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Effects of Childhood Trauma on the Psychological Distress of Black Homeless Youth: The
Moderating Role of Social Support

by

Tiffany Edwards Doh

Under the Direction of Eric R. Wright, PhD

A Thesis Submitted in Partial Fulfillment of the Requirements for the Degree of

Master of Arts

in the College of Arts and Sciences

Georgia State University

2023

ABSTRACT

Youth homelessness is a growing issue in the United States. Black homeless youth are a unique subgroup to be studied because these youth must simultaneously manage stressors that accompany racial minority and homeless statuses during critical stages of development. Using data from the Atlanta Youth Count Needs Assessment, this thesis explores the impact of childhood trauma on psychological distress of Black homeless youth (N=556). In addition, this thesis examines whether the relationship between childhood trauma and psychological distress is conditioned by the level of social support reported by Black homeless youth. Results show that childhood trauma experienced by Black homeless youth is associated with higher levels of psychological distress. Although greater social support is linked to lower levels of psychological distress, social support does not moderate the link between childhood trauma and psychological distress. These findings are intended to inform health policy and resource options for Black homeless youth.

INDEX WORDS: Black homeless youth, Psychological distress, Childhood trauma, Social support, Homeless youth count

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2023

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Moderating Role of Social Support

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August 2023

DEDICATION

I dedicate this thesis to my family. To my parents, who laid the foundation, through regular and at-home summer education and perseverance, you inspire me and have never left my side. You believed in me first and were never more than a call away. To Grace Y. Edwards, our first scholar, for being an example and instilling in me to “get my lesson.” To my incredible siblings, nephew Evien (who knew the word thesis, before many others), and aunts Ernestine and Davina, who encouraged and celebrated me through every step. To all of my family who have gone on, Asé.

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For the homeless youth who shared their lived experiences and stories - you are not invisible. I will continue to tell your story. To De’Lauren, your story challenged my every emotion. I love you and did not give up because of you.

Lastly, I thank the younger me, little Tiffany, for believing we could BE.

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LIST OF ABBREVIATIONS

ACES - Adverse Childhood Experiences

AYCNA - Atlanta Youth Count Needs Assessment

SMI - Severe Mental Illness

1 INTRODUCTION

In recent decades, social and behavioral science research has focused on providing evidence that childhood adversity or trauma can have lasting effects beyond childhood. Studies indicate traumatic events have physiological and psychological effects over the course of one's life (Chapman et al. 2004). Earlier research typically examined the impact of single, acute childhood traumas to assess their psychological consequences (Browne and Finkelhor 1986; McCauley et al. 1997). However, more recent research confirms that some individuals have experiences of multiple occurrences of childhood traumas that can have compounding effects. These multiple occurrences are better assessed collectively, believing that the impact of traumatic childhood experiences on adult physical and mental health is both strong and cumulative (Felitti et al. 1998; Herrenkohl and Herrenkohl 2007; Stinson et al. 2016). This study advances prior research by accounting for multiple occurrences of traumatic events in childhood.

Childhood trauma is not experienced randomly across the US population. For example, child trauma exposure appears to be relatively high in Blacks (Jiminez et al 2016; Morsey and Rothstein 2019) and among homeless populations (Alim 2006; Davies and Allen 2017). Given that those who identify as Black or African American are overrepresented in the homeless population (First et al. 1988; Thompson et al. 2003; Jones 2016; HUD 2017), understanding the experiences and associate factors of childhood trauma among homeless Black youth is important. However, while it is reasonable to anticipate that Black homeless youth would be at increased risk for childhood trauma and psychological distress due to their dual marginalized, racial and homeless, statuses, little is known about the experiences and associate factors of childhood trauma among homeless Black youth.

Moderating the relationship between childhood trauma and psychological distress, social support has been shown to effectively decrease levels of psychological distress. As a buffer to stress, social support has been proposed as a possible protective factor that can mitigate the negative consequences of social stressors on health (Umberson et al. 2010). The significance of social support is analyzed in predicting levels of psychological distress and its potential stress-buffering effects in the relationship between childhood trauma and psychological distress

Using the 2015 Atlanta Youth Count and Needs Assessment data, this thesis will examine the significance of trauma as a predictor of psychological distress in Black homeless youth populations, net of their age and gender. The final sample includes large numbers of Black homeless youth providing an exceptional opportunity to improve our understanding of the characteristics and needs of Black homeless youth. This unique dataset has important implications to contribute to the existing literature by providing a careful look at the relationship between critical life experiences and mental health among Black homeless youth in more depth than has been done in the past.

