Child Abuse & Neglect 35 (2011) 401–407

Contents lists available at ScienceDirect

Child Abuse & Neglect

Brief communication

Screening homeless youth for histories of abuse: Prevalence, enduring effects, and interest in treatment

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ARTICLE INFO

Article history:
Received 30 April 2010
Received in revised form 25 January 2011
Accepted 26 January 2011
Available online 8 June 2011

Keywords:
Child abuse
Physical abuse
Sexual abuse
Homeless
Screening

ABSTRACT

Objectives: To identify the incidence of self-reported physical and sexual child abuse among homeless youth, the self-perceived effects of past abuse, and current interest in treatment for past abuse among homeless youth with histories of abuse.
Methods: Homeless and street-involved persons aged 18–23 filled out a questionnaire and participated in a structured assessment of histories of abuse, tobacco use and substance abuse.
Results: Sixty-four homeless youth in Salt Lake City, Utah completed the study, 43 males and 21 females. Eighty-four percent screened positive for childhood physical and/or sexual abuse occurring before the age of 18; 42% screened positive for both physical and sexual abuse; 72% reported still being affected by their abuse. Among all abuse victims, 44% were interested in treatment for their abuse history and 62% of homeless youth who reported still being affected by their abuse were interested in treatment. Individuals were more likely to be interested in treatment if they were female, had not completed high school or had been previously asked about family dysfunction. Many victims who declined treatment offered spontaneous insight into their decision. Interest in treatment was similar to interest in treatment for other behaviors such as smoking and substance abuse.
Conclusions: Histories of abuse are common among homeless youth. A majority of those reporting a history of abuse are still affected by their abuse. Interest in treatment for a history of abuse was comparable to interest in treatment for other morbidities in the homeless youth population such as tobacco use and substance abuse. Our finding that homeless youth continue to be impacted by their abuse and are interested in treatment should prompt more screening for histories of abuse.

Introduction

Although estimates vary greatly, between 800,000 and 2 million youth become homeless in the United States each year, and up to 40% of these homeless youth will not return home (Raleigh-DuRoff, 2004; Sanchez, Waller, & Greene, 2006). Factors that increase the risk for youth homelessness include family conflict, dysfunction, and abuse in social, home, or school settings (Busen & Engebretson, 2008; Harper, Davidson, & Hosek, 2008; Kral, Molnar, Booth, & Watters, 1997; Martinez, 2006; Zielinski, 2009). Although some studies demonstrate that most homeless youth will access some type of social service while homeless (Carlson, Sugano, & Millstein, 2006), homeless youth tend to underutilize community-based resources intended

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doi:10.1016/j.chiabu.2011.01.015

to address medical or mental health needs (De Rosa et al., 1999; Slesnick, Meyers, Meade, & Segelken, 2000; US General Accounting Office [GAO], 1989). Homeless youth have high rates of past abuse, with up to two-thirds of homeless youth reporting a history of childhood physical or sexual abuse (Busen & Engebretson, 2008; Kral et al., 1997; Ryan, Kilmer, Cauce, Watanabe, & Hoyt, 2000). Homeless youth demonstrate increased rates of tobacco use, substance abuse, high-risk sexual behavior, victimization, and mental illness compared to their non-homeless peers in most (Busen & Engebretson, 2008; Chen, Thrane, Whitbeck, & Johnson, 2007; Kipke, Simon, Montgomery, Unger, & Iversen, 1997; Martinez, 2006; Ryan et al., 2000; Tyler, Whitbeck, Hoyt, & Cauce, 2004; Zerger, Strehlow, & Gundlapalli, 2008) but not all studies (McCaskill, Toro, & Wolfe, 1998). A history of prior abuse may contribute to increases in risky and impulsive behavior (Nelson et al., 2002). This may lead to medical and mental health risks among homeless youth (Whitbeck, Hoyt, Yoder, Cauce, & Paradise, 2001). Once homeless, past traumas and current high-risk behaviors contribute to a continuing state of homelessness (Molnar, Shade, Kral, Booth, & Watters, 1998; Robertson & Toro, 1998).

