THE STORIES OF HOMELESS STREET YOUTH:
A NARRATIVE INQUIRY OF
TIME PERSPECTIVE, HEALTH, AND HEALTH PROMOTION

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ABSTRACT

Homeless youth represent a highly vulnerable population who engage in high-risk behaviors or “survival strategies” and suffer disproportionate risk of mortality from their circumstances (Kidd, 2012). A growing body of theory and research suggests that time perspective, a psychological construct representing an individual’s way of relating to the past, present, and future (Zimbardo & Boyd, 1999), can impact one’s current course of action. Adults and children with positive future orientation tend to experience better life outcomes than those with a negative future orientation (Aronowitz & Morrison-Beedy, 2004; Robbins & Bryan, 2004; Vankineeste et al., 2004). This study addressed a gap in the scientific literature by providing a rich understanding of homeless street youth, specifically with regard to their time perspective, and the connection it may have on their health and health promotion.

A descriptive study design was employed for this research and narrative inquiry was chosen as the methodology in order to obtain and explore the stories of homeless street youth. Storytelling is considered a primary way by which people make sense of, give meaning to, and share their experiences (Duffy, 2007). Stories allow people to understand their past, present, and future and this has an effect on present actions and future goals (Polkinghorne, 1988).

Narrative analysis (Polkinghorne, 1995) was used to analyze the stories of thirteen homeless street youth. Participants in the study were between the ages of 18 and 21 years old. There were six females, five males, and two female to male transgender individuals. A semi-structured, interview guide was used in each case to allow the participant to contribute his/her own ideas. All participants were initially asked to tell their story, in
their own words, any way they wanted to tell it. Additional questions were designed to invite the research participants to discuss being homeless and their time perspectives, health, and health promotion.

The product of the narrative analysis was a collection of thirteen stories of homeless street youth. Additionally, analyses of story uniqueness and similarities were performed. As a collection, the stories provided rich information to answer the research questions and revealed specific details about childhood family conflict, violence exposure and victimization, alcohol and drug abuse, survival strategies, health, health promotion, and time perspective; and the possible connection that time perspective has to health and health promotion. Through their stories, homeless youth participants provided meaningful insights into a very complicated phenomenon, street life. Two important findings in this study are: 1) many homeless street youth possess positive future time perspectives; and 2) a possible connection between time perspective, health, and health promotion may exist.

This study provides clinicians, educators, and researchers with valuable information about the homeless youth population. By making a contribution to the literature, this research can guide the development of further studies and possible interventions to improve healthcare for this population. From this study there is a potential for expanding nursing knowledge in multiple ways including: the development of theories; practice innovations; research; health promotion education; and policies for addressing the needs of homeless youth for optimal health and well-being.
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CHAPTER 1: INTRODUCTION

I lie awake cold and alone  
No place to call my home.  

Upon the night  
Darkness is my light.  

Everywhere I roam  
To find a place to sleep.  

With no shoes on my feet  
No material things do I keep.  

The ground is cold,  
My stomach is empty  
As I see people who have plenty.  

No one cares for me  
For I am homeless you see.  

I have had a hard life.  
It started the day I lost my mom.  

I don’t want sorrow or pity  
Just some love and care.  

Maybe some shampoo  
to wash my hair.  

People pass me by.  
Without a tear in their eye  
Never giving a hand.  

What if I was an angel?  
Sent from God above  
to test man of his brotherly love?  

You will never know  
If you never give brotherly love.  

For we entertain angels unaware,  
Never knowing the true spirit hidden there.  

This poem is given to you as a lesson.  
Whenever passing someone in need  
Let go of the greed.  

Stop and heed to your heart  
To the call your heart has been given.  

Help those in need while you are living  
And you will entertain angels unaware!

