Posttraumatic Stress Disorder and Substance Abuse Among Youth Who Are Homeless: Treatment Issues and Implications

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The research on comorbidity indicates that posttraumatic stress disorder and substance abuse co-occur at high rates. As co-occurrence portends a more severe course than would occur with either disorder alone, the added challenges of homelessness and the life stage of youth into young adulthood require developing treatment strategies that address the needs of this unique population of youth who are homeless. Although the literature is limited concerning comorbidity among homeless youth, the purpose of this article is to review empirical research concerning treatment issues and options appropriate for this population. Two treatment modalities are identified that may address issues of homelessness while providing treatment that is tailored to the specific needs and unique concerns related to the context of the street. These modalities include strengths-based approaches and cognitive-behavioral methods. [Brief Treatment and Crisis Intervention 6:206–217 (2006)]

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The research on comorbidity indicates that posttraumatic stress disorder (PTSD) and substance abuse co-occur at high rates (Kessler, Sonnega, Bromet, & Hughes, 1995; Stewart, Pihl, Conrod, & Dongier, 1998). In adult community samples, co-occurrence of substance abuse and PTSD have been reported as high as 43% (Kessler et al., 1995); rates of PTSD occurring among adults in substance-abuse treatment settings vary from 20% to 59% (Triffleman, Carroll, & Kellogg, 1999). A growing number of studies suggest that PTSD symptoms negatively impact substance-abuse outcomes as these patients relapse more quickly and have more negative consequences from substance use than those with only substance-related disorders (Chilcoat & Breslau, 1998). Typically, comorbid conditions are more clinically challenging than either disorder alone (Rowe, Liddle, Greenbaum, & Henderson, 2004).

Despite the consensus concerning the prevalence of PTSD and substance abuse in adult populations, the research on comorbid conditions among adolescents and young adults is less well developed. In the relatively few studies addressing comorbidity among young people, substance abuse is frequently associated
with conduct disorder, depression, and anxiety (Kilpatrick et al., 2000). Although very little research has evaluated the association between PTSD and substance abuse among adolescents, studies have suggested that PTSD is a common co-occurring diagnosis among adolescents who abuse substances (Brown, Recupero, & Stout, 1995).

Problems associated with trauma and substance use are challenging in general youth populations; however, the pervasiveness is higher among youth who engage in other risky behaviors, such as running away from home, unprotected sexual behavior, school failure, and delinquency (Kipke, Unger, Palmer, & Edgington, 1996; Stewart et al., 2004). One population of particular concern are youth who run away from home, remain outside the family for extended periods of time, and become homeless (Kipke, Montgomery, Simon, & Iverson, 1997; Whitbeck, Hoyt, & Bao, 2000). Homeless youth typically live in unsupervised conditions, such as with strangers, in public shelters, rented rooms, or outdoors (Bailey, Camlin, & Ennett, 1998). Best prevalence estimates indicate that between 310,000 and 1.6 million youth in the United States run away or are forced to leave parental homes each year (Ringwalt, Greene, Robertson, & McPheeters, 1998). In order to survive, homeless young people tend to be very involved in “street economies,” peer networks, and “street culture.” Their primary communities comprised other street-involved young people who get most, if not all, of their needs met through engaging in the street economy, such as eating at soup kitchens, sleeping outdoors, and spare changing/begging for money (Roy et al., 2004). These adolescents are at significantly increased risk for serious health problems such as malnutrition, sexually transmitted diseases, and premature death due to suicide, murder, and drug overdose (Powers, Eckenrode, & Jaklitsch, 1990). The longer these youth are exposed to life on the streets, the more likely they are to become acculturated to the streets and the street economy (Auerswald & Eyre, 2002; Gaetz, 2004; Kidd, 2003).

Developmental trajectories into young adulthood are greatly affected by being homeless and experiencing comorbid disorders. Co-occurrence portends a more severe course of the disorders than would occur with a single diagnosis; however, the added challenges presented by homelessness require the development of treatment strategies that address the compounding needs of this unique youth population. Although the literature is limited concerning comorbidity among homeless youth, the purpose of this article is to review empirical research concerning treatment issues and options targeting mitigation of PTSD and substance-use symptoms and their application to homeless young people.

