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PTSD, Complex PTSD, and Childhood Abuse: Gender Differences Among a Homeless Sample

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Abstract

The current study examined the potential relationship between homelessness, gender, and occurrence of Post-Traumatic Distress Disorder (PTSD) and Complex PTSD. Participants were 90 homeless persons from shelters located in a large, South Central Texas, metropolitan city of approximately 1.9 million persons. The study found that homeless participants reported high levels of childhood emotional, physical, and sexual abuse. Homeless women reported higher rates of childhood abuse and were affected by PTSD at a higher frequency than homeless males. PTSD, Complex PTSD, and traumatic experiences such as childhood abuse appear to be contributing factors to homelessness. Results suggest the need for increased advocacy among counseling and psychology professionals is warranted for homeless persons experiencing PTSD.

Keywords: Homeless; Gender; PTSD; Complex PTSD; Childhood Abuse, Advocacy

Introduction

It is difficult to determine an exact count of homeless persons living in the United States (U.S) however, in 2003 the U.S. Conference of Mayors reported the number of homeless individuals to be between 2.5 and 3.4 million (U.S. Conference of Mayors, 2016). The 2017 Annual Homelessness Report (AHAR) to Congress reported an estimated 553,742 individuals who were experiencing homelessness during a January 2017, Point-in-Time Count (Henry, Watt, Rosenthal, & Shivji, 2017). In addition, 33% (184,661) of the homeless were individuals in homeless families with children; and 7% (40,799) were an unaccompanied youth who experienced the highest rate of unsheltered living conditions (55%) (Henry et al., 2017). Difficulties in estimating homelessness rates may be traced back to the transient nature of homelessness and lack of consistent nationwide data collection methods.

There are many, often overlapping causes of homelessness. These include a lack of affordable housing, low-paying jobs, mental illness, substance abuse, domestic violence, unemployment, and poverty (U.S. Conference of Mayors, 2015). In spite of the increased spending to alleviate homelessness, Lucas (2017) determined that marginalized sub-groups within the homeless population including unsheltered youth, lack adequate services due to limited federal funding. Much of the research pertaining to the homeless is now quite dated and more current studies are needed. Recent socioeconomic trends towards more significant income disparity and changing demographics (Kochan & Riordan, 2016) warrant further investigation into homelessness. To this end, our research goals were to examine the potential relationship among homelessness, gender, and occurrence of Post-Traumatic Distress Disorder, (PTSD) and Complex PTSD, and if present, increase attention and potential advocacy for this homeless PTSD/Complex PTSD subpopulation via research publication.

The literature on mental health provider advocacy for the homeless is mostly addressed in social work journals. School counseling literature provides some insight into the topic as it relates to families and minors. Also, the American Counseling Association's (ACA) division journal of the Association for Specialists in Group Work published a limited number of articles specific to social justice constructs and homeless (Brubaker, Garrett, Rivera, & Tate, 2010; Coker, Meyer, Smith, & Price, 2010). Despite this, a paucity of research literature specific to homelessness and the need for advocacy among this population exists in professional counseling journals. This lack of homelessness specific literature in professional counseling journals is surprising since Section A.7a of the ACA Code of Ethics calls for advocacy. Specifically, the Code states, "When appropriate, counselors advocate at individual, group, institutional, and societal levels to address potential barriers and obstacles that inhibit access and/or the growth and development of clients" (ACA, 2014, p. 5). Concomitantly, the Ethical Principles of Psychologists and Code of Conduct Principle D: Justice and Principle E: Respect for People's Rights and Dignity (American Psychological Association, 2017) and the APA Presidential Task Force on Psychology's Contribution to End Homelessness (2010) indicate the need to advocate on the behalf of America's homeless to ensure fairness, justice, and people's rights and dignity. The American Psychological Association (APA) addresses homelessness in a limited manner through the Advocacy on Socioeconomic Status Project (American Psychological Association, 2018b). A 2017 congressional briefing focused on family homelessness and the link between childhood abuse and homelessness (American Psychological Association, 2018a). However, a search of APA journals revealed only a limited number of articles addressing homelessness advocacy, with the majority having been published in the 1980s and 1990s.