Entertain Angels Unaware (Cas, 2011, pp. 10-11)
Through his poetry, Cas (2011) reveals the power that one voice can have by providing us with a glimpse into what it means to experience life on the streets as a homeless adolescent. “For we entertain angels unaware, Never knowing the true spirit hidden there.” These words speak of a child who longs to be known; a child who is rejected day after day by a society unaware of who he really is.

This research sought to address the concerns voiced by Cas and, perhaps, many other homeless youth whose true spirits we don’t know, but should. This study fills a gap in the scientific literature by providing a rich understanding of homeless street youth. Specifically, this research describes their time perspective, or views of the past, present, and future, and the connection their time perspective may have on their health and health promotion.

On a personal level, this study was conducted to transcend knowledge acquired from the numerous articles I have read about the “problem” of homelessness and my own experiences as a nurse working with the homeless youth population. It is seen as one more step towards truly knowing homeless youth, as best I can, so that my nursing practice can make a difference clinically, within nursing education, and in science.

The study was accomplished using narrative inquiry methodology in which I obtained and analyzed the stories of thirteen homeless street youth from a metropolitan area on the east coast of the United States. Storytelling was chosen for this research because it is considered a primary way by which people make sense of, give meaning to, and share their experiences (Duffy, 2007). Stories allow people to understand their past, present and future. Nursing research grounded in narrative inquiry values subjective experience and views the relationship between a nurse researcher and participant as a
vehicle for creating meaning and insuring wholeness. This study supports Munhall’s claim that “Embracing another’s subjectivity is the critical activity for compassionate nursing practice” (2007, p. 31). Furthermore, this research is also timely as there has recently been a call for a “critical dialogue about youth homelessness that might assist in reenergizing a field that seems increasingly stagnant with a research body focused on risk” (Kidd, 2012, p. 534).

**Background**

Adolescents and young adults make up approximately 21% of the United States population (U.S. Census Bureau, 2008). Adolescence is a period of critical transition that includes the biological changes of puberty and the need to master key developmental tasks such as increasing independence and normative experimentation (McNeely & Blanchard, 2009). During this developmental stage, adolescents and young adults are particularly vulnerable to environmental influences (Mulye et al., 2009). Family, peers, neighborhood, school, societal cues, and policy have the potential to either support or challenge young people’s health and well-being (Rew, 2005). Behavioral patterns established during this vital period contribute to young people’s current and future health status (National Research Council and Institute of Medicine, 2009).

Improving the comprehensive health status of adolescents and young adults has recently emerged as a top public health priority with the inclusion of adolescent health as a distinct topic area for the Healthy People 2020 agenda (U.S. Department of Health and Human Services, 2011). Healthy People is a national program consisting of specific, measurable, science-based objectives. Program targets to be achieved over the decade include improving health, achieving health equity, and creating healthy social and
A set of core adolescent health objectives now provide the nation with a strategic focus for state and community efforts to improve the health of this population. Of the 600 objectives that Healthy People 2020 has identified, 25% are directly relevant to adolescent and young adult health and come from multiple categorical topic areas (U.S. Department of Health and Human Services, 2011).

Even under the best of circumstances, adolescence can be a challenging time in a young person’s life due to the physiological, psychological, social, and cognitive changes during the transition from childhood to adulthood (Erikson, 1968; Rew, 2005). Social conditions have a profound bearing on human health and well-being. Youth growing up in unstable environments, characterized by poverty for example, face enormous hurdles and are at increased risk for a variety of negative outcomes, including poor physical and mental health, delinquency, and risky sexual behavior (Leventhal & Brooks-Gunn, 2004).

Adolescents and young adults who are experiencing homelessness, especially those who are unaccompanied by parents or guardians and living primarily on the streets, face even greater challenges. With few to no options available, many homeless youth enter into a lifestyle of mere survival, or “street life”. In this situation, risky behaviors are used to try to meet basic and immediate needs but typically compromise health (Fest, 1998; Rew, 2008).

