Title Page

**Exploring the Trauma Experiences of Homeless Families: A Literature Synthesis**

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Abstract

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University of Pittsburgh, 2019

**Abstract**

“Trauma” comes from the Greek word meaning “wound” as in a physical injury to the body. Only in the late nineteenth and early twentieth centuries did trauma take on the psychological connotations we attach to the word today. From experiences of trauma resulting from a single event to complex trauma resulting from extended, repeated traumatic events, the effects of trauma can be long-lasting and negatively affect both mental and physical health.

Families experiencing homelessness constitute 33% of the total homeless population. Homelessness itself presents numerous challenges, but many families also struggle to cope with problems that preceded homelessness and/or that may compound it. This literature synthesis explores trauma in the lives of homeless families. The findings suggest that the trauma histories of homeless families are quite extensive and include abuse and neglect as children as well as intimate partner violence in adulthood. Children in homeless families often witness abuse suffered by their caregivers. In terms of the impact of trauma, depression, Posttraumatic Stress Disorder (PTSD), and other psychiatric disorders are not uncommon among homeless mothers. Children are similarly negatively affected. They may experience internalizing and/or externalizing problems. Internalizing problems include depression, anxiety, and PTSD whereas externalizing problems include aggression and other behavioral problems.

There are many interventions designed to help members of families who have experienced traumatic events. However, homeless families may not be able to take advantage of such offerings because of housing instability. While it is certainly important for homeless families to eventually receive trauma-related interventions, what can be done at the point of homelessness? One option is for providers of services to the homeless to follow trauma-informed practices, which are outlined as part of this literature synthesis.

Homelessness in and of itself is a significant public health problem. For example, homelessness is associated with physical and mental health problems and barriers to accessing care. With respect to trauma and homelessness, the severity of trauma symptoms is predictive of long-term housing instability for families. Thus, it is important to address trauma among homeless families to help keep them out of shelters and other unstable living situations.

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# Introduction

The U.S. Department of Housing and Urban Development [HUD] reports that over half-a-million Americans experienced homelessness in 2018 on a single night (HUD, 2018). While the number of families who are homeless has declined overall, families experiencing homelessness still make up 33% of the total population of homeless people (HUD, 2018). Given that homeless families are generally made up of a mother with two children under age 6, they face immense challenges in finding and maintaining stable housing (Bassuk, DeCandia, Beach, & Berman, 2014). This may be especially true for families struggling to cope with problems that preceded and/or may compound homelessness. For example, many homeless families have trauma-filled histories that stretch from childhood into adulthood (Bassuk et al., 1996; Hayes, Zonneville, & Bassuk, 2013; Schuster, Park, & Frisman, 2011).

This literature synthesis examines how trauma affects the lives of members of homeless families. I provide a brief history of trauma that focuses on nineteenth century and early twentieth century conceptions of psychological trauma. I also provide an overview of homelessness. I outline the literature search methods that were used and then present the findings of the literature review, including information about the trauma-related predictors of homelessness, trauma histories of families, and the impact of trauma on homeless mothers and children. Finally, I discuss the results of the search and introduce trauma-informed care as an option for providers of services to homeless families.

# Background

## Trauma

### Defining Trauma

“Trauma” comes from the Greek word meaning “wound” as in a physical injury to the body (Trauma, n.d.). Outside of the medical profession, “trauma” now largely refers to the psychological experience of people exposed to some stressful event (Thompson & Walsh, 2010). It is important to distinguish between trauma as an event that causes a physical or psychological injury and trauma that is experienced following the event. For clinical purposes, the American Psychiatric Association (2013) defines traumatic events as those that involve “exposure to actual or threatened death, serious injury, or sexual violence” (Posttraumatic Stress Disorder, Criterion A). The American Psychological Association (2016) expresses a similar yet broader view in defining trauma as a “shocking or overwhelming” event or experience that threatens one’s “physical, emotional or psychological safety” (p. 6). The Substance Abuse and Mental Health Services Administration’s (n.d.) definition of trauma encompasses both the event and the resulting experience, defining trauma as

an event, series of events, or set of circumstances that is experienced by an individual as

physically or emotionally harmful or life threatening and that has lasting adverse effects

on the individual’s functioning and mental, physical, social, emotional, or spiritual well-

being. (para. 3)

Others describe trauma in more general terms. For instance, Herman (2015) describes psychological trauma as disrupting the “ordinary systems of care that give people a sense of control, connection, and meaning” (p. 33). Similarly, Van derk Kolk (1996) states that traumatization occurs, when one’s internal and external resources are overcome by external threats.

As the small sample of definitions show, there is a range from narrow to more inclusive conceptions of trauma (Krupnik, 2018). Dalenberg, Straus, and Carlson (2017) note that the definition of trauma provided by the American Psychiatric Association leads to equating trauma with the likelihood of the traumatic experience leading to a diagnosis of Post-Traumatic Stress Disorder (PTSD). Shapiro (2017) refers to the type of trauma defined by the PTSD criteria as a “big T” trauma. Small “t” trauma encompasses the more “ubiquitous adverse life events” that can have a “lasting negative effect on the self or psyche” (Shapiro, 2017, p. 39).

### Brief History of Trauma

#### Hysteria

Only in the late nineteenth century and early twentieth century did trauma take on the psychological connotations we attach to the word today (Danese & Baldwin, 2017; Fassin & Rechtman, 2009). In the nineteenth century, “railway spine” referred to the phenomenon in which victims of railway accidents who had not suffered any significant physical injury nevertheless showed psychosomatic signs of distress (Harrington, 2003). John Erichsen, the British surgeon who first described railway spine, attributed those symptoms to minor injuries to the spine (Allan & Waddell, 1989). However, others disagreed with his assessment. Jean-Martin Charcot, a French neurologist, attributed the symptoms shown by railway accident victims to hysteria (Charcot, 1888).

“Hysteria” comes from a Greek word meaning “uterus” (Micale, 1990). While never truly systematically defined, until Charcot described male hysterics in the late nineteenth century, hysteria was thought with few exceptions to be an infirmity confined to women and adolescent girls (Herman, 2015; Micale, 1990). The “patriarch of the study of hysteria,” Charcot worked out of the famous Salpêtrière in Paris where he gave popular lectures about hysteria, often with live demonstrations featuring female patients (Herman, 2015). For over 200 years the Salpêtrière admitted female patients only, but by the 1880s Charcot was treating male patients in the outpatient clinic, in the general infirmary, and in a special ward for men with nervous and neurological disorders (Micale, 1990). In addition to male victims of railway accidents, Charcot had among his patients veterans of wars that had ended years before their placement in his care (Jones & Wessely, 2007). He documented a puzzling range of symptoms in the men that included nightmares, heart palpitations, chest pain, and trembling in the hands and neck (Jones & Wessely, 2007). Charcot applied two new diagnostic terms, ‘névrose traumatique’’ and “hystérie traumatique,” to these cases (Jones & Wessely, 2007). Charcot theorized that the emotions associated with being involved in a traumatic event were enough to cause the neurosis (Micale, 1995). For Charcot, fear was perhaps the “most potentially pathogenic” (Micale, 1995, p. 107). Charcot also believed that such hysteria was the product of an inherited predisposition, which was then triggered by the traumatic event (Jones & Wessely, 2007).

Pierre Janet and Sigmund Freud, who were among the many influenced by Charcot’s work at the Salpêtrière, became rivals in their quests to discover more about hysteria (Herman, 2015). Janet published *L’Automatisme Psychologique* in 1889. He argued that the memory of a traumatic experience, which occurs when a person’s emotions overtake their ability to act appropriately, becomes “dissociated” because it cannot be properly absorbed (van der Kolk, Brown, & van der Hart, 1989, p. 366). The dissociated memory then returns “as fragmentary reliving of the trauma, as emotional conditions, somatic states, visual images, or behavioral reenactments” (van der Kolk et al., 1989, p. 366). Janet was the first person to draw attention to dissociation as an important component of post-traumatic symptoms (van der Kolk et al., 1989). At close to the same time, Freud and his collaborator Joseph Breuer also posited that emotional responses led to an “altered state of consciousness,” which they referred to as “double consciousness” (Herman, 2015, p. 12). Janet thought that subconscious fixed ideas conceived earlier in life led to neurotic symptoms following a traumatic event among hysterical patients (Herman, 2015; Jones & Wessely, 2007). Breuer and Freud (as cited in Herman, 2015) similarly noted that “hysterics suffer mainly from reminiscences” (p.12). It seemed that both Janet and Freud had come to a similar understanding that psychological trauma produced hysteria (Herman, 2015).

