# Trauma Among Unaccompanied Homeless Youth: The Integration of Street Culture into a Model of Intervention

**Holly H. McManus** and **Sanna J. Thompson**

## Abstract

Homeless adolescents comprise a population particularly vulnerable to developing symptoms of post-traumatic stress. Research has shown that prevalence of trauma-related symptoms among homeless youth living in shelters and on the streets without families is approximately 18%. The detrimental effects of traumatic experiences often inhibit homeless youths' ability to employ the psychosocial skills necessary to a transition out of homelessness. Consequently, interventions targeting the mitigation of post-traumatic stress symptoms among this population are crucial. This article aims to address the symptoms and needs of unaccompanied homeless youth who experience post-traumatic stress disorder symptomatology and offers a strength-based intervention framework for understanding, identifying, and beginning to address trauma-related mental health needs within the cultural context and experience of youth homelessness.

### Keywords

## INTRODUCTION

Relatively few studies have examined the impact of trauma exposure and development of post-traumatic stress disorder (PTSD) symptoms on adolescents; however, a growing body of research suggests traumatic experiences often have numerous debilitating consequences for youth (Foa, Johnson, Feeny, & Treadwell, 2001) that can hinder normal developmental processes (Becker et al., 2004a). Exposure to trauma during these developmental periods can derail emotional growth and adversely affect youth's self-esteem, emerging sense of self, developing conceptualization of the world, ability to relate to and trust others, manage stress, plan for the future, and avoid future victimization. Adolescents who lack fundamental cognitive, emotional, familial, societal, and cultural supports are at increased risk for suffering adverse effects of trauma exposure (Becker et al., 2004a, 2004b).

Youth who are homeless comprise a population exposed to high rates of trauma, both on the streets and prior to becoming homeless (Gaetz, 2004; Kidd, 2003; Whitbeck & Hoyt, 1999). Many become homeless due to prematurely exiting or being forcibly removed from their homes, often in response to abuse by their primary caregivers. It has also been argued that the experience of being homeless is a form of psychological trauma (Goodman, Saxe, & Harvey, 1991), as life on the street is characterized by extremely impoverished conditions, constant threats to survival in terms of daily struggles to meet basic needs (Ayerst, 1999), repeated victimization, and decreased life expectancy (Gaetz, 2004; Tyler, Hoyt, Whitbeck, & Cauce,

Address correspondence to: Sanna Thompson, PhD, University of Texas at Austin, School of Social Work, Substance Abuse Research Development Program, 1717 W. 6th Street, Suite 335, Campus Box R5000, Austin, TX 78703 (SannaThompson@mail.utexas.edu).

2001; Whitbeck & Hoyt, 1999). Consequently, homeless adolescents comprise a population particularly vulnerable to the detrimental effects of trauma exposure, including developing PTSD (Stewart et al., 2004).

Estimates indicate that annually over 1 million youth spend some period of time living outside of families with no stable residence (Cauce et al., 2000; Kidd, 2003). Once homeless, acculturation to the streets and street economy progresses with the length of exposure to homelessness and homeless peers (Auerswald & Eyre, 2002; Gaetz, 2004; Kidd, 2003), as does the risk of victimization and death (Tyler et al., 2001). The detrimental effects of traumatic experiences often inhibit homeless youths' ability to employ the psychosocial skills necessary to transition out of homelessness (Stewart et al., 2004).

Clinical and research literature is minimal regarding effective, evidence-based interventions for homeless youth (Karabanow & Clement, 2004); interventions are nonexistent regarding treatment of the trauma-related symptoms among members of this acutely and continuously traumatized population. Accordingly, interventions are urgently needed to attend to the trauma-related mental health needs of these youth. Recognizing the importance of incorporating the cultural context and perspective of homeless clients, this article aims to: (a) identify the trauma-related symptoms and needs of unaccompanied homeless youth, (b) provide an analysis of the applicability of several practice strategies for homeless youth from the context of street culture, and (c) propose a strength-based intervention framework for understanding, identifying, and beginning to address the trauma-related needs of homeless youth within their cultural context and experiences of homelessness. The objective of this intervention model does not seek to eradicate trauma symptoms but to provide the initial steps needed to mitigate symptoms. Providing this foundation is needed for targeted and long-term trauma work to be accomplished.

