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Chapter 4

**CHILDHOOD ABUSE
AND ADULT HOMELESSNESS**

***Graham Pluck^{1,*}, Sobhi Girgis², Kwang-Hyuk Lee²
and Randolph W. Parks¹***

¹Academic Clinical Psychiatry, University of Sheffield, Sheffield, UK

²Sheffield Health and Social Care NHS Foundation Trust, Sheffield, UK

ABSTRACT

Childhood abuse has multiple negative impacts on lifetime development. Increased levels of psychiatric problems are well documented, in particular personality disorder and substance abuse. Furthermore, effects can be long lasting and heavily influence the life course of the abused individuals. It is therefore perhaps not surprising that homeless adult populations in industrialised countries tend to report high levels of childhood physical and sexual abuse. Studies of homeless individuals can shed light on the socioeconomic consequences of severe childhood abuse. Furthermore, they provide insights into the impact of such abuse on mental health in a population in which levels of abuse and mental illness are both high. From a systematic analysis of case notes and clinical interviews, we have collected data on 217 homeless adults in the city of Sheffield, England. More than one in four homeless individuals reported high levels of physical abuse or sexual abuse during their childhoods, and levels of psychiatric illness were high, particularly schizophrenia and personality disorder. Furthermore, histories of abuse were found to be associated with being female and with having been raised in local authority care. In adulthood, sexual abuse was associated

* Corresponding author: Dr Graham Pluck. E-mail: g.pluck@sheffield.ac.uk.

with personality disorder; whereas, physical abuse was more linked with self-harm. The results reveal a complex picture of psychosocial problems linked to childhood trauma among many homeless adults.

INTRODUCTION

Homeless people constitute some of the most socially marginalised and socioeconomically disadvantaged groups across the world. In developing countries, wars, natural disasters and structural factors, in particular crippling poverty, are often the main sources of both adult and child homelessness. The homeless are generally also the most traumatised, for example due to their experiences of being refugees and of the processes that led to their displacement (Huijts, Kleijn, van Emmerik, Noordhof, & Smith, 2012). However, they face a range of urgent immediate concerns focused on day to day survival. It is perhaps not surprising that they tend to suffer poor mental health (Reed, Fazel, Jones, Panter-Brick, & Stein, 2012).

In Western developed countries, sizeable groups of citizens are less frequently displaced by conflict or natural disasters and governmental social welfare programs usually exist with the aim of preventing destitution. Industrialised countries generally have developed health services which should be able to minimise the effects of trauma and serious mental illness from leading to street living. Industrialised nations, for example in Europe the USA and Australia, have policies aimed at dealing with homelessness, although they may be inconsistently applied (Minnery & Greenhalgh, 2007). Nevertheless, homeless individuals are a common feature in many industrialised and developed countries. In fact over recent years, homelessness has ceased to be seen as a problem only of the developing world and has risen to become an important social and political issue in virtually all industrialised countries (Toro, 2007).

The size of the global homelessness problem is practically impossible to estimate, due not only to logistical problems, but also problems with definition, as what would be considered homeless varies across cultures (Springer, 2000). Some organisations have suggested that adult homelessness in large geopolitical areas can be estimated, for example in the European Union the number is countable in millions (Avramov, 1999). Others have pointed out that the problem of youth homelessness or 'street children' in developing countries has never even been formally estimated (Thomas de

Benitez, 2011). It is therefore impossible to put a global figure on levels of homelessness.

Due to the variety of expressions of homelessness globally, it would be misleading to look for associations between trauma, homelessness and mental health in general. Therefore, this chapter will focus on homelessness in industrialised countries. In particular, we report original data that was gathered in the UK which examined factors associated with histories of trauma in homelessness adults, though much of the literature discussed is based on clinical research from the USA, Australia, the UK and other European countries. The focus is on the psychological consequences of traumatic events, for example on mental illness and personality disorder in homeless populations. Indeed homeless adults report high levels of lifetime traumas in general. In one study of homeless adults in Sydney, Australia, all of the women and over 90% of the men reported at least one lifetime trauma, including half of the women and 10% of the men reporting that they had been raped (Buhrich, Hodder, & Teesson, 2008). The traumas reported by homeless women in the USA also describe adult lifetime traumatic events, however childhood traumas are also significant in their trajectories towards homelessness (Hamilton, Poza, & Washington, 2011).