In the United States, the number of youth between the ages of 14 and 17 years who are homeless each year is estimated to be one to two million (Hammer, Finkelhor, & Sedlak, 2002; Office of Applied Studies, 2004). Although homelessness is a widespread and distressing problem in America for all age groups (U.S. Conference of Mayors,
2008), homeless street youth are considered one of the most vulnerable groups due to their age; unaccompanied, unsheltered, and socioeconomic status; poor health; risky behaviors; and survival strategies (Robertson & Toro, 1999; Toro, Dworsky, & Fowler, 2007).

Youth who are homeless face daily challenges which endanger their lives and put them at increased risk for many medical and psychosocial problems (Molino, 2007; Rew, 2008). While research on homeless youth remains limited, the negative effects of being homeless have been identified and include the following: poor overall health; HIV and other sexually transmitted diseases (STDs); alcohol and drug abuse; mental health problems; self-harm behaviors; suicide; delinquent behaviors; unplanned pregnancy; prostitution; and trauma (Moskowitz, Stein, & Lightfoot, 2012; Rew, 2008; Stewart et al., 2004). Further compounding the problem is the fact that homeless youth lack adequate healthcare and face numerous obstacles to participating in health promoting activities (Rew, 2008).

According to the Institute of Medicine’s (IOM) (2001) Committee on Health and Behavior, positive health encompasses the following: “a healthy body; high-quality personal relationships; a sense of purpose in life; self-regarded mastery of life’s tasks; and resilience to stress, trauma, and change” (p. 23). Since positive health depends on a combination of biological, psychological, social, and environmental variables, factors previously considered irrelevant to health status may actually be critical to the well-being of individuals and populations (IOM, 2001) such as homeless youth.
Statement of the Problem

Many homeless youth suffer from exposure to factors that have negative effects on health. In order to survive each day, they engage in risky behaviors that compromise their health status and often have fatal consequences. The leading causes of illness and death among adolescents and young adults are largely preventable (Mulye et al., 2009). The financial burden of preventable health problems in adolescence is large and includes the long-term costs of chronic physical and mental illness along with associated social consequences and service needs. Current efforts aimed at youth homelessness prevention, early intervention, and health promotion appear to be failing while at the same time the size of the population is increasing (Kidd, 2012). It is speculated that factors necessary for better understanding homeless youth, that could ultimately play a role in their health and well-being, are being overlooked. One of these overlooked factors may be time perspective.

“The concept of health implicitly includes a time dimension. Current wellness or illness must be considered together with prospects for the future (IOM, 2001, p. 23)”.

According to Fest (1998), homeless youth seem to view time differently than people in the dominant culture. Specifically, this population appears to be focused on the present with little regard for the past or future. Given the fact that many homeless youth have traumatic histories and lead lifestyles aimed at day to day survival, a time perspective that is predominantly present oriented is understandable. Still, the importance of a future time perspective for homeless youth must be addressed. Raffaelli & Koller (2005) state:

The challenge policy makers and practitioners face is how to provide street youth with alternative visions of the future, given their present conditions.
Developmental researchers can contribute to this goal by identifying individual, social, and contextual factors that support the formation of positive future expectations among homeless and impoverished youth. (p. 259)

A growing body of theory and research suggests that time perspective, a psychological construct representing an individual’s way of relating to the past, present, and future (Zimbardo & Boyd, 1999), can impact one's current course of action. Adults and children with positive future orientation tend to experience better life outcomes than those with a negative future orientation (Aronowitz & Morrison-Beedy, 2004; Robbins & Bryan, 2004; Vankineeste et al., 2004).

Adopting health promoting behaviors requires a time perspective focused on the future in order to imagine, anticipate, and plan for anticipated change (Bandura, 1991). Simply put, if the future is not valued, health benefits in the future cannot be valued (Adams & Nettle, 2009). The role time perspective plays in the lives of homeless youth has not yet been explored but may offer insight for improved health and well-being. Given the plight of homeless youth in the nation, innovative areas of research must be pursued (Kidd, 2012). Understanding the time perspectives of homeless youth is necessary in order to gain a more comprehensive knowledge base about this population.

