Impacts of Adverse Childhood Experiences on Minnesota Homeless Youth:

An Adlerian Perspective

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Abstract

Research suggests there is a strong connection between Adverse Childhood Experiences (ACE’s) and youth homelessness. Homelessness among youth is a growing problem in Minnesota (Wilder Research, 2014). These problems have largely been elicited by childhood trauma, abuse, and neglect. Further research is needed to better understand the role of early adversity in homelessness as well as services to prevent youth homelessness. This paper presents a conceptual framework that seeks to explore the correlation between adverse childhood experiences and the risk of future homelessness.
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Impacts of Adverse Childhood Experiences and Minnesota Homeless Youth Population

On any given night, an estimated 6,000 Minnesota youth experience homelessness (Wilder Research, 2015, p. 1). More specifically, young adults age 18-24 have been shown to be especially vulnerable to homelessness, and those experiencing homelessness exhibit high prevalence for numerous kinds of abuse and negative health outcomes (Zerger, Strehlow, & Gundlapalli, 2008). Youth homelessness is a growing problem across Minnesota (Wilder Research, 2015). Nearly three-quarters (73%) of homeless youth are African American, American Indian, Asian, Hispanic, or of mixed race. Yet, youth in these groups represent only 26% of Minnesota’s total youth population (Wilder Research, 2015, p. 2) For example, historical-trauma and the generational impact of discriminatory housing and child welfare policies, as well as other systemic inequities, have contributed to the overrepresentation of youth of color in Minnesota’s homeless population (Wilder Research, 2015).

In addition, the high prevalence of childhood adversity in homeless individuals has led researchers to speculate that Adverse Childhood Experiences (ACE) may also be risk factors for adult homelessness (Herman, Susser, Struening, & Link, 1997). According to the Minnesota Department of Health (MDH), an ACE is a traumatic experience in a person’s life, occurring before the age of 18, which the person recalls as an adult (MDH, 2011). More specifically, adverse childhood experiences are defined as emotional, physical, or sexual abuse; emotional or physical neglect; growing up in a home with substance abuse, mental illness, or violence; parental separation or divorce, or an imprisoned family member (ACE Reporter, 2003).
Prevalence of ACES in Minnesota Homeless Youth

High rates of childhood adversities have been linked to adult homelessness using the adverse childhood experiences study (Ross, 2013), and there is a compelling relationship between ACEs and the risk behaviors leading from youth to adult homelessness (Burt, 2001). According to the most recent data gathered by Wilder Research (2015) on October 26, 2015, there are over 15,000 homeless adults, youth, and children in Minnesota. Wilder Research also counted 1,463 unaccompanied youth on their own, including 213 youth age 17 and younger and 1,250 age 18 through 24. More specifically, the 1,463 homeless youth only represents the youth who were counted on one day. Consequently, children and youth age 24 and younger are the most likely of all age groups to be homeless (Wilder Research, 2015). The implications of homeless youth can be attributed to ACEs such as abuse and neglect.

Dickrell (2016) noted that “a huge percentage, about nine in 10 homeless youth, have had at least one adverse childhood experience” (p. 4). Youth experiencing homelessness have often experienced serious turmoil before reaching adulthood. For example, Wilder Research (2015) noted that 54% of homeless youth report that they had been physically abused, sexually abused, or neglected as a child while 59% of all youth reported having a parent who had been incarcerated, either while the youth was a child (47%) or since childhood (12%). According to the National Coalition for the Homeless, 5 to 7% of American youths become homeless in any given year (National Coalition for the Homeless, 2008). Homeless youth are among the least visible and most vulnerable homeless people (Wilder Research, 2014).
Prevalence and Present Impact

Homeless youth and young adults are considered one of the most vulnerable populations worldwide with an estimated 100 million globally, and 500,000 to 2.8 million in the U.S. alone (Slesnick, Guo, Brakenhoff, & Bantchevska, 2015). The definition of “homeless youth” varies from study to study. The term “homeless youth” has been defined by the 2013 Minnesota Homeless Youth Act as a person 21 years of age or younger who is unaccompanied by a parent or guardian and is without shelter where appropriate care and supervision are available (Office of the Revisor of Statutes, State of Minnesota, 2013). This also includes youth who are residing with a friend or relative for less than 30 days without being offered a permanent place to live.