A significant barrier encountered by advocates arises from the complexity of defining homelessness, its causes, and appropriate interventions. Also, advocates striving to meet the needs of homeless individuals often encounter political or systemic obstacles created by the need for research-driven funding. Different ideas arising from research generate competing claims for funding and other resources. This leads to interventions tailored

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around only a few of the identified risk factors for homelessness while objectifying a marginalized population (Farrugia & Gerrard, 2016). While causes for homelessness such as alcohol and substance abuse as well as mental illness are frequently targeted, PTSD, Complex PTSD, and a history of childhood abuse seem to be less of a focus.

Homeless Americans must cope with hardships that accompany homelessness as well as the stigmatizing treatment to which they are frequently subjected. Previous research found that the poor and the homeless are often stigmatized and blamed for their dire circumstances (Belcher & DeForge, 2012; Phelan, Link, Moore, & Stueve, 1997). In reality, there is a myriad of problems facing those struggling with homelessness. In general, mental health concerns and history of alcohol and drug abuse occur at higher rates among U.S. homeless persons (Fazel, Khosla, Doll, & Geddes, 2008; Narendorf, Cross, Santa Maria, Swank, & Bordnick, 2017). Lee, Tyler, and Wright (2010) reported between 30-40% of homeless persons experience significant mental health concerns. In addition, the literature on mental health problems encountered by the homeless suggests that these individuals often experience higher levels of psychological distress and suicidal ideation than the non-homeless (Schutt, Meschede, & Rierdan, 1994; Dietz, 2011). Children and adolescents seem especially vulnerable. Youth who reported sexual abuse were at increased risk of running away from their parents' homes and becoming homeless (Chen, Tyler, Whitbeck, & Hoyt, 2004). The limited existing literature suggests homeless persons have experienced an above average number of traumatic events (Lee & Schreck, 2005). This includes higher childhood physical abuse rates, estimated as 37%; and sexual abuse rates estimated as 32% for females, and 10% for males (Sundin & Baguley, 2015). By comparison, the childhood abuse rate among the general U.S. population was estimated at 3.3% for physical abuse. General U.S. sexual abuse rates were 6.7% for females, and 9.6% for males (Finkelhor, Ormrod, Turner, & Hamby, 2005).

PTSD and Complex PTSD

According to Herman (1992) trauma occurs when actions fail, and one's self-defense system is overwhelmed and disorganized. Furthermore, individuals react to trauma by alternating between intrusion and constriction (numbing) the emotional state. Neither allows full traumatic experience integration, which is critically important to healing and traumatic experience resolution (Herman, 1992). Those experiencing PTSD, Complex PTSD, and childhood sexual abuse often behave and experience the world in a manner others may interpret as pathological. Such behaviors and experiences may represent a trauma victim's attempt to cope with intrusive memories or heightened arousal (van der Kolk, McFarlane, & Weisaeth, 1996). Succinctly put, PTSD is a natural reaction to an extrinsic event or stated differently, a normal reaction to abnormal experiences.

Two trauma categories are discussed in the literature. One refers to single episode events such as car accidents, which can lead to the development of PTSD (Pelcovitz, DeRosa, Mandel, & Salzinger, 2000). The other refers to trauma caused by recurrent interpersonal events such as continued child abuse, which may lead to derailment of healthy development in affected individuals (Freyd, 1994; Herman, 1992). Complex PTSD or Disorders of Extreme Stress Not Otherwise Specified (DESNOS) differ from PTSD. Specifically, a PTSD diagnosis focuses on clients' re-experiencing of traumatic memories or attempts to avoid stimulation associated with a traumatic event. Conversely, DESNOS focuses on emotional and somatic dysregulation, dissociation, and trauma-related behavioral patterns (Scoboria, Ford, & Lin, 2008).