2 LITERATURE REVIEW

2.1 Homeless Youth in the United States of America

Homelessness, among youth, is a growing concern in the United States. A growing homeless, specifically youth, population has led to increased research looking to examine the unique characteristics and needs of homeless youth, as compared to homeless adults (Ennett et al. 1999; Kidd and Taub 2004, O'Brien et al. 2020, Winiarski et al. 2020). However, estimates of prevalence vary, partly due to differing definitions of homelessness and difficulty accessing homeless youth (Whitbeck et al. 2004, Anthony and Fischer 2016). With varying definitions, the U.S. Department of Housing and Urban Development (HUD) estimates 38,303 unaccompanied homeless youth in 2017, while the Department of Education estimates 1.5 million homeless children in public schools, including accompanied youth, couch surfing, living in hotels/motels, and doubled up situations (Anon n.d.). Suggesting that there may be important differences between these distinctions, research has grouped homeless youth in subgroups (O'Brien et al. 2020). To operationalize homeless youth for this thesis, excluding youth experiencing homelessness with their families, homeless youth will include youth in unstable living situations, from sleeping on the streets, living in shelters, running away, being thrown out, and couch surfing (Voices of Youth Count, 2017).

Homeless youth have been understudied because they are more often transient in nature and difficult to locate. National counts of homeless youth occur annually on a single night in January, making it challenging to accurately locate homeless youth to estimate and report prevalence at the state and national levels. The exact number of homeless youths is harder to estimate, and therefore mitigate, because the population is often “hidden away” to avoid police

or child services authorities or “hidden in plain sight”, a term highlighting the difficulty to distinguish homeless from housed youth (Glier 2019).

Homeless youth become homeless for a myriad of reasons. Youth most often cite familial conflict as the major reason for their homelessness (APA 2014, Fernandes-Alcantara 2019). “Over one-third of youth experienced the death of a parent or caregiver, underscoring early trauma and disruptions that can contribute to paths of instability and, ultimately, homelessness” (Voices of Youth Count 2017). They had traumatic family experiences, including sexual and physical abuse, parental drug addiction and family violence (Chamberlain and Johnson 2013). 46% of homeless youth report experience abuse (APA 2014). Various forms of trauma experienced during adolescence can have lasting effects on the youth’s mental and physical health. These youth are in greatest need of mental health services, but being part of a marginalized and underserved population often makes it more difficult to obtain essential health services.

2.2 Childhood Trauma

Trauma experienced during and prior to adolescence negatively affects one’s psychological distress (Schad et al. 2008; Exner-Cortens et al. 2013; Wade 2014; Hicks et al. 2020; Gangamma et al 2021). Traumatic childhood experiences, once evaluated individually for their impact on one’s life course, are now more accurately evaluated collectively for their cumulative effect. Cumulative trauma appears to increase symptom complexity (Briere, Kaltman, and Green 2008). For this thesis, childhood trauma is defined as difficult, stressing events, the result of a physical or psychological attempt and/or the presence of its threat in childhood on the physical integrity, self-esteem, as well as the life of the child or the life of a

person significant to the child (Gersamiya, Menshikova, and Yakovlev 2016). A 2003 study shows that the accumulation of objectively nonviolent experiences such as parental divorce and failing a grade in school, along with witnessing violence, represent significant predictors of PTSD (Lloyd and Turner 2003). All childhood traumas, according to my definition, originate externally, none generated solely within the child's own mind, yet may cause lasting changes within the child.

Between 1992 and 1995, Kaiser Permanente began completing a standardizing of medical evaluations to assess the relationship between childhood abuse and dysfunction and multiple risk factors for some of the leading causes of death in adults (Felitti et al. 1998). Adverse childhood experiences (ACEs) were created as a questionnaire to quantify these negative/toxic occurrences. ACEs have been described as moderately to severely stressful experiences during the first 18 years of life (Felitti et al. 1998). These experiences include, but are not limited to, emotional, sexual and physical abuse, neglect, parental psychopathology, parental incarceration and parental separation (Felitti et al. 1998). Presence of one or more ACEs leads to higher levels of psychological distress (Felitti et al. 1998; Gangamma et al. 2021).

Trauma is a common experience amongst homeless youth prior to homelessness and, for many, figured in the causal pathways to homelessness (Martijn and Sharpe 2006; Chamberlain and Johnson 2013). Many studies recognize the strong associations of adults reporting traumatic childhood events with greater prevalence of a wide array of health impairments, including overlapping mental health problems (Shonkoff et al. 2009; Varese et al. 2012; Stinson et al. 2016). The impact of childhood traumas has been shown to have effects later in the life course but may also have effects manifesting in the adolescent and young adult years (Breslau et al. 1991; Turner and Butler 2003; Schilling, Aseltine, and Gore 2007).

Most notably, the presence of childhood trauma is a social determinant of homelessness. Homeless youth often come from conflict-laden, violent, and dysfunctional families (Jibeen 2014; Embleton et al. 2016; Lim et al. 2016). That is, they face challenges that stem both from their lives on the streets and their life experiences that led to their becoming homeless. Many of these early life experiences are captured in various versions of ACEs. At the same time, suicide has become one of the leading causes of death among homeless youth (Roy et al. 2004) and more undoubtedly needed attention is being given to suicide prevention and documenting suicide attempt and completion rates (Yoder 1999; Roy et al. 2004). However, addressing the mental health needs of homeless youth requires a more well-rounded approach that recognizes the importance of childhood traumatic events as well as a better understanding of the supports youth have to protect their mental health. The distinctive health trajectories of the less and more privileged, may be due to conditions that long antecede the decades in which these trajectories take shape (Pearlin et al. 2005).