However, homeless youth are a heterogeneous population and are described as runaways (i.e., youth who have spent more than one night away from home without parental permission), throwaways (i.e., youth forced to leave by their caregivers), street youths (i.e., youth who live in high risk environments such as abandon buildings and under bridges), and systems youth (i.e., youth whom have been in foster care or juvenile system (Edidin, Ganim, Hunter, & Karnik, 2011). Throwaways, referring to youths being forced to leave the home by a caregiver, have higher levels of mental health difficulties than youth who report leaving home under their own discretion (Kidd & Shahar, 2008).

In addition, homelessness effects youth in several different ways. Homeless youth often lack basic needs for survival such as food, clothing, and shelter. Many homeless youth only recourse is survival strategies such as selling drugs, stealing, and prostitution. They may also exhibit risky behaviors such as unprotected sex which may lead to sexually transmitted diseases, exposure to HIV, and unwanted pregnancies. In like manner, homeless young women are five times more likely to become pregnant (Greene & Ringwalt, 1998). Many homeless youth resort
to drug and substance abuse as a means of coping with feelings of loneliness, fear, worthlessness, and shame (Shannon & Hess, 2008). Fifty percent of homeless youth ages 16 and older drop out of school and encounter immense obstacles in trying to finish (Lohmann, 2011).

**ACE Study**

The ACE study is an ongoing collective collaboration between Dr. Vincent Felitti of Kaiser Permanente’s Health Appraisal Center (HAC) in San Diego, California along with Dr. Robert Anda of the U.S. Centers for Disease Control (CDC). This wide ranging epidemiological study with an original sample size above 17,000 participants was designed to examine the “influence of childhood traumatic experiences on the emergence of behaviors that underlie the leading causes of disability, social problems, health related behaviors, and causes of death in the United States” (ACE Reporter, 2003, p. 2), was groundbreaking in 1998.

An ACE Score is attained by adding the number of “yes” responses to any of the following 10 categories prior to the age of 18: physical abuse, emotional abuse, sexual abuse; domestic violence; living with a mentally ill household member, growing up with a substance abusing household member; experiencing the incarceration of a household member; emotional neglect; physical neglect; and loss of a parent (Felitti et al., 1998). Subsequently, one point is attributed to each category of trauma the participant experienced before age 18. Thus, the accumulation of points is referred as the “ACE score”. Each category of trauma counts as one point with the sum of all points between 0-10, which indicate the ACE score (Anda, n.d., p. 8). An accumulation of ACEs has a compelling and collective impact on the health and functioning of adults (Minnesota Department of Health, 2011).

Since adverse childhood experiences often co-occur, the ACE score is a measure of the cumulative impact of multiple traumatic experiences before adulthood. For example, an
individual who’s been physically abused, with an alcoholic parent, and a mother who was beaten up has an ACE score of three.

In addition, (Larkin & Park, 2012) implies that ACEs increase individual susceptibility to societal circumstances such as poverty and lack of affordable housing. ACE study findings suggest that higher ACE scores were strongly associated among individuals experiencing homelessness. Recent research from ACE studies has shown a strong correlation between the ACE score and high-priority health and social problems such as smoking, obesity, sexually transmitted diseases, substance abuse, promiscuity, attempted suicide, homelessness, and teen pregnancy (Dube, Anda, Felitti, Chapman, & Giles, 2003).

In 2011, the Minnesota Department of Health collaborated with the CDC to research ACE scores on a state level. The research findings from this large-scale study were consistent with other state scores and the initial ACE study that ACES are common and have a strong impact on the health and functioning of adults (Minnesota Department of Health, 2011).

Moreover, a study researching the correlation between adverse childhood experiences and lifetime homelessness found a strong link within each type of ACE category and future risk of lifetime homelessness. Roos et al. (2013) suggested “Individuals with lifetime homelessness experienced higher rates experienced higher rates of all childhood adversities compared with individuals without lifetime homelessness” (p. 280).

**The Developing Brain and ACE Trauma**

Early stress can affect brain function, learning, and memory adversely and permanently. New research provides a scientific basis that children who experience extreme trauma in their earliest years are at greater risk for developing a variety of cognitive, behavioral, and emotional difficulties in life (Center of the Developing Child, 2007). In order to understand how adverse
childhood experiences affect physical, emotional, and behavior outcomes, it is critical to have a basic understanding of brain development.

The framework and functional capacity of the human brain is dependent upon a remarkable set and sequence of developmental and environmental experiences that influence the expression of the genome (Perry & Pollard, 1998; Teicher, 2000). This sophisticated sequence is vulnerable to extreme, repetitive, or abnormal patterns of stress during critical periods of childhood brain development that can impair, often permanently, the activity of major neuron-regulatory systems, with profound and lasting neurobehavioral consequences (Anda, et al. 2006).