The American Psychiatric Association (APA) introduced PTSD as a formal diagnosis in the third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III) (Herman, 1992). Since then, research has supported the validity and relevance of PTSD (Courtois, 2004; van der Kolk & Courtois, 2005). Concomitantly, further research suggested the negative psychological impact caused by chronic, interpersonal trauma. This was especially noted when such trauma began in childhood and was not adequately addressed (van der Kolk & Courtois, 2005). During the DSM-IV development, the APA conducted field trials to investigate the utility of creating a Complex PTSD/DESNOS diagnosis, but in the end, it was not included in the DSM-IV or the DSM-5 as an independent diagnosis. Instead, Complex PTSD/DESNOS symptoms were subsumed under

associated PTSD features (Scoboria, Ford, & Lin, 2008) because during the DSM-IV field trial it was found that individuals with Complex PTSD/DESNOS frequently also qualified for a PTSD diagnosis (van der Kolk et al., 1996). Likewise, the DSM-5 offers a brief description of DESNOS symptoms as associated features supporting a PTSD diagnosis (American Psychiatric Association, 2013). In the 10th edition of the International Classification of Diseases (ICD-10), the World Health Organization (WHO) acknowledged the impact trauma has on individuals by offering the diagnostic criteria "lasting personality changes following catastrophic stress" (World Health Organization, 1992). The ICD-11 edition, which has been released in June of 2018 and is scheduled to be fully adopted on January 1, 2022, goes even further. In contrast to the DSM-5, the ICD-11 for the first time includes a new diagnostic category for Complex Post-Traumatic Stress Disorder.

The Current Study

The purpose of this current investigation was to examine the relationship between homelessness, gender, and occurrence of PTSD as well as Complex PTSD. Researchers predicted elevated PTSD and Complex PTSD levels would be found in homeless participants. It was further predicted that there would be higher levels of the history of childhood abuse reported by homeless participants compared the general U.S. population. In addition, it was predicted that positive correlations would be found between the history of childhood abuse and PTSD, as well as Complex PTSD. Lastly, it was hypothesized that there would be differences between male and female homeless participants. It was predicted that female homeless participants would report higher instances of PTSD, Complex PTSD, and a history of childhood abuse.

Method

Participants

A total of 90 participants were recruited from local homeless shelters. The population for this study is considered vulnerable, and care was taken to protect participants from harm and/or coercion. Specifically, participants were recruited by requesting participation after group sessions or life skills classes held at various shelters. Participation was strictly voluntary, and participants were informed about the purpose of the study. As an incentive, a five-dollar gift certificate was offered to all participants. Risks to the participants from the study were considered minimal, and deception was not necessary. Possible risks to the research participants included but were not be limited to reflecting upon potentially stressful events that might have been uncomfortable.

The shelters from which participants were recruited were located in a large, South Central Texas, metropolitan city of approximately 1.9 million persons. The mean age of participants was 37.64 ($\boldsymbol{\sigma}$ = 10.85); the minimum age was 18, and the maximum age was 61.

Forty-two percent of participants (38) were male, and 58% (52) were female. Nearly 37% (33) were Caucasian, 28.9% (26) were Hispanic, and 18.9% (17) were African American. Approximately 8% (7) described themselves as 'other,' and 7.8% (7) did not respond. Thirty-four percent (31) reported being single, 5.6% (5) reported being in a partnership other than marriage, 31.1% (28) reported being married, 8.7 (8) reported being separated, 15.6% (14) reported being divorced, 3.3% (3) reported being widowed, and 1.1% (1) did not respond. Table 1 describes the frequency of homelessness among the participants.

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Table 1. Length of Homelessness

Length of Homelessness	%	n
Less than 1 mo.	8.8%	(8)
> than 1 mo. – 3 mo.	21.1%	(19)
> than 3 mo. – 6 mo.	18.9%	(17)
> than 6 mo. – 1 yr.	15.5%	(11)
> 1 yr. – 2 yrs.	11.1%	(12)
> 2 yrs. – 4 yrs.	4.4%	(5)
> 4 yrs. – 6 yrs.	5.5%	(5)
> 6 yrs.	2.2%	(2) [20yrs]
> didn't reply	10.0%	(9)
> not categorizable	2.2%	(2)

Procedures

Institutional Review Board approval was obtained, and participants' informed consent was secured prior to data collection. The study used a descriptive and between-group correlation design; group membership was based on gender. Participants completed a survey packet consisting of a questionnaire; the Structured Interview for Disorders of Extreme Stress (SIDES); and the Trauma Center PTSD Symptom Scale. The constructs under investigation were PTSD, Complex PTSD, and a history of childhood trauma. Instruments were administered to participants in the order indicated above.