#### War

Friedman (n.d.-a) notes that the connection between traumatic military experiences and psychological symptoms has a long history. For example, in 1761, an Austrian physician referred to “nostalgia” affecting soldiers. Symptoms included melancholia, longing for home, anxiety, and trouble sleeping (Friedman, n.d.-a). In 1918, a British psychiatrist Lewis Yealland published a treatise, *Hysterical Disorders of Warfare*, in which he promoted the use of threats, punishment, and shaming for veterans of the recent war who were suffering from symptoms such as uncontrollable weeping, mutism, memory loss, and sensory loss (Herman, 2015). Military officials first tried to hide reports of psychiatric illness amongst soldiers, but then later attributed such breakdowns to physical trauma related to exploding shells and their concussive effects (Herman, 2015; Jones & Wessely, 2007). “Shell shock,” however, was clearly not the cause of the symptoms as soldiers who had experienced no physical trauma also had symptoms (Gersons & Carlier, 1992; Herman, 2015). Next, the moral character of the soldiers was called into question. Many medical officials accused patients of being cowards and of being lazy (Herman, 2015). In one instance, Yealland applied electric shocks to the throat of a mute patient for hours until he finally spoke (Herman, 2015). Among the British Army, at least 7 to 10% of officers and 3 to 4% of non-officers experienced “mental breakdowns” (Gersons & Carlier, 1992, p. 743). Crocq and Crocq (2000) note that soldiers suffering from stress disorders were most certainly among the 346 British and Commonwealth soldiers ordered shot by military command for cowardice or desertion.

Not all medical authorities subscribed to the belief that the soldiers were of low moral character. Instead of shaming and threats, they promoted more humane treatment based on the belief that even men of great courage could be overwhelmed by fear in times of war (Herman, 2015). Following World War I, many outpatient clinics sprung up throughout England to respond to the needs of traumatized soldiers (Gersons & Carlier, 1992).

While interest in war or combat neurosis waned somewhat after World War I, it ramped back up again with the beginning of World War II (Herman, 2015). Rather than diagnosing soldiers with shell shock, they were instead thought to be suffering from battle fatigue, or Combat Stress Reaction (Friedman, n.d.-a). During the Russian-Japanese War (1904-1905), psychiatrists had developed the idea of forward psychiatric treatment whereby soldiers suffering psychological ailments were not evacuated but were instead treated near the front line (Crocq & Crocq, 2000). As with many lessons learned in earlier combat scenarios, the idea of forward treatment was initially forgotten at the onset of World War II. Thus, of the many psychiatric casualties at the beginning of the war who were sent hundreds of miles away from the front, only 5% were cleared to return to duty (Crocq & Crocq, 2000). In 1943, forward treatment, or the “front line” approach, was brought back to the fore (Crocq & Crocq, 2000; Gersons & Carlier, 1992). Thus, 50% to 70% of psychiatric casualties returned to duty (Crocq & Crocq, 2000). Herman (2015) states that relatively little attention was paid to the long-term psychological condition of the soldiers. However, Gersons and Carlier (1992) note that the rise of community mental health centers in the United States was the result of the public’s awareness of psychic disorders and their impact on members of the population.

According to Herman (2015), it was not until after the Vietnam War that any significant investigations into the long-term effects of combat were undertaken. Veterans affected by what was called “post-Vietnam syndrome” or “delayed-stress syndrome” organized “rap groups,” which were gatherings at which veterans told stories about their traumatic experiences during the Vietnam War (Herman, 2015; Jones & Wessely, 2007). While the rap groups, which were sometimes attended by psychiatrists offering professional assistance, gave comfort to the veterans who participated, they also brought public awareness to the effects of war (Herman, 2015). Under pressure from veterans’ organizations, the Veterans’ Administration established Operation Outreach, a psychological treatment program, and commissioned studies about the impact of combat on the lives of veterans (Herman, 2015). The result was the publication of a 5-volume study outlining post-traumatic stress and linking it to combat exposure (Herman, 2015). Using research about the Vietnam veterans as well research about survivors of the Holocaust and other traumatic events, the American Psychiatric Association included a new category in its manual of mental disorders, “post-traumatic stress disorder.” (Friedman, n.d.-a; Herman, 2015). A significant point in including PTSD in the manual was the acknowledgement that a traumatic event, something that occurs outside an individual, could account for a psychiatric disorder (Friedman, n.d.-a; Friedman, n.d.-b; Gersons & Carlier, 1992).

#### PTSD

Adding PTSD to the third edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-III)* was not the end of the story. Many studies have demonstrated the clinical relevance of PTSD diagnosis for individuals who have experienced a single traumatic incident (van der Kolk, 2000). However, there are more patients seeking treatment who have experienced more than one traumatic event and present with a range of psychological issues, not all of which were covered in the *DSM-III* (van der Kolk, 2000).

In her study of childhood trauma, Terr (1991) developed the idea of type I and type II traumas. Type I traumas are the result of “unanticipated single events” (Terr, 1991, p. 14). They are the most common type of posttraumatic stress disorder in childhood and often meet the diagnostic criteria for PTSD found in the *DSM-III* (Terr, 1991). Type II trauma disorders “follow from long-standing or repeated exposure to eternal events” (Terr, 1991, p. 15). The first response to such an event is surprise, but as the event is repeated, a sense of anticipation is created and defense and coping mechanisms are activated (Terr, 1991). Type II traumas were not truly represented in the diagnostic criteria in the *DSM* (Herman, 2015).

In 1992, Judith Herman proposed a new diagnostic category, complex post-traumatic stress disorder (Herman 2015). She thought trauma was best understood on a spectrum. That spectrum ranged from simple experiences of trauma never requiring intervention to complex trauma experiences that resulted from extended, repeated traumatic experiences (Herman, 2015). Included in the list of traumas that would qualify were being held hostage, being a prisoner of war, being a victim of domestic violence, and being a victim of childhood physical or sexual abuse (Herman, 2015). It was not until the 5th edition of the *DSM* that the definition of trauma moved away from requiring a single traumatic event to allowing for multiple events as is the case with complex trauma (Briere & Scott, 2015). This change recognizes that psychological symptoms and disorders are predicted by the number and range of traumas experienced over a lifetime (Briere & Scott, 2015).

### Effects of Trauma

The effects of trauma can be long-lasting and negatively affect both mental and physical health (Kendall-Tackett, 2009; Lambert et al., 2017). This may be especially clear when considering people who experienced or witnessed a traumatic event(s) as children. In the United States, nearly two-thirds of adolescents report experiencing at least one potentially traumatic event by the age of 17 (McLaughlin et al., 2013). Moreover, nearly 5% of adolescents in the United States meet the lifetime criteria for PTSD (McLaughlin et al., 2013).

#### Stress

One way to conceptualize trauma is to view it as a type of stress response (Krupnik, 2018). For example, Krupnik (2018) defines three potential categories of stress response that exist along a continuum: normative stress response, pathogenic stress response, and traumatic stress response. This is somewhat similar to other treatments of stress. The National Scientific Council on the Developing Child (2005) describes three types of stress: positive, tolerable, and toxic. Positive stress is moderate stress experienced for a brief time and includes experiences such as getting immunized or meeting new people. Tolerable stress responses come about when someone is faced with a more intense challenge in a brief timeframe. Challenges might include the death of a loved one or an accident. In the case of both positive and tolerable stress, supportive relationships are an important component of the stress response. Finally, toxic stress responses are the result of events that are experienced over an extended period (e.g., abuse) and/or without the supportive relationships needed to mitigate the damage (National Scientific Council on the Developing Child, 2005).

Toxic stress can cause significant changes in the brain (McEwan, 2005; McEwan, 2006; Shonkoff & Garner, 2012). In early childhood, brains are especially vulnerable to the negative effects of stress (National Scientific Council on the Developing Child, 2005). Stress experienced during this period may affect brain circuits and hormonal systems in a way that results in a stress response that is hypersensitive or stays “on” too long when faced with perceived threats (National Scientific Council on the Developing Child, 2005). Because of elevated cortisol levels in response to toxic stress, children’s immune response can be negatively impacted (National Scientific Council on the Developing Child, 2005). Furthermore, elevated cortisol levels can contribute to deficits in memory and learning because of its effect on the hippocampus (Lupien et al., 1998; National Scientific Council on the Developing Child, 2005).

#### Adverse Childhood Experiences

Kessler, Davis, and Kendler (1997) studied childhood adversity and its association with psychiatric disorders such as mood, anxiety, and addictive disorders. They examined 26 adversities, including death of a parent, maternal or paternal depression, interpersonal traumas such as rape, and other adversities such as witnessing trauma. Three-fourths of study participants reported experiencing childhood adversities with more than half of participants indicating they had experienced more than one. Kessler and colleagues (1997) found that the adversities were linked with the onset of psychiatric disorders, but not the persistence. However, they note that their finding on persistence is inconsistent with previous studies.