## YOUTH HOMELESSNESS AND PTSD SYMPTOMATOLOGY

Research has shown that prevalence of trauma-related symptoms among homeless youth living in shelters and on the streets without families is approximately 18% (Stewart et al., 2004; Whitbeck et al., 1999). These rates are similar to adolescents with a history of trauma (12–15%), but much greater than found among adolescents in community samples (2–6%) (Giaconia, Reinherz, Silverman, & Pakiz, 1995). Risk factors associated with adolescent homelessness are similar to risk factors for PTSD (Stewart et al., 2004), such as poverty, chaotic family environments, parental substance abuse, and physical, sexual, and emotional abuse (Kidd, 2003; Stewart et al., 2004; Whitbeck et al., 1999).

Homeless youth reside in environments often marked by reoccurring violence, victimization, and danger. Although limited research has focused attention on the trauma-related issues of homeless young people (Cauce et al., 2000; Stewart et al., 2004; Tyler, Whitbeck, Hoyt, & Johnson, 2003), findings of these studies provide developing knowledge of how trauma symptoms are manifested among youth who are homeless. It is critical for providers to gain an increased understanding of how trauma symptoms are manifested in order to develop effective interventions as it could be a matter of life and death for many of these vulnerable young people.

## TRAUMA/PTSD SYMPTOMS

Although characteristic symptoms of PTSD have been identified across cultures, genders, and ages, clinical presentation of symptomatology is often diverse and individualistic (Albucher & Liberzon, 2002). The individual's experience, interpretation, and response to the traumatic event are often influenced by the individual's culture, community, and surroundings (Gadpaille, 2004). Trauma symptoms are often comorbid with other disorders commonly found

among homeless youth, such as mood, anxiety, and conduct disorders. Other comorbid factors highly prevalent among homeless youth, such as substance abuse, increased risk-taking behaviors, and serious mental health issues (Cauce et al., 2000), may also exacerbate and/or mask trauma symptoms. These factors suggest that the cultural context of youth homelessness or street culture influences manifestation of trauma-related symptoms among these unaccompanied youth.

Characteristic symptoms of PTSD are classified in the *Diagnostic and Statistical Manual of Mental Disorders-IV-TR* (American Psychiatric Association, 2000) into three clusters: (a) re-experiencing the trauma, (b) increased sense of arousal, and (c) avoidance and numbing. The likelihood of developing PTSD and increased severity of PTSD symptoms are related to the frequency and duration of trauma exposure. The following examines the expression of PTSD symptoms in homeless youth according to the categorization of symptoms by Stewart et al (2004) and based on their research with members of this population.

### Intrusion and Re-Experiencing

Hallmarks of trauma symptoms are intrusive thoughts related to the traumatic event, as well as persistent re-experiencing of the event via nightmares, flashbacks, and strong physical and emotional reactions to traumatic stimuli (Herman, 1992). While several studies suggest that homeless youth meet full diagnostic criteria for PTSD (Cauce et al., 2000; Stewart et al., 2004; Tyler et al., 2003), specific examples of intrusive thoughts and persistent re-experiencing of traumatic events by these youth are not found in current research literature. A recent study by Stewart et al. (2004) provides some insight, however, into the degree to which this symptom may be experienced by homeless youth. Of the study' sample of 301 homeless young people, 24.6% report intrusive and upsetting thoughts about traumatic events, 17% experienced nightmares of the trauma, and 11% endured flashbacks.