Unsurprisingly, there are high prevalence levels of many psychiatric problems in homeless adults in industrialised countries, and research suggests that it tends to precede the onset of homelessness (Munoz, Vazquez, Koegel, Sanz, & Burnam, 1998). One systematic review focusing on Western countries reported a meta-analysis of data from several samples of homeless adults from Europe and the USA with one study from Australia (Fazel, Khosla, Doll, & Geddes, 2008). The reported prevalence estimates were 11% for major depression, 23% for personality disorder, 38% for alcohol dependence and 24% for drug dependence. Estimates for the prevalence of psychosis varied greatly between the included studies, from 3% to 42%, with a pooled prevalence of around 13%. Indeed, another systematic review focusing specifically on schizophrenia estimated that at any point in time about 11% of homeless people could be diagnosed with the illness (Folsom & Jeste, 2002).

Such high levels of psychopathology may be linked to the high levels of childhood traumas reported by homeless adults (Spence et al., 2006). Adult psychiatric illness, including substance dependence and personality disorder, is frequently associated with childhood trauma, particularly childhood sexual abuse (Bernstein & Fink, 1998). Psychotic disease in adulthood is more common in people who have experienced childhood traumas, and in fact there

is a dose-response relationship suggesting causality (Read, van Os, Morrison, & Ross, 2005).

Psychosis was found in one study of 136 homeless adults in Scotland to be one of the two main causes of functional impairment, affecting about a third of the sample (Geddes et al 1996). The other main source of functional impairment was cognitive problems, e.g. dementia. The source of cognitive problems may in some cases be acquired, particularly through substance abuse. Another study of homeless adults in Scotland has reported that 78% were drinking hazardous levels of alcohol and in fact 21% displayed cognitive test performance consistent with alcohol related brain damage (Gilchrist & Morrison, 2005). In that sample, 82% were said to be cognitively impaired. Other sources of acquired cognitive impairment include a high frequency of physical injury, which has been reported in homeless populations, due to their vulnerability that results in frequent emergency room visits (Padgett, Struening, Andrews, & Pittman, 1995). Indeed one study of around 600 homeless adults in Toronto, Canada, reported that more than half had a lifetime history of traumatic brain injury (Hwang et al., 2008).

In addition, low levels of IQ have also been reported in homeless populations. In general, samples of homeless adults display IQ scores around one standard deviation below the normal population mean. This has been observed in both the USA (Solliday-McRoy, Campbell, Melchert, Young, & Cisler, 2004) and the UK (Pluck, Lee, David, Spence, & Parks, 2012), though the extent to which this reflects abnormal development, acquired impairment, downward social mobility or consequences of socioeconomic deprivation remains unclear.

However, there is some evidence that low cognitive function observed in homeless adult samples may be linked to experiences of childhood traumatic events. In a study in the UK, it was found that there were significant correlations between various childhood traumas and IQ scores in a group of homeless adults. Sexual abuse, physical neglect and emotional neglect displayed negative correlations with IQ, suggesting that the more severe the childhood traumatic experiences, the greater the decline in IQ (Pluck et al., 2011). Furthermore, that report included measures of personality linked to frontal lobe function, which were rated by the homeless individuals for the period before they became homeless. The results suggested that the homeless adults had been displaying personality features consistent with neuropsychological impairments even before becoming homeless, and that these features were also correlated with the severity of childhood traumas.

Abnormalities of personality are not unusual in homeless populations. As described above, the prevalence of personality disorder amongst homeless populations in western countries has been estimated at around 23% (Fazel, et al., 2008). Personality disorder, by definition, has a developmental course originating in childhood (American Psychiatric Association, 1994). Abnormal childhoods, in particular traumatic contexts such as sexual abuse or neglect are therefore strongly associated with the development of personality disorder.

In fact trauma is likely to have a causative role in the onset of homelessness. As previously noted, mental health problems generally precede the start of homelessness in the lives of homeless people (Munoz, et al., 1998), and complex interpersonal and social problems tend to precede homelessness and remain after rehousing (Vostanis, Grattan, & Cumella, 1998). In one study of homeless youths traumatic experiences were critical antecedents in more than half of the trajectories leading to homelessness (Martijn & Sharpe, 2006). A similar finding has been described in homeless female war veterans in the USA (Hamilton, et al., 2011).

It was therefore anticipated that there would be high levels of childhood traumatic events and psychopathology in the sample of homeless adults described in the current research. The aim of this chapter is to describe the ways in which childhood traumas, in particular sexual and physical abuse, relate to later life psychiatric, forensic and homeless related variables. The benefits of such an approach with homeless individuals are twofold. On the one hand, homeless populations report high levels of various mental health and forensic problems and almost by definition demonstrate significant socioeconomic deprivations. They therefore present something of an enhanced sample for the study of the negative effects of childhood trauma on later life development, which may be generalizable to other populations. On the other hand, they also help us to directly understand the complex histories and processes that have rendered these vulnerable citizens homeless and at significant future risk.