Subsequently, coinciding evidence from neurobiology and epidemiology suggests that early life stress such as trauma and related adverse childhood experiences cause brain dysfunction that affect health and quality of life. For instance, neurobiologists have analyzed ACE Study data adverse to neurobiological defects that result from early childhood trauma and found that “early experiences have profound long-term effects on the biological systems that govern responses to stress” (Anda et al., 2006, p. 176).

In addition, attachment theory is also important in understanding homeless youth. For instance, attachment theory views infants as innately competent and motivated. The primary caregiver is used as a secure base from which the infant explores the world (Karen, 1990, p. 5). When necessary, the infant utilizes the secure base as a safe haven and a source of comfort.

Furthermore, when the primary caregiver is chaotic, unpredictable, rejecting or emotionally unavailable, the infant develops difficulties with attachment that may result in maladaptive behaviors (Karen, 1998, p. 444). Henk (2001) noted, “When the secure base is threatened, the infant’s behaviors reflect a problem with attachment, a similar problem found among homeless and runaway youth” (p. 59). This theory also suggests that there is a critical
period of 0-5 years for infants to reach attachment. If an attachment has not developed throughout this period then, the child will suffer irreversible developmental problems such as aggression and lower intelligence (McLeod, 2009).

Research indicates that primary caregivers of homeless youth often failed to provide adequate and constant safety and comfort for their youth. Thompson, Bender, Windsor, and Cook (2010) cite the research of Whitbeck, Hoyt and Ackley in 1997 stated “When contrasted to non-homeless adolescents, for example, one study found that homeless youth reported lower rates of parental monitoring and supportiveness and higher rates of parental rejection” (p. 201).

**ACE & the Stress Response System**

Stress response systems are immature at birth and therefore vulnerable to maltreatment and neglect (MDH, 2011). When children experience abuse as a result of ACE’s, areas of their brain structure are negatively impacted that affect self-regulation and cognitive functioning (Craig, 2017). Self-regulation requires development of the frontal cortex of the brain. ACE’s prevent the development of neuropath ways that help a child to access this region which is responsible for awareness, emotional attunement, emotional intelligence, social cognition, and interpersonal competence (Guenette, Kitchenham, & O’Neil, 2010).

In addition, the quality and type of experiences that occur in the first few years of life impact the pathway that are formed between neurons in the child’s brain to help cope with stressors (National Scientific Council on the Developing Child, 2005). According to Harvard University Center on the Developing Child (2007), adverse childhood experiences can cause toxic stress such as recurrent child abuse or neglect, severe maternal depression, parental substance abuse, or family violence. Toxic stress is defined as “frequent or prolonged activation
of the body’s stress response system without adequate protective relationships and other mediating factors” (Center for the Study of Social Policy, 2015, p. 1).

The hypothalamus-pituitary-adrenal (HPA) axis is responsible for controlling important bodily functions including the body’s stress response system and capacity to control self-regulatory behaviors (Craig, 2017, p. 27). The HPA is a part of the brain which connects the nervous system to the endocrine system from the pituitary and adrenal glands (Craig, 2017, p. 27). During adolescence, the HPA axis is evident with increased stress reactivity. Craig (2017) suggests that “stress sensitive cortical brain areas such as the prefrontal cortex that continue to mature during adolescence may be particularly vulnerable to these shifts in stress reactivity” (p. 27).

Individual’s biological stress response is comprised of different, connecting systems that work together in response to stress. For example, when a child is threatened, the brain initiates the body to react. Thus, stress hormones such as cortisol are released into the system by the amygdala which engages the fight, flight or freeze response (Craig, 2017).

McEwen (2011) suggested that early life abuse and neglect have adverse effects upon the developing brain and body that can result in poor self-control and emotional regulation, impair cognitive development, and increase the risk of cardiovascular, metabolic, and immune system diseases.

According to the National Scientific Council on the Developing Child (2005), early exposure to trauma, extremely fearful events, and high levels of stress affect the developing brain, particularly the amygdala and the hippocampus areas associated with emotions and learning. For example, early trauma causes adaptations to brain architecture that influence cognition, cognitive flexibility, reaction time, and the ability to predict consequences (Craig,
Thus, early trauma slows the development of the prefrontal cortex and executive function from adolescence into adulthood. Correspondingly, a pattern of dysfunction in the hippocampus, amygdala, medial prefrontal cortex, and limbic structures believed to moderate anxiety and mood dysregulation make emotional and self-regulation more difficult for teens with early trauma experiences (Craig, 2017, p. 20).