Instruments

The survey packet consisted of self-completion questionnaires that took about 45 minutes to complete. The packet contained a demographic questionnaire that was used to collect demographic and experience histories such as gender, age, ethnicity, homelessness status, family history, history of physical and mental health concerns, history of domestic violence, and history of childhood abuse.

SIDES. Complex PTSD was assessed using the SIDES. The SIDES (Trauma Center Assessment Packet, 2003) is a 45-item instrument that assesses functioning on six dimensions. Instrument authors purport these six dimensions represent areas of impairment in reference to Complex PTSD. Each of the six dimensions contains diagnostic criteria to be met (see table 2 for more information).

Table 2. Complex PTSD/DESNOS Symptom Categories Assessed by the SIDES

Major Scale	Sub-Category
(I) Alterations in Regulation of Effect and Impulse	
	Affect regulation
	Modulation of Anger
	Self-destructive
	Suicidal preoccupation
	Difficulty modulating sexual involvement
	Excessive risk taking
(II) Alterations in Attention or Consciousness	
	Amnesia
	Transient dissociative episodes & depersonalization
(III) Alterations in self-perception	
	Ineffectiveness
	Permanent damage
	Guilt and responsibility
	Shame
	Nobody can understand
	Minimizing
(IV) Alterations in relations with others	
	Inability to trust
	Revictimization
	Victimizing others
(V) Somatization	
	Digestive system
	Chronic pain
	Cardiopulmonary symptoms
	Conversion symptoms
	Sexual symptoms
(VI) Alteration in systems of meaning	
	Despair and hopelessness
	Loss of previously sustained beliefs

The SIDES was developed to capture Disorders of Extreme Stress Not Otherwise Specified (DESNOS) symptoms (Trauma Center, 2013), which were originally represented in the DSM-IV-TR under Associated Features of PTSD (American Psychiatric Association, 2000). For the purpose of the present study, the self-report version of the SIDES was used. The instrument is able to assess lifetime as well as current symptom presence. The severity of symptoms was also assessed. It must be noted that the SIDES-SR underreports DESNOS symptoms related to affect dysregulation and modulation of anger in comparison to the clinician-administered version (Trauma Center Assessment Packet, 2013). To date, the SIDES and the SIDES-SR (self-report version) are the only validated instruments for DESNOS assessment (Luxenberg, Spinazzola, & van der

Kolk, 2001). The literature on the self-report version does not provide validity information, however, convergent validity between the clinician-administered version and the self-report version of the SIDES was established with correlation coefficients ranging between 0.60 to 0.78 in reference to individual dimensions, and a full-scale correlation coefficient was reported as 0.86 (Trauma Center Assessment Packet, 2013). Reliability of the instrument was based on 520 participants and ranged from $\alpha = 0.53$ to $\alpha = 0.90$ on subscales/dimensions (Pelcovitz et al., 1997) and a Chronbach $\alpha = 0.90$ for the full SIDES scale (Zlotnick & Pearlstein, 1997).

Trauma Center PTSD Scale. PTSD was assessed using the Trauma Center PTSD Scale. This instrument is a 17-item self-report measure designed to assess PTSD symptoms as defined by the DSM-IV-TR (Trauma Center, 2003). It has been adapted from the Modified PTSD Symptoms Scale (MPSS-SR). Psychometric properties demonstrated overall good reliability ($\alpha = 0.96$). The adaptation consisted of adding the ability to also assess lifetime presence of PTSD symptoms (Trauma Center, 2003). Assessing lifetime experiences of PTSD was necessary for this study. The Trauma Center PTSD scale assesses the frequency and severity of PTSD symptoms during the last two weeks as well as lifetime occurrence. It assesses intrusion, avoidance/numbing, and arousal symptoms of PTSD (Trauma Center, 2003).