In this study we examined the frequency of two forms of childhood trauma, physical abuse and sexual abuse, in a large sample of homeless adults in the UK. In addition, the ways in which such traumas are linked to demographic factors and specifically homeless related data, and to psychiatric and forensic variables, are explored. The basic data comes from a combination of direct face to face interviews and of case note review of homeless adults.

It should be noted that there is an inherent problem with using case note derived data. This is because the information recorded by clinicians is not for the purpose of research. Whereas a professional researcher will consistently

record data in the same manner, a clinician commenting in case notes has different priorities, and will likely only record that which they feel to be relevant to the care of the individuals. Nevertheless, we would expect certain things to be recorded fairly consistently, for example a psychiatric assessment would not usually miss out a section asking about the youth of the individual and whether they had experienced childhood traumas. Consequently, although the limitations of case note analysis should be kept in mind, providing that any academic analyses focus on clinical related issues, the reliability of the data should be acceptable. In fact, it is possible that in some instances case note derived data may be more valid: psychiatrists have experience in eliciting the relevant information and clients are perhaps more willing to disclose with their clinician than with an unknown research assistant.

On the other hand, direct interviewing is generally considered the better source of clinical data for research purposes. Standardised criteria can be applied systematically. It is surprising that relatively little research is conducted to assess and compare case note analysis with direct interviewing. Furthermore, what evidence does exist tends to be conflicting. One study of affective disorders reported that case note analysis was remarkably accurate, correctly identifying diagnoses in about 95% of cases (Kessing, 1998). In contrast, a study of diabetes patients revealed that basic demographic information (i.e. sex, date of birth or marital status) was misreported in about 12% of cases and diagnostic information was frequently omitted (Williams, Fuller, & Stevens, 1989).

Therefore, it seems prudent that case note derived data should be accompanied whenever possible with actual directly recorded survey data. This will allow comparisons to gain some idea of the validity and reliability of the data collected. Nevertheless, it should be noted that perfect concordance should not be expected. There will likely be selection effects in play which mean the different samples (e.g. case note and interview) will have become available for different reasons. In the current research, we compared two samples; the first was of 148 referrals for assessment by a specialist homelessness health and social care team, data was gleaned from individual case notes. The second sample was of 69 homeless individuals recruited from homeless services, and the data was obtained via direct interviewing. Clearly, in the first group, by nature of referral, we may expect a higher level of problems. In particular psychiatric problems, as the team is psychiatrically focused, this is the main reason for referral. We therefore anticipate that although both the case note and interview series will report high levels of

psychiatric involvement and illness, this will likely be higher in the referred case note series.

METHODS

Setting

This research was conducted in collaboration with the Homeless Assessment and Support Team (HAST) of the local National Health Service Trust. The team serves Sheffield, an industrial city in the UK (population 555,500). The HAST service provides health and social support for referrals of homeless adults and includes social workers, a psychiatric nurse and a consultant psychiatrist. Neuropsychological and counselling services are also available on psychiatric referral. Ancillary neurological workups are undertaken when there is a suspicion of dementia or acquired brain injuries. Rapid streamlined psychiatric inpatient services are an integral part of interventions when homeless individuals are experiencing acute psychotic episodes (e.g. the same consultant psychiatrist oversees inpatient treatment). The HAST main offices are located with a community surgery in an inner-city area frequented by many homeless individuals. Case notes of 148 clients were analysed to derive basic demographic information as well details of childhood abuse, lifetime chronic illnesses and features associated with adult homelessness (e.g. former prisoner, former armed forces). Further information about this service has been published previously (Spence, 2009).

Procedure

The data collection for this research took part in two stages. In the first stage data was collected via systematic analyses of the case notes of 148 referrals to the HAST team. In the second stage, 69 homeless adults in the same city underwent a standardised interview in order to obtain information on the same basic features. These were recruited from hostels and meals services for homeless adults in the city. The full final sample included data on 217 homeless adults. This research was funded by a series of regional NHS grants. Homeless service users had input into the study design and how data was collected.

Inclusion Criteria and Operational Definition of Homelessness

For the first part of the study, individuals were considered as homeless due to them being referred to and accepted by the HAST team. For the interviewed sample, we used a three part definition: 1) lacking a secure housing tenancy, 2) self-describing as homeless 3) accessing services for homeless adults. All three criteria had to be fulfilled for inclusion. Exclusion criteria included not being able to provide written informed consent and not being able to attend the interview sober.