### Persistent Avoidance and Numbing of General Responsiveness

This symptom category is characterized by various avoidant behaviors, such as efforts to avoid thoughts, feelings, or conversations associated with the trauma and efforts to avoid activities, places, or people that arouse recollections of the trauma. Because many youth are often retraumatized or victimized while living on the street, and as living on the street is characterized by impoverished conditions and constant threats to survival, chronic exposure to trauma is characteristic of being homeless. Avoidance of current traumatic circumstances, then, is very difficult for youth who are homeless. Thus, examination of PTSD among these young people requires looking beyond these behaviors to other methods of avoidance.

Research suggests these youth use substances to cope with emotional pain by numbing themselves to the experiences and emotions of traumatic event(s) (Auerswald & Eyre, 2002; Fest, 2003; Kidd, 2003). The incredibly high rates of substance use and abuse among homeless youth is well documented, as are high rates of use among their social networks (Auerswald & Eyre, 2002; Williams, Lindsey, Kurtz, & Jarvis, 2001). Although society would view these young people's drug and alcohol use as a hindrance to successfully transition off the street, numbing the daily experiences of life on the street is viewed as a common and useful strategy. Kidd and Kral (2002) found that homeless youth spoke of using drugs as a method of forgetting the stresses of street life, their past, and as a means to put aside their pain.

Self-injurious behavior, often in the form of cutting into the skin with sharp objects, is found to be disproportionately high among youth who are homeless (Ayerst, 1999; Tyler et al., 2003). Some of these young people report that the act of cutting helps them avoid and detach by taking their attention and thoughts away from abuse they have endured and the realities of their current life circumstances. Nearly half (47%) of participants in one recent study reported

feeling no pain while engaging in various forms of self-mutilation. Of note, approximately 36% of the study's participants also met diagnostic criteria for PTSD (Tyler et al., 2003).

Previous research has shown that suicide is the leading cause of death among homeless youth (Roy et al., 2004). Suicide attempts among youth who are homeless, especially among those youths who were abused as children, are shockingly high (Cauce et al., 2000; Kidd, 2003). In addition, memories of past abuse and trauma are often associated with suicidal thoughts and attempts among homeless youth (Kidd & Kral, 2002). Homeless youth frequently describe feelings of being trapped in painful situations, with little hope for the future. They report suicide attempts/ideation as efforts to escape from the dire circumstances of homelessness, and as manifestations of their hopelessness for the future (Williams et al., 2001) and lack of control over their lives (Kidd & Kral, 2002). These feelings may be viewed as symptoms often associated with PTSD (Becker et al., 2004a, 2004b).

### Increased Arousal

Specific manifestations of hyperphysiological arousal and fear associated with victimization while living on the street are typical among homeless youth (Auerswald & Eyre, 2002; Thompson, McManus, Lantry, Windsor, & Flynn, 2006). Many young homeless individuals report that falling and staying asleep is extremely difficult (Ayerst, 1999). They often intentionally remain awake for days, guarding their own safety as well as the safety of other homeless youth (Ayerst, 1999; Kidd, 2003; Whitbeck & Hoyt, 1999). Other forms of hyperarousal can be seen in youth's marked distrust of others, especially adults (Baer, Peterson, & Wells, 2004; Fall & Berg, 1996; Whitbeck & Hoyt, 1999). This mistrust is often reflected in underutilization of formal services. As many have been exploited and victimized by adults, including members of their own families, they may be extremely distrustful and "always keeping their guard up" (Auerswald & Eyre, 2002, p. 1504).

## ELEMENTS OF EFFECTIVE INTERVENTIONS WITH HOMELESS YOUTH

In assessing and treating the trauma-related mental health needs in homeless youth, it is important to recognize that they are members of a unique cultural group: the culture of youth homelessness (Barry, Ensign, & Lippek, 2002). These youth have a similar lifestyle and common values, attitudes, dress, and slang (Fall & Berg, 1996); thus, treatment approaches must be delivered in a manner that is "culturally competent" and incorporates their unique perspectives.