Concomitantly, the Adverse Childhood Experiences (ACE) study found that exposure to stressors in childhood could lead to negative health and mental health outcomes in adulthood (Felitti et al., 1998). Felitti and colleagues (1998) assigned seven types of adverse childhood experiences into two categories: abuse (psychological, physical and sexual) and household dysfunction (substance abuse, mental illness, domestic violence, and criminal behavior). More than half of the participants in the study had experienced at least one adverse event and 6.2% of participants reported experiencing 4 or more. What the researchers found was a strong dose-response relationship between the number of adverse events experienced in childhood and risk factors for leading causes of death in adults. There was a relationship between adverse event exposure and certain disease conditions, including cancer, lung disease, ischemic heart disease, and liver disease (Felitti et al., 1998). A recent study of the relationship between adverse childhood experiences and mental health outcomes found that compared to participants with no exposure to an adverse event, those reporting six or more had “2.73 times increased odds of reporting depressed affect during adulthood, 24.36 ties increased odds of attempting suicide, 3.73 times increased odds of reporting drug use, and 2.84 times increased odds of reporting moderate to heavy drinking” (Merrick et al., 2017, p. 15).

In terms of mental health generally, Lambert and colleagues (2017) discuss four patterns relating to childhood trauma and mental disorders. First, compared to children without exposure to trauma, children exposed to trauma are at higher risk of developing a mental disorder over the course of their lives. Second, children who experience a traumatic event maintain increased susceptibility to mental disorders over the course of their lives. Third, children who experience traumatic events are more likely to do develop several common mental disorders such as anxiety, mood, substance use, and behavioral disorders. Fourth, a large proportion of mental disorders in the United States can be explained by childhood trauma exposure (Lambert et al., 2017). For example, Green et al. (2010) calculated population attributable risk proportions. They found that “32.4% of all disorders, 41.2% of disruptive behavior disorders, 32.4% of anxiety disorders, 26.2% of mood disorders, and 21.0% of substance use disorders” were explained by childhood adversities (Green et al., 2010, p.118). Taken together, these patterns show the importance of childhood trauma as a determinant of mental disorders (Lambert et al., 2017)

## Homelessness

### Defining Homelessness

There are many definitions of homelessness. For example, the U.S. Department of Education, the U.S. Department of Housing and Urban Development [HUD], and the U.S. Department of Health and Human Services use different definitions of homelessness as it relates to youth (United States Interagency Council on Homelessness, 2018). In its role as the major funder for services for emergency and transitional housing, HUD’s definition of homelessness is one that is widely used (Curran-Groome, 2017).

HUD’s (n.d.) definition of homelessness has four categories. The first category is literal homelessness in which an individual or family lacks a “fixed, regular, and adequate nighttime residence” (HUD, 2012, p. 1). The second category is for those in imminent danger of becoming homeless. The criteria for this category include that the nighttime residence will no longer be available within 14 days, that no future nighttime residence has been located, and that the individual or family does not have the resources to acquire permanent housing at that time. The third category is for people who would qualify as homeless under other federal statutes. The final category includes individuals and families fleeing or attempting to flee domestic violence (HUD, 2012).

Lee, Tyler, and Wright (2010) note that contemporary definitions of homelessness often fail to account for the “precariously or marginally housed,” which includes individuals or families who are “doubled up” (i.e., living with family or friends) or living in unconventional housing such as sleeping in cars or occupying apartment buildings that have been abandoned (p. 503). They assert that housing situations fall along a continuum rather than a simple housed versus unhoused split. Furthermore, there is a temporal component necessary for definitions of homelessness (Lee et al., 2010). Lee and colleagues (2010) state that there are three types of homelessness: transitional, episodic, and chronic. Transitional, or temporary, refers to individuals or families who are briefly homeless before finding stable housing. Episodic homelessness occurs when individuals or families find themselves in and out of homelessness over short timeframes. Chronic homelessness occurs when individuals are essentially permanently homeless (Lee et al., 2010).

Even though most people who experience homelessness fall in the transitional or episodic categories, the chronically homeless tend to be overrepresented in various tallies (Lee et al., 2010). For example, transitionally homeless people accounted for 33% of bed days in a shelter system in one study (Culhane & Metraux, 2008). Episodically homeless people accounted for 17% of bed days. Finally, chronically homeless people accounted for 50% of bed days while comprising only 11% of the total shelter population (Culhane & Metraux, 2008). Culhane and Metraux (2008) found that transitionally homeless people had lower rates of mental health and substance abuse treatment compared to the episodically and chronically homeless populations. They were also younger with fewer disabilities. Unsurprisingly, the chronically homeless tend to be older with high rates of mental health and substance abuse problems as well as disabilities (Culhane and Metraux, 2008).

It is also helpful to think about what homelessness used to be when defining it. “Old” homelessness in the post-World War II era was very different from the “new” homelessness that characterizes the mid-1970s onwards (Rossi, 1994). By contemporary definitions of homelessness, many of those who were deemed homeless in the 1950s and 1960s would not be called so today (Rossi, 1994; Shlay & Rossi, 1992). In the 1950s and 1960s, the homeless lived in “hobohemia,” or skid rows, where they occupied boarding houses and single occupancy hotels (Shlay & Rossi, 1992, p.130). Skid row neighborhoods also had bars and low-priced restaurants in addition to employment agencies for their transient labor residents (Shlay & Rossi, 1992). In the old model of homelessness, homelessness was essentially living without a family (Rossi, 1994; Shlay & Rossi, 1992). Homeless people in that period were primarily older men working at temporary jobs or subsisting on pensions from social security (Rossi, 1994). As the need for transient labor decreased, the number of people living in skid rows declined so considerably that people began to predict homelessness would shortly be at an end (Shlay & Rossi, 1992; Rossi, 1994). However, that was not to be the case.

The mid-1970s saw a dramatic increase in the number of homeless people (Rossi, 1994). This was perhaps due to chronic unemployment resulting from a restructured labor force, racial discrimination, and trends in the housing market (Rossi, 1994). Unlike the skid row occupants who came before them, the homeless population in the 1970s and onward met the definition of literal homelessness and therefore became more visible in addition to being more numerous (Rossi, 1994). There was also a shift in demographics. The new homeless population was much younger with an average age in the mid-30s (Rossi, 1994). Black and Hispanic people began to outnumber white people in the major cities (Rossi, 1994). Another major shift was in sex. While there were very few women categorized as homeless in the 1950s and 1960s, there was a significant increase by the mid-1980s when women made up 20-25% of the single homeless population (Rossi, 1994). Even more significant was the increase in family homelessness. In the 1950s and 1960s, there were no remarks about homeless families (Rossi, 1994). As Rossi (1994) notes, this may have been because of the definition of homelessness at the time or because children were removed from the family by child protective services prior to the family becoming homeless.

### Family Homelessness

#### Prevalence

The 2018 Annual Homeless Assessment Report (AHAR) point-in-time count defines homelessness as lacing a “fixed, regular, and adequate nighttime residence” (HUD, 2018, p.2). According to AHAR, there were 552,830 homeless people on a single night in January 2018 (HUD, 2018, p.2). The majority (65%) of those people were in shelters. The racial/ethnic background of the homeless population was 48.9% white, 39.8% black or African American, 22.2% Hispanic/Latino, and 11.4% other. In terms of gender, 60.2% were male, 39.1% female, 0.5% transgender, and 0.2% gender non-conforming. With respect to age, the majority (71.1%) of homeless people were over 24-years of age. However, there was a significant portion of people under the age of 18 (20.2%). Overall, homelessness has declined by 15% since 2007 (HUD, 2018).

According to the 2018 AHAR, homeless families with children comprised one-third of the total homeless population (HUD, 2018). The average size of homeless families was 3.2 people and the majority (9 in 10) of homeless families with children were in shelters. Sixty percent of people in homeless families are children younger than 18-years old. Of all homeless families with children, African Americans made up the majority (51%). In terms of chronic homelessness, only 5% of homeless families with children were considered chronically homeless. Since 2007, the number of homeless families has dropped by 23% and the number of homeless family households dropped by 28% (HUD, 2018).