Results

Demographic questionnaire results revealed nearly two-thirds (69.8%; 37) of homeless women and a little less than half (40.5%; 15) of homeless men reported having been in an abusive relationship in the past. It was not clear if the respondents were the perpetrator or victim in the abusive relationships because the questionnaire did not address this. Homeless participants also reported mental health conditions. The following four diagnoses were reported most frequently: depression (22.2%), Bipolar disorder (15.6%), anxiety (5.6%), and PTSD (4.4%) (see table 3 for information pertaining to ethnicity and PTSD).

Table 3. Ethnicity and PTSD Rates of Homeless Sample

	Ethnicity		PTSD	
	%	n	%	n
Caucasian/Anglo	39.8%	(33)	43.4%	(13)
Hispanic	31.3%	(26)	28.6%	(6)
African American	20.5%	(17)	25.0%	(3)
Asian	N/A		N/A	
Other	8.4%	(7)	33.3%	(2)

Note. None responses were not included in the calculation of percentages.

Table 4 describes additional results pertaining to the demographics of the study participants. It is important to note that while this table shows differences in gender and ethnicity for some variables, none were statistically significant. Most salient in terms of gender was that male participants reported higher rates of having a professional trade than women, and more male participants spend most of their time alone. Female participants reported experiencing severe depression and anxiety frequently at a higher rate than male participants did. In addition, African Americans reported the highest rate of having a professional trade; the highest rate of not having someone to help them financially; the highest rate of spending most of their time alone; and the highest rate of having a close relationship with their mother. African American participants also reported the lowest rates of experiencing serious anxiety frequently. Hispanic participants reported the highest rate of having trouble understanding, concentrating, or remembering; the highest rate of having problems controlling violent

behaviors sometimes; and the highest rate of fathers who have/had problems with alcohol. Caucasian homeless participants reported the highest rate of taking prescribed medication for mental health problems while African Americans reported the lowest. Overall, it is important to note that education completion rates are based on those participants who responded to the question; the non-response rate was 33.7%, which possibly skewed the results.

In terms of childhood abuse, 38.2% (13) of male participants and 53.8% (28) of female participants reported emotional abuse; 41.2% (14) of male participants and 52.9% (27) of female participants reported physical abuse; and 23.5% (8) of male participants and 52.9% (27) of female participants reported sexual abuse. When asked about suicidal ideation, 8.1% (3) of male participants reported they thought about suicide often, and 18.9% (7) reported they thought about suicide sometimes. In turn, 7.5% (4) of female participants reported having suicidal ideation often or very often, and 26.4% (14) stated they thought of suicide sometimes. In terms of suicide attempts, 27% (10) of male participants and 26.4% (14) of female participants reported that they had attempted suicide in the past.

