research to have an impact on youth homelessness: risk and protective factors associated with child abuse, improved methods for identifying and targeting homeless youth for research and interventions, and the costs of youth homelessness.

Abuse

More research is needed to learn what factors help children who experience abuse cope in the healthiest way possible. Although many child abuse survivors experience adverse outcomes and exhibit high-risk behaviors, some survivors never exhibit serious dysfunction or psychopathology. Understanding these children and differences between them and their maladjusted peers may provide insight into aspects of healthy adjustment and coping. Such understanding of resilience factors could also help us develop interventions that aim at developing or improving these resilience factors and teaching survivors healthier and more effective ways to cope with psychological sequelae and better interact with the world.

Another area that merits more attention is the effects of the specific aspects of the child abuse. For example, the age of first abuse, the severity of the abuse, and the length of time the abuse continued (e.g., months, years) are all variables that are related to the severity and duration of the adverse effects of child abuse. It is helpful to understand the possible impact of various components of the abuse on a child so that mental health professionals and other service providers can tailor the survivor's treatment to the severity of such details (Stevenson, 1999).

Targeting youth for interventions

More research is needed to improve identification of youth who are at risk of being abused or becoming homeless for primary prevention. Many homeless youth distrust adults and authority, often as a result of years of maltreatment, conflict with parents, or involvement with government institutions such as child protective services or the juvenile justice system. As a result, many of these youth refuse to utilize available

services, such as emergency shelter. Because services must be utilized to be effective, it is important to understand the reasons some youth do not use available services and how to address their hesitation and improve relations and communication between homeless youth.

Accurately targeting those most at-risk is one of the most difficult parts of successful implementation of prevention services. This optimizes use of limited resources and improves the public impact of these services. Accurately identifying the target population is difficult and requires extensive knowledge of the health outcome to be prevented and the characteristics of persons and their circumstances most likely to precede it.

Identifying youth for studies

Although the literature on homeless youth and abused homeless youth is growing, there is still much that needs to be understood about this vulnerable and often untrusting group. Research on homeless youth has been limited by the difficulty of finding and recruiting these youth in studies. Homeless youth can be difficult to identify because they are often indistinguishable from housed youth, and are less likely to frequent shelters or other conspicuous places than are homeless adults. Further, these youth are often very distrusting of adults, making another obstacle to recruitment. To more effectively and efficiently recruit homeless youth for studies, researchers need to develop a systematic way of identifying these youth, as well as strategies for successfully recruiting them once found.

Cost of Homelessness

Better estimates of prevalence and incidence are also needed to document the economic and societal burden of homelessness. Better research methods are needed to document the extent of homelessness. Some studies have examined the cost of healthcare but these are believed to underestimate the true costs. Health care providers do not always recognize which patients are homeless. Studies that compare health care costs of the homeless and housed find that health care costs are higher for the homeless. More accurate estimates could help policy-makers determine appropriate allocations of funds for service.

6.2 Prevention and Interventions

Although the outlook for homeless youth appears bleak, prevention strategies and intervention programs can be implemented at numerous points to prevent further harm and minimize the effect of past harm. More and better prevention efforts targeting at-risk youth are needed, as are interventions for those who have already been abused or become homeless. Homeless youth need more accessible and adolescent- friendly assistance programs to service their basic, immediate needs such as shelter or temporary housing, food, and basic care. Just as important are programs and services designed to help break the cycles of victimization and homelessness and help youth become functional adults. These include educational and skills training programs, treatment for psychological sequelae, social deficits, and related problems, and more permanent, safe housing solutions.

Abuse

Child abuse is a leading reason youth run away from home. The best way to address the issues of child abuse and homelessness is to prevent them from occurring in

the first place. Because of the numerous adverse outcomes associated with abuse and homelessness, effectively implementing primary prevention with such persons could make a major impact.

Home visitation is largely considered the most effective of abuse intervention services (Stevenson, 1999). This service involves a trained professional visiting a family's home, often multiple times, to help parents learn about functional parenting. Home visitation services can be used for primary prevention and secondary prevention of child maltreatment. Early child home visiting involves visitation during pregnancy until the child is approximately two years old, and has shown promising outcomes. There are a number of challenges that can decrease positive changes, however, such as getting parents to attend and comply with treatment. Making such interventions more parent-friendly is an important step toward improving compliance and making interventions more effective (Stevenson, 1999).