Data Collection Protocol

Wherever possible, collection of data via interviews was similar to that from the case notes. Demographic information concerning age, sex and ever incarcerated was taken directly from the notes and interviewed participants were asked directly. To describe the current housing situation, housing type was recorded from the case notes at the point at which the individual was referred to HAST. The 148 cases could be classified into eight basic housing types: 1) Rough sleeping (i.e. sleeping outdoors or in a tent) or squatting (i.e. living in an empty property without any tenancy or ownership rights), 2) in a hostel or temporary shelter, 3) in interim accommodation, 4) in rented accommodation, 5) in legal system controlled property (e.g. a probation hostel), 6) with family or friends, 7) in supported housing and 8) in hospital. The same classifications were used for the interview derived data; however the classification was based on where the individual had slept the previous night. Psychiatric history was recorded from the cases with three variables: 1) any past contact with psychiatric services, 2) any prior admission to a psychiatric ward (including for detoxification) and 3) ever detained under the Mental Health Act of England and Wales (i.e. compulsory psychiatric hospitalisation). For the interview data, the individuals were asked about these directly. These were all recorded as either present or absent.

The presence or absence of actual psychiatric and neurological illnesses was recorded directly from the case notes. This included any history of self-harm. In the interview, individuals were asked if they had ever committed self-harm, and the term was explained to them. In addition, the presence of the following chronic conditions was recorded: schizophrenia/psychosis, obsessive compulsive disorder, personality problems or disorder, Korsakoff's syndrome or alcoholic dementia, and epilepsy. During the interview,

individuals were simply asked, has any healthcare professional ever told you that you have (e.g.) schizophrenia?

Forensic history was recorded with three dichotomous variables. Firstly, any police contact was noted from the case notes. In the interviews, individuals were asked if they had 'been in trouble with the police in the past?' Secondly, from the case notes, any documented violence towards others was recorded. In the interviews, individuals were simply asked 'have you been involved in violence in the past?' The interview versions of the two questions were worded to be somewhat less judgmental and confrontational while still accessing the same basic ideas. Thirdly, ever been incarcerated was recorded from the case notes and in the interviews, individuals were asked if they had ever been to prison.

Childhood history was recorded from the case notes as whether or not the individual had received special educational provision and whether or not they had spent time as a child under local authority care or were adopted. Interviewees were directly questioned on the topic. Two variables of childhood trauma were recorded from references in the notes; the presence or absence of either sexual or physical abuse. To record this sensitive information on physical and sexual abuse from the interviewees, we used the self-report Childhood Trauma Questionnaire (CTQ). We assumed that to be recorded in the medical notes of an adult, childhood abuse would likely be severe. Therefore, we used the cut off scores on the CTQ of 13 or above, which are taken to indicate severe levels of abuse (Bernstein & Fink, 1998).

Statistical Analyses

The only continuous variable collected was age, this is given as a group mean to one decimal place. Statistical comparisons of age were made with t-tests. All the other variables were nominal. These were compared with χ^2 tests unless expected cell counts were less than five, in which case appropriate alternatives were used; e.g. Fisher's test for binary 2x2 tables and likelihood ratios for larger tables. All calculations from inferential statistics (e.g. t-tests, χ^2) are given to two decimal places. The critical level was set at $p=.05$ and all tests were two tailed. Group means (i.e. age) and frequencies as percentages (e.g. sex, former prisoner) are given to one decimal place.

RESULTS

Comparison of the Two Series

Comparisons of the two series (case note, $n=148$; interview, $n=69$) are shown in Table 1, which includes details of statistical tests of significance. Also included in this table are the data for the full sample ($N=218$). Regarding the basic demographics of the two series, they appear to be remarkably similar. In both, about 87% were male and about 9% were former armed forces personnel. The case note series, compared to the interview series, were about two and half years older on average. However the difference was not statistically significant.

Although all were homeless in one way or another, housing status varied greatly in both groups, and eight different categories were needed to capture this diversity. The two series differed significantly on housing status; however, due to the size of the contingency table the actual focus of the difference between series is unclear. The interview series, compared to the case note series, contained more individuals who had been rough sleeping and less who had recently been staying in hostels or shelters. It also contained more who were in supported housing, probably due to there being several insecurely housed individuals recruited in the interview series who were living in a residential alcohol rehabilitation programme. It is of particular interest that the interview series was able to include a sizeable proportion of rough sleepers. These are generally the most difficult to access cases and tend to be absent from medical statistics due to their highly transient lifestyles and disengagement from mainstream health and social services. We therefore consider it a positive aspect of the current research that rough sleeping individuals are represented in the overall sample. Due to the particular interest of this group in homelessness research, in the further analyses described below, housing status has been reduced to a dichotomous variable of rough sleeping, yes or no.

Regarding psychiatric status, around two-thirds of both series appeared to have past contact with psychiatric services. This was slightly higher, though not significantly so, in the interview series. In contrast, the case note series appeared to have significantly higher levels of both psychiatric hospital admissions and having ever been detained under the Mental Health Act. The frequency of self-harm within the two series was almost identical, at about 41%.