Comorbidity and Homeless Youth

According to the National Comorbidity Study, lifetime prevalence rates for PTSD among community samples of adolescents aged 15 to 24 range from 5% to 10% (Kilpatrick et al., 2003). Alcohol and illicit drug use among American high school students rank among the highest in industrialized countries; 21–50% report using alcohol and 15–37% report marijuana use during a 30-day period (Johnston, O'Malley, & Bachman, 2002). When these disorders co-occur among young people, rates range from 35% to 52% (Kessler et al., 1995). A growing body of research suggests traumatic experiences coupled with substance abuse often result in debilitating consequences that can hinder normal youth development (Becker et al., 2004; Foa, Johnson, Feeny, & Treadwell, 2001).

Homeless youth appear to be particularly vulnerable to exposure to traumatic events, developing PTSD symptoms, and engaging in greater substance use than other adolescent populations (Kipke et al., 1997). Johnson, Whitbeck,
and Hoyt (2005) found that nearly 40% of homeless youth who met diagnostic criteria for substance abuse also met criteria for PTSD. It has been argued that the experience of being homeless is a form of psychological trauma (Goodman, Saxe, & Harvey, 1991; Thompson, 2005). Homeless youth reside in environments often marked by reoccurring violence, victimization, and danger (Cauce et al., 2000; Stewart et al., 2004; Tyler, Whitbeck, Hoyt, & Johnson, 2003). The research in this area suggests that drugs and alcohol are often used as a means to cope with the symptoms resulting from traumatic experiences suffered while in the home, as a result of precocious departure from the family, and victimization experienced while living on the streets (Auerswald & Eyre, 2002; Kidd, 2003).

The act of running away creates a variety of stressors, as exiting the family environment may disrupt familiar routines of school attendance, family life, and daily contact with friends (Cauce et al., 2000). Abuse in the home prior to running away is also a factor associated with the youth leaving home and continuing homelessness (Whitbeck et al., 2000). Many homeless youth report high rates of physical and sexual abuse and exposure to domestic violence in their homes (Kidd, 2003; Whitbeck, Chen, Hoyt, Tyler, & Johnson, 2004). As Stewart et al. (2004) suggest, traumatized homeless youth may expend excessive amounts of emotional resources in the anticipation of further victimization. This often leads to strong mistrust of others and poor interpersonal relationships and interferes with academic, vocational, and other forms of social functioning (Becker et al., 2004). Thus, long-term exposure to trauma and subsequent substance use is likely to inhibit the development and use of prosocial skills needed for these youth to transition out of homelessness.

Frequent exposure to community and interpersonal violence are often found among youth who are homeless (Cauce et al., 2000; Gaetz, 2004; Kidd, 2003). Life on the street is often characterized by extremely impoverished conditions, constant threats to daily survival in terms of meeting basic needs, and high rates of exposure to violence and injury (Auerswald et al., 2002; Kidd, 2003). One study found that 20% of homeless youth had seen someone killed, 50% had been threatened with serious physical injury, and 19% reported being stabbed while living on the street (Kipke et al., 1997).

Those who live outside of familial homes in unstable, even abusive, situations often engage in a variety of high-risk behaviors including substance use (Greene, Ennett, & Ringwalt, 1999). Distress produced by a variety of sources of victimization can lead youth to engage in behaviors that reduce negative emotions, such as situational avoidance or substance use. Among youth who are homeless, using substances as a means of coping with traumatic events may be construed as an effective, though maladaptive, strategy to diminish negative emotions (Kilpatrick et al., 2000). Research and homeless youth themselves report that drug and alcohol use is encouraged within the culture of homelessness and that substance use is largely related to peer group association and the peer’s level of use (Ennett, Bailey, & Federman, 1999). In a study examining suicidality among homeless youth, participants stated they often used substances to block memories of traumatic events, to forget the stress of street life, and to contend with their painful emotions (Kidd, 2003). For some of these youth, substance use may be viewed as a useful, even necessary, means of surviving life on the street. Within their environment, substance use often appears to be an adaptive, culturally sanctioned way of coping with trauma, homelessness, and emotional pain. Therefore, youth with clinically significant reactions to trauma, such as symptoms of PTSD, may attempt to “self-medicate” with alcohol and other drugs.
The numbing effects of drugs become a way to relieve the emotional affects of trauma (Auerswald et al., 2002; Kidd, 2003).