There now exist evidence-based treatment options specific for survivors of child abuse (Hetzel-Riggin, Brausch, & Montgomery, 2007). Although general screening for mental illness among vulnerable populations is recommended by mental health organizations (Center for Substance Abuse Treatment, 2007), most studied interventions are designed to address drug use, provide case management, and improve vocational ability among homeless youth (Slesnick, Dashora, Letcher, Erdem, & Serovich, 2009). To our knowledge, evidence-based mental health interventions such as Trauma-Focused Cognitive Behavioral Therapy that address the long-lasting effects of childhood abuse (Cohen, Deblinger, Mannarino, & Steer, 2004) have not been studied among populations of homeless youth.

A first step towards introducing evidence-based treatment for abuse to this high-risk population is to better understand perceived ongoing effects and interest in treatment for histories of childhood abuse among homeless youth. Using a self-reporting tool, we examined the prevalence of abuse histories and high-risk behavior among homeless youth in Salt Lake City, UT. Furthermore, we assessed for self-reported effects from previous abuse histories and interest in mental health interventions designed to treat distress associated with past abuse. Finally, we compared the self-reported interest in treatment for histories of abuse to behaviors commonly screened for in the homeless population such as tobacco use, substance abuse, and mental illness.

Methods

The study describes a 12-month pilot-screening project funded by American Academy of Pediatrics Community Access to Child Health (CATCH) program. A CATCH grant funds residents in pediatric training programs to develop community-based initiatives to address clinically observed problems concerning access to care. The University of Utah IRB committee approved review of the data collected during the clinical intervention. Project participants were recruited at a local daytime center that provides basic resources to homeless youth and young adults in Salt Lake City, UT. The center serves individuals who meet the federal definition of homelessness, which includes, "an individual who lacks a fixed, regular, and adequate nighttime residence" (US Department of Housing & Urban Development, 1987).

The screening project included any center clients between 18 and 23 years of age consenting to participation. Prior research has identified homeless youth as children and young adults from 12 to 24 years of age (Slesnick et al., 2009). We excluded clients under 18 years of age due to challenges of obtaining parental consent for homeless minors. Recruitment for participation was made through general announcements in the common area of the center.

The project consisted of a 2-part assessment. Each participant first completed a 70-item questionnaire about childhood experiences and current behaviors. The questionnaire was a modified version of the Adverse Childhood Experiences questionnaire (Felitti et al., 1998). This questionnaire was designed to explore histories of child abuse among a general population of adults. We modified the questionnaire to reduce the length and make it gender neutral. None of the abuse specific questions were changed from the original questionnaire. (Please reference http://www.cdc.gov/nccdphp/ace/questionnaires.htm for ACE questionnaires.) After completing the questionnaire, all participants completed a structured interview with the physician or project assistant. In this interview, the questionnaire was reviewed and participants were asked follow-up questions to assess current perceived effects and motivation to engage in treatment related to reported histories of abuse, tobacco use, substance use, and mental illness.

As part of this structured interview, all individuals who endorsed a history of abuse were asked the following two questions:

> "Some people who experienced (physical/sexual abuse) when they were younger continue to be bothered by what they experienced as children. This can affect their friendships, relationships, family, school or work. Do you think that what you experienced still affects you today?"

If yes, the participant was asked:

> "Would you be interested in working with someone to help work through what you experienced with the idea that it will not affect you as much in the future?"

If the participant endorsed a history of abuse and an interest in treatment, treatment was offered based on an algorithm that listed different community based services. This process was repeated for each reported type of childhood abuse history.

Table 1
Comparison of homeless youth with and without a history of child abuse.