While the point-in-time counts are the primary data source about homeless people, they are not without controversy (Schneider, Brisson, & Burnes, 2016). Multiple cities have, for example, used service provider databases to gather numbers that are much higher than those found in the point-in-time counts (Schneider et al., 2016). Furthermore, counts of homeless people miss those who are not in shelters or who remain out of sight at the time of the count (Hopper, Shinn, Laska, Meisner, & Wanderling, 2008). Because the point-in-time counts do not include doubled up situations, HUD may be significantly underestimating the number of homeless families (Bassuk et al., 2014). Another criticism is that the point-in-time count is not consistently administered by the states leading to frustration for those interested in ending homelessness (Schneider et al., 2016).

Historically, another potential obstacle for achieving accurate counts around family homelessness might have been shelter policies (Rossi, 1994; Weinreb & Rossi, 1995). According to Weinreb and Rossi (1995), family shelters constituted 39% of the total number of shelters making them the most numerous type of shelter in the categories recorded by HUD. Shelters generally had the power to choose who they would allow to reside there (Weinreb & Rossi, 1995). They had a great deal of impact on perceptions of homeless families because of this power (Weinreb & Rossi, 1995). Thus, many definitions of family homelessness did not include childless couples or parents of non-minor children (Weinreb & Rossi, 1995). Furthermore, many shelters’ rules permitted only women and children to stay, therefore, men who were part of the family had to find shelter elsewhere (Weinreb & Rossi, 1995). In Weinreb and Rossi’s (1995) review, adolescent males were also prohibited from staying in a significant number of shelters. Shelter policies certainly played a role at one time in determining what got counted as a homeless family (Nunez & Fox, 1999; Weinreb & Rossi, 1995).

#### Causes

Literature on the causes of homelessness tends to fall into one of two camps, structural causes versus individual causes, with homelessness being more frequently attributed to structural causes (Main, 1998). One structural cause might be the economy (Bassuk et al., 2014; Main, 1998; Rossi, 1994). Rossi (1994), for example, notes economic restructuring, or the shift from a manufacturing to a service-based economy, as one potential cause of early family homelessness. Bassuk and colleagues (2014) attribute a rise in homeless children from 2007 to 2010 to the continued effects of the Great Recession, which resulted in job losses and increased foreclosures. Other structural causes of homelessness linked to the economy are high rates of unemployment and significant decreases in the number of low-skilled jobs (Schneider et al., 2014). Finally, the housing market with its lack of affordable housing is thought to be a major source of homelessness in the United States (Bassuk et al., 2014; Buckner, 2014; Main, 1998).

Individual causes of homelessness largely center on mental health and substance abuse problems (Main, 1998). Beyond that, however, there are individual risk factors for family homelessness that can be considered (Buckner, 2014). Having young children, being pregnant, or having given birth in the past year are all risk factors for family homelessness (Buckner, 2014; Shinn et al., 1998). Race/ethnicity is also important as racial/ethnic minorities are more likely to be homeless (Bassuk et al., 2014; Shinn et al., 1998). Shinn and colleagues (1998) found that frequent moves were also a risk factor as was crowding in the residence just prior to a family being admitted into a shelter. The latter point is important as 59% of the families in Shinn et al.’s (1998) study were doubled up at some point in the year prior to visiting a shelter.

#### Costs

A study published in 2010 explored the costs associated with the utilization of services by individuals and families in multiple communities around the country who were experiencing homelessness for the first time (Spellman, Khadduri, Sokol, & Leopold, 2010). Spellman and colleagues (2010) found that families had much higher homeless systems costs on average ($3,184 to $20,031) compared to individuals ($1,634 to $2,308) because of higher daily costs associated with their stay in homeless programs and the length of their stays. On the latter point, families averaged 3 to 10 months for stays compared to 5 to 10 weeks for individuals. However, Spellman and colleagues (2010) note that the median length of stay was much lower than the average, meaning a small number of households had extended stays that raised the average. Surprisingly, larger families do not cost much more than smaller families. Spellman and colleagues (2010) estimate that adding a child, for example, increases the costs by 6%. However, there is an increased cost based on the age of the children in the family. If the youngest child is of grade school age, then the cost is 21% higher than for families with pre-school age children (Spellman et al., 2010).

One way to assess the cost of homelessness is to compare the cost of housing families in emergency shelters, transitional housing, and permanent supportive housing to fair market rent in the same communities (Spellman et al., 2010). With respect to families, the fair market rent is significantly lower than the average cost per month of the housing programs (Spellman et al., 2010). For example, the average emergency shelter cost per month in Houston was $1,391 compared to $743 for fair market rent. In upstate South Carolina, the average cost per month for transitional housing was $1,209 compared to $599 for fair market rent. Regarding emergency shelters for families, which are as expensive or even more so than other program options in the communities studied, Spellman and colleagues (2010) advise that communities consider interventions like rapid rehousing to place families into permanent housing as quickly as possible as a cost savings measure. Of course, fair market rent covers housing only and not the supportive services offered by transitional housing that some homeless families may need. Yet, Spellman and colleagues (2010) suggest that communities consider potential cost benefits of different interventions or of offering rent subsidies with standalone supportive services rather than wraparound services.

# Methods

This essay is a literature synthesis focusing on trauma in the lives of homeless families. It covers trauma-related predictors of homelessness, the trauma histories of homeless families, the elements of homelessness that may contribute to traumatization, and the effects of trauma and homelessness on homeless families. A literature search was conducted between December 2018 and January 2019 in multiple sources, including EBSCO databases, ProQuest databases, Web of Science, and Scopus. This analysis combines results from three ProQuest databases: *PsycINFO*, *PsycARTICLES,* and *Psychology Database*. Inclusion criteria for the ProQuest searches were any peer-reviewed empirical articles in English about family homelessness and trauma in the United States. Exclusion criteria included articles that were only about homeless mothers who did not have custody of their children as well as articles that were about unaccompanied homeless youth.

The first search in ProQuest included the terms “trauma\*” and “homeless families.” It yielded 395 results. After limiting the results to full-text articles, the number was reduced to 207 items. Applying the inclusion and exclusion criteria further reduced the number to 10 articles to be included in the analysis.

The second search in ProQuest included the terms “trauma\*” and “families experiencing homelessness.” There were 63 citations. Limiting the results to full-text articles reduced the count to 30. After removing duplicates, only 1 of those 30 articles was included in the analysis.

The average homeless family consists of a single mother with young children under age 6 (Bassuk et al., 2014). Thus, subsequent searches used the following keywords in various combinations: “trauma\*,” “homeless mothers,” “homeless women,” “homeless children,” and “children experiencing homelessness.” After applying the inclusion and exclusion criteria and removing duplicates, those searches yielded no new results.

Additional articles were identified through citation mining. A few of the mined citations are theoretical articles that provide context for various findings and were cited multiple times by empirical studies. A total of 21 articles were found through this method. The total number of articles included in this analysis is 32.

# Findings

## Trauma

The articles found through citation mining did not necessarily use any variation of the word “trauma,” but did refer to events that were described as traumatic in other studies. While all the articles found in ProQuest use some variation of the word “trauma,” they do not consistently define trauma in the same way, if they define it at all. For example, Williams and Hall (2009) asked homeless mothers to identify an event in their lives that they found “most disturbing” (p. 203). Other studies explicitly associate trauma with physical or sexual abuse (Goodman, 1991a; Wood, Valdez, Hayashi, & Shen, 1990; Zlotnick, Tam, & Bradley, 2007). Some studies associate trauma with violence more generally, whether experienced by homeless mothers and children directly or witnessed by them (Buckner, Beardslee, & Bassuk, 2004; Harpaz-Rotem, Rosenheck, & Desai, 2006; Stainbrook & Hornik, 2006). A few studies count as traumatic events that are not considered traumatic in other studies. For example, Zlotnick and colleagues (2007) count a range of adverse childhood events as traumatic including being placed in foster care or a group home, running away from home, being kicked out of the home, or placed in a juvenile detention facility. In adulthood, Zlotnick and colleagues (2007) also count as traumatic the experience of being chronically homeless. Herbers, Cutuli, Monn, Narayan, and Masten (2014) worked from a list of stressful life events that could potentially be traumatic. They included an incarcerated parent, hospitalization, attack by an animal, experiencing a natural disaster, death of a sibling, and being kidnapped.