**Treatment Issues**

The high rates of trauma and substance abuse among homeless youth suggest that these problems are the norm rather than the exception in this population. Without social service intervention, there is an increased likelihood of prolonged homelessness, repeated exposure to trauma, victimization, and substance abuse (Gaetz, 2004). Therefore, agencies providing services to homeless individuals must adopt a proactive approach by contacting and offering assistance to homeless youth early in their homeless experience before they become entrenched in street culture (Reid & Klee, 1999). As the majority of services to homeless youth are entirely voluntary, greater weight must be given to their preferences and needs than is required in other youth-oriented programs (Karabanow & Rains, 1997). To meet the needs of homeless youth, it has been argued that “service providers must understand the natural service utilization practices and perceptions of these youth” (De Rosa et al., 1999, p. 450), as well as what it means to be homeless (Thompson, McManus, Lantry, Windsor, & Flynn, 2006).

**Culture of Youth Homelessness**

Intervening with homeless youth has been characterized as cross-cultural work (Fest, 2003). When assessing and treating trauma-related and substance-abuse needs of homeless youth, it is important to recognize that they are members of a unique cultural group who have similar lifestyles, values, attitudes, dress, and means of communication (Fest, 2003). In order to survive, they must learn where to find resources, establish who to trust, and adapt to the social structures of the street economy (Lankenau, Clatts, Welle, Goldsamt, & Gwadz, 2005). “Street smarts,” gained through observation and experiences while homeless, may not be “prosocial” behaviors; however, they enable homeless youth to develop competencies to endure their daily existence (Rew, 2000b). For example, these young people may protect themselves from harm by carrying a weapon, avoiding certain places or people, and networking with streetwise peers who can protect them (Greenblatt & Robertson, 1993). Many form surrogate families with other street youth—connections which offer all parties involved an increased sense of security and belonging (Rew, 2000a).

Youth homelessness can be characterized as a daily struggle for survival while in a constant state of crisis. The priorities for members of this population involve meeting the basic needs of food, shelter, and clothing (Kidd, 2003) and ensuring physical safety (Gaetz, 2004). Such circumstances necessitate that homeless youth focus their efforts and attention on the immediacy of their daily existence. Because their current circumstances constantly demand their immediate attention, they are limited in their ability to expend emotional, physical, and intellectual energy toward planning for the future. This “present-centered” way of relating to time is typical, even a cultural norm, among youth who are homeless (Fest, 2003). It must be recognized that homeless youth require focused, conscious attention on the immediacy of dangerous, even life threatening, situations for their survival; therefore, there is limited capacity to consider their future, potential or expectations (Rew, 2000b). Service providers must take these unique characteristics into account if service delivery is to be effective.

**Resistence to Service Utilization**

The daily life of homeless youth is comprised trying to secure the most basic needs (Baer,
Peterson, & Wells, 2004; Kidd, 2003) and to fend off further victimization (Gaetz, 2004; Thompson et al., 2006). Homeless youth are also very mobile, often staying in the same location for only a few days at a time (Baer et al., 2004). These youth tend to rely heavily on themselves, placing strong value on their autonomy and independence (Baer et al., 2004). Although most services are delivered free of charge, homeless youth are reluctant to seek assistance due to previous negative interactions with helping professionals, such as police, case workers, and foster families. Consequently, homeless youth are often described as “difficult to engage,” “difficult to manage,” vulnerable, and disadvantaged (Crome, 2004).

Homeless youth describe their own guardedness as a means to help them identify and avoid reliance on undependable people, especially exploitive adults. As many have been victimized by those professing to be their protectors and providers, including parents, they must balance their ability to fend for themselves with seeking assistance from others (Thompson et al., 2006). These youth often describe wanting to be independent and have control over their lives and decisions (Reid & Klee, 1999). Many have escaped home environments marked by violence and hostility and have learned to survive the challenges associated with living on the street; they have become accustomed to meeting their own survival needs (Rew & Horner, 2003). Therefore, they resist providers who do not respect their fundamental need for autonomy (Kidd, 2003).