Table 4. Demographic Questionnaire Items

Item	Gender				Ethnicity					
	Males		Females		African American		Caucasian		Hispanic	
	%	n	%	n	%	n	%	n	%	n
Taking prescribed medication for physical ailment on a regular basis.	31.4%	(11)	30.6%	(15)	43.7%	(7)	36.7%	(11)	16.7%	(4)
Taking prescribed medication for mental health problems on a regular basis.	22.7%	(8)	34.0%	(17)	14.3%	(2)	48.5%	(16)	20.9%	(5)
Completed 12 years or more of education.	69.9%	(18)	79.3%	(23)	54.4%	(6)	73.9%	(17)	69.2%	(9)
Having a professional trade.	70.3%	(26)	43.4%	(23)	70.6%	(12)	60.6%	(20)	38.5%	(10)
Not having someone to help financially.	91.9%	(34)	76.9%	(40)	100.0%	(17)	81.2%	(26)	76.9%	(20)
Spending most of their time alone.	45.9%	(17)	25.5%	(13)	56.2%	(9)	46.4%	(13)	19.2%	(5)
Do not have any close friends.	30.3%	(10)	22.4%	(11)	26.7%	(4)	20.0%	(6)	20.8%	(5)
Experiencing serious depression frequently.	18.9%	(7)	41.5%	(22)	23.6%	(4)	39.4%	(13)	30.8%	(8)
Experiencing serious anxiety frequently.	21.6%	(8)	40.4%	(21)	12.5%	(2)	36.3%	(12)	38.4%	(10)
Having trouble understanding, concentrating, or remembering frequently.	21.6%	(8)	38.5%	(20)	31.2%	(4)	21.2%	(7)	53.8%	(14)
Having problems controlling violent behaviors frequently.	13.5%	(5)	3.9%	(2)	5.9%	(1)	6.2%	(2)	12.0%	(3)
Having problems controlling violent behaviors sometimes.	29.7%	(11)	35.3%	(18)	35.3%	(6)	18.8%	(6)	52.0%	(13)
Having a close relationship with their mother.	69.4%	(25)	47.9%	(23)	75.0%	(12)	50.0%	(15)	58.3%	(14)
Having a close relationship with their father.	36.4%	(12)	34.0%	(17)	21.4%	(3)	36.7%	(11)	32.0%	(8)
Mother has/had problems with alcohol.	17.6%	(6)	18.8%	(9)	11.8%	(2)	27.6%	(8)	16.7%	(4)
Father has/had problems with alcohol.	39.4%	(13)	53.2%	(25)	33.3%	(5)	46.4%	(13)	60.0%	(15)
Mother has/had problems with drugs.	2.9%	(1)	12.5%	(6)	5.9%	(1)	13.8%	(4)	4.2%	(1)
Father has/had problems with drugs.	9.1%	(3)	19.1%	(9)	0.0%	(0)	21.4%	(6)	16.0%	(4)

Results indicated PTSD (current and lifetime) in homeless participants reported higher PTSD both current and lifetime than the general U.S. population. When considering gender, results showed 25.8% (8) of male homeless participants and 42.2% (19) female homeless participants qualified for a current PTSD diagnosis. Also, 29.4% (10) of male homeless participants and 47.1% (24), of female homeless participants qualified for a lifetime PTSD diagnosis. These differences were statistically not significant. Lifetime PTSD occurrence in the general U.S. population using DSM-IV-TR diagnostic criteria has been reported as 8.7% (American Psychiatric Association, 2013). Results for this homeless sample based on the SIDES found that 3.3% (3) of homeless participants qualified for a Complex PTSD diagnosis. Notably, 61.8% (55) of homeless participants reached diagnostic levels on at least one SIDES dimension or more. A total of 42.7% (38) homeless participants reached diagnostic levels on two or more SIDES dimensions, and 28.1% (25) of homeless participants reached diagnostic levels on three SIDES dimension. Additionally, 19.1% (17) homeless participants reached diagnostic levels on four or more SIDES dimension, and 5.6% (5) reached clinically diagnostic levels on five or more SIDES dimensions. The most frequently represented Complex PTSD dimensions were *Alterations in Relationship with Others* (endorsed by 41.9%), and *Alterations in Attention and Consciousness* (endorsed by 36.8%). Complex PTSD has been reported as 0.6% in a community population (Wolf et al., 2015).