Although studies of homeless adults specify that cognitive functioning improves once individuals are housed, it is unclear whether cognitive deficits in children and adolescents improve if housing is attained. Research that has examined the effects of stress on cognitive functioning in children implies that the effects may be permanent; specifically, stress appears to increase the speed at which the prefrontal cortex develops and stunts neural growth (Edidin, Ganim, Hunter, & Karnik, 2011, p. 358).

**Prevalence of Childhood Trauma in Homeless Youth**

Homeless youth have significant mental health problems, including depression, anxiety disorders, posttraumatic stress disorder (PTSD), suicidal ideation, and substance abuse disorders (Cochran, Stewart, Ginzler & Cauce, 2002). Most of these youths experienced potentially traumatic events before they left home, and many of them are re-traumatized once they arrive on the street (Stewart, Steiman, Cauce, Cochran, Whitbeck, & Hoyt, 2004). Moreover, homeless youth experience higher rates of childhood trauma than housed youth. Non-homeless youth experience trauma at a rate of 15% (Cuffe et al., 1998) to 40% (Giaconia et al., 1995). In a study by Keeshin and Campbell (2011), 84% of homeless youth screened positive for childhood physical or sexual abuse while 72% of the youth state that the history of abuse still has detrimental effects on them now.
Homeless children and youth are more likely to witness or experience violence prior to homeless episodes; they are exposed to violence due to the public nature of their lives and vulnerable living conditions associated with poverty, such as being on the streets, in shelters, doubling up with others, or crowded housing (Anooshian, 2005, p. 129). According to the United States Conference of Mayors (USCOM, 2007), violence at home is one of the major predictors of whether children and youth will experience homelessness. For example, among homeless mothers with children, more than 80% previously experienced domestic violence (USCOM, 2007). Further, many homeless youths leave home after years of physical and sexual abuse, strained relationships, addiction of a family member, and parental neglect. Disruptive family conditions are the principal reason that young people leave home (National Coalition for the Homeless, 2008).

Although various studies have found that a significant number of homeless youth have histories of abuse, there is evidence to imply the correlation between trauma, including abuse, and homelessness may be a product of trauma (Edidin et al., 2011).

Moreover, there is also a strong connection between adverse childhood experiences, compound trauma, and homelessness. As noted in (Cockersell, 2018), ‘compound trauma’ chronicles a situation in which a person experiences a sequence of traumatic events which begin in infancy or childhood compounded with adolescent and adult traumas (p. 17). The prevalence of compound trauma has links to youth homelessness. For example, evidence from research with homeless youth supports the complexity of the relationship between multiple traumas, homelessness, and mental health outcomes. Youth are more likely than adults to have experienced early trauma, abuse, or neglect but are more likely to experience alike traumas in later life (Cockersell, 2018).
In addition, many homeless youths are also victims of collective trauma experienced by their community members that has significant structural and social consequences. For instance, teens that are exposed to traumatic narratives firsthand may develop a traumatic response similar to that of those directly involved. Craig (2017) noted that “Because non-White youth are overrepresented in economically depressed areas, they are more likely to experience collective trauma that is the result of neighborhood-level social and physical environmental stress” (p. 91). These structural factors identify why Black and Latino teens are significantly more likely than White peers to have a murdered friend or family member (Craig, 2017).

**Implications of Homelessness**

There is no single cause for homelessness; however, research suggests family breakdown, economic problems, and residential instability are the most common factors for youth homelessness (Edidin et al., 2011). Homeless youth experience high rates of trauma and abuse prior to becoming homeless. According to a Seattle based study of 328 youth (12-21 years-old) living on the streets or in shelters, eighty-two percent of participants reported past experiences of physical abuse, 26% endorsed sexual abuse, and 43% described family neglect. In a more recent study, 50% of the participants had witnessed domestic abuse, 50% had been physically abused, 39% had been sexually abused, and 68% had experienced verbal abuse (Edidin et al., 2011).