Engagement

Establishing rapport and treatment engagement appear key challenges for service providers due to the culture of homelessness and the youths’ guardedness concerning treatment professionals. This process must begin with establishing a trusting relationship with service providers (Barry, Ensign, & Lippek, 2002) by conveying respect and acceptance (Springer, 2001). In a study of mental health interventions for homeless youth, the gradual development of a strong, therapeutic relationship with their primary service provider was crucial for decreasing symptoms of depression, problem behavior, and substance abuse; self-esteem also increased (Cauce et al., 1994). De Rosa et al. (1999) also found that homeless youth were more likely to frequent those services which they perceived to provide assistance “tailored to the needs of each individual client,” have greater flexibility, less restrictive rules, and less necessity to disclose personal information (p. 456). To address this unique population’s needs, “low-threshold interventions” that do not require consistent, regular attendance, adherence to strict rules, and extensive disclosure by the youth may improve initial engagement (Baer et al., 2004). Recognizing the role of choice in the youths’ street involvement is necessary to providing services that respect their perceptions concerning what problem areas require change (Thompson et al., 2006). Kidd (2003) suggests “[c]ore elements of any such work should include recognition of the youth’s independence and incorporate a sense of control on their part” (p. 240). In order for them to seek or utilize services, they must begin with establishing trust in the relationship and believe that accessing services will lead to positive experiences (Kidd, 2003). These youth most appreciate client-centered services and service providers that truly listen to them, work with the youth from “where they are,” both literally
and figuratively, and encourage their active participation in service development and provision (de Winter & Noom, 2003; Thompson et al., 2006). Basic needs, such as crisis remediation, safe shelter, food, clothing, and medical care must be provided before other therapeutic strategies can be introduced (Karabanow, 2003; Kidd, 2003). Some have shown that allowing space for homeless youths’ pets can have positive implications for their service engagement (Rew, 2000a). Thus, services to homeless youth must be delivered through “low-threshold” mechanisms that stimulate opportunities for longer term treatment of trauma symptomatology and co-occurring substance abuse.

Treatment Options

Given the lack of research on homeless young people with comorbid PTSD and substance abuse, little direction for treatment of these disorders is available in the empirical literature. However, the prevalence and comorbidity of substance use and PTSD suggest that clinicians providing treatment to runaway/homeless youth are highly likely to encounter these dual conditions. Thus, innovation is needed to cultivate treatment options from the growing body of research concerning comorbid disorders, while addressing the unique challenges and needs presented by youth homelessness.

Treatment of comorbidity is fraught with numerous difficulties related to diagnostic assumptions and the treatment setting in which the comorbidity is identified. Researchers and clinicians have increasingly emphasized greater integration of services for co-occurring mental health and substance misuse disorders (Mueser, 2004) as the two disorders are functionally interrelated (Stewart et al., 1998). Some consider substance-use disorders to be secondary to other comorbid disorders, especially trauma symptoms (Kessler, Davis, & Kendler, 1997). Others suggest that if only trauma symptoms are addressed in treatment, substance-use relapse is much more likely (Brown et al., 1995), and substance abuse can intensify as individuals reexperience the traumatic events (Stewart et al., 1998). Although not definitive, it appears that integrating PTSD and substance-use treatment is more effective than treating each separately.

Although there have been no specific treatment studies of homeless adolescents with PTSD and substance-abuse disorders, trauma research has shown that “basic environmental safety and stability are prerequisites to discussing interpersonal issues or trauma material” (Newman, 2000). Current evidence-based treatments for PTSD among populations that continue to be traumatized, such as homeless youth living on the street, must be implemented with caution. For example, exposure therapy modalities require the individual to reexperience the trauma with the potential for further psychological harm. Employing exposure therapies is discouraged with populations, such as homeless youth, who experience comorbid psychiatric or substance-abuse disorders and lack adequate support and basic environmental safety (Wilson, Friedman, & Lindy, 2001). Based on these issues, two treatment modalities have been identified that may address substance use and posttraumatic reactions, while providing treatment that is tailored to the specific needs and unique concerns related to youth living within the context of the street. These modalities include strengths-based approaches (Selekman, 2005) and cognitive-behavioral methods (Najavits, 2002).