Table 1. Details of the range of demographic, forensic and psychiatric variables recorded in the full sample of homeless adults and also the data obtained from the case notes series compared with that obtained from direct interviews. Absolute numbers (+%) are shown except where indicated.

	Full sample	Case note series	Interview series	Statistical significance
n	218	148	69	
Demographic				
Age (Mean +SD)	36.4 (11.5)	37.2 (12.2)	34.6 (9.4)	$t_{(215)}=1.55$, $p=.12$
Female	38 (17.1)	25 (16.9)	12 (17.4)	$\chi^2_{(1)}=.01$, $p=.93$
Former armed Forces	20 (9.2)	14 (9.5)	6 (8.7)	$\chi^2_{(1)}=.03$, $p=.86$
Housing				
Rough / Squat	25 (11.5)	9 (6.1)	26 (23.2)	Likelihood ratio ₍₈₎ = 54.89, $p<.01$
Hostel/Temporary Shelter	129 (59.4)	100 (67.6)	29 (42.0)	
Interim Accommodation	21 (9.7)	18 (12.2)	3 (4.3)	
Rented	9 (4.1)	9 (6.1)	0 (0)	
Legal system / Probation hostel	3 (1.4)	0 (0)	3 (4.3)	
Family / Friends Supported	7 (3.2)	4 (2.7)	3 (4.3)	
Housing	19 (8.8)	4 (2.7)	15 (21.7)	
Hospital	1 (0.5)	1 (.7)	0 (0)	
Unknown	3 (1.4)	3 (2.0)	0 (0)	
Psychiatric				
Contact with services	139 (64.1)	91 (61.5)	48 (69.6)	$\chi^2_{(1)}=1.33$, $p=.25$
Psychiatric hospital admission / Detox	103 (47.5)	88 (59.5)	15 (21.7)	$\chi^2_{(1)}=26.85$, $p<.01$
Detained under Mental Health Act	39 (18.0)	32 (21.6)	7 (10.1)	$\chi^2_{(1)}=4.21$, $p=.04$

Table 1. (Continued)

	Full sample	Case note series	Interview series	Statistical significance
n	218	148	69	
Self-harm	88 (40.6)	60 (40.5)	28 (40.6)	Chi ² ₍₁₎ =0, p=.99
Schizophrenia	42 (19.4)	36 (24.3)	6 (8.7)	Chi ² ₍₁₎ =7.64, p=.01
Obsessive compulsive disorder	5 (2.3)	4 (2.7)	1 (1.4)	Fisher's p=1.00
Personality disorder	31 (14.3)	23 (15.5)	8 (11.6)	Chi ² ₍₁₎ =.60, p=.44
Korsakoff's / Alcoholic dementia	3 (1.4)	3 (2.0)	0 (0.0)	Fisher's p=.55
Epilepsy	10 (4.6)	6 (4.1)	4 (5.8)	Fisher's p=.73
Forensic				
Police involvement	134 (61.8)	77 (52.0)	57 (82.6)	Chi ² ₍₁₎ =18.63, p<.01
Former prisoner	88 (40.6)	44 (29.7)	44 (63.8)	Chi ² ₍₁₎ =22.62, p<.01
Violence	84 (34.7)	50 (33.8)	34 (49.3)	Chi ² ₍₁₎ =4.76, p=.03
Childhood				
Attended special school	42 (19.4)	21 (14.2)	21 (30.4)	Chi ² ₍₁₎ =7.96, p<.01
Period 'in care' as a child	46 (21.2)	28 (18.9)	18 (26.1)	Likelihood ratio (2) = 4.29, p=.12
Adopted	4 (1.8)	4 (2.7)	0 (0)	
Trauma				
Sex abuse	41 (18.9)	22 (14.9)	19 (27.5)	Chi ² ₍₁₎ =4.93, p=.02
Physical abuse	55 (25.3)	34 (23.0)	20 (30.4)	Chi ² ₍₁₎ =1.39, p=.24

Chronic psychiatric and neurological conditions were also compared between the groups. Reasonably high levels of schizophrenia or other psychoses were reported in both groups, though this was significantly higher

in the case note series. In contrast, other chronic conditions tended to be reported only at low levels in both series. The prevalence of obsessive compulsive disorder was below 3% in both series, and Korsakoff's disease or other alcoholic dementias were not recorded at all in the interview series and only by 2% of the case note series. Around 12% of the interview series appeared to be positive for personality disorder, a figure which was slightly higher, though not significantly so, in the case note series.