**Purpose, Aims, and Research Questions**

The overall purpose of this study was to gain an understanding of the time perspectives of homeless street youth. Narrative was chosen as both the sensitizing framework and the qualitative research methodology to guide this research process. The specific aims of the research were:

1. Conduct a narrative analysis of the stories of homeless street youth;
2. Describe the meanings that homeless street youth give to their experiences;
3. Identify the time perspectives of homeless street youth and examine what past, present, and future mean to them;
4. Determine if and how the time perspectives of homeless street youth influence their health and health promotion

These aims led to the following research questions:

1. What are the stories told by homeless street youth?
2. What meanings do homeless street youth give to their experiences?
3. What are the time perspectives of homeless street youth and what meaning do past, present, and future have to them?
4. Does time perspective influence the health and health promotion of homeless street youth? If so, how?

**Definition of Terms**

Adolescence: An 11 year age span that is divided into the following three stages: early, 10-13 years; middle, 14-17 years; and late, 18-21 years (often referred to as young adulthood) (Rew, 2005).

Health: A dynamic concept with multiple meanings representing the following:
a) not only the absence of illness but a multitude of dimensions that contribute to the well-being of individuals, families, groups, communities, societies and populations; dimensions include physical, mental, social, spiritual, emotional, cultural, socioeconomic, educational, and environmental; b) the process of becoming as experienced by the human being (Parse, 1992); c) the embodiment of wholeness and integrity in living and dying, including unity, harmony, balance, and integration physically, psychologically, and
spirited (Willis, Grace, & Roy, 2008); d) “…broader than delivery and reimbursement systems, but extending to health-related sociocultural issues such as violation of human rights, homelessness, hunger, violence, and the stigma of illness” (American Nurses Association [ANA], 2001, p. 25).

Health promotion: “The process of enabling people to increase control over, and to improve, their health. It moves beyond a focus on individual behavior towards a wide range of social and environmental interventions” (World Health Organization [WHO], 2012)

Homeless youth: Adolescents and young adults age 16 to 21 years old who are unaccompanied by parents or guardians; lack a fixed, regular, and adequate nighttime residence; and may reside with family, friends, or acquaintances, in shelters or other system-based institutions, or stay on the street (or other outdoor locations such as parks, beaches etc.). They may be former or current runaways, throwaways, foster, or systems youth (Taylor-Seehafer et al., 2007; U.S. Department of Health and Human Services, 2008).

Homeless street youth: Homeless youth per the definition above who identify the street (or other outdoor locations such as parks, beaches etc.) as a significant place where they live or stay (U.S. Department of Health and Human Services, 2008).

Narrative: The structured quality of the experience studied; the "story”; useful for understanding life as temporal experience (Clandinin & Connelly, 2000).

Narrative inquiry: A methodology in qualitative research for studying “stories lived and told” (Clandinin & Connelly, 2000).
Social determinants of health:
The complex, integrated, and overlapping social structures and economic systems that include the social environment, physical environment, and health services; structural and societal factors that are responsible for most health inequities. SDH are shaped by the distribution of money, power and resources at global, national, and local levels, which are themselves influenced by policy choices. (Centers for Disease Control and Prevention, 2010)

Time perspective: A psychological construct representing an individual’s way of relating to the past, present, and future that influences all of human behavior (Zimbardo & Boyd, 1999); related to one’s cultural values, spiritual orientation, socioeconomic status, gender, age, education, and occupation (Boniwell & Zimbardo, 2004).