Strengths-Based Approach—Solution-Focused Brief Therapy

Service providers and homeless youth report brief, strengths-based practices delivered in the youths’ environments can be effective, more so than “problem-oriented” approaches.
Homeless youth respond best to client-centered services that are flexible and encourage them to continually strive to attain goals despite relapses and setbacks (Cauce et al., 1994). Strengths-based approaches focus on the strengths already possessed by the client and those found within their environment. Solution-focused brief therapy (SFBT) is a strengths-based model that utilizes a cognitive-behavioral approach to help clients imagine what could be different and what would be required to make changes occur (Gingerich, 2000). Although SFBT has not been examined as a treatment approach for comorbid conditions of PTSD and substance abuse among homeless youth, one study of adolescent offenders in juvenile justice custody demonstrated increased levels of optimism for the future, greater ability to feel empathy, and decreased levels of substance abuse following SFBT treatment (Gingerich, 2000). Due to similarities in their respective high-risk environments, the findings of this study suggest potential benefit of SFBT for reducing PTSD symptomatology and substance abuse among youth who are homeless.

The SFBT approach views the client as the expert on his/her life and aims to increase client autonomy (Selekman, 1997). Emphasis is on empowerment through identifying and amplifying client strengths and resources as tools to use in the reduction of the problem (Green, 2004). Springer (2001) notes that the solution-focused techniques are especially useful during the assessment phase to establish rapport and build therapeutic alliance. SFBT’s emphasis on strengths and solutions assists in building the expectation that not only is change possible but also is likely. Change using the SFBT model is typically achieved in incremental steps, with a basic assumption that small changes elicit larger changes (Selekman, 2005).

SFBT, with its emphasis on the strengths, resiliency, and instilling hope, could facilitate building rapport with youth who are homeless and increase their sense of self-efficacy by assisting them to identify strengths and resources (Springer, 2001). Helping the youth explore solutions and mobilize resources and strengths to attain desired goals increases their sense of control over their lives, a common difficulty among traumatized persons (Ouimette, Brown, & Najavits, 1998). Feelings of powerlessness and the need to self-medicate through substances could also be reduced. Utilizing a strengths-based approach could assist homeless youth in looking toward the future with the belief that they have the power to effect positive change in their lives and overcome the challenges associated with trauma and substance abuse and transition out of homelessness.

Cognitive-Behavioral Therapy—“Seeking Safety”

Available research concerning effective treatment of comorbid substance use and PTSD for adolescents has suggested the effectiveness of cognitive-behavioral therapy (CBT) (Cohen, Mannarino, Zhitova, & Capone, 2003; Green, 2004). CBT focuses on restructuring thinking through the identification, examination, and alteration of thoughts and beliefs that are maladaptive (Aisenberg & Mennen, 2000). The principle goal of cognitive-behavioral approaches is to enhance coping by developing new or modified perceptions and regaining control over the apprehension and anxiety associated with traumatic experiences and the related substance use.

One manual-based CBT-focused therapy model, “Seeking Safety,” is an integrated treatment designed to help individuals attain abstinence from substances and decrease the overt symptoms of PTSD, such as anger, irritability, intrusive thoughts, and emotional numbing (Najavits, 2002). “Safety” is defined as abstinence from substances, reduced self-destructive
behavior, establishing support networks, and self-protection from dangers associated with using substances and associated victimization (Najavits, Weiss, Shaw, & Muenz, 1998). Clients are educated concerning each disorder and the interaction between them and taught skills to increase coping and manage the affects of these disorders. The overarching goal is to assist clients attain safety in their relationships, cognitions, behavior, and emotions. Open-group sessions are designed to focus on seeking help, self-care, setting boundaries, coping with triggers to substance use, and life choices. By using an open-group format, youth could enter and exit the groups according to their needs, without having to commit to attending groups on a regular basis for a specified period of time. This modality meets the low-threshold criteria for effective service delivery with homeless youth, accommodating the transient nature of street youth culture, and recognizes the priority of these youths’ to meet basic needs.