Whereas psychiatric variables, as hypothesised, were generally recorded with greater frequency in the case note series compared to the interview series, the opposite pattern is evident with regard to forensic history. Involvement with police, having been incarcerated and history of violence were all recorded significantly more frequently in the interview series than in the case note series. This may reflect the fact that they have less relevance to an individual's clinical care, and are therefore not always recorded in clinical notes. We can be reasonably confident that a diagnosis of schizophrenia, if present, would be recorded in the case notes of the homeless assessment team. This is less likely the case for ever having been imprisoned. Nevertheless, it is clear that details of forensic histories were often recorded as police involvement was noted in over half of the case records.

Frequency of Childhood Traumas

In Table 1 we can also see the frequency of reporting of either sexual or physical childhood abuse in both groups. In the case note series, there were reports of sexual abuse in about 15% of cases and nearly double that prevalence in the interview series. Indeed, there were significantly more cases in the interview series. A similar pattern was observed for physical abuse. Nearly one-in-four of the case note series had apparently been physically abused as children. This was somewhat higher, but not significantly so, in the interview series.

The Full Sample

The data from the two series were used to produce a full sample of 218 cases. The characteristics of the full sample are also given in Table 1. Naturally, the full sample reflects the proportions of the various demographic, psychiatric and forensic variables explored in the case note and interview

series. Eighty-three percent of the sample was male and the mean age was 36. Most, almost 60%, had been living in temporary hostels or shelters. Psychiatric illness was common, 64% had past contact with psychiatric services and the most common chronic condition was schizophrenia. Overall, any form of abuse was present in 72/218 (33.2%) of the participants (case note series, 43/148, 29%; interview series, 29/69, 42%; difference not significant). Considering sexual abuse alone, this was reported in about 19% of the full sample; physical abuse was reported in about 25%.

Factors Associated with Abuse

To investigate which of those factors shown in Table 1 are statistically linked to abuse, individuals from the full sample were divided into those with or without histories of sexual abuse and those with or without histories of physical abuse. The pairs of groups were then statistically compared. The results are shown in Table 2. Housing is now represented by one dichotomous variable, rough sleeping or not, as it represents the most severe state of homelessness and also allows for simpler analyses.

It was found that several factors were significantly associated with childhood sexual or physical trauma in the overall homeless sample. Women were significantly more likely than men to have suffered either form of abuse. Furthermore, those who spent time as children under local authority care or who were adopted were significantly more likely to have suffered either form of abuse. Interestingly, those who suffered sexual abuse as children were significantly more likely to have a personality disorder but significantly less likely to have ever been detained under the Mental Health Act. In contrast, those who suffered physical abuse were no more or less likely to have either a personality disorder or to have been detained under the Mental Health Act, though they were significantly more likely to have self-harmed. There were no significant differences related to forensic history.

The differences described above appear to show a dissociation between the long-term consequences of the two distinct forms of abuse in this population. Sexual abuse was linked to personality disorder whilst physical abuse was more closely linked to self-harm. Nevertheless, physical and sexual abuse were also closely related, of those 55 who reported physical abuse, 24 (43.6%) also reported sexual abuse. In contrast, of the 162 without physical abuse histories, only 17 (10.5%) also reported sexual abuse. This difference was significant, $Chi^2_{(1)}=29.43$, $p<.001$. To examine the general effect of any

form of abuse, the calculations shown in Table 2 were repeated, with the groups being those with or those without any form of abuse. Although with higher statistical power, this revealed fewer significant differences. Those with any form of childhood abuse were significantly more likely to be female (66.2% of women reported abuse, only 27.2% of men did), $Chi^2_{(1)}=16.90$, $p<.01$. They were also significantly younger, mean ages 33.7 ($SD=9.7$) and 37.7 ($SD=12.2$), $t(215)=2.38$, $p=.02$. Finally, those with any form of childhood abuse were more likely to have self-harmed (50% of abused individuals self-harmed, vs. 35.9% in those without abuse histories), $Chi^2_{(1)}=3.99$, $p<.05$.

DISCUSSION

The two series of data, the case note analyses and the direct interviews, produced remarkably similar results. Although obtained in very different ways, the two samples appear to reflect the same basic population. They both contained the same male:female proportion, the same proportion of former armed forces personnel and the average age was about the same. In terms of mental health issues, they reported equivalent levels of self-harm and past psychiatric contact. However where they did differ, was in the proportions with previous psychiatric admissions and the proportions who had been detained under the Mental Health Act. In both instances, the case note series were more likely to be positive for the feature. This may reflect no more than people underreporting embarrassing information such as psychiatric hospital admissions in interviews. Though, it is more probable that it highlights a real difference, that the case note series were somewhat more severe cases of mental illness. This would be consistent with the fact that the case note series were all referred for clinical evaluation, while the interview series were selected based mainly on their use of homeless services. Nevertheless, the two series are similar enough that they could be combined and considered as a single dataset.