**Personal Statement of the Researcher**

An essential aspect of the qualitative research process is for the researcher to reflect on her presumed ideas about the topic and identify personal and professional biases as well as the worldview or interpretive frameworks that undergird a particular research project (Munhall, 2007). Because qualitative researchers come to their projects with layers of meaning achieved through a lifetime of experiences embedded within social, cultural, familial, and professional contexts, Munhall (2007) describes a form of knowing, namely “unknowing”, that is central to good qualitative research. For Munhall, unknowing denotes the researcher’s openness to the views of others and receptivity to what may be learned by listening to and observing others. By privileging the view of the “other” and operating from within the philosophical/epistemological assumption that the one being inquired about has the best access to the ‘knowledge’ of a particular life
circumstance (e.g. being a homeless youth), qualitative nurse scientists are provided with a way of conceptualizing processes for knowledge development that “makes accessible the possibility for positive helpful or caring human interaction during encounters” (Averil & Clements, 2007, p.395)

I situate my research with homeless youth within the paradigm of inquiry known as social constructionism. That is, as a nurse operating from within a social constructivist frame of reference, I view “reality” unfolding within the research process as co-constructed, with multiple meanings possible. As my understanding intersects with the understanding and meanings of the research participants I engage with, a new level of understanding emerges. Conceptualizing from within this interpretive framework, I recognize that my own knowing is shaped and biased by my own personal historical narrative. Consequently, this personal knowing is part of the co-constituted meanings ultimately interpreted within the research process of collecting and analyzing data. Although it is humanly impossible to be completely free of biases within the context of conducting qualitative research, I have reflected on my personal and professional biases so they could can be acknowledged and attempts made to look for ways "in which to break through or beyond them" (Strauss and Corbin, 1998, p.99).

In the following paragraphs of this section, I will provide my personal statement as a researcher. I will describe some of the experiences that have led me to this research and the issues that influenced my interpretation of the data. Ultimately, the data were primary but my understandings and insights about the data in relation to the research purpose and aims constituted the final product of this research, an interpretation made by me of the interpretations of the participants.
The impetus for the present research arose from several factors: (a) my experiences working as a registered nurse and later as a nurse practitioner; (b) my interest in social justice and promoting healthy lives for vulnerable groups, especially homeless youth; (c) my belief that facilitating humanization, meaning, choice, quality of life, and healing is the focus of nursing (Willis et al., 2008); and (d) my philosophical view of human beings as unfolding, or always in the process of being and becoming, with individual and collective identities rooted in past experiences that influence present and future identity, meanings, health, and well-being.

As I celebrate my twentieth anniversary as a nurse this year, what I cherish most in my career are the times that I have spent listening to my patients’ stories. During these occasions I was able to be truly present with them, caring in a way that was consistent with what I believe the discipline of nursing symbolizes. As a new graduate registered nurse working the night shift on an oncology floor at the National Institutes of Health Clinical Center, I had many occasions to sit with cancer patients who were receiving experimental chemotherapy treatments as a “last chance” because all other treatments had failed. I recall a 26 year old woman with breast cancer who shared her life story with me and the fear she had about dying and leaving her daughter. I also remember spending an entire shift with an 18 year old young man, monitoring him on a new drug regimen, and listening to his story about having lymphoma and his desire to “beat it” so that he could fulfill his dream of being a pediatrician. Later, in another nursing position, I had the honor of working at an inpatient hospice in Atlanta where all of the eight beds on the unit were dedicated to men who were dying of AIDS. Most of the patients were dying alone as their family members had “disowned” them and/or did not know where they were.
Often in the final hours of life, patients would share their story. Despite labored breathing, confusion, and other physical signs and symptoms of suffering, men would try to make sense of their life in order to find peace before they passed away. Once, while suctioning a patient who was choking on his oral secretions, actively dying, and nonverbal for several days, the man squeezed my hand, opened his eyes, and asked if he could tell me something. I stopped suctioning, sat down, and listened for 30 minutes to his story. He had been physically abusive for many years to his ex-wife and children, he was sorry, and he wished he would have received help. We sat in silence for a few minutes and then the patient passed away. I believe that having the opportunity to tell his story brought about some comfort to this patient. While the high dose narcotics and oxygen he was being given could only do so much to help ease his suffering, telling his story seemed to give him freedom and peace.