As discussed, results indicated that homeless participants experienced higher levels of childhood abuse compared to the general population as reported in the literature (see table 5). Also, in terms of a relationship between childhood abuse and PTSD, an association was found between current PTSD diagnosis and reporting a history of childhood abuse, $\chi^2(1, N = 76) = 20.580$, $P < 0.0005$. The association was of moderate strength: $\phi = .462$. Results also showed that 88.9% (24) of male and female homeless participants who qualified for a current PTSD diagnosis also reported a history of childhood abuse. Results based on gender, PTSD, and history of childhood abuse were also significant. Male participants who reported childhood abuse had significantly higher PTSD occurrence, $\chi^2(1, N = 31) = 10.819$, exact $P = 0.002$. The association was of moderate strength: $\phi = .509$. Also, female participants who reported childhood abuse had significantly higher PTSD rates, $\chi^2(1, N = 45) = 8.991$, exact $P = 0.004$. The association was of moderate strength: $\phi = .408$. In terms of type of abuse, significant results were found only for a history of sexual abuse; 52.9% (27) of female participants reported a history of childhood sexual abuse compared to 23.5% (8) of male participants for this type of abuse, $\chi^2(1, N = 85) = 7.286$, exact $P = .008$. The association was approaching moderate strength: $\phi = .281$. No significant relationship was found between gender and current or lifetime diagnosis of PTSD. Also, no significant relationship was found between gender and Complex PTSD/DESNOS scores.

Table 5. History of Childhood Abuse by Family Member or Acquaintance in Homeless Participants Compared to the General U.S. Population

Group	overall abuse		emotional abuse		physical abuse		sexual abuse	
	%	n	%	n	%	n	%	n
General Population[a]	13.3%	n/a	10.1%	n/a	3.3%	n/a	7.6%	n/a
Homeless Men	45.9%	(17)	41.2%	(14)	44.1%	(15)	23.5%	(8)
Homeless Women	63.5%	(33)	52.9%	(27)	52.0%	(26)	52.0%	(26)

[a]Results derived from Finkelhor, D., Ormrod, R., Turner, H., & Hamby, S. L. (2005).

Note. Only valid percent are reported for the present study. Nonresponses by participants were not included in calculations.

There was no significant association between Complex PTSD/DESNOS diagnosis and history of childhood abuse. While most participants did not qualify for a full Complex PTSD/DESNOS diagnosis, calculating the overall Complex PTSD/DESNOS scores showed that male and female homeless participants who reported a history of childhood abuse had higher levels of Complex PTSD/DESNOS scores than those who did not report a history of childhood abuse. A Pearson product-moment correlation (in lieu of point bi-serial correlation) between history of childhood abuse (recoded to reflect 1=no and 2=yes) and sum of Complex PTSD/DESNOS showed a significant positive correlation ($r = .386$, $N = 89$, $P = 0.01$, two-tailed). The strength of the correlation is considered moderate. These findings indicate that those participants who reported a history of childhood abuse had higher overall DESNOS scores.

Discussion

This study examined the relationship between homelessness, gender, and incidence of PTSD/Complex PTSD. Study findings reflect existing, often dated literature and suggest homeless men and women suffer from PTSD (current and lifetime) at a much higher rate than the national average. As hypothesized, homeless women in this study were affected by PTSD at a higher rate than their male counterparts. Women were twice as likely than men to develop PTSD. As predicted, male and female homeless participants reported much higher levels of childhood abuse (emotional, physical, and sexual) in comparison to the general U.S. population. Our findings support previous studies that reported similar results (Finkelhor, Ormrod, Turner, &Hamby, 2005; Lee & Schreck, 2005; Sundin & Baguley, 2015). Also confirming our hypothesis, homeless women reported higher rates in all three child abuse subcategories in comparison to their male counterparts. In terms of childhood sexual abuse, homeless women reported over twice the abuse rates than their male counterparts. Complex PTSD was also found to be present in participants at a greater rate than reported in a previous community sample (Wolf, 2015). It is important to note that while many did not qualify for a full Complex PTSD diagnosis, some of the homeless participants did experience Complex PTSD symptoms to varying degrees. These symptoms may negatively impact the lives of homeless participants and their ability to cope with day-to-day demands, as well as stressful situations. It is of interest to note that the demographic questionnaire self-report of PTSD was much lower than was found using the PTSD and Complex PTSD assessment instruments. This suggests PTSD is often underdiagnosed in homeless populations. The present study confirmed our hypothesis that there would be correlations between the history of childhood abuse, PTSD, and to a limited extent, Complex PTSD in homeless individuals.