Chronically traumatized populations' problem areas often parallel the difficulties experienced by homeless youth, such as struggling with trust, power, and control. Many chronically traumatized persons (Newman, 2000) and homeless youth (Kidd & Kral, 2002) have difficulty feeling an internal sense of self-efficacy and safety. These individuals also tend to grapple with issues of shame and have diminished understanding of self-care. Corresponding to these problem areas, Newman (2000) suggests the goals of therapy with chronically traumatized persons are to assist them to (a) develop trust appropriately, (b) exercise control over their own lives and internal experience, (c) decrease shame, and (d) increase self-esteem and self-care.

When a client presenting with trauma symptoms is in a state of crisis due to life circumstances or other factors, the initial goal of treatment must be restoration of some degree of safety and control (Wilson, Friedman, & Lindy, 2001). From what is known about treating trauma, "the greatest need of any traumatized individual is to feel safe, and this often requires attention to various practical dimensions" (Wilson et al., 2001, p. 247). Similarly, research suggests the basic needs of homeless youth, such as crisis remediation, safe shelter, food, clothing, and medical care, must be provided before other therapeutic interventions are introduced (Kidd, 2003).

While the ideal would be to immediately transition a homeless youth into a housed setting where a physically safe environment could be established and direct trauma work could begin, the reality is that transitioning off the streets is a gradual process. It often begins with establishing a trusting relationship with a service provider or program (Barry et al., 2002). These youth must perceive that accessing services is a positive experience, rather than a capitulation of their autonomy and control. Assisting homeless youth to seek and utilize shelters or other services is a choice to be anticipated, rather than an immediate outcome.

Attaining autonomy and a sense of independence are also fundamental tasks of adolescence. For homeless youth, the importance of fostering autonomy, power, and control over themselves and their environments is especially important, independent of the trauma they may have experienced (Kidd, 2003). Homeless youth want to feel optimistic and to have the opportunity for accomplishments that give them a sense of worth (Fall & Berg, 1996). In addition, providers are more likely to successfully engage these youth when they acknowledge the strength, courage, skill, and determination that it takes to survive as a homeless adolescent and recognize the role choice plays in the youths' street involvement (Fest, 2003). Homeless youth are more likely to utilize services they perceive are tailored to their needs, are flexible, have less restrictive rules, and require limited disclosure of personal information (De Rosa et al., 1999). They appreciate services and providers that truly listen to them, encourage their active participation in service development and provision, and respect their perspective concerning problem areas (Thompson et al., 2006). In sum, there is a consensus in research literature that strength-based interventions offered in the youths' environments are the most effective therapeutic approaches for this population (Baer et al., 2004; Cauce et al., 2000; Kidd, 2003)

## CURRENT TREATMENTS OF PTSD IN ADOLESCENTS

Available research concerning effective treatment of PTSD in adolescents is minimal (Cohen, 2003; Green, 2004; Perrin, Smith, & Yule, 2000; Ruggiero, Morris, & Scotti, 2001). However, existing outcome studies consistently report cognitive behavioral (Cohen, 2003; Green, 2004; Perrin et al., 2000; Ruggiero et al., 2001) and cognitive-behavioral exposure therapies (Bryant, Moulds, Guthrie, Dang, & Nixon, 2003; Green, 2004; Pine & Cohen, 2001) as the most effective interventions for adolescents. Cognitive behavioral therapy (CBT) focuses on restructuring thinking through the identification, examination, and alteration of thoughts and beliefs that are maladaptive (Aisenberg & Mennen, 2000). Other elements of CBT involve the development of cognitive coping skills, such as anxiety management (Perrin et al., 2000). The principal goal of cognitive-behavioral approaches in the treatment of PTSD in adolescents is to enhance coping by developing new or modified cognitive structures through which the traumatic event may be viewed and placed in perspective. The goal is to regain control over life experiences (Aisenberg & Mennen, 2000). While completely eliminating the fear, apprehension, and anxiety associated with the trauma is unrealistic, the development of positive coping skills increases the individual's sense of control, mastery, and well-being (Perrin et al., 2001).