	Homeless youth ($n = 64$)			
	All participants n (%)	No abuse history n (%)	History of abuse n (%)	p value
Demographics				
Homeless youth	64 (100.0)	10 (15.6)	54 (84.4)	
Sex				0.15
Female	21 (32.8)	1 (10.0)	20 (37.0)	
Male	43 (67.2)	9 (90.0)	34 (63.0)	
Race/ethnicity[a]				
White, Non-Latino	46 (73.0)	8 (80.0)	38 (71.7)	0.72
Non-White and/or Latino	17 (27.0)	2 (20.0)	15 (28.3)	
Education				
High school degree	36 (56.3)	5 (50.0)	31 (57.4)	0.74
No high school degree	28 (43.8)	5 (50.0)	23 (42.6)	
Origin				
Utah	32 (50.0)	4 (50.0)	28 (51.9)	0.73
Outside Utah	32 (50.0)	6 (60.0)	26 (48.1)	
Family and social supports				
Lived with a caregiver with alcoholism	39 (60.9)	5 (50.0)	34 (63.0)	0.49
Lived with a caregiver with mental illness	44 (68.9)	5 (50.0)	39 (72.2)	0.26
Felt taken care of by family	32 (50.0)	9 (90.0)	23 (42.6)	0.01
Felt loved by family	30 (46.9)	8 (80.0)	22 (40.7)	0.04
Felt close to family	21 (32.8)	9 (90.0)	12 (22.2)	<0.01
At least one close friend[b]	45 (72.6)	3 (30.0)	42 (77.8)	0.03
Health history and behaviors				
Medical provider asked about family problems	31 (48.4)	0 (0.0)	31 (57.4)	<0.01
Ever seen a psychiatrist, psychologist or therapist	36 (56.3)	2 (20.0)	34 (63.0)	0.02
History of suicide attempt	32 (50.0)	3 (30.0)	29 (53.7)	0.30
Current smoker	55 (85.9)	9 (90.0)	46 (85.2)	1.00
Current street drug use	29 (45.3)	3 (30.0)	26 (48.2)	0.33

[a] Race/ethnicity missing in one subject.
[b] Close friend response missing in two subjects.

An algorithm of no-to-low cost community based resources was developed as part of the clinical project. The algorithm consisted of low to high intensity interventions from which the participant could choose. For example, options for a history of sexual abuse included an established support group, a clinic appointment with a general practitioner or referral to a mental health center. A resource card that included all of the resources offered was given to the participant, allowing the interviewer to highlight chosen options. At the conclusion of the follow-up interview, subjects were given a $10 gift card to a local grocery store for their participation.

This brief report presents observations gathered from this pilot project. Two-sided Fisher's exact tests were calculated to compare study subjects based on a history of abuse and interest in treatment for a history of abuse.

Results

Demographics

Sixty-four homeless youth between 18 and 23 years of age completed the questionnaire (Table 1). Participants were more likely to be male (43, 67%) and White (50, 78%). Half (32, 50%) of the participants were from outside of Utah. Twenty-eight (44%) had not earned a high school or high school equivalency degree.

Past abuse

Fifty-four of the 64 (84%) participants screened positive for a history of either physical or sexual abuse before the age of 18 (Fig. 1). Twenty (31%) reported a history of physical abuse and seven (11%) reported a history of sexual abuse. Twenty-seven (42%) screened positive for both physical and sexual abuse. Thirty-nine (72%) of the participants with any history of abuse reported that their history of abuse still affected them (Table 2).

We identified few differences in demographics between participants with and without a history of abuse. Female participants were more likely to report a history of abuse than men (95% vs. 79%, $p = 0.15$). Participants were similar in race, ethnicity, state of origin, and education levels regardless of abuse history (Table 1).