It is important to note that findings suggest that in addition to the customarily cited reasons for homelessness (lack of affordable housing, low-paying jobs, mental illness, substance abuse, domestic violence, unemployment, poverty, and prison re-entry) PTSD, complex PTSD, and childhood abuse may be significant factors contributing to homelessness. Stated differently, childhood abuse experiences may be a contributing factor to the development of PTSD and Complex PTSD, and in turn, may contribute to homelessness.

Findings suggest the existence of homeless subgroups that might also suffer from Complex PTSD. As shown in the literature, this distinction is vital for treatment efficacy. PTSD and Complex PTSD may require alternative types of clinical and supportive interventions. For example, exposure therapy techniques, which are successfully used to treat simple PTSD may not be appropriate for the treatment of Complex PTSD. In terms of Complex PTSD alternative therapeutic modalities are referenced in the literature, such as focusing on establishing more adaptive coping strategies. For example, Cloitre et al. (2011) suggest trauma education, anxiety/stress management, emotional regulation interventions, narrative and cognitive interventions, and interpersonal skills training for those who experience Complex PTSD symptoms. Self-reported mental health problems and elevated suicide ideation, as well as attempts, are also causing for concern. Further research should be conducted to follow up on these critical areas.

Lastly, when working with and advocating for homeless clients, it is essential also to consider gender and

ethnic differences highlighted in table 4. Although statistically not significant, there were differences based on gender and ethnicity on several of the questionnaire items. It is crucial to consider the additive effect of multiple marginalization experiences of homeless clients. Homelessness, gender, and ethnicity appear to intersect and create individual challenges. It is crucial to consider commonalities as well as individual differences among homeless individuals. For example, advocacy is necessary to dispel stereotypes such as viewing the majority of homeless people as high school dropouts and unskilled laborers. In addition, the lack of social connectedness and family support seem to be prevalent among the homeless and may be contributing factors to becoming and staying homeless.

There are several limitations that should be considered when evaluating the results of the study. The present study used a convenience sample of homeless participants who were staying in either emergency shelters or transitional shelters. Homeless participants living on the street were not included in the study. Also, not using a randomly selected sample, volunteerism, reliance on self-report data, and possible respondent bias may have introduced errors to the study. Furthermore, correlations/associations do not establish causation. It is possible that the relationships identified may be due to extraneous variables that were not included in this study. For example, being homeless and unstable living situations by themselves are traumatic and may also have influenced PTSD and Complex PTSD symptoms in participants. Additional research is needed to support the findings of this study.

Recommendations

These findings should be considered when addressing homelessness concerns in agency/treatment settings when devising policy and in advocacy efforts. Gender differences and other factors highlighted in this study should be taken into account. Program effectiveness may be undermined if PTSD, Complex PTSD, and history of childhood abuse are not attended in an appropriate manner. With the release of the ICD-11, focus on Complex PTSD will hopefully increase and it is crucial for agencies and treatment providers involved with the homeless to become knowledgeable in this area. Also, advocacy efforts should address educating the public as well as other stakeholders such as the police and first responders. It has been established that traumatized individuals may react in unpredictable ways when confronted with stressors. Traumatic memories can be triggered by any number of events and may lead to extreme emotional distress. The triggering event may seem mild or innocuous to the onlooker. However, physiological reactions to triggers may be accompanied by unpredictable intense emotionality in those suffering from PTSD/Complex PTSD (van der Kolk, 2008). Provider training, research, and increasing awareness that homeless individuals may suffer from trauma-related problems are vital to furthering advocacy for the homeless.

Conclusion

Counseling most often occurs within the walls of a counseling practice or clinic; however, outreach is a vital tool for connecting with marginalized populations (Coker, Meyer, Smith, & Price, 2010). Larkin et al. (2016) suggest strengthening educational curriculum and building partnerships between education institutions, service agencies, local and national policy makers, and government agencies. For example, incorporating current homelessness data into the educational curriculum would help to increase trainee knowledge related to the needs of homeless clients (Lane, McLendon, & Mathews, 2017); this should include crucial information pertaining to the occurrence of PTSD/complex PTSD and history of childhood abuse in the homeless.

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