Basic demographic data on the full sample can be compared with a previous survey of homeless adults conducted in the same city on a single day in 1988 (George, Shanks, & Westlake, 1991). In that survey, data was collected on 340 homeless adults. Of that sample 14% were women, which compares with 17% in the current sample. In addition, the sample in 1988 was somewhat older, with a mean age of 43, as compared with 36 in the current sample. More of the homeless individuals in 1988 were reported to be former prisoners, 49%, compared to 41% in the current sample, but less were former psychiatric inpatients, 38%, compared with 48% in the current sample.

Table 2. Comparison of homeless adults with and without histories of either sexual or physical abuse on the demographic, forensic and psychiatric variables. Absolute numbers (+%) are shown except where indicated.

		Sexual Abuse			Physical Abuse		
		Yes	No	Significance	Yes	No	Significance
	n	41	176		55	162	
Demographic	Age (Mean+SD)	34.2 (9.8)	36.9 (11.9)	$t_{(215)}=1.32, p=.19$	33.82 (9.9)	37.22 (12.0)	$t_{(215)}=1.90, p=.06$
	Female	15 (36.6)	22 (12.5)	$\text{Chi}^2_{(1)}=13.64, p<.01$	16 (29.1)	21 (13.0)	$\text{Chi}^2_{(1)}=7.55, p<.01$
	Former armed Forces	4 (9.8)	16 (9.1)	Fisher's $p=1.0$	6 (10.9)	14 (8.6)	$\text{Chi}^2_{(1)}=.25, p=.62$
Housing	Rough sleeping	7 (17.1)	18 (10.2)	Fisher's $p=.27$	6 (10.9)	19 (11.7)	$\text{Chi}^2_{(1)}=.27, p=.87$
Psychiatric	Contact with services	29 (70.7)	110 (62.5)	$\text{Chi}^2_{(1)}=.30, p=.32$	36 (65.5)	103 (63.6)	$\text{Chi}^2_{(1)}=.06, p=.80$
	Psychiatric hospital admission / Detox	20 (48.8)	83 (47.2)	$\text{Chi}^2_{(1)}=.35, p=.85$	25 (45.5)	78 (48.1)	$\text{Chi}^2_{(1)}=.12, p=.73$
	Detained under Mental Health Act	3 (7.3)	36 (20.5)	$\text{Chi}^2_{(1)}=.39, p<.05$	8 (14.5)	31 (19.1)	$\text{Chi}^2_{(1)}=.59, p=.44$
	Self-harm	22 (53.7)	66 (37.5)	$\text{Chi}^2_{(1)}=.36, p=.06$	29 (52.7)	59 (36.4)	$\text{Chi}^2_{(1)}=4.53, p=.03$
	Schizophrenia	6 (14.6)	36 (20.5)	$\text{Chi}^2_{(1)}=.72, p=.40$	9 (16.4)	33 (20.4)	$\text{Chi}^2_{(1)}=.42, p=.52$

		Sexual Abuse			Physical Abuse		
		Yes	No	Significance	Yes	No	Significance
	n	41	176		55	162	
	Obsessive compulsive disorder	1 (2.4)	4 (2.3)	Chi ² ₍₁₎ =.01, p=.95	2 (3.6)	3 (1.9)	Fisher's p=.60
	Personality disorder	10 (24.4)	21 (11.9)	Chi ² ₍₁₎ =.42, p=.04	10 (18.2)	21 (13.0)	Chi ² ₍₁₎ =.91, p=.39
	Korsakoff's / Alcoholic dementia	0 (0)	3 (1.9)	Fisher's p=1.0	0 (0)	3 (1.9)	Fisher's p=.41
	Epilepsy	2 (4.9)	8 (4.5)	Fisher's p=1.0	2 (3.6)	8 (4.9)	Fisher's p=1.0
Forensic	Police involvement	27 (65.9)	107 (60.8)	Chi ² ₍₁₎ =.36, p=.55	30 (54.5)	104 (64.2)	Chi ² ₍₁₎ =1.62, p=.20
	Former prisoner	20 (48.8)	68 (38.6)	Chi ² ₍₁₎ =1.42, p=.23	25 (45.5)	63 (38.9)	Chi ² ₍₁₎ =.73, p=.39
	Violence	14 (34.1)	70 (39.8)	Chi ² ₍₁₎ =.44, p=.51	18 (32.7)	66 (40.7)	Chi ² ₍₁₎ =1.1, p=.29
Childhood	Attended special school	11 (26.8)	31 (17.6)	Chi ² ₍₁₎ =1.81, p=.18	14 (25.5)	28 (17.3)	Chi ² ₍₁₎ =1.76, p=.19
	Period 'in care' as a child	15 (36.6)	31 (17.6)	Likelihood ratio ₍₂₎ =6.76, p=.03	26 (47.3)	20 (12.3)	Likelihood ratio ₍₂₎ = 28.52, p<.01
	Adopted	1 (2.4)	3 (1.7)		0 (0)	4 (2.5)	