2.3 Psychological Distress Among Homeless Youth

Psychological distress is defined as non-specific symptoms of stress, anxiety and depression. High levels of psychological distress are indicative of impaired mental health. In some cases, however, psychological distress may indicate the beginning of mental disorders, like depressive and anxiety disorders (Cuijpers et al. 2009; APA 2023). Various studies indicate that child abuse can have impactful, severe, and diverse psychological impacts (Briere, 2004).

The lifetime prevalence of psychiatric disorders is almost as twice as high for homeless youth compared to housed youth (Kamieniecki 2001). Homeless youth also have disproportionately high rates of untreated mental health problems and are therefore vulnerable to

the effects of homelessness (Winiarski et al. 2020). The rates of psychological disorders at the point of homelessness are greater than in normative samples (Martijn and Sharpe 2006). More than 80 % of homeless youth who range in age between 14 and 25 years suffer from depression, anxiety, and aggression and 43% report having attempted to commit suicide (Klee and Reid 1998; APA 2013). In a study of 146 homeless youth, from several major cities in the U.S., trauma was identified as the most common risk factor for psychopathology among thirty-five homeless youth with 77% reporting experienced physical abuse, sexual abuse, or both (Ryan et al 2000; Martijn and Sharpe 2006).

2.4 Black Homeless Youth

The face of homelessness has changed. Once thought of as a population of older white men, the homeless population has become a much more racially heterogeneous group (Baxter and Hopper 1981; Jones 2016). People who identify as Black or African American are overrepresented in the homeless population. Blacks were 43% of the sheltered homeless population while only 12.7% of the U.S. population (First et al. 1988; Thompson et al. 2003; Jones 2016; HUD 2017). With the homeless population reflecting a more diverse group, the needs of varying races need to be better understood.

Trends in the national Point-In-Time data suggest greater variability with regard to race (Henry et al. 2017). The cultural variance model assumes that ethnic differences are due to variations in culture specific values, histories, and experiences and to the unique struggles of minority groups (Cauce et al. 1998). Therefore, it is necessary to explore the unique needs across differing racial homeless populations. Black homeless youth's needs may differ from their white counterparts, because due to dual marginalized statuses, Black homeless youth may

simultaneously manage stressors that accompany racial minority and homeless statuses during critical stages of development (Gattis and Larson 2015). Marginalized statuses affect the probability of experiencing particular circumstances capable of producing stress, which then affect the probability of experiencing mental health problems (Gattis and Larson 2015).

Trauma exposure appears to be high in Blacks, especially among those living in more stressful urban environments (Alim et al. 2006). Black youths face a number of stressors not experienced by their white peers, which may account for the data showing that Black youths in the general population having greater exposure and vulnerability to stress and consequently poorer mental health, including higher rates of depressive symptoms than their white counterparts (Gore and Aseltine 2003; Adkins et al. 2009). Black children and youth are among the most vulnerable to victimization compared to other racial/ethnic groups [13.9 per 1000], only second to American Indian/Alaskan Native [14.2 per 1000] (Child Maltreatment 2016). Victimization includes harm caused by another human being in violation of social norms, including but not limited to abuse, neglect, and exposure to violence, sex crimes, or bullying (Finkelhor 2011).

Because discrimination, racism, and structural disadvantages are associated with having lower socioeconomic status, more Blacks experience trauma by an earlier age and at a greater rate than their white counterparts (Adkins et al. 2009). Theories, like minority stress, describe the chronically high levels of stress faced by stigmatized minority groups, such as Blacks. This supports the notion that holding a racial minority status also presents a unique amount of stress for this homeless population.

Homelessness itself is a major life stressor. However, the intersecting identities of being youth (i.e., under 25 years of age) and Black may have distinctive outcomes since minority

children are twice as likely as White children to experience poverty, which has also been found in multiple studies to impose greater risk for mental and physical health problems (Brooks-Gunn, Duncan and Maritato 1997; Roosa and Gonzales 2000). In short, Black homeless youth, who already experience higher levels of stress due to their race, may be at particularly high risk of experiencing added psychological distress because they also are likely to have experienced more childhood traumas.

2.5 Social Support

Research suggests that social support can act as a buffer for physical and mental health problems (Unger et al. 1998). The existence or number of social relationships and the nature and quality of supportive relationships are important determinants of population health (Thoits 2010; Umberson and Montez 2010). Prior studies suggest that social support resources are helpful in ameliorating stress and psychological distress and have shown that perceived social support could be important in lowering the negative impact of life experiences and circumstances on mental health outcomes among the homeless population (LaGory et al. 1990; Irwin et al. 2008; Lee et al. 2010; Fitzpatrick 2016). Youth can overcome adversity by relying on a dynamic network of relationships with the wider community through the development of supportive non-kin relationships, positive school experiences, and encouraging role models (Grotberg 1995; Yates and Masten 2004).