The above stories were among the first I heard as a nurse and they deeply affected me, forever changing my approach to nursing. I realized that being totally present with a patient and simply listening as they shared about their life and tried to make sense of who they is a meaningful nursing intervention, just as important as the more technical work that nurses are often known for doing.

In my recent work over the years with homeless youth, I have wanted to gain a better understanding of who homeless youth really are. In my role as a nurse practitioner, I’ve obtained comprehensive health and psychosocial histories, performed complete physical examinations, interpreted laboratory values, identified diagnoses and established treatment plans for each of the homeless youth. However, despite this level of knowledge about my patients, I have never felt like I truly knew them, like I should, as a
nurse. Although I had a sufficient amount of information about the population as a whole, I was not satisfied with the available research guiding my nursing practice because it was mostly pathologizing. I was disappointed to discover that there is relatively little literature focused on the strengths of homeless youth and their potential for experiencing health and well-being. There are very few interventions targeted at building upon their strengths to promote health or facilitating their humanization, meaning, choice, quality of life, and healing which is the central foci of the discipline of nursing (Willis et al., 2008).

For a long time I have wanted to hear the stories of homeless youth. I’ve been motivated to improve the care they receive by knowing who they are presently, who they used to be, and who they want to become. I believe that having knowledge of whom they are will allow me to care for homeless youth better and use what I know to teach others about humanistic care for homeless youth that is likely to be relevant for addressing their developmental, psychological, physical, social, educational, spiritual, and relational needs. Given the state of the science on humanistic care for homeless youth, discovery of new knowledge is called for that can serve as a foundation for the development, testing, and refining of acceptable and feasible health promoting interventions, and ultimately the determination of effective best practices and health and social policy initiatives that privilege homeless youths’ well-being and future potentials (Kidd, 2012).

In my encounters with other nurses, healthcare providers, and community stakeholders, I have observed that many people tend to express views that homeless youth don’t care about their future; that “homeless youth only live for today.” How do we know this? This question has strongly influenced my decision to conduct this
narrative inquiry of homeless youth and their time perspectives. For example, for some youth, tomorrow may be as far into the future they can consider. Does such a time perspective mean that they do not have a future? Another question that has motivated me to pursue this research is: What does ‘future’ mean to homeless youth and what is the significance of the meaning of the future for their health and health promotion? I have personally heard homeless youth describe how they live as “not just day to day, but hour to hour, or minute to minute”. They engage in behaviors for survival – to meet their physical, psychological, social, and emotional needs. While many of homeless youths’ actions are considered “wrong” or “deviant” by society, I have also heard these same youth discuss plans, hopes, and dreams for tomorrow, in a week, in a month, and in five years. My thought is that homeless youth often do not articulate the same time and health related perspectives as many healthcare providers do and as a consequence, the youth can be perceived by healthcare providers as not interested in improving their life or being healthy. I have heard many healthcare providers comment that essentially “They (homeless youth) are just not on the same page as we are.” However, I wonder if we as healthcare providers are not on the same page as them?

To answer my research questions I set out to obtain the stories of homeless youth and learn about their time perspectives (past, present, future) and the possible connection between their time perspectives and health and health promotion. Narrative inquiry methodology is a good fit with the research purpose and questions because it focuses on how individuals use stories to make sense of, give meaning to, and share their experiences (Duffy, 2007), thus providing for an understanding of past, present and future. From a nursing perspective grounded in the ideal and actions of ‘facilitating
humanization, meaning, choice, quality of life, and healing’, understanding a homeless youth’s views about a personal past, present, and future is relevant to health, health promotion, and the alleviation of undue suffering. Without understanding a person’s time perspective, it is difficult for the nurse, it could be argued impossible, to be able to assist the person in achieving an optimal state of health and well-being.