Exposure therapies, through the use of various repeated exposure exercises to traumatic stimuli, aims to reduce avoidance and integrate traumatic memories (Pine & Cohen, 2001; Taylor et al., 2003). This method of treatment "forces a confrontation with fear-arousing situations and stimuli associated with the trauma" and has been found to assist individuals to manage emotions accompanying memories or reminders of the trauma (Green, 2004, p. 286). Diminished PTSD symptoms and improved psychosocial functioning have been found in several studies evaluating the efficacy of combined CBT/exposure approaches with children and adolescents (Perrin et al., 2000; Pine & Cohen, 2001; Ruggiero et al., 2001).

Standard CBT with adolescents often involves, and in some instances requires, collaboration with parents or guardians, and typically consists of regular therapeutic sessions over relatively long periods of time (Green, 2004; Perrin et al., 2000; Pine & Cohen, 2001). These requirements are not practical for youth who are homeless. Moreover, others (Wilson et al., 2001) underscore, "addressing cognitive schemas which organize the person's protection should be addressed with caution, as the predictions about dangerousness of the world may be well-founded and critical to survival" (p. 248). In light of the constant threat to safety encountered by youth living in homelessness, this concern seems particularly salient for treating trauma with this population.

The use of exposure therapies, while reportedly effective in mediating the effects of PTSD, should be used cautiously and preferably when adequate support to the client is available. For some vulnerable populations, such as persons with comorbid psychiatric or substance abuse disorders, this therapeutic strategy may not be appropriate (Wilson et al., 2001). As homeless youth are, by definition, a vulnerable population lacking adequate support and often experience co-morbid mental health and substance use problems, the use of exposure techniques that repeatedly require youth to re-experience traumatic stimuli is likely to engender increased fragility in these youth.

Traditional psychotherapy requires a great deal of commitment from clients (Newman, 2000). At the very least, persons needing or seeking therapy must locate a service provider, contact him/her for an appointment, come to the initial appointment, and return for scheduled sessions. Research has shown such requirements are immediate barriers to access and utilization of services by homeless youth (Kidd, 2003). As the daily life of homeless youth comprises attempts to secure the most basic needs and fending off further victimization (Gaetz, 2004), setting and keeping of appointments is not a high priority for these youth (Baer et al., 2004). In addition, they are highly mobile, seldom staying in the same location more than a few days at a time (Baer et al., 2004). Finally, many homeless youth distrust persons in "helping roles," rely heavily on themselves, value their autonomy and independence, and are leery of engaging with or accepting assistance from social service providers (Baer et al., 2004; Barry et al., 2002).

Although limited, some research has addressed the effectiveness of available treatments for PTSD for individuals who are still exposed to traumatic situations (Wilson et al., 2001). This growing body of research stresses the importance of recognizing that cultural differences have implications for assessment and treatment of PTSD (Becker et al., 2004b). Homeless youth experience a street culture that constantly exposes them to high-risk situations and limits access to adequate food, shelter, clothing, medical care, and general safety. Insofar as "basic environmental safety and stability are prerequisites to discussing interpersonal issues or trauma material" (Newman, 2000, p. 274), the use of current evidence-based treatments for PTSD with youth still living within a street culture must be considered with caution. The current evidence-based, trauma-related treatments for adolescents often do not lend themselves to the unique needs and circumstances of youth who are homeless. Thus, to avoid the potential for further harm, their use is not advisable and treatment approaches should be tailored to the specific needs and unique concerns related to the cultural context of the street.