## Predictors of Homelessness

Several authors have found that trauma may contribute to the descent of some families into homelessness (Bassuk et al., 1996; Browne & Bassuk, 1997; Hayes et al., 2013; Shinn et al., 1998; Shinn, Knickman, & Weitzman, 1991). Hayes et al.’s (2013) work reveals that the severity of trauma symptoms is predictive of long-term housing instability. Shinn and colleagues (1998) found in their study of homeless families in New York City that domestic violence in adulthood and/or abuse or separation from one’s family in childhood were important risk factors for homelessness in adulthood. Similarly, in their study comparing homeless mothers and low-income housed mothers, Browne and Bassuk (1997) reported that homeless mothers’ cumulative experiences of childhood sexual molestation and physical violence in childhood or adulthood differentiated them from housed mothers. There are other studies that found no significant differences in trauma experiences between homeless and housed women, which would make trauma less predictive of homelessness (Bassuk et al., 1997; Weitzman, Knickman, & Shinn, 1992). Weitzman and colleagues (1992) explored three potential risk factors: psychiatric history, substance abuse, and victimization. They discovered that victimization was less predictive of homelessness because victimization histories were common among both homeless and housed mothers. Bassuk and colleagues (1997) reached the same conclusion.

Another way that trauma could affect a family’s housing stability is through social relationships (Bassuk & Rosenberg, 1988; Bassuk et al., 1997; Goodman, Saxe, & Harvey, 1991; Shinn, Knickman, & Weitzman, 1991; Stainbrook & Hornik, 2006). Some studies have shown that homeless families have more fragmented social networks than do their housed counterparts (Bassuk & Rosenberg, 1988; Stainbrook & Hornik, 2006; Wood et al. 1990). By doubling up with people or by securing other resources through those networks, low-income families are able to avoid seeking shelter (Bassuk & Rosenberg, 1988; Shinn et al., 1991). In contrast, Bassuk and Rosenberg (1988) discovered that while 74% of housed mothers could name three adult supports, only 26% of homeless mothers could. Similarly, Wood and colleagues (1990) found that two-thirds of homeless mothers had no one or only one adult on whom they could rely for support.

While social networks can provide support for low-income or homeless families, they may also contribute to homelessness (Shinn et al., 1991). Bassuk and colleagues’ (1997) study revealed that conflict within a family’s social support network is included among the various risk factors for homelessness. As Shinn and colleagues (1991) note, certain detrimental relationships may serve as a drain on families’ resources or may keep families from seeking out much needed support. Also, it may be the case that escaping an abusive domestic relationship results in homelessness (Toro et al., 1995). As for trauma, experiencing trauma may result in isolation and a lack of trust in others (Bassuk & Rosenberg, 1988; Browne, 1993; Goodman et al., 1991). Bassuk and Rosenberg (1988) suggest that the trauma histories of homeless mothers may lead to an inability on their part to develop and maintain the types of supportive relationships needed to avoid homelessness. Goodman and colleagues (1991) discuss social disaffiliation and how trauma victims often feel let down by others. Trauma victims suffer rejection, are blamed for their problems, and are perceived as unpleasant people around whom no would want to be (Goodman et al., 1991).

As with trauma as a risk factor for homelessness, there are studies that found the opposite result in terms of social support available to homeless families. For example, Goodman (1991) reports that homeless and housed mothers were very similar when it came to the number of available supports, including friends, family, and professionals. She also notes that homeless and housed mothers had similar numbers of people in their social networks who fell in the categories of “positive,” “negative,” and “conflicted” (Goodman, 1991b, p. 330). Goodman’s (1991) findings are in line with Shinn and colleagues (1991), who found that homeless mothers had more contact with the people in their social networks than did their housed counterparts. One potentially significant difference in Shinn and colleagues’ (1991) study was that they interviewed families as they were requesting shelter rather than after they had been homeless for some time. Shinn and colleagues (1991) note this may have affected their results as newly homeless families may have reached out to people in their social networks in last ditch efforts to avoid going to a shelter.

## Trauma Histories of Homeless Mothers

Browne (1993) notes that it has only been since 1975 that violence against women has been studied in a systematic way. It was believed up to that point that most women’s domestic responsibilities kept them at home more than men and that having family members around provided some measure of protection for women. Therefore, most studies on interpersonal violence were limited to men and boys as they were thought to be at higher risk of being both perpetrators and victims. However, minority women and poverty-stricken women have a high risk of victimization as well (Browne, 1993; Browne & Bassuk, 1997; Wood et al., 1990). For example, the Institute for Children, Poverty, and Homelessness (as cited in Bassuk et al., 2014) reports that between 20% and 50% of homeless women describe intimate partner violence as their reason for homelessness. In their comparison of the characteristics of homeless mothers in family shelters and in domestic violence shelters, Stainbrook and Hornik (2006) found that 73% of the women in the family shelter had ever experienced intimate partner violence. Furthermore, 21% had experienced intimate partner violence within the three months prior to their interview with the researchers. While the prevalence of intimate partner violence is naturally higher among women in domestic violence shelters, these figures highlight the stark reality of intimate violence histories among homeless mothers in family shelters.

A few studies have found that over 90% of homeless mothers have experienced at least one traumatic event either in childhood or adulthood (Bassuk et al., 1996; Hayes et al., 2013; Schuster et al., 2011). Goodman (1991) reported her surprise at the fact that only 11% of the homeless and housed low-income mothers in her study had never experienced physical or sexual abuse. Hayes and colleagues (2013) found that of homeless mothers in various housing programs, 93% had experienced trauma in their lifetimes and that 81% had experienced more than one traumatic event. Schuster and colleagues (2011) had very similar findings with 93% of their participants having experienced at least one traumatic event and 73% having experienced multiple traumatic events over their lifetimes. In terms of multiple events, the mothers in Williams and Hall’s (2009) study had a median average traumatic score of 7.8 out of 12 events. The total number of distressing or traumatic events experienced by those mothers was more than double the number described by women in a larger community sample (Williams & Hall, 2009). Harpaz-Rotem and colleagues (2006) found that homeless mothers averaged 9.15 (range: 0-17) traumatic events over their lifetimes. The average lifetime trauma event exposure (range: 0-8) varied across housing programs for Hayes and colleagues (2013). Mothers in emergency shelters averaged 3 events while those in transitional housing or permanent supportive housing averaged 3.5 events.

Trauma exposure started early for homeless mothers with many experiencing traumatic events in childhood (Bassuk & Rosenberg, 1988; Bassuk et al., 1997; Browne & Bassuke, 1997; Goodman, 1991a; Hayes et al., 2013; North, Thompson, Smith, & Kyburz, 1996; Stainbrook & Hornik, 2006; Weitzman et al., 1992; Wood et al., 1990; Zlotnick et al., 2007). In Hayes and colleagues’ (2013) study, 79% of homeless mothers had experienced a traumatic event in childhood. Fifty-six percent had experienced multiple traumas in childhood. According to their research, the average number of traumatic events experienced in childhood was 3.2. Physical and sexual abuse in childhood were high among homeless women with physical abuse being more common (Bassuk et al., 1997; Browne & Bassuk, 1997; Goodman, 1991a, North et al., 1996; Weitzman et al., 1992). Goodman (1991a) used a severity scale to distinguish minor violence (e.g., pushing, throwing objects, and slapping) from severe violence (e.g., kicking, hitting with a fist or object, burning, and beating). She found that of the homeless women in her study, 40% had experienced no physical abuse, 12% had experienced minor physical abuse, and 48% had experienced severe physical abuse. Using essentially the same definition of severe violence, Browne and Bassuk (1997) report that 66.5% of homeless mothers in their sample were subjected to severe violence by caretakers. With regard to sexual abuse, Goodman (1991a) found that 42% of homeless mothers had been sexually abused as children. By contrast, Weitzman and colleagues (1992) reported that only 9.9% of the homeless women in their study were sexually abused. Some of this discrepancy might be accounted for by different interviewing techniques as Goodman (1991a) used a wider range of questions than usual to elicit responses. Furthermore, other studies show results that are much closer to the higher number (Bassuk et al., 1996; Browne & Bassuk, 1997; North et al., 1996; Zlotnick et al., 2006). In addition to physical and sexual abuse, homeless mothers experienced other potentially traumatic events including placement in foster care or congregate care, homelessness as a child, and involvement with the juvenile justice system (Bassuk et al., 1997; Wood et al., 1990; Zlotnick et al., 2006).