The stress process model (Pearlin et al. 1981) analyzes the sources of stress, the mediators or moderators of stress, and the manifestation of distress. In addition to its direct effect, as a moderator, social support serves to buffer the negative health consequences associated with chronic stress exposure (Thoits 1982; LaGory, Ritchey, and Sells 1997). “The

general formulation of the stress buffer model begins with the assumption that external stressors such as life changes and daily hassles, if unchecked, disrupt an individual's psychological equilibrium and induce physiological and psychological responses in the form of stress" (LaGory, Ritchey, and Sells 1997: 211). However, according to the stress-buffering hypothesis, the negative health consequences associated with chronic stressors may be relatively lower among those with greater social support.

Social support usually refers to support from significant others, such as family members, friends, coworkers, etc., who provide instrumental, informational, and/or emotional assistance (Thoits 1995). Perceived or received social support have shown to have an effect on mental health (Thoits 1995). Studies have shown that perceived emotional support is associated directly with better mental health (Cohen and Willis 1985; Thoits 1995).

While homeless youth's social support networks can be difficult to capture (Wright et al. 2017), the AYCNA did incorporate four questions that asked homeless youth to describe their personal support networks. Specifically, the youth were asked how many family members, friends their age, adult friends, or professionals they felt they could talk to about "important matters." The responses to these four questions were used together to assess the direct and moderating effect of social support in the relationship between childhood trauma and psychological distress.

2.6 Contribution to Existing Literature

There is a dearth of research that specifically studies the Black homeless youth population. Very few studies focus explicitly on Black homeless youth, their experiences, and/or levels of psychological distress. As described in the reviewed literature above, Black individuals

may have an unique set of trajectories over the life course. Previous research also suggests Black homeless youth are more likely to have support from family members than other homeless youth (Wright, Attell, and Ruel 2017), which may have distinctive mental health outcomes. There is a gap in the current literature exploring the relationship between childhood trauma, psychological distress, and social support, specifically among Black homeless youth. This lack of prior research is where my study will contribute to the existing literature.

3 METHOD

3.1 Data

The Atlanta Youth Count and Needs Assessment (AYCNA) is a study of homeless youth ranging in age from 15 and 25, designed to estimate the size and needs of the homeless youth population. The AYCNA study consisted of a total of 1,102 contacts with homeless youth. Homelessness was established by asking if the respondent had either “doubled up” or stay overnight with someone, if they stayed at a motel or hotel, if they stayed in a shelter or other facility that provides short-term housing, or stayed overnight in a car park, public place, abandoned building bus or train station, or airport because they didn’t have a regular, adequate, and safe place to stay the night or sleep (Atlanta Youth Count, 2016).

The AYCNA study utilized systematic capture-recapture field sampling methods. Data were collected in two two-week waves. To be eligible for inclusion in the AYCNA sample, youth must have been between the ages of 14 and 25, not have a permanent stable residence of their own, and without consistent parental or familial support. Survey data were collected from 855 youth; 51 surveys were eliminated due to ineligibility or incompleteness. One hundred and ten duplicate surveys were eliminated from participants believed to have taken the surveys more than once. These procedures resulted in a final dataset of 693 unique surveys. Youth who completed the survey received a \$10 gift card, along with a list of resources and services.

3.2 Analytic Sample

For this thesis research, the Black homeless youth within the homeless youth population were studied. Of the 693 unique surveys, 78.6% (545) answered YES as Black, when asked “What race do you consider yourself?”. Respondents could answer “yes” in more than one race

category including “other.” Using a listwise approach of the racial identities entered in “other,” additional respondents that answered a racial combination including Black, Haitian, Bahamian, or African (i.e., Native American/Black) were added into the sample *Black* population. The resulting sample size was 556 remaining cases.

3.3 Measures

3.3.1 Psychological Distress

Psychological distress was assessed using the Kessler 6 (K6) nonspecific distress scale. K6 is a general measure of screening to estimate the prevalence of serious mental illness (SMI) (Kessler et al. 2003) with strong reliability and validity (Kessler et al. 2003, 2010). Respondents were asked to report whether during the past 30 days they felt nervous, felt hopeless, felt restless, felt so depressed that nothing could cheer you up, felt that everything was an effort, and felt worthless. Items are rated on a 5-point Likert scale measuring frequency of occurrence, and recoded, at the ordinal level, where 0 = “none of the time,” 1 = “a little of the time,” 2 = “some of the time,” 3 = “most of the time,” and 4 = “all of the time.” For this study, K6 scores were summed to create a continuous variable (full scoring range of 0–24 for each respondent). A score of greater than or equal to 13 signified probable severe mental illness (Kessler et al. 2010) and a score from 5 to 13 was defined as moderate mental distress (Prochaska, J. J. et al., 2012).