A strong emphasis is on making the treatment accessible and engaging to maximize involvement, a major difficulty often reported by clinicians working with homeless youth (De Rosa et al., 1999). The use of a group format is useful for social support and validation of similarly situated others; normalizing the experiences of homeless youth can relieve some of the self-blame and other negative affects they often suffer (Najavits, Weiss, & Liese, 1996).

Seeking Safety methods do not promote exploration of the traumatic experiences but focus on safety and self-care. The tone of the treatment is optimistic, compassionate, and focused on the present. Similar to solution-focused methods, this modality draws extensively on the use of praise and accountability for life choices. Homeless youth would likely find this focus helpful in that they have a time perspective that is present oriented rather than thinking far into the future (Rew & Horner, 2003).

Practical Implications for Homeless Youth Service Settings

Treatment settings for homeless youth are typically found in youth emergency shelters and drop-in centers. Emergency crisis shelters serve runaway and homeless youth 12–18 years of age and provide a variety of crisis and residential services on a short-term basis (Greene, Ringwalt, & Iachan, 1997). Youth shelters have a stated mission to stabilize family relationships and attempt to reunify youths with their families or to teach them the skills necessary to live independently and reduce the youths’ likelihood of involvement in high-risk behaviors (Johnson et al., 2005).

Conversely, drop-in centers typically focus services on risk reduction mechanisms for homeless young people aged 16–23 years. These centers are generally located in urban areas frequented by homeless youth; they offer showers, laundry facilities, clothing, food, and a safe environment for homeless young people during daytime hours (Karabanow & Clement, 2004). Many of these service agencies offer medical/dental care and case management services, while requiring limited documentation and disclosure of personal information (De Rosa et al., 1999).

Both emergency shelters and drop-in centers provide locations for homeless youth to congregate and access services. These spaces present opportunities for assessment and intervention. For example, centers may offer support groups facilitated by staff with whom the youth have developed some degree of rapport. Programs using these avenues of service delivery could designate space and staff for the facilitation of low-threshold services, such as open-group Seeking Safety sessions. Holding these groups in emergency shelters and drop-ins increases their accessibility to homeless youth by providing them within the context of their environment and culture (Greene et al., 1997).
Case managers in both these service agencies are most likely to make the initial assessment and referral for youth with comorbid disorders. As substance-abuse disorders are frequently treated in the absence of knowledge of the trauma, which may underlie presenting symptomatology, the need for routine screening of trauma among substance-using homeless youth is warranted (Brown et al., 1995). Providers must be careful not to threaten the individuals’ self-sufficiency but develop a relationship of support that meets the needs of these youth as opposed to dictating to them (Fest, 2003). Case managers and counselors working with homeless youth could adopt strengths-based approaches by incorporating SFBT language and techniques into development of service and treatment plans. For example, scaling questions could be used to collaboratively identify goals most important to the youth and steps needed to bring him/her closer to the desired goal’s attainment. Thus, successful providers engage the youth in the process of change by recognizing the importance of encouraging active participation with the youth in developing goals and working toward achieving their desired outcomes.

The objectives of frontline intervention models for homeless youth are not meant to eradicate PTSD and substance-use symptoms. These methods are meant to mitigate symptoms to the extent that they are no longer hindering service utilization, placing the youth at risk for additional harm, or preventing them from conceptualizing the possibility of a healthier, safer present and future. Recognizing that homelessness exposes youth to a significantly higher risk for trauma and substance abuse, treatment goals must focus on beginning to transition out of homelessness and into a physical and emotional place where more targeted trauma and substance-use treatment can begin. This is likely to be most successful if the comorbid disorders of PTSD and substance abuse are treated in a way that acknowledges the integrated nature of these two disorders.

Further research is needed to analyze and understand issues associated with the comorbidity of PTSD and substance abuse among youth who are homeless. In particular, service providers need guidance in how best to engage homeless youth, not only in services that address basic needs but also to build prosocial, supportive relationships with these youth. Research is needed to better understand the varied aspects of the culture of youth homelessness, as engagement with these youth requires more than providing basic services of shelter, food, and clothing. Providers require tested evidence for strategies aimed at successfully engaging and treating this unique and independent-minded group of young people, especially those who have co-occurring PTSD and substance-abuse disorders.

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References