## Trauma Histories of Homeless Children

While there appears to be a dearth of literature on the trauma histories of homeless children, what there is suggests that trauma plays a significant role in their lives as well (Buckner, Bassuk, Brooks, & Weinreb, 1999; Harpaz-Rotem, Rosenheck, & Desai, 2006; Herbers et al., 2014; McGuire-Schwartz, Small, Parker, Kim, & McKay, 2015). Children can be traumatized in two ways (Herbers et al., 2014). The first is by being exposed to direct threats to themselves. The second is by events that are threats to their caregivers. The National Center on Family Homelessness (as cited in McGuire-Schwartz et al., 2015) found that by age 12, 83% of homeless children had been witness to or were directly victims of violence. In their study of school-age homeless children, Buckner and colleagues (1999) explored traumatic and negative life events experienced by the children. Those included death of a parent, serious injury to the child, witnessing violence in the community, witnessing the mother being abused, and being placed with a relative or in foster care. Buckner and colleagues (1999) found that homeless children experienced more stressors and traumas in their lives than did their housed counterparts. Specifically, placement in foster care or with a relative, unstable housing situations, and physical and sexual abuse were more prevalent. Asked about violence exposure in the home or community, 45% of children were revealed to have been exposed with 19% of them being direct victims (Harpaz-Rotem, Rosenheck, & Desai, 2006). Herbers and colleagues (2014) report that of a range of 0-10 potentially traumatic life events, the average number experienced by children was 3.05.

## Homelessness as Traumatic

In their seminal article, Goodman and colleagues (1991) conceptualize homelessness as a potentially traumatic experience in and of itself. Homelessness may result in psychological trauma through three pathways. The first is the loss of one’s home, whether it happened over a prolonged period or quite suddenly. In addition to the loss of shelter, homelessness may result in ruptured social connections, including friends, neighbors, and even other family members as shelter policies might require families to split up. The second pathway is the experience of being homeless and living in shelters. Some people who find themselves homeless may end up in chaotic environments that lack familiarity and predictability in addition to potentially being unsafe. Furthermore, shelter rules and routines may do damage to a homeless person’s sense of autonomy. Each pathway may lead to the development of trauma symptoms. However, even if the first two pathways do not produce symptoms of trauma, the third pathway may exacerbate trauma symptoms from previous traumatic experiences. As has been discussed, many homeless mothers and children have extensive trauma histories that could lead to the realization of the third pathway (Goodman et al., 1991).

Two symptoms of trauma that are thought to be common among homeless families are social disaffiliation and learned helplessness (Goodman et al., 1991a). As previously discussed, homeless people may experience a breaking of bonds between themselves and others either as a precursor to homelessness or as a consequence of homelessness (Bassuk & Rosenberg, 1988; Bassuk et al., 1997; Browne, 1993; Goodman et al., 1991). This isolation may result in the inability of individuals in the family to play their customary roles within the family and within the broader social environment (Goodman et al., 1991). If homeless people feel as though others were unwilling to help them at critical moments, then they may begin to lose trust in people in general while at the same time feeling as though they cannot take care of themselves (Goodman et al., 1991). The loss of belief in someone’s ability to control the direction his or her life takes, or learned helplessness, can come to the fore in a number of ways for those who are homeless (Goodman et al., 1991). For example, homeless families in shelters rely on others for a place to sleep, food to eat, and other resources that may be available (Goodman et al., 1991). Furthermore, homeless mothers face parenting in an environment that is not always conducive to them doing so, which may make them question their parenting ability (Goodman et al., 1991).

Researchers have found evidence that supports Goodman and colleagues’ (1991) conceptualization of homelessness as traumatic (Banyard & Graham-Bermann, 1998; Hausman & Hammen, 1993; Koblinsky, Morgan, & Anderson, 1997; Schuster et al., 2011; Williams & Hall, 2009). Hausman and Hammen (1993) note that “virtually all the high risk conditions that have been studied for their negative impact on mothers and children come together in the situation of homelessness” (p. 365). Chaotic shelter environments cause stress for mothers, who may also have to contend with criticism of their parenting techniques from shelter staff and other mothers (Hausman & Hammen, 1993; Koblinsky et al., 1997). Overstressed mothers may lose confidence in their parenting ability and simply give in to the demands of others who have undermined their authority (Hausman & Hammen, 1993; Koblinsky et al., 1997; Mayberry, Shinn, Benton, & Wise, 2014). In their study of housed and homeless mothers, Banyard and Graham-Bermann (1998) found that stress among the homeless mothers was linked to higher levels of depression and avoidant coping. Depression is one of the markers of learned helplessness and Banyard and Graham-Bermann (1998) explicitly state their findings support Goodman et al.’s (1991) view of learned helplessness among the homeless population. As to the question of homelessness as trauma generally, when asked to identify their most recent stressful event, over one-third of participants in Schuster and colleagues’ (2011) study answered that homelessness was the most stressful event they had experienced. Williams and Hall (2009) asked homeless mothers about a traumatic event that was most disturbing to them. While the majority indicated an event that happened prior to becoming homeless, 44% answered that it was an event that occurred during homelessness.

## Impact of Trauma and Homelessness on Homeless Mothers

Among homeless mothers the rate of depression is quite high (Banyard & Graham-Bermann, 1998; Bassuk et al., 1998; Hayes et al., 2013; McGuire-Schwartz et al., 2016). Even compared to their housed low-income counterparts who also have high rates of depression, homeless mothers have still higher rates of depression (Banyard & Graham-Bermann, 1998; Bassuk et al., 1998; Goodman, 1991a, McGuire-Schwartz et al., 2016). In Hayes et al.’s (2013) study, depressive symptoms were the chief mental health complaint among homeless women; sixty percent of homeless mothers reported depressive symptoms. Hayes and colleagues (2013) also noted that depressive symptoms are linked to trauma exposure and the experience of homelessness. Stress is also linked to higher levels of depression among homeless mothers (Banyard & Graham-Bermann, 1998). Banyard and Graham-Bermann (1998) report that homeless mothers were most stressed by abusive partners, money issues, problems with friends, crowded housing, and dangerous neighborhoods. Browne (1993) outlines some of the effects of trauma sustained after a physical assault or threat by intimates. Homeless women may experience fear, psychological paralysis, withdrawal, betrayal, confusion, and hopelessness. This is on top of responses to physical assault or threat generally, which include anger, shame, guilt, and feeling like a failure (Browne, 1993).

Banyard and Graham-Bermann (1998) caution that more work needs to be done to answer the question of whether the high rate of depression among homeless women might be the cause of homelessness or an effect. Zlotnick and colleagues (2007) found that that 29.5% of homeless mothers in their study had their first outpatient mental health visit before they were homeless. Five percent had an outpatient visit after they became homeless. Yet, most homeless mothers (65.4%) had never had an outpatient mental health visit.

Homeless mothers have high rates of PTSD (Bassuk et al., 1998; Hayes et al., 2013; McGuire-Schwartz et al., 2016; Williams & Hall, 2009). Among their sample of homeless mothers, 36.1% of homeless mothers had a lifetime prevalence of PTSD (Bassuk et al., 1998). The lifetime prevalence of PTSD in their sample was much higher than in the general population. The prevalence of PTSD was higher still in the sample obtained by Williams and Hall (2009). More than two-thirds of homeless mothers in their study had PTSD. Hayes and colleagues (2013) note that PTSD affects people in a variety of ways. It can have an impact on cognitive ability, emotional regulation, and on relationships. While individuals react differently to traumatic events, typical PTSD symptoms include intrusive thoughts, flashbacks, memory loss, nightmares and other sleep disturbances, restricted affect, hypervigilance, anxiety, psychological numbing, and irritability (Browne, 1993; Goodman et al., 1991).

## Impact of Trauma and Homelessness on Homeless Children

The mental health and well-being of homeless children is often linked to the mental health of their mothers, many of whom are in psychological distress while homeless (Browne & Bassuk, 1997; Buckner et al., 2004; Buckner et al., 1999; Harpaz-Rotem et al., 2006; Hausman & Hammen, 1993; Koblinsky et al., 1997; Masten, Miliotis, Graham-Bermann, Ramirez, & Neemann, 1993; McGuire-Schwartz et al., 2016; Rescorla, Parker, & Stolley, 1991). Psychologically distressed mothers in chaotic environments may be unable to provide the level of nurturance needed by their young children (Hausman & Hammen, 1993; Koblinsky et al., 1997; McGuire-Schwartz et al., 2016). As Koblinsky and colleagues (1997) found in their study, for example, homeless mothers were less likely than their housed counterparts to “provide their children with a structured, organized, and attractive physical environment; toys, books and materials that promote learning; stimulation of academic behavior; variety in experience; and warmth and acceptance” (p. 42). Koblinsky and colleagues (1997) posit that the stress of shelter life left the mothers drained and unable to respond appropriately to their children’s needs. Harpaz-Rotem and colleagues (2006) note the positive correlation between a mother’s psychiatric symptoms and the child’s level of depression and anxiety. There is a similarly positive association between a mother’s trauma exposure and the child’s level of depression and anxiety (Harpaz-Rotem et al., 2006).