## AN INTEGRATED MODEL OF INITIAL STEPS IN TREATING TRAUMA SYMPTOMS AMONG HOMELESS YOUTH

To prevent further harm, prior to transitioning off the streets into a more secure, stable, and safe living arrangement, work targeting trauma symptomatology and its manifestations in homeless youth requires an indirect approach. An "outreach model" of intervention has been recommended to incorporate the cultural context of homelessness. It appears that greatest

success is found when youth are met through "intercepts on the street or through open times at agencies where youth come for food, shelter or other services" (Baer et al., 2004, p. 320). Combining Levy's (1998) model of outreach with mentally ill homeless adults, strength-based solution-focused techniques (Selekman, 2005; Bender, Thompson, McManus, Lantry, & Flynn, 2007), and Newman's (2000) treatment goals offer an integrated approach that may initiate the process of addressing trauma issues among homeless street youth.

Levy's (1998) model defines the outreach process as attempts to communicate with the individual (pre-engagement), in order to build a functioning relationship (engagement), which encourages and assists the person in setting goals (contracting). "Contract implementation" concentrates on the process of goal achievement, followed by the final stage (termination) that consists of maintaining the achievements (Levy, 1998). Research has shown that the engagement phase is most important when working with homeless individuals as it facilitates movement to subsequent phases. This model also incorporates an Eriksonian developmental perspective to the outreach process, redefining it as "an attempt at forming a trusting relationship (trust vs. mistrust), while respecting and promoting client autonomy (autonomy vs. shame) in order to build initiative toward positive change (initiative vs. guilt)" (Levy, 1998, p. 125). This combination of intervention strategies corresponds to the developmental tasks of adolescence (Becker et al., 2004a), mirrors Newman's (2000) trauma treatment goals, and adheres to what is known about elements of effective approaches with homeless youth (Barry et al., 2002).

## STRENGTHS-BASED APPROACH

Service providers and homeless youth report brief, strength-based practices delivered in the youths' environments to be an effective modality with this marginalized population (Baer et al., 2004; Cauce et al., 2000; Kidd, 2003; Rew, 2002; Bender et al., 2007). Homeless youth appear to respond best to client-centered services that are "flexible and forgiving" and encourage them to continually strive to attain goals despite relapses and setbacks (Cauce et al., 2000). Strength-based treatment approaches focus on the strengths already possessed by the client, as well as those found within his/her environment. Solution-focused brief therapy (SFBT) is a strength-based model that utilizes a cognitive-behavioral approach to help clients imagine how s/he "would like things to be different and what it will take to make that happen" (Gingerich, 2000, p. 476). Although SFBT has not been examined as a treatment approach for PTSD, or as an intervention with homeless youth, several authors (De Rosa et al., 1999; de Winter & Noom, 2003; Greene, Lee, Trask, & Rheinscheld, 1996; Kidd, 2003; Rew, 2002) support the use of strength-based and solution-focused therapeutic approaches for homeless youth because these approaches focus on mobilizing the strengths and resources of the client. Others recommend the integration of solution-focused principles and techniques in crisis intervention models as a practical, conceptual framework for intervening with sheltered, runaway youth (Springer, 2001).

Using a SFBT treatment approach entails assuming the "solution," or at least some part of the solution, is within the client as well as within reach (Gingerich, 2000). Emphasis is on empowerment through identifying and amplifying client strengths and resources as tools to use in the reduction of the frequency/intensity of the presenting problem (Green, 2004). SFBT's emphasis on strengths and solutions helps build expectations for change. Change using the SFBT model is typically achieved in incremental steps, with small changes eliciting larger changes (Greene et al., 1996). Suppositional language and presuppositional questions can be used to instill hope in the future, as well as invite the youth to think about change and imagine a time when s/he was not confronted with constant stressors.