3.3.2 Trauma

The trauma variable was created from responses to questions that asked about difficult experiences the youth may have had before age 18. The trauma scale created contained 7 items. The traumas included witnessed violence in your home, witnessed violence in your neighborhood, witnessed a parent going to jail or prison, experienced abuse as a child, been in

the foster care system because of abuse or neglect, been in the foster care system because of juvenile criminal or delinquent behavior, received service from child welfare other than placement in foster care. The individuals responded “yes” = 1 or “no” = 0 to each question. A total trauma score was calculated by summing the YES responses resulting in a variable that ranged from 0-7.

3.3.3 Social Support

The support variable was created from the responses to the questions asking about the amount of support available to the homeless youth. The support scale created was based on whether the youth had family members you can talk to about important matters or turn to for help when you have a problem, friends your age you can talk to about important matters or turn to for help when you have a problem, adult friends you can talk to about important matters or turn to for help when you have a problem, or professionals you can talk to about important matters or turn to help when you have a problem. The individuals responded based on the number of persons they had in each category. The responses were coded at the ordinal level with “none/0” = 0, “1-3” = 1, or “4-more” = 2. The total support score ranged from 0-8.

3.3.4 Gender

The respondents were asked to identify what gender they identified as. The gender categories provided were *man/male*, *woman/female*, *part-time in both*, *gender queer*, *transgender*, *intersex*, *gender non-conforming*, and *something else*. Gender, a control variable, was coded, at the ordinal level, into three categories: man/male became cis-male = 1, woman/female became cis-female = 2, and all other non-cis categories were collapsed into trans = 3. Cisgender is a term that is used to describe people whose gender identity matches the sex they were assigned at birth (IAPAC 2021).

3.3.5 Age

The demographic variable measuring age is a control variable. Due to eligibility being dependent on age, each participant answered the question “How old are you?” Age was coded as a continuous variable, with responses ranging from 15 to 25 years of age. Age was a qualifier to participate in the survey.

4 ANALYSIS

This study uses a 2015 sample of homeless youth in Atlanta and all statistical procedures were analyzed using SPSS version 28. The analyses conducted during this study were divided into three categories: univariate, bivariate, and multivariate analysis. Univariate analysis consisted of examining descriptive statistics. First, gender was recoded into a trichotomous variable (cis-male, cis-female, and trans) collapsing the eight categories of responses. Second, I calculated a continuous psychological distress variable by summing the values of the responses to all six of the K6 questions, with higher values representing greater levels of psychological distress (Cronbach’s $\alpha = 0.788$). I also calculated a continuous trauma variable by summing the values of the dichotomous responses to occurrences of difficult experiences in childhood, with higher values representing greater levels of trauma (Cronbach’s $\alpha = 0.603$). Lastly, I calculated a continuous social support variable by summing the values of the responses to the four questions regarding their available support network, with higher values representing greater levels of social support (Cronbach’s $\alpha = 0.657$).

For bivariate analysis, bivariate correlations were performed to test how closely related the variables were. Next, multivariate linear regression analysis were performed. For the purposes of the bivariate correlations and linear regression models, the three-category responses

for gender were recoded into a set of dummy variables (cis-female and trans) where zero represents the reference category, cis-male. I examined the relationship between psychological distress and trauma and social support, controlling for age and gender.

5 RESULTS

5.1 Sample Characteristics

Descriptive statistics for the control variables are provided in Table 1. The sample was 60.9% cis-male, 33.2% cis-female, and 5.9% trans. The mean of the age variable was 21.49 (n=556), with a standard deviation of 2.61. The ages of the respondents ranged from 15 years to 25 years old.

Table 2a presents the trauma variable statistics. The average trauma score was 2.77 (range = 0.00 - 7.00). 91.3% of the sample reported having experienced at least one early childhood traumatic experience while over 50% experienced at least two. 79% witnessed violence in their neighborhood and 54% witnessed violence in their homes. 49% witnessed a parent going to jail or prison and 36% experienced abuse as a child. 24% had been in the foster care system because of abuse or neglect and 15% in foster care because of juvenile criminal or delinquent behavior. 19% received services from child welfare, other than placement in foster care.

Psychological distress frequency statistics are provided in Table 3a. The average psychological distress score was 11.02 (range = 0.00 - 24.00), well above the score of 5, indicating moderate mental distress, and approaching 13 indicating severe mental illness (SMI). Specifically, 74% scored 5 or higher on the scale, signifying moderate mental distress. Approximately, one quarter of the Black homeless youth (24.7%) scored 13 or higher, signifying severe mental illness. On average, the Black homeless youth reported feeling *nervous, helpless,*

restless or fidgety, so depressed that nothing could cheer you up, or worthless between a little or some of the time (Table 3b). On average, the youth reported *feeling that everything was an effort* some of the time (mean 1.99).