We noted differences in family and social supports based on a history of abuse. Participants with a history of abuse tended to report living with someone suffering from alcoholism (63% vs. 50%, $p = 0.49$) or mental illness (72% vs. 50%, $p = 0.26$) during childhood more often than those without a history of abuse, although these differences were not statistically significant (Table 1). Those with a history of abuse were significantly less likely to recall feeling loved, looked after, or cared for by

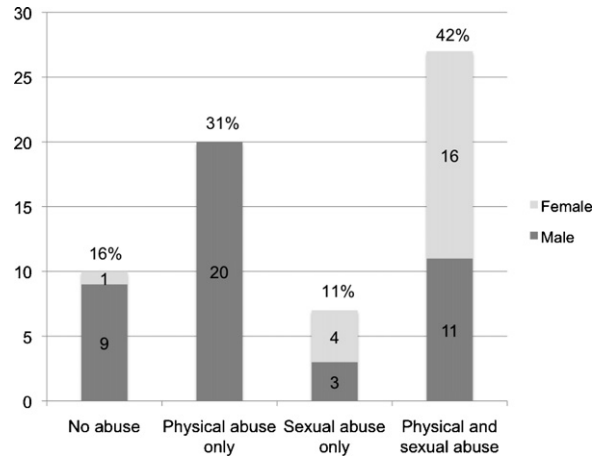

Fig. 1. Prevalence of childhood abuse histories among homeless youth surveyed ($n = 64$).

family members during childhood than participants without a history of abuse. Participants with a history of abuse were more likely to have at least one close friend at the time of the interview (78% vs. 30%, $p = 0.03$).

Compared to individuals without an abuse history, participants with a history of abuse were more likely to report having been asked about family problems by a medical provider (57% vs. 0%, $p = 0.001$) and to report having previously seen a psychiatrist, psychologist or therapist (63% vs. 20%, $p = 0.02$). Those with a history of abuse tended to have a higher rate of suicide attempts (54% vs. 30%, $p = 0.30$) and current drug use (48% vs. 30%, $p = 0.33$), although these differences did not reach statistical significance (Table 1).

Interest in treatment

Of the 54 victims, 24 (44%) were interested in treatment (Table 2). This level of interest in treatment for histories of abuse was comparable to interest in smoking cessation among current smokers (47%) and in drug treatment among current drug users (41%) (Table 3). Of the 39 youth that reported still being affected by their abuse history, 24 (62%) reported an interest in treatment ($p = 0.64$).

Participants interested in treatment for a history of abuse were more likely to be female (50% vs. 27%, $p = 0.1$) (Table 2). The lack of a high school degree, a history of having been asked about family dysfunction in the past and a self-perception that as a child, the victim felt taken care of by his/her family were associated with increased interest in treatment. Participants

Table 2
Interest in treatment for history of abuse among homeless youth with a history of abuse.

	Homeless youth with a history of abuse ($n = 54$)			
	All participants *n* (%)	Interest in treatment *n* (%)	No interest in treatment *n* (%)	*p* value
Abuse history				
Abused homeless youth	54 (100.0)	24 (44.4)	30 (55.6)	
Physical abuse only	20 (37.0)	8 (33.3)	12 (40.0)	0.78
Sexual abuse only	7 (13.0)	2 (8.3)	5 (16.7)	0.44
Physical and sexual abuse	27 (50.0)	14 (58.3)	13 (43.3)	0.41
Bothered by abuse history	39 (72.2)	24 (100.0)	15 (50.0)	<0.01
Demographics				
Female	20 (37.0)	12 (50.0)	8 (26.7)	0.10
Non-white and/or Latino	15 (28.3)	6 (26.1)	9 (30.0)	1.00
High school degree	31 (57.4)	10 (41.7)	21 (70.0)	0.05
From Utah	28 (51.9)	14 (58.3)	14 (46.7)	0.43
Family and social supports				
Lived with a caregiver with alcoholism	34 (63.0)	15 (62.5)	19 (63.3)	1.00
Lived with a caregiver with mental illness	39 (72.2)	18 (75.0)	21 (70.0)	0.77
Felt taken care of by family	23 (42.6)	14 (58.3)	9 (30.0)	0.05
Felt loved by family	22 (40.7)	12 (50.0)	10 (33.3)	0.27
Felt close to family	12 (22.2)	7 (29.2)	5 (16.7)	0.33
At least one close friend	42 (77.8)	19 (79.2)	23 (76.7)	1.00
Health history and behaviors				
Medical provider asked about family problems	31 (57.4)	18 (75.0)	13 (43.3)	0.03
Ever seen a psychiatrist, psychologist or therapist	34 (63.0)	17 (70.8)	17 (56.7)	0.40
History of suicide attempt	29 (53.7)	13 (54.2)	16 (53.3)	1.00