Scaling questions can be used to collaboratively identify which goals are most important to the youth, as well as how s/he is feeling and what s/he could do to improve the situation or mood. These questions are frequently used in engagement and contracting stages to assist the youth in choosing a goal and identifying which steps will bring him/her closer to goal attainment. An SFBT approach facilitates the youth in defining, evaluating, and developing his/her own goals and strategies to attain them, which serves to reinforce his/her sense of autonomy. Levy (1998) recommends the following SFBT-oriented questions to facilitate this process: "What changes would you like to see in your life? If you had three wishes to change your current situation, what would you wish for? If a miracle were to happen today, what would be different?" A solution-focused approach recommends following up these questions by exploring how current behaviors link with identified goals.

Strength-based, solution-focused interventions view the client as the expert on his/her life, and aims to increase client autonomy (Selekman, 2005). Helping the youth to explore solutions and mobilize their resources and strengths to attain desired goals diminishes the sense of futurelessness, increases self-efficacy, and decreases feelings of shame and powerlessness common among traumatized persons. Incorporating these approaches, the proposed developmental model of outreach also seeks to increase a sense of safety by encouraging the client to set the tone and pace of the therapeutic interaction. Once a modicum of equilibrium has been attained through the use of these methods, specific treatment approaches, such as CBT, can be utilized more effectively, easily, and ethically to mediate trauma symptomatology

### Pre-Engagement

Newman's (2000) treatment goals for work with chronically traumatized persons correspond to the service needs of youth who are homeless. In addition, Levy's (1998) developmental model of street outreach provides a framework for service delivery that is supported by research evidence regarding elements of effective interventions with this population. Pre-engagement, the first step in working with homeless youth concerning trauma-related issues, begins by establishing communication and trust between youth and provider. This phase may require days to months, due to high levels of distrust often encountered among homeless youth, as well as the myriad of ways trauma symptoms are expressed (Levy, 1998).

Attending to the immediate needs of persons who are homeless by offering basic items such as food, clothing, and hygiene supplies can initiate the necessary mechanisms for establishing communication and trust. The primary aims of this phase of treatment are to convey respect, empathy, and a genuine desire to be of assistance (Fall & Berg, 1996; Levy, 1998). The worker is cautioned to not come on "too strong because of the adolescent's safeguards of distrust and anger, and not being too relaxed because of the adolescent's perception that adults are uncaring and unwilling to help" (Fall & Berg, 1996, p. 434). Consonant with the need to begin demonstrating to the traumatized youth that the worker will respect his/her boundaries in the context of their relationship, it is important to appreciate the boundaries set by the youth and cease further engagement attempts if the youth requests it at that time. However, once communication has been initiated, the worker can gradually move toward engagement. The following example of the outreach practices of a street outreach program illustrates how the pre-engagement phase might unfold and transition into engagement.

The street outreach program offers hygiene supplies to homeless youth encountered on outreach. While providing youth with the supplies they have requested, outreach workers begin to establish rapport and assess for further needs. This is accomplished by asking the youth general questions, such as whether they might need medicated foot powder to attend to "boot rot" (feet that have become blistered or fungal due to damp socks). Outreach workers also briefly describe services provided by the program and hours of operation. By taking this approach, the worker is trying to convey to the youth that s/he understands elements of street

culture and is there to provide client-centered assistance. By not introducing potentially charged topics at the onset, the worker is letting the youth know that s/he will give the youth space to initiate such discussions. Through the delivery of information about available services, the worker is presenting the youth with service-oriented options from which to choose based on need and trust levels. Each time outreach workers encounter the same youth, and as the youth gains familiarity with the workers, the workers gradually try to engage the youth in longer conversations concerning street experiences, needs, and requests for various types of assistance.