For social support, the majority of Black homeless youth (77.5%) with an average score of 2.99, scored 4 or less (range = 0.00 - 8.00), suggesting low social support (Table 4a).

However, due to coding, the estimate of the effect of social support may be conservative. In Table 4b, 79% reported *having family members you can talk to about important matters or turn to for help when you have a problem*. 86% had *friends your age you can talk to about important matters or turn to for help when you have a problem*. While 84% had *adult friends you can talk to about important matters or turn to for help when you have a problem* and only 49% had *professionals you can talk to about important matters or turn to for help when you have a problem*. On average, Black homeless youth had 1-3 family members, friends their age, adult friends, or professionals that they had in their network for social support. While many youths reported having someone for social support in the various categories, they reported mostly having fewer than 3 people.

Table 5 shows correlations among the study variables. Childhood traumas are significantly positively correlated with psychological distress (0.276), as anticipated, and significantly negatively correlated with social support (-0.132), suggesting that traumatic childhood experiences decrease Black homeless youth from seeking or obtaining social support. Psychological distress is significantly negatively correlated with social support (-0.154) and significantly negatively correlated with trans (0.115). There was a significant negative correlation between trans and age (-.177).

5.2 Linear Regression

Table 6 shows the results of the multivariate linear regression used to analyze the effect of trauma and social support on psychological distress. Beginning in Model 1, I assess the effect of childhood trauma on psychological distress. Childhood trauma has a positive, significant relationship with psychological distress, where for every unit increase in childhood trauma there is a .969 increase in psychological distress ($p < 0.001$). Model 1 accounts for 7.6% of the variance in psychological distress ($R^2 = 0.076$). Model 2 shows the results of regressing psychological distress on social support. There is a negative, significant relationship between social support and psychological distress ($b = -.440$, $p < 0.001$), suggesting that the more social support a Black homeless youth has, the less psychological distress they report.

In Model 3, I regress psychological distress on trauma and social support. Every unit increase in trauma increases psychological distress by .933, controlling for support ($p < 0.001$). Controlling for trauma, there is a .326 decrease in psychological support ($p < 0.01$). Both variables are significant predictors of psychological distress. That is, the effect in the population is not zero; we can generalize their effects to the population.

In subsequent models, I added in additional variables for gender (cis-female), gender (trans), and age. Trauma ($b = .904$, $p < .001$) and support ($b = -.301$, $p < .05$) remain significant predictors. Cis-female negatively affects psychological distress ($b = -.968$) but the effect is insignificant. However, trans ($b = -2.983$) significantly, negatively affects psychological distress, controlling for the other independent variables ($p < .01$). It is not surprising that as I added more variables, R-squared increased, meaning that the additional variables added explanatory power to my analysis. Model 4 had a R-squared of .113 which means I am able to explain around 11.3% of the variation within psychological distress among Black homeless youth.

In Model 5, an interaction term of trauma x support was tested. There was not a significant relationship ($b = 0.036$), indicating that the relationship between trauma and psychological distress does not vary by level of social support.

6 DISCUSSION

In at least three ways, my findings are consistent with prior studies of childhood traumas or adversities and their impact on psychological distress. The overall pattern is similar to other studies that did not study only Black youth or even youth at all. My findings support the general hypothesis that increased childhood trauma contributes to an increase in psychological distress. This has important implications for intervention because prevention of only a single childhood adversity among individuals exposed to many is unlikely to have important effects. Early intervention to reduce exposure to all childhood adversities and later intervention to address long-term adult maladaptive psychological consequences of having been exposed to childhood adversities (Kessler et al 2010) is necessary. Substantial evidence has accumulated supporting a causal link between childhood adversity and risk for poor health years and even decades later, implying childhood as perhaps the point at which intervention efforts are likely to be most effective (Turner 2015).

These findings contribute to a better understanding of factors leading to psychological distress among homeless youth. Some common thoughts are that those suffering from psychological distress may be genetically predetermined, however, here we see that social determinants, like witnessing violence or a parent going to jail, are a significant predictor in the level of psychological distress of an individual. The social determinants of health framework refer generally to the health effects of the material, behavior, and psychosocial conditions shaping people's lives (Marmot and Wilkinson 2006). This information will be helpful in

understanding the needs of the homeless youth population, particularly the Black homeless youth, and recognizing the prevalence of psychological distress. Social workers, police officers, healthcare providers, and others who encounter or support homeless youth should have a cultural competence of their unique needs.

The original ACEs research, by Drs. Felitti, Anda and colleagues (1998), demonstrated a strong relationship between the number of childhood adversities that a sample of predominately white, middle-class adult, Kaiser Permanente patients reported experiencing. Their sample held racial privilege, comparatively, an advanced age, and presumably class privilege, having health insurance. This research expands the scope of their groundbreaking research by analyzing Black, homeless, youth, and largely uninsured. Continuing to follow the social determinants of health framework, it would suggest that the Black homeless youth may have poorer outcomes and would benefit from more support. Setting ACEs research in the broader context of the social determinants of health helps address the lack of information for this understudied population.