Table 3
Interest in treatment for common health risks among homeless youth.

	Interest in treatment for given health risk *n* (%)	95% confidence interval
Homeless youth currently smoking (*n* = 55)	20 (47.3)	33.7–61.2
Homeless youth currently using street drugs (*n* = 29)	12 (41.4)	23.5–61.1
Homeless youth with any history of abuse (*n* = 54)	24 (44.4)	30.9–58.6
Homeless youth bothered by any history of abuse (*n* = 39)	24 (61.5)	44.6–76.6

with a history of both physical and sexual abuse tended to express interest in treatment more often that those with a history of just physical or sexual abuse, although this did not reach statistical significance (52% vs. 37%, $p = 0.4$).

Participant comments

Follow-up questions during the structured interviews prompted a number of notable responses from the youth, many of whom declined treatment. Study interviewers did not ask the youth why they were not interested in hearing about different treatment options, but if spontaneous statements were offered, the interviewers recorded them by hand. These responses can be loosely placed into two different categories.

One group of responses talked about past treatment experiences. For example, one female who reported sexual abuse that involved both being touched as well as intercourse stated, "(I have been) going to treatment since I was 8 years old, (therapy) has not worked." She did agree that her sexual abuse still affected her. A male youth who was both physically and sexually abused, and reported interest in treatment for his sexual abuse, said of his physical abuse, "I've worked through most of it." Another female who had suffered both physical and sexual abuse declined sexual abuse treatment even though it still bothered her, stating, "people went to prison, that has helped out a lot."

Another group who had suffered abuse but declined treatment talked about the positive aspects of having gone through the abusive experiences. One female who had suffered both physical and sexual abuse commented that her physical abuse experience "helps me raise my son better, to draw the line." A male physical and sexual abuse victim who agreed that his physical abuse continued to bother him went on to state that the experience "helps to motivate me to do better."

Discussion

In this sample of homeless youth, we identified high rates of adverse childhood experiences, including physical and sexual abuse. We identified higher rates of abuse histories (84%) in the homeless youth population than prior studies (30–63%) (Feitel, Margetson, Chamas, & Lipman, 1992; Herman, Susser, Struening, & Link, 1997; Ryan et al., 2000), which may indicate varying populations or differences in the method of obtaining histories of abuse. More importantly, nearly 3 out of every 4 homeless youth in our study who reported a history of physical or sexual abuse felt that their abuse still affected them today. Although many studies show the high correlation between histories of abuse and youth homelessness (Busen & Engebretson, 2008; Harper et al., 2008; Martinez, 2006; Zielinski, 2009), the fact that homeless youth perceive that they are still affected by their history of abuse is a key finding of this study. This is especially important when determining interest in treatment, where in our study 6 out of every 10 homeless youth who reported continuing effects from their abuse were interested in treatment options.

Abuse victims who were interested in treatment options were more likely to not have graduated from high school. Some literature suggests that those with higher educational levels have increased resilience when they experience abuse (Bonanno, Galea, Bucciarelli, & Vlahov, 2007), and more severely abused individuals tend to have lower educational attainment (Wise, Zierler, Krieger, & Harlow, 2001). In our cohort, affected individuals were likely to be encouraged to look for additional educational support as the community center where the study was completed actively encouraged clients to work towards a high school equivalency degree.