### Engagement

The next phase, engagement, the worker collaborates with the youth to identify strengths, goals, and solutions. Rapport can be established and maintained with the young person by allowing them to choose the subject and direction of conversation, focusing on their strengths, and by "not rushing the client to change or make any long term plans" (Fall & Berg, 1998, p. 435). During this stage, emphasis should be placed on fostering a sense of control, autonomy, and self-efficacy by way of collaborating with the client and allowing him/her to establish the direction of the interaction and target for change. Engagement may eventually lead to contracting and setting goals, while contract implementation involves taking the steps necessary to attain set goals. Techniques of SFBT lend themselves to these tasks.

## TRAINING

Training service providers in this integrated model consists of overlapping training and education in the areas of street culture, crisis intervention, SFBT theory and techniques, as well as incorporating stages of the model of outreach. While training in culturally competent practice is now a fundamental component of professional education in the areas of counseling and social work, such training often centers on cultural elements as they relate to race, ethnicity, and religion. Training and work with homeless youth involves cultural considerations beyond these elements that encompass the unique social, environmental, economical, developmental, and trauma-related cultural dimensions of youth homelessness. Accordingly, it is recommended that all providers, regardless of education level, receive training in homeless youth street culture. Due to the perilous environment in which homeless youth live, as well as high rates of substance abuse and mental health issues among this population, service providers should also receive training in crisis intervention models (Springer, 2001). Training service providers in SFBT can be accomplished utilizing resources provided by the Solution-Focused Brief Therapy Association (http://www.sfbta.org/), the Brief Therapy Center (http://www.brief-therapy.org/), and other publications (Selekman, 2005). Equipped with a crisis intervention framework and grounding in SFBT theory and techniques, service providers may more competently conduct risk and needs assessments, establish rapport, attend to emotions, and develop a plan with youth for crisis remediation. Ideally, programs providing services to homeless youth have Licensed Master Social Workers or other trained counselors on staff (Springer, 2001), with youth presenting with pressing mental health concerns, including suicidal ideation, being quickly referred to counselors for further assistance. When budget constraints make the employment of licensed staff prohibitive, it is important for service providers to refer youth and assist them in accessing additional, appropriate community resources.

## CONCLUSION

This integrated, culturally sensitive model of initial treatment of PTSD in youth who are homeless is limited in several areas. Namely, it does not directly address many PTSD symptoms associated with persistent re-experiencing of traumatic events, avoidance of traumatic stimuli, numbing of general responsiveness, and increased arousal. Instead, this integrated model

"covertly" attends to these symptoms and their manifestations by fostering a trusting relationship between service provider and client, instilling a sense of hope, orientation towards the future, promoting increased self-efficacy, and challenging negative cognitions through solution-focused interventions, as well as restoring a sense of safety via crisis intervention and the provision of basic needs. The objective of this model is not to eradicate a homeless youth's PTSD symptoms. Rather it intends to mitigate these symptoms to the extent that they are no longer hindering service utilization, placing the youth at risk for additional harm, or preventing him/her from conceptualizing the possibility of a healthier, safer, nonhomeless future. In this way, the model's goal is to assist youth in beginning to transition out of homelessness and into a physical and emotional space wherein more targeted trauma work can be accomplished.

Further research is needed to understand the development and manifestation of PTSD symptoms among chronically traumatized populations, especially youth who are homeless. Examining the characteristic symptoms of the disorder from within the context of street culture could provide useful insight in the development of effective treatments of PTSD with other populations exposed to ongoing trauma. Examining PTSD and trauma from within the cultural context of youth homelessness additionally underscores critical aspects of assessment and treatment, such as the need for cultural competency, and the importance of not inflicting further harm by way of taxing instruments or poorly timed treatment interventions.

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## Biographies

Holly H. McManus, MSSW, is a licensed social worker who received her degree from the University of Texas at Austin, School of Social Work in 2005. She has extensive experience providing drop-in and outreach services to homeless/runaway youth in Austin, TX

Sanna J. Thompson, PhD, is an Associate Professor at the University of Texas at Austin, School of Social Work. Her research has focused primarily on high-risk youth and their families, with special emphasis on runaway and homeless youth populations