Trauma exposure is a strong predictor of children’s mental health (Buckner et al., 2004). As Browne and Bassuk (1997) note in their study about violence in the lives of homeless women, children are negatively affected by witnessing their mothers being abused or by being abused themselves. Such children may experience internalizing and/or externalizing problems (Buckner et al., 1999; Buckner et al., 2004; McGuire-Schwartz et al., 2016). Internalizing problems include depression, anxiety, and PTSD whereas externalizing problems include aggression and other behavioral problems (Buckner et al., 2004). Buckner and colleagues (1999) reported that past trauma exposure was predictive of high rates of internalizing and externalizing behaviors among homeless children. Buckner and colleagues (2004) found that violence exposure damaged children’s self-esteem which led to increases in internalizing. One study found that homeless boys were doubly burdened by mental health disorders compared to their housed counterparts (Buckner & Bassuk, 1997). However, homeless girls were not similarly burdened compared to their housed counterparts. The authors speculate that perhaps boys are more influenced by shelter dynamics due to the lack of a same-sex parent than are girls, which leads to internalizing and externalizing problems (Buckner & Bassuk, 1997).

Homeless children also face significant challenges in terms of learning and academics (Harpaz-Rotem et al., 2006; Hayes et al., 2013; Koblinsky et al., 1997; Rescorla et al., 1991). Preschool-aged children were less likely than their housed counterparts to be enrolled in early childhood education programs (Rescorla et al., 1991). They were behind in vocabulary and visual-motor development in addition to having higher rates of behavioral problems (Rescorla et al., 1991). Koblinsky and colleagues (1997) also found that homeless children scored lower on tests measuring learning and academics, which they attributed to the mothers providing less stimulation. School-aged children are less likely to be enrolled in school and more likely to have attendance problems when they are enrolled (Harpaz-Rotem et al., 2006). Hayes and colleagues (2013) found that one-quarter of the children in their study had to repeat a grade because of academic challenges.

# Discussion

Homeless people are a hard-to-reach population with respect to conducting research on them (Crosby, Salazar, DiClemente, & Lang, 2010). A significant part of the problem relates to their transient nature, which may lead to high attrition in studies (Crosby et al., 2010; Goldade et al., 2011; Ojo-Fati et al., 2017). Attrition was generally not an issue for the studies reviewed as part of this literature synthesis. The exception was the study by Hayes and colleagues (2013). Hayes and colleagues (2013) used a longitudinal design that included baseline interviews with follow-ups at 15 months and 30 months. The attrition rate for the study was 29%, which was lower than anticipated.

Another potential concern is probability versus nonprobability sampling. Almost all the studies used convenience sampling by recruiting at local shelters or with housing programs. In their study on the impact of trauma experienced in adulthood on homeless mothers, Zlotnick and colleagues (2006) engaged in a secondary data analysis using the National Survey of Homeless Assistance Providers and Clients (NSHAPC), which was made up of nationally representative sample. When it comes to probability versus nonprobability sampling, however, Crosby and colleagues (2010) argue that nonprobability sampling in cases like these “should be viewed more as a cautionary note rather than a flaw in the study design” (p. 3).

Definitions of homelessness used in the studies may explain some differences in findings. For example, Browne and Bassuk (1997) defined homelessness as residing in a shelter for at least seven days. Most other studies recruited directly from shelters as well. By contrast, Zlotnick and colleagues (2006)’s study used the Stewart B. McKinney Act definition of homelessness. That definition is more inclusive and includes people living not only in shelters, but also people who are doubled up or living in abandoned buildings or cars among other things. Zlotnick and colleagues (2006) note that shelter openings are rare and that the more inclusive definition allows for the idea that families in shelters may differ in meaningful ways from homeless families in other situations though that is not explored in this particular study.

A more general concern not specific to the homeless population is the method of eliciting information about distressing events from study participants. For example, Goodman (1991) explains that discrepancies in abuse prevalence rates between her study and similar studies could be attributed to differences in interview approaches. To help tap into participants’ memories, Goodman (1991) used a broad range of questions that were stripped of “value-laden” words such as “abusive” or “beating up” (p. 498). The questions focused on physical interactions and were labeled as abusive if they met pre-established definitions rather than relying on participants’ beliefs about the nature of the interactions. Thus, Goodman (1991) believes that she was able to get a more complete and accurate report of abuse from participants in her study and that abuse may have been underreported in studies using different methods. Researchers must also consider social desirability bias. As Banyard and Graham Bermann (1998) note, dependence on self-report measures comes with the understanding that participants may place limits on what they choose to share. For example, Zlotnick and colleagues (2006) expressed concerns about underreporting of involvement with the child welfare system or other sensitive topics such as mental health or substance abuse problems.

Even when researchers use variations of the word “trauma” as descriptors for events in the lives of homeless families, they are not necessarily referring to the same things. For example, some authors may be working from a list of pre-defined traumatic events whereas others solicit from study participants a longer list of events that could be defined as traumatic. Several of the studies refer to traumatic events, but did not measure trauma symptoms that might give clues about how study participants reacted to those events. People can respond in very different ways to the same experience. Thus, what is traumatizing for one person may not be so for another. When not measuring trauma symptoms, describing events as “potentially” traumatic is one way to get around the assumption that so-called traumatic events are traumatic for all people.

Evidence around trauma as a risk factor or predictor of homelessness is mixed. Several studies point to trauma as a potential precursor to homelessness. However, similarities between homeless mothers and housed mothers in terms of trauma exposure cause others to question the link between trauma and homelessness. Similarly mixed is the evidence around social networks and homelessness. It may be the case that trauma victims’ lack of supportive relationships because of isolation and an inability to trust others contributes to homelessness. Yet, some studies found that the social support networks for homeless mothers matched those of their housed counterparts, making it less likely that social network fragmentation is predictive of homelessness.

The trauma histories of homeless families are quite extensive. For many homeless mothers, trauma exposure begins early in childhood and continues into adulthood. This is consistent with research that has shown that adverse childhood experiences increase the risk of homelessness in adulthood (Bassuk et al., 1997). Physical abuse and sexual abuse were common in childhood for homeless mothers. Browne and Bassuk (1997) noted that violence exposure in childhood was predictive of intimate partner violence in adulthood. This is borne out by the fact that intimate partner violence proves to be a significant problem for homeless mothers. It is not only a problem for the homeless mothers who experience it, but also for the children who witness it. Given that trauma exposure as a child is associated with homelessness in adulthood, it is important to recognize that the trauma histories of children encompass not only their direct experiences, but also those of their mothers.

The direct experiences of traumatic events by homeless children are also interesting in terms of how they might fit in with what we know about the exposure to violence and abuse among children generally. Finkelhor, Turner, Shattuck, and Hamby (2015) examined data from the National Survey of Children’s Exposure to Violence (NatSCEV). Of the 4000 children and youth ages 0-17 in the sample, they found that 37.3% of them had been physically assaulted in the last year. In the study, child maltreatment consisted of physical, emotional, or sexual abuse as well as neglect and custodial interference. Finkelhor and colleagues (2015) noted that 15.2% of children and youth had experienced child maltreatment. Taking into account all forms of exposure, Finkelhor and colleagues (2015) conclude that exposure is extensive both the short term and over the span of years. Finkelhor (2011) and Finkelhor and colleagues (2015) describe “poly-victims”, or children who have experienced more than one kind of victimization He notes the increased likelihood of additional victimization with the experience of even one kind (Finkelhor, 2011). Finkelhor (2011) also notes that victimization rises to the level of “condition” for some children in that multiple negative events happen to them over a short timeframe (p. 22). One pathway to poly-victimization is the experience of adversity within the family, including homelessness (Finkelhor, 2011). Finkelhor (2011) writes, “This pathway likely operates through mechanisms like poor supervision, emotional deprivation, and exposure to a lot of potentially predatory persons, deficits that lead to peer victimization, sexual victimization, and other victimizations” (p. 22).

The idea of homelessness as traumatic in and of itself is an interesting one. Goodman et al.’s (1991) description of the ways in which homelessness can lead to or exacerbate psychological trauma is compelling. In particular, the claim about the experience of living in shelters as psychologically traumatic is backed up by research. Studies show that the mothers themselves count homelessness as a distressing or traumatic event or as a time when something traumatic has happened to them. Social disaffiliation and learned helplessness take their toll on the mothers’ ability to cope with their new reality.

A key identifier of learned helplessness is depression. The rate of depression among homeless mothers is quite high. Depression can be linked to experiences associated with being homeless and with trauma exposure. There are some questions about depression and whether it is an antecedent to homelessness or a consequence. It could also be the case that depression is both a cause and an effect. While most homeless mothers had never sought out professionals for mental health treatment in one study, it seems likely that some mothers who needed or wanted to seek help were not in a position to do so either prior to or during an episode of homelessness.