Youth experiencing homelessness have increased rates of mental illness (Edidin et.al., 2011; Merscham, van Leeuwen, & McGuire, 2009). Further, there is emerging evidence that psychological disorders strongly predict youth homelessness. Crockersell (2018) suggested that behaviors leading to homelessness may be correlated with mental illness such as personality disorder (PD), post-traumatic stress disorder, and complex trauma and conduct disorders in children (p. 110).
Homeless youth were six times more likely than housed youth to struggle with mental illness (Merscham, et al., 2009). Further, homeless adults were seven times more likely to have Post Traumatic Stress Disorder (PTSD) than non-homeless adolescents and twice as likely to have a major depressive episode (Whitbeck, Johnson, Hoyt, & Cauce, 2004). In addition, homeless youth between the ages of 6 and 17 struggle with anxiety and depression at a rate 30 percent higher than non-homeless youth in that age group (Collins, 2015). Homeless youth exhibit higher rates of mental health problems such as anxiety disorder, depression, and psychosis disorders and personality disorders (Cockersell, 2018).

Resilience

Adverse childhood experiences and related trauma in childhood, however, do not dictate the future of the child. Many homeless youth show signs of resilience. Resilience can be understood as an ability to mobilize people and social resources to protect oneself against risks (Kidd & Shahar, 2008). A recent study conducted by Kidd and Shahar (2008) examined the interactions between risk and resilience factors among homeless youth. Their research found that youth with strong self-esteem and social involvement demonstrated stronger resilience during adversities. Consequently, Kidd and Shahar (2008) suggest that any interventions for homeless youth should include evaluating self-esteem, social involvement and emphasizing the value of self.

Moreover, homeless youth continue to be resilient, and many are accessing the much-needed resources and services available to support them. For example, homeless youth in Minnesota are pursuing educational opportunities. According to the Wilder Research one-night statewide homeless youth survey conducted on October 22, 2012, over 91% of minors were enrolled in school, 68% of youth age 19-24 had completed high school or a GED, and 52% of
young adults were enrolled in an educational program (Wilder Research, 2013). Research suggests that these adolescents have the capacity to make healthy adaptations to stress, and in drastic cases, bounce back from severe or persistent trauma (Craig, 2017).

**Trauma Informed Care**

“Trauma informed care” is a strengths-based framework that is grounded in an understanding and responsiveness to the impact of trauma that emphasizes physical, psychological, and emotional safety for both providers and survivors that creates opportunities for survivors to rebuild a sense of control and empowerment (Hopper, Bassuk, & Olivet, 2010, p. 83). Additional trauma-informed practices may include: services that are voluntary rather than mandatory, conducting early interventions by trained staff, and ensuring informed consent is easily understood for all clients. Moreover, trauma-informed care includes establishing visible leadership roles for clients and ongoing opportunities for engagement, providing trauma training for all staff regarding trauma and its effects, and engaging in strategic planning to utilize best practices (Prescott, Soares, Konnath, & Bassuk, 2008).

In addition, trauma sensitive schools are committed to creating a culture of inclusion and belonging that celebrates individual differences (Craig, 2017, p. 25). Craig (2017) noted a school that employees a trauma-sensitive “lens” to care about their students has the influential opportunity to help a hurting student become a resilient and confident adult prepared to break through the barriers of trauma (p. 1).

Equally, being trauma-informed is more than just being empathetic and compassionate to a student who has experienced trauma and abuse. Being trauma-informed requires that professional school counselors are competent in current research on trauma and brain development and how it impacts human behavior.
Implications for School Counselors

In 2012, the National Center for Homeless Education (NCHE) reported that 1,065,794 children in schools experienced homelessness nationwide, an increase of over 50% since 2007 (NCHE, 2012). As youth homelessness continues to be a problem, school counselors are increasingly being relied upon to implement early prevention programs, along with supportive services to curb the youth homelessness epidemic. In response to the growing crisis among youth experiencing homelessness, policymakers designed the McKinney-Vento Homeless Assistance Act to provide access to education and removing barriers in order to ensure that all schools address the specific and unique needs of students experiencing homelessness (National Coalition for the Homeless, 2008). This Act requires that school districts provide transportation to and from the school of origin for all students experiencing homelessness even if the students relocate outside the home school parameters. According to the American School Counseling Association (ASCA), an important role of school counselors is to promote awareness and understanding of the McKinney-Vento Homeless Assistance Act and the legal rights of students experiencing homelessness (ASCA, 2016). Further, the act allows homeless youth to enroll in school immediately without required paperwork such as immunization records or educational records and have an assigned school homeless liaison to ensure that all provisions are being met. In particular, school counselors must be aware and understand the McKinney-Vento program guidelines and advocate for their effective implementation in the comprehensive school counseling program (Baggerly & Borkowski, 2004).