Abused individuals who had been screened for family dysfunction as children or reported that during their childhood they felt taken care of by their family were significantly more likely to be interested in treatment options. It is possible that individuals who had more support during childhood are more open to future treatment options for abuse histories than those who did not receive support.

Although our project did not include formal qualitative methodology, extemporaneous disclosures given by our participants offer a glimpse into the self perceived resiliency and variety of coping strategies abused individuals use to protect themselves from their abuse. Most observers would argue homelessness as an adolescent or young adult correlates with poor global functioning (Craig & Hodson, 1998). However, many homeless youth, especially those who have fled from family violence, perceive their current state of homelessness as an improvement compared to their previous home and family circumstances (Martinez, 2006). It is important for providers to be aware of this conflict between objective functional impairment and a self-perception of improved circumstances as they consider assessing for perceived continuing effects and referral for treatment of abuse histories. Future research in this area may benefit from qualitative methodologies to better understand the subjective experiences of homeless youth with a history of abuse.

Limitations

We recognize the limitations to this study. This study is a small sample of homeless youth in Salt Lake City, Utah. It is unclear if this information can be generalized to homeless youth in other cities or rural areas. Eighteen- to 23-year olds were recruited for the study, and it is unclear whether or not the data obtained can be generalized to younger homeless youth. Many clinically important differences observed in our study do not reach statistical significance. This may be related to limitations of our sample size.

Reporting the interest in treatment for different morbidities was to illustrate that interest in treatment for abuse histories is comparable to interest in other commonly screened for behaviors such as tobacco use and substance abuse. However, these rates could be an artifact of selection bias, where individuals interested in filling out a questionnaire may be more likely to be open to treatment options for various conditions.

Finally, as a result of the method used in the follow up assessment, only those who stated that they were still affected by their abuse histories were offered treatment options. Therefore, it is possible that some individuals who would have been interested in treatment options were not offered the chance to express interest in treatment because they had stated that their abuse history no longer affected them. This may have resulted in an underreporting of the total number of homeless youth interested in treatment.

Conclusion

This study adds to the literature by exploring the history of physical and sexual child abuse among homeless young adults in a small urban setting, and by describing interest in treatment for abuse histories within this population. The rate of abuse in our homeless population was high, with over 80% of homeless youth reporting some history of childhood abuse. As reported in other abused populations, it was quite common for our homeless youth to have suffered multiple types of abuse (Ryan et al., 2000; Warren, Gary, & Moorhead, 1994; Whitbeck, Hoyt, & Ackley, 1997). Over 40% of individuals reporting a history of childhood abuse expressed interest in seeking mental health treatment for this abuse history. Over 60% of those reporting continued effects from this history of childhood abuse expressed interest in treatment.

There are several implications to this study. From a clinical perspective, awareness by providers that homeless youth continue to be impacted by their abuse and are often interested in community based treatment options may prompt more screening and case finding for abuse histories. From a research perspective, prospective studies trialing the short and long-term efficacy of evidence-based treatment for abuse for homeless youth with a history of abuse are needed. Trauma-Focused Cognitive Behavioral Therapy is one of several evidence based treatment options shown to be efficacious in the treatment of abused children (Cohen et al., 2004) and may be worth researching in this population. Furthermore, just as some substance abuse treatment models have looked at the impact of childhood abuse on success rates (Slesnick, Kang, & Aukward, 2008), future studies may consider addressing histories of childhood abuse in comprehensive treatment models designed for individuals that access daytime centers for homeless youth. Finally, from a policy perspective, our study demonstrates that in general, homeless youth are interested in community-based mental health treatment services for a variety of conditions, including histories of childhood abuse. These results highlight the need to continue to develop and support accessible mental health treatment options to this vulnerable population.

Acknowledgements

The authors wish to acknowledge Dr. Joan Sheetz, a pediatrician and advocate for homeless youth in Salt Lake City, for her invaluable advice and mentorship in the formation and implementation of this project.

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