The frequency of reports of childhood traumas seems to be lower than would be expected in the case notes series, when compared to the interview series. This is probably indicative of underreporting of very personal information in the case notes, as compared to the interview, which used a self-report scale. It is thought that such self-report scales may encourage greater disclosure than clinical interviews (Bernstein & Fink, 1998). This underreporting interpretation would be consistent with the assumed higher level of psychopathology in the case note series, in which case, if anything, more childhood trauma would have been anticipated. If we accept that there is some underreporting, this is not a huge flaw in the research as we still found high levels of sexual and physical abuse in both series. Therefore, the evidence suggests that the underreporting was relatively minor. In fact overall, nearly one in five of the homeless individuals reported childhood sexual abuse, one in four reported childhood physical abuse and one in three reported either form of abuse.

Women were more frequently victims of both childhood sexual and physical abuse than men in the overall homeless sample. This is consistent with the common finding that girls are more frequently sexually abused than boys, but contrasts with the observation that physical abuse tends not to have a pronounced sex difference (Briere & Elliott, 2003). The reason why homeless women were more likely than homeless men to be victims of physical abuse is unclear. Although it should be noted that homeless women are the minority in this sample and in single homeless populations in general, which tend to be male dominated. It could be therefore that women require a higher level of past adversity before becoming homeless.

The homeless sample as a whole reported a high frequency of having been raised in local authority care; this was reported by more than one in five of the cases. Furthermore, early onset of psychosocial problems is reflected in the fact that a similar proportion required special education provision. It was also observed that people who had been raised in care by the local authorities or who had been adopted more frequently reported high levels of both forms of abuse. This is unsurprising, as frequently the reason for children being separated from their natural parents is the occurrence of abuse. However, in this research a distinction was not made between abuse suffered before or after being taken into care or adopted, so formally this cannot be confirmed or refuted. However, it was noted that many of the participants in the interview series described such abuse as occurring whilst in local authority care. Nevertheless, it can be seen that the levels of abuse were high in this already

vulnerable group and it would be naive to think that such abuse had not contributed to the problems that led to homelessness as an adult.

It is interesting that physical abuse and sexual abuse appear to have had different influences on the individuals concerned. Sexual abuse was most closely linked to personality disorder, whilst physical abuse was more closely linked to self-harm. This seems to imply that sexual abuse promotes development of DSM-IV axis ii disorders (i.e. personality disorders) whilst physical abuse has more influence on axis i disorders (e.g. depression). This is also supported by the observation that those who were sexually abused were significantly less likely to have been detained for compulsory psychiatric treatment in the past, such treatment would only usually be for axis i disorders. Nevertheless, it is a fact that self-harm in general is very closely linked with personality disorder and there can be no clear distinctions made at the group level between the expressions of axis i and axis ii disorders, particularly in the current context of one third of the sample reporting childhood abuse.

These rates are considerably lower than the 89% of homeless adults reporting childhood trauma previously reported (Pluck, et al., 2011). However it should be noted that the severity of the trauma reported in this sample was likely higher than in many previous reports. In those individuals who were interviewed, we used a cut-off score which identified only severe levels of abuse. Presumably, abuse in the case note series would only likely be reported by the individual and recorded in case notes if it was also a significant cause of trauma. We can therefore assume that the reported levels of abuse in the full sample (19% for sexual and 25% for physical abuse) probably represent only the most severe cases, and that many others in the sample experienced childhood physical and sexual abuse. Indeed, as all of the cases reported here were homeless, it would be fair to assume that homelessness itself was for many a consequence of the abuse they suffered as children.

To conclude, childhood sexual or physical abuse was a feature of a third of the sample of 218 homeless adults from a single English city, indicating a high incidence in this population. Homeless women and people who had been raised in local authority care were at even greater risk. Indeed, 66% of the homeless women and 40% of the homeless individuals who were raised in care or adopted reported childhood abuse. In fact, all of the homeless adult women who were raised in care or adopted reported that childhood physical or sexual abuse. Specific consequences of such childhood traumas appear to be raised levels of self-harm and personality disorders. Though in reality the damage caused by such abuse will have been far more wide reaching and ultimately

will be contributing to the ongoing psychosocial and economic problems faced by them as adults, including their homelessness.

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