According to ASCA, (2016) the mission of school counselors is to advocate for the achievement of all students. School counselors play a vital role in helping homeless students by implementing interventions that support students in the domains of academic, social/emotional,
and career (ASCA, 2016). Moreover, school counselors advocate for homeless students by exposing and changing discriminatory practices and stigmas in the school system, providing support and resources to families, and implementing interventions that support students and families who have become or are on the brink of homelessness.

Furthermore, one crucial component to combat youth homelessness is to provide stable adult housing as an effective way to intervene early to prevent chronic homelessness. For example, the Housing First Model (Pearson, Montgomery, & Locke, 2009), which provides housing without requiring potential client’s to engage in treatment or be abstinent, has been efficacious in keeping clients with mental illness and substance abuse along with their families securely housed.

**Evidence Based Trauma Interventions**

**The Tiered System of Support (TSS)**

Early intervention and treatment can minimize the social and emotional impact of a child’s exposure to a traumatic event. There are numerous evidence-based methods available to school counselors in helping traumatized youth. The implementation of a tiered system of support (TSS) is a service-delivery model that relies on public health risk assessments to determine needed student support. For example, risk factors such as ACES, poverty, trauma history, emotional and behavioral concerns determine the type of tiered support intervention provided (Craig, 2017). Craig (2017) noted that these interventions are designed to provide adolescents with opportunities to explore the brain’s interacting social systems, while learning how to collaborate safely with adults (p. 82).

Correspondingly, Tier 1 interventions are typically universal supports that suffuse the school climate. They reflect expectations agreed upon by staff members to help students whose
coping skills are not developed. (Craig, 2017) suggested specific Tier 1 interventions such as supportive and calm staff who provide verbal and non-verbal redirection to students and giving ample time to transition from an activity to another. Furthermore, the objective for Tier 1 interventions is to teach students good mental health competencies such as self-awareness, self-management, social awareness, relationship skills, and responsible problem solving (Craig, p. 81). As a result, students are screened or observed by school staff to identify if they are making adequate progress with solely Tier 1 support.

Given that, Tier 2 interventions usually occur in small-group settings facilitated by mental health workers, counselors, and teachers with the objective to reduce student level of arousal to pre-trauma levels of cognitive functioning and behavior. Thus, emphasis is placed on interventions that relax the limbic or emotional area of the brain thus restoring students’ ability to participate in bonding relationships with adults that is often diminished by attachment failures in early childhood (Craig, 2017, p. 82). In addition, Craig (2017) suggests that poor caregivers shifted the dynamic of the adult-child relationship from bonding to power-based opposition while jeopardizing child safety in the process (p. 82). Consequently, these children progress into adolescence and adulthood without the necessary therapeutic tools to emotionally and psychologically cope with past adverse family dynamics. Craig (2017) implies that many teens find that yoga and deep breathing classroom activities are effective coping interventions to practice self-management and self-regulation. Furthermore, Craig (2017) noted that cognitive strategies such as affirmations and positive self-talk help reassure teens about their ability to cope; while relaxation techniques and reflective activities teach them to observe their internal state and clear their minds of unnecessary worries (p. 93). Moreover, the goal of Tier 2
interventions is to stabilize or regulate teens’ arousal to the point where they can function and participate in social and academic activities relying solely on Tier 1 supports.

Additionally, Tier 3 interventions are the most intense in terms of duration and frequency and help teens with self-regulation. Craig (2017) noted that students who require this level of intervention experience “over-activity” in the brain stem which leads to difficulty in impulsivity control and aggressive behaviors (p. 82). Generally, Tier 3 interventions are one to one with an educational specialist in sensory integration or cognitive behavioral therapy. The goal of Tier 3 interventions is re-creating the circadian rhythm learned in infancy through comparative experiences with caregivers (Craig, 2017). These interventions include short, predictable, repetitive, and patterned interactions; rhythmic movement; drumming; attempts at sustained eye contact; and joint attention. Craig (2017) suggests that the school counselor’s role in Tier 3 interventions is primarily collaborative with the level of support following the recommendation of the student intervention team (p.83).