Second, I observe a similar pattern of the theoretical assumptions, that social support would alleviate some symptoms of psychological distress. Social exclusion, often a component of homeless youth, should not be ignored, in the evaluation of homeless youth. Showing the improving effects of social support on psychological distress, suggests a need for funding of community and social resources allotted to the homeless youth. This implies the necessity of spaces that provide inclusion for homeless youth.

One complicating factor in establishing mental health care in the homeless population is provider mistrust (Winiarski et al. 2020). Homeless youth present with numerous mental health and social needs, but they are also less likely to seek out support from providers due to low perceptions of trust of the mental healthcare field and a fear of judgement from providers (Edidin

et al. 2012). Because being part of a marginalized and underserved population often makes it much more difficult to advocate for and obtain essential healthcare and health services (Lamb et al. 2011), it is not unlikely that homeless youth have frequently encountered frustrations and injustices in the healthcare system. This may hinder youths from seeking care and ultimately reduce compliance. Research shows that negative experiences in an area of the healthcare system can adversely impact utilization and perception of other social and health services in the future (LaVeist, Isaac, and Williams 2009).

Good mental health is critical for stable employment and the formation of reliable and safe support networks; thus, mental health problems can play a direct role in perpetuating the cycle of homelessness (Winarski et al, 2020). It is therefore essential to prioritize developing mental health programs for vulnerable youth. Improved understanding of Black homeless youth and their risk to remain homeless or become homeless again, would allow service providers to more effectively identify youth who require specialized support services in order to make a transition to stable housing (Castro et al 2014). Policies created to provide mental health services should include psychotherapy and medication. Understanding these patterns among Black homeless youth, we will be in a better position to develop culturally specific interventions for these youth.

6.1 Future Research and Limitations

To further explain the relationship between compounded trauma and psychological distress among homeless youth, the questions of the survey regarding trauma and psychological distress should be expanded to allow open ended questions. This would allow respondents to elaborate on answers. Extending the survey to a semi-structured retrospective interview would allow information on history of homelessness, mental health status, and transience level.

A limitation of the study was the limited questioning on the extent of trauma or social support that the homeless youth experienced, as well as the conservative coding of the social support variable. The homeless youth were not able to expound beyond the questions of the survey. There may also be some degree of response bias, as the survey was a self-reported measure administered with an interviewer present. With greater resources, time, and new knowledge of this understudied population, more detailed interviews could be obtained. Another limitation of the study was the almost racially homogeneous population. In United States, there are many different lived experiences across races. The types of trauma can be quantified and analyzed further.

For future research, I would suggest an expansion of the homeless youth count using the AYCNA model. With more resources and time, a larger sample may be obtained using their highly effective capture-recapture method. If a more racially diverse population was located in the same racially heterogeneous metropolitan area, it would be beneficial to analyze trauma's effects on psychological distress across races. If the sample's racial ratios remained similar, that would contribute to the knowledge of the shift in the demographics of homeless youth. Both would provide insight on new policies and resources being created for this marginalized population.

An important implication of this study is a focus on the compounding nature of trauma as a key risk factor of psychological distress. This suggests that creating services to reduce abuse before homelessness are more effective to reducing mental health issues than creating services to treat mental illness once homeless. These services should include social support with social workers and other individuals in similar circumstances. Many of the current programs are staffed by bachelor's or lower-level professionals who may not be equipped with extensive training or

the knowledge of the systematic differences in trauma experienced across races. To make higher level providers accessible, providers could use social media to allow youth to access clinicians and treatment from various locations. These technologies should be tested for their effectiveness.

7 CONCLUSION

The homeless youth population is a growing, yet often overlooked population. Due to their invisibility in traditional homeless populations, their prevalence and needs tend to be underestimated. The AYCNA has identified and subsequently estimated a larger homeless youth population located in Atlanta, GA. Atlanta's homeless youth population were majority Black, making them unique compared to most of the existing homeless youth literature.

The relationship between Black homeless youth's trauma exposure and the development of psychological distress are clear. Efforts to directly help youth cope with trauma should be provided in addition to services to reduce risk factors. With such clear consequences, trauma prevention and intervention efforts need to be prioritized in society, namely the homeless youth populations.

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APPENDIX

Appendix A - Tables

Table 1. Descriptive Statistics

		# of respondents
Trauma		528
Range	0-7	
Mean	2.77	
Std. Dev	1.68	
Psychological Distress		538
Range	0-24	
Mean	11.02	
Std. Dev	5.88	
Support		529
Range	8.00	
Mean	2.99	
Std. Dev	2.05	
Gender		555
Cis-male	60.9%	
Cis-female	33.2%	
Trans	5.90%	
Age (Years)		556
Range	15-25	
Mean	21.49	
Std. Dev	2.61	

Data from the 2015 Atlanta Youth Count and Needs Assessment.