Child abuse survivors frequently exhibit a broad range of psychosocial dysfunction, making interventions which only address the abuse less effective. However, treatments do exist to address a number of such issues. Abused children often exhibit social deficits, and social skills training can be useful in helping these children develop important skills that aid in creating and maintaining close relationships. Because social support and affection improve a person's resilience to various life stressors, development of social competencies that help child abuse survivors get meaningful interactions with others can prove effective in a child's recovery.

Mental Health

Because homeless youth often suffer from depression and/or anxiety and post traumatic stress disorder, and these disorders are associated with a decreased chance for obtaining an education that can result in fewer job opportunities and a greater risk of homelessness, it is important to offer mental health services. Outreach programs for homeless youth with these disorders are needed to help them learn better coping skills and resilience can help prevent dependence on alcohol and other drugs. Teaching positive behaviors, such as assertiveness, can help to prevent victimization.

Education

Educational and vocational training programs for homeless youth are needed to provide these youth with valuable skills to support themselves. In addition, institutions such as foster care, psychiatric hospitals, juvenile detention centers, and residential schools should offer more vocational training to institutionalized youth. The completion of General Equivalency Degrees (GEDs) can help adolescents who never completed high school compete for better-paying jobs than if they had no degree. Such programs are necessary if these youth are ever to make an income sufficient to maintaining housing and getting out of poverty. For some older adolescents, such education may also reduce their dependence on subsistence strategies by enabling them to find work.

Housing Programs and Policies

Transitional Housing

Supportive housing programs such as Housing First have shown great promise in helping vulnerable populations of homeless persons maintain housing and get the care and assistance they need to become functional. Populations such as the chronically homeless, often those who are mentally ill and/or substance abusers, have already been

targeted for tailored supportive housing programs, and have shown great promise. Compared to their other homeless peers with the same issues, participants are more likely to stay housed, have better treatment outcomes, and generally have similar total costs to the public. As adolescents are young and have their entire adult life before them, the potential impact of the benefit of such programs could be great, not only to improving the participants' quality of life and ending their homeless episodes, but also in increasing their productivity and helping them meet their potential to be functional, healthy adults who can make a positive contribution to their communities.

Emergency/ Temporary Housing

Shelter admission policies that require a parent or guardian to sign in a child prevent unaccompanied homeless youth from admission, and these youth may resort to sleeping on the streets or in other unsafe environments. Because of the significant number of unsupervised homeless youth, it is important that we provide more opportunities for them to obtain safe emergency shelter. This would also decrease their chances of being victimized by adults in these settings.

Criminal Justice Policies

Unaccompanied, homeless youth often have contact with the juvenile justice system. Although some of these youth are arrested for criminal offences such as theft or prostitution, youth are also arrested for status offenses, which are acts that are illegal because the subject is a minor. An example of a common status offense is being out without an adult after curfew. Interactions with the juvenile justice system sometimes lead to recidivism and other negative outcomes. Decriminalization of youth homelessness and changing criminal justice responses to such things as status offenses

could make way for more positive and effective ways of changing the youths' situation. Alternatives to institutionalization in the justice system could include drug treatment programs, programs designed to foster positive youth development, and services like transitional housing for homeless youth, and educational and skills training to help youth get re-housed and become functional adults.

6.3 Conclusion

The adverse health outcomes associated with child abuse and homelessness are great and often lasting. Yet there are effective and promising solutions to prevent, stop, and minimize these types of adverse experiences and their associated outcomes. As such, it would be ethically wrong to ignore these vulnerable groups. Because the homeless condition has such far reaching impact on a person's health and well-being, and because homelessness is completely preventable, this issue has public health importance and the public health community can and must help address it. Child abuse and youth homelessness can be reduced and eliminated, but a focused and organized effort must be made, with inter-organizational partnerships and attention and resources devoted to creating and implementing better primary prevention and outreach programs. Further, education and skills training programs are essential for homeless youth to develop the skills necessary for gainful employment.

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