**Trauma- Focused Cognitive Behavioral Therapy (TF-CBT)**

Numerous trauma specific evidence-based treatments have been created and proven helpful within the homeless youth population. Trauma-Focused Cognitive Behavioral Therapy (TF- CBT) is a psychosocial treatment model designed to help treat post-traumatic stress disorder (PTSD) and related emotional and behavioral problems in children and adolescents age 3 to 18 (Substance Abuse and Mental Health Administration, 2016). Getz (2012) noted that “many clinicians claim TF-CBT has been the most effective treatment they utilized in working with young trauma patients” (p. 22). TF-CBT is based on the acronym PRACTICE: Psycho education for parent and child, Relaxation skills for parent and child, Affective expression, Cognitive coping and processing, Trauma narrative, In-vivo master of trauma reminders,
Conjoint child-parent sessions, & Enhancing future child safety and development (Cohen, Mannarino, & Deblinger, 2008)

TF-CBT consists of six core values compromised of the acronym CRAFTS: 1) Components-based, 2) Respect, 3) Adaptability, 4) Family focused, 5) Therapeutic relationship, and 6) Self-efficacy (Cohen & Mannarino, 2015). The goals of TF-CBT are to address and manage the child’s affective, behavioral, biological, cognitive, and social domains of the traumatic experience (Cohen & Mannarino, 2015).

One important component of TF-CBT is whether the child has experienced at least one remembered trauma including complex trauma (Cohen & Mannarino, 2015). When it has been determined that a child would benefit from TF-CBT, treatment may begin. Further, Cohen & Mannarino (2015) state that the primary components in TF-CBT include 3 phases: 1) a coping skills-building phase, 2) trauma narrative and processing, 3) treatment consolidation and closure phase. Generally, there are 18-25 fifty-minute sessions that therapists devote approximately the same number of treatments sessions for all 3 phases (Cohen & Mannarino, 2015).

Moreover, non-offending caregivers can have a significant impact on their child’s TF-CBT treatment. For example, TF-CBT can help caregivers recognize and respond appropriately to their child’s trauma response and set appropriate behavioral boundaries (Cohen & Mannarino, 2015). Cohen and Mannarino (2015) suggests that TF-CBT enables parents to provide the traumatized child with continuing opportunities to relearn or learn that people can be safe and trustworthy (p. 558). Thus, there is reason to imply that family-focused treatment that includes caregivers can substantially improve outcomes for traumatized children.

Youth who live in foster homes often hesitate to include their foster parents in therapy because they may not trust the caregiver with personal past traumatic experiences. Recent
research suggests that foster parents who participate in TF-CBT have a better understanding of complex trauma, supportive attitude and behavior toward foster youth, and better outcomes for youth with complex trauma (Dorsey, 2012).

**An Adlerian Perspective**

**Encouragement**

Adler stated that “learning is only possible when children look hopefully and joyfully toward the future. . .An educator’s most important task- perhaps his or her holy duty - is to see that no child is discouraged” (Evans, 1996). A discouraged adolescent may not feel worthy of others’ company and trust. As a result, discouraged individuals feel insignificant and disregarded. Predominantly, choosing a life on the streets may reinforce a discouraged adolescent conviction that he or she deserve to be homeless.

In retrospect, Adler was a strong believer in encouragement. (Wong, 2015) stated that Adler deemed encouragement a core component of human development and psychotherapeutic treatment (p. 180). Alder believed that all humans are intrinsically oriented towards social interest- a desire to belong and contribute to others and society. In fact, Adlerian Psychologist Dreikurs believed the ability to encourage others as the greatest attribute in getting along with other people (Wong, 2015, p. 180). For Adlerians, the goal of encouragement is not simply to change behavior but to instill courage and confidence to change.

**Social Interest and Sense of Belonging**

Social Interest, a term introduced in the 1900’s by Alfred Adler, relates to a person’s kinship with other living beings and a sense of belonging in the human community (Adler, 1964) According to Adler (Ansbacher & Ansbacher, 1979), “well- developed social interest enables people to identify with others, to feel part of the whole, and to see life through the spectacles of
reason or common sense. In addition, Clark (2017) suggests individuals with social interest exhibit cooperative, constructive, and contributing movement in the context of building empathetic relationships.

In retrospect, many homeless adolescents suffer from lack of social interest and need help from mental health professionals to overcome the complexities of isolation, lack of belonging, and discouragement. Fall and Berg (1996) noted that “Individual Psychology can benefit the homeless adolescent population by providing an egalitarian therapeutic relationship, encouragement, collaborative effort for insight and change, focus on self-responsibility for change, and immersion into the community to enhance the feeling of social interest” (p. 434).