Table 2a. Trauma Variable Statistics (n=529)

# of traumas	Frequency	Valid Percent	Cumulative Percent
0	45	8.5	8.7
1	97	18.3	27.0
2	99	18.7	45.7
3	105	19.8	65.6
4	89	16.8	82.4
5	67	12.7	95.1
6	22	4.2	99.2
7	4	0.8	100
Total	529	95.1	100
Mean	St. Dev.	Range	
2.77	1.68	0 - 7	

Table 2b. Trauma Variable Statistics

	Mean	Std. Dev
Witnessed violence in your home?	0.54	0.498
Witnessed violence in your neighborhood?	0.79	0.406
Witnessed a parent going to jail or prison?	0.49	0.50
Experienced abuse as a child?	0.36	0.481
Been in the foster care system because of abuse or neglect?	0.24	0.430
Been in the foster care system because of juvenile criminal or delinquent behavior?	0.15	0.356
Received services from child welfare, other than placement in foster care?	0.19	0.395

*Cronbach's Alpha = 0.603; Possible range = 0 - 7

Table 3a. Psychological Distress Frequency Statistics (n=538)

	Frequency	Percent	Valid Percent	Cumulative Percent
0.0 - 4.0	140	25.2	26.0	26.0
5.0 - 12.0	246	44.2	45.7	71.7
13.0 +	152	27.3	28.3	100.0
Total	538	96.8	100.0	
Mean	St. Dev.	Range		
11.02	5.88	0.00 - 24.00		

Table 3b. Psychological Distress Variable Statistics

	Mean	Std. Dev
In the last 30 days, about how often did you feel...		
Nervous?	1.63	1.36
Helpless?	1.39	1.41
Restless or fidgety?	1.69	1.46
So depressed that nothing could cheer you up?	1.35	1.40
That everything was an effort?	1.99	1.51
Worthless?	0.96	1.30

*Cronbach's Alpha = 0.788; Possible range = 0.00 - 24.00

Table 4a. Social Support Statistics (n=529)

	Frequency	Valid Percent	Cumulative Percent
0.00	67	12.7	12.7
1.00	69	13.0	25.7
2.00	96	18.1	43.9
3.00	99	18.7	62.6
4.00	79	14.9	77.5
5.00	49	9.3	86.8
6.00	37	7.0	93.8
7.00	22	4.2	97.9
8.00	11	2.1	100.0
Total	529	100.0	
Mean	St. Dev.	Range	
2.99	2.05	0.00 - 8.00	

Table 4b. Social Support Statistics

	Mean	Std. Dev
Family members you can talk to about important matters or turn to for help when you have a problem	0.79	0.721
Friends your age you can talk to about important matters or turn to for help when you have a problem	0.86	0.724
Adult friends you can talk to about important matters or turn to for help when you have a problem	0.84	0.788
Professionals you can talk to about important matters or turn to help when you have a problem	0.49	0.677

*Cronbach's Alpha = 0.657; Possible range =0.00 - 8.00

Table 5. Correlations Among Study Variables (n=556)

	(1)	(2)	(3)	(4)	(5)	(6)
(1) # of Trauma Events	1.00					
(2) Psychological Distress	0.276***	1.00				
(3) Social Support	-0.138**	-0.154***	1.00			
(4) Cis-female	-.022	-.050	.107*	1.00		
(5) Trans	-.063	-.115**	-.009	-.177***	1.00	
(6) Age	-0.009	0.072	-0.053	.079	.009	1.00

* $p \leq .05$; ** $p \leq .01$; *** $p \leq .001$.

Table 6. Psychological Distress Regressed on Trauma and Social Support

	Model 1 (n=519)		Model 2 (n=525)		Model 3 (n=508)		Model 4 (n=508)		Model 5 (n=508)	
Independent Variables	b (s.e.)	β	b (s.e.)	β	b (s.e.)	β	b (s.e.)	β	b (s.e.)	β
# of Trauma Events	.969*** (.147)	.276			.933*** (.149)	.267	.912*** (.148)	.261	.792*** (.252)	.231
Social Support			-.440*** (.124)	-.154	-.326*** (.122)	-.114	-.297* (.122)	-.104	-.293* (.123)	-.101
Cis-female ^a							-.981 (.535)	-.079	-.975 (.535)	-.080
Trans ^a							-3.024** (1.079)	-.120	-2.972** (1.082)	-.118
Age							.163 (.097)	.071	.161 (.097)	.072
Trauma ^a *Support									.039 (.071)	.031
Constant	6.228*** (.481)		10.319*** (.448)		7.307*** (.635)		11.256*** (3.141)		11.440*** (3.164)	
R ²	0.076		.024		.092		.113		.114	

*p<.05; **p<.01; ***p<.001.

^areference group = Cis-male