Many homeless mothers also suffer from PTSD, which is not surprising given their history of trauma. Not all homeless mothers’ symptoms rise to the level of a potential clinical diagnosis of PTSD. However, it is important to recall the concept of “big T” versus “small t” trauma (Shapiro, 2017). “Big T” traumas lead to one meeting the criteria for PTSD. The studies that measured whether homeless mothers and children had PTSD were at least capturing big T traumas. Small t traumas may not bring about PTSD. Yet, they can still have long-lasting, negative effects. Thus, failing to meet the criteria for PTSD does not necessarily preclude one from being traumatized.

The impact of trauma and homelessness on children is often associated with the condition of their mothers. Psychologically vulnerable mothers who are attempting to parent their children in shelter environments do not always provide the care and attention their children need to thrive. Moreover, exposure to trauma is predictive of a child’s mental health. Parents who are themselves struggling with mental illness may not be prepared to deal with the manifestations of mental illness in their children. Children may suffer from depression and anxiety as internalizing problems. They may also display externalizing behaviors. Homelessness and its sequelae can take a toll on all aspects of a child’s functioning. For example, many homeless children are behind their housed counterparts in learning and academics. Not being enrolled in school, attendance problems, and repeating grades could lead to detrimental outcomes for those children if they continue to lag behind their peers throughout the course of their schooling.

## Trauma-Informed Care

There are many interventions designed to help members of families who have experienced traumatic events (McGuire-Schwartz et al., 2015; National Child Traumatic Stress Network, n.d.). However, homeless families may not be in a position to take advantage of such offerings because of housing instability. For example, Trauma Adapted Family Connections (TA-FC) is an intervention designed around the idea that trauma negatively affects caregivers’ ability to provide for their children’s basic needs (National Child Traumatic Stress Network, 2012). TA-FC requires that families meet with a provider once a week for six months. This could be quite burdensome for families who are doubled up, or living in shelters, or who are otherwise unsure about where they will be residing over the course of the intervention. Other interventions are similar in requiring multiple visits over a relatively extended period of time (National Child Traumatic Stress Network, n.d.). Thus, it is important that families be stabilized. For example, the Housing First approach provides homeless people with permanent housing as the priority rather than insisting on mental health or substance abuse treatment first (Tsemberis, 2010). It is only after they are stably housed that supportive services are introduced (Tsemberis, 2010).

While it is certainly important for homeless families to eventually receive trauma-related interventions, what can be done at the point of homelessness? One option is for providers of services to the homeless to follow trauma-informed practices. Those service providers and systems might include shelters, housing programs, education, health care, and child welfare (Kilmer et al., 2012). Hopper, Bassuk, and Olivet (2010) conducted a literature review that yielded definitions of trauma-informed care provided by various groups. Because the definitions from each source were unique, Hopper and colleagues (2009) developed a consensus-based definition: “Trauma-Informed Care is a strengths-based framework that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment” (p. 133).

Essentially, trauma-informed care represents a change from more traditional service models that were focused on professionals as experts, conformity to rules by families, and the negative aspects of family life (Guarino, 2014). By contrast, trauma-informed care makes families the experts on their experiences, promotes the positive aspects of family life, and emphasizes recovery rather than focusing on diagnoses (Guarino, 2014). Guarino, Soares, Konnath, Cervil, and Bassuk (2009) describe eight principles of trauma informed care:

* Understanding trauma and its impact
* Promoting safety
* Ensuring cultural competence
* Supporting consumer control, choice, and autonomy
* Sharing power and governance
* Integrating care
* Healing happens in relationships
* Recovery is possible (p. 17-18)

Guarino and colleagues (2009) argue that programs and services need to be trauma-informed for four reasons. First, homelessness itself is traumatic and on top of that homeless families have histories of trauma. Second, a history of trauma influences how members of homeless families relate to others. A lack of trust and the belief that others may try to harm them may prevent them from accessing needed services. Third, internalizing and externalizing behaviors are a means of coping with trauma. Services providers can help homeless families develop more positive coping mechanisms. Finally, those who have experienced trauma need interventions that are tailored to them rather than having programs use blanket approaches (Guarino et al., 2009).

Hopper and colleagues (2009) note that not much is known about the efficacy of offering trauma-informed practices in settings that serve homeless people. What is known is that trauma-informed practices lead to better outcomes than treatment as usual when addressing many symptoms (Hopper et al., 2009). There have been some indications that trauma-informed care helps promote housing stability. Trauma-informed care also leads to improved outcomes for children, including better relationships with others, increased self-esteem, and increased safety (Hopper et al., 2009).

At present, there is a dearth of programs and providers for homeless families providing trauma-informed care (Hopper et al., 2009). Adhering to trauma-informed principles and approaches might be too much for overworked and underpaid providers who are focused on the basics such as shelter and food (Hopper et al., 2009). Providers may also show trepidation about implementing trauma-informed practices because of fears about being able to handle appropriately traumas that homeless families may share with them (Hopper et al., 2009). Thus, implementing trauma-informed care generally means overhauling the culture of an organization and changing staff attitudes and perceptions about the work to be done (Hopper et al., 2009; Unick, Bassuk, Richard, & Paquette, 2018).

There are steps that organizations can take to become trauma-informed. First, they must become knowledgeable about trauma and its impact and build buy-in among the staff (Guarino, 2014; Hopper et al., 2009). Second, after deciding to implement trauma-informed services, organizations must evaluate their efforts (Guarino, 2014). This can be done by using a variety of resources, including the *Trauma-Informed Organizational Toolkit*, which includes an organizational self-assessment (Guarino, 2014; Guarino et al., 2009; Kilmer et al., 2012). Third, the organization could establish a trauma workgroup to keep track of goals, develop new ideas, provide information about trainings, and keep in touch with homeless families through various means such as surveys, focus groups, and interviews (Guarino, 2014). Finally, trauma-informed organizations must sustain their efforts (Guarino, 2014). They can do so by continuing to engage in self-assessments, setting and achieving goals, offering frequent trainings and refreshers, keeping the trauma workgroup going, and developing communities of practice with similar organizations that are trauma-informed (Guarino, 2014).

In terms of practice recommendations, Hopper and colleagues (2009) make several recommendations. They suggest that homeless services settings make use of a theoretical model or framework to promote consistency in implementation. Furthermore, service providers should also screen all clients for histories of trauma using appropriate standardized measures. Because trauma-informed practices are strengths-based, providers should perform assessments of clients’ strengths and assets as well. Moreover, they should promote empowerment and client involvement in charting a path into stable housing. Integrating trauma services with other services (e.g., mental health and substance abuse) is also crucial to fostering better outcomes. At the same time, offering trauma-specific services to those who want more targeted interventions is also beneficial. Given what is known about the trauma histories of children, it is also important to extend trauma-informed practices to children and youth. Finally, cultural and linguistic competence are a critical component of trauma-informed services (Hopper et al., 2009).

# Conclusion

We have come a long way in our understanding of trauma since early conceptions of trauma as associated with hysteria among women or with low moral character among men. The creation of PTSD as a clinical diagnosis with its attendant symptomology provided a framework in which discussions about trauma could be had. However, early definitions of traumatic events failed to capture complex traumas that were the result of repeated experiences over time. There is also the idea that not all experiences of trauma and trauma symptoms rise to the level of a clinical diagnosis of PTSD. That can make it difficult to recognize that someone has indeed been traumatized and would benefit from trauma-informed treatment.

Homeless mothers and their children have extensive histories of trauma, whether experienced directly or witnessed. Some researchers have even classified homelessness itself as a traumatic experience. The effects of trauma on homeless families can have a profound, long-lasting, negative impact on their well-being. They can also contribute to a family’s housing instability. For example, traumatic events may be precursors to homelessness. They may also prevent families from making connections with others or with services that could assist them due to social disaffiliation. Furthermore, the effects of trauma can negatively impact how homeless mothers parent their children. This in turn may lead to internalizing and externalizing behaviors in their children as they too struggle with trauma and homelessness.

One avenue that providers of services to homeless families can take is to implement trauma-informed practices. Such practices restore a sense of autonomy and control for homeless mothers by focusing on the families’ strengths and resources. Trauma-informed principles also highlight empowerment as a means by which traumatized people can achieve their goals. There is a lack of service providers for homeless people who practice trauma-informed care. This is due to a variety of reasons, particularly the lack of resources to do so. However, if organizations and individual providers want their families to achieve long-term housing stability, then it is vital that they attend to the effects of trauma experienced by those families.

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