Furthermore, homelessness is more than an absence of a home or physical shelter. (Cockersell, 2018) suggests homelessness can be thought as a theory of not only a state of physical ‘displacement’ but as ‘psychological homelessness ‘conveyed through alienation, exclusion, distrust, and impactful in building and sustaining relationships with others (p. 164). Adler writes:

Since true happiness is inseparable from the feeling of giving, it is clear that a social person is much closer to happiness than the isolated person striving for superiority. Individual Psychology has very clearly pointed out that everyone who is deeply unhappy, the neurotic and the desolate person stem from among those who were deprived in their younger years of being able to develop the feeling of community, the courage, the optimism, and the self-confidence that comes directly from the sense of belonging. This sense of belonging that cannot be denied anyone, against which there are no arguments, can only be won by being involved, by cooperating, and experiencing, and by being
useful to others. Out of this emerges a lasting, genuine feeling of worthiness. (Adler, 1926)

Family Dynamics

The Adlerian perspective seeks to understand the homeless individual by examining them within their social context. Many homeless youths have been devastated by detrimental family dynamics. According to the United States Department of Human Services (USDHS), about 90 percent of runaway youth in shelters run by the Family Youth Service Bureau (FYSB) and 75 percent in residential programs reported family dynamics as substantial issues leading to their homelessness (United States Department of Human Services, 2008). Adlerians place great emphasis on family dynamics, specifically caregivers, on the development of a child’s sense of belonging and well-being. Children learn to overcome their inferiority feelings, seek significance and superiority through interactive and purposeful behaviors within their families and social community (Griffith & Powers, 2007).

Lifestyle

From its inception, Adlerian psychology emphasized that humans are indivisible and function holistically. Adler believed that people needed to be perceived in the context of their social and physical environment. Adler emphasized that each individual develops a distinctive style of living in early childhood, which determines how one responds and behaves within their environment. Carlson and Maniaci (2012) quoted Adler’s description of lifestyle as “this unity in each individual- in his thinking, feeling, acting: in his so-called conscious and unconscious- in every expression of his personality” (p. 16). From an Adlerian perspective, lifestyle is an accumulation of thoughts, feelings, and behaviors from past and present experiences that disclose
a person’s private logic. Private logic is a person’s response to the question of who he or she is, what the world is like, and where do they fit in the world (Del Corso, Rehfuss, & Galvin, 2011).

Furthermore, lifestyle can be perceived from how human beings attempt to attain a sense of accomplishment and belongingness while also fulfilling the Adlerian life tasks of relationship, work, and community. Beyond these influences, lifestyle is reflected in the way people experience and respond to their family atmospheres, role(s) in family origin, their genetic endowments and special abilities, early developmental experiences, and long-term health status (Oberst & Stewart, 2003, p. 199). For example, children that are abused, hated, neglected, or pampered may develop early schema of themselves as damaged, unworthy, and deserving of negative treatment. Thus, the private logic of these children may evolve into a destructive and self-defeating Life Style deriving from the experiences of abuse early in life (Oberst & Stewart, 2003). Adler noted “By the time a child is five years old his attitude to his environment is usually so fixed and mechanized that it proceeds in the same direction for the rest of his life. His apperception of the external world remains the same” (Ansbacher & Ansbacher, 1964, p. 189).

Consequently, negative experiences from early childhood, such as abuse and trauma, greatly impact lifestyle. These traumatic experiences may lead to an increase in the risk for future homelessness.

**Conclusion**

This master’s project suggested evidence of a strong link between adverse childhood experiences, trauma, and youth homelessness. The findings from ACE data and youth homelessness statistics in Minnesota have implications for additional support and research for at-risk youth who have experienced adverse childhood experiences.
In addition, service providers, researchers, and agencies should recognize the links between adverse childhood experiences and youth homelessness. This recognition could translate into more effective approaches to combat youth homelessness in Minnesota such as incorporating specific ACEs assessments to assess homelessness risk or identifying particular areas of support that youth may need to prevent episodes of homelessness.

Furthermore, schools and teachers can improve their students’ academic and social experience if they are accurately informed on current research on ACE’s, trauma, and youth homelessness. Future research recommendations include an exploration of ACEs and resources with other vulnerable groups, study of helpfulness of prevention or intervention services, and research on ACE-informed programs specific to the youth homeless epidemic.

In addition, implementing Adlerian techniques into a comprehensive school counseling program can help school counselors improve relationships and better understand homeless youth. The acknowledgement of discouragement, the use of encouragement, emphasis on social interest, lifestyle, private logic, and that all behavior is purposeful will help elevate strong relationships with homeless youth and help curb the homeless youth epidemic.
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