**Assumptions**

The basic assumptions that underlie this research are:

1. Homeless street youth possess personal strengths and resources.

2. Knowing a person’s story is the best way to truly gain an understanding of their experience.

3. While the survival lifestyle that is characteristic of homeless street youth suggests a time perspective focused on the present, with little regard for the future, this phenomenon has not yet been studied.

4. Understanding a person’s time perspective has important implications for health and health promotion.

**Theoretical Underpinnings**

In this research, it was important to maintain philosophical, theoretical, and methodological cohesion as a means of increasing trustworthiness of the results. Although some qualitative researchers maintain that their work is atheoretical, there’s much debate in the literature about this issue (Hanson, 1958; Speziale & Carpenter, 2011). In the present study, the influence of theory must be recognized. In the section that follows, I describe the philosophical views and theoretical underpinnings that
influenced this research. Narrative inquiry as a methodology will be described in chapter three.

**Epistemological Foundations**

Epistemology is the branch of philosophy concerned with the development and justification of knowledge (Schick, 2000). Epistemological assumptions concerning what constitutes knowledge, how knowledge is generated, and the criteria by which knowledge should be judged can powerfully influence the course of an inquiry and the nature of its product.

According to Merriam (1998), “Qualitative researchers are interested in understanding the meanings people have constructed, that is, how they make sense of their world and the experiences they have in the world” (p. 6). The theoretical underpinning of this research is narrative theory. This theory comes from a constructivist philosophical framework, specifically social constructivism.

**Constructivism**

Constructivism is compatible with the purpose and aims of this study because it emphasizes an individual’s own perspectives, experiences, and meanings. Social constructivism implies that meaning is created by human interaction with objects and people whom we encounter in the world. In the following section, a description of constructivism will be provided, followed by social constructivism.

Constructivism is best explained in terms of its ontology (beliefs regarding existence and reality) and its epistemology (assumptions about the nature and justification of knowledge). Constructivist ontology believes there may be an objective reality, but we cannot access it. Our only direct access is to our own perceptual and
conceptual worlds. According to von Glaserfeld (1991), the world that we experience is the world we construct. The observer is simultaneously constructing his or her account of reality while at the same time is transforming reality and his or her self (Fosnot & Perry, 2005). Constructivist epistemology has been described as ‘pragmatic’ (von Glaserfeld, 1991). Rather than seeking justification of knowledge by correspondence to an objective reality, a constructivist approach evaluates knowledge by its functionality and utility (von Glaserfeld, 2005).

Constructivism is based on key assertions about how knowledge and meaning are generated. Constructions are internal mental representations of knowledge and meaning that are actively created by the individual based on his or her experience. Thus, knowledge and meaning are constructed by individual persons as acts of interpretation (Steedman, 1991) and pre-existing constructions profoundly influence how new knowledge and meanings are constructed (von Glaserfeld, 1991). Identity is a special case of construction: one’s identity consists of one’s constructions of self. Adaptation is the process by which internal representations are reconstructed when experience conflicts with existing constructions (Fosnot & Perry, 2005; von Glaserfeld, 2005).

Constructivism was formulated in response to critical problems with positivism and realism. According to positivism, no statement has meaning unless it is objectively verifiable (Schick, 2000). Realism holds that there is an objective reality independent of the observer, and that the aim of science is to accurately represent this reality (Schick, 2000). Together, positivist and realist assumptions formed the basis of most scientific inquiry through the 19th and early 20th centuries. By the mid-20th century, positivism and realism were subject to increasing criticism. Hanson (1958) argued that there is no such
thing as atheoretical observation, an argument that undermined realist notions of scientific objectivity. Beliefs held by Kuhn (1970) were also influential. His views about scientific paradigms; the way paradigms structure the socialization of scientists and define the kinds of questions scientists investigate; and his observation that there is no way to choose rationally between alternative paradigms undermined the absolutism of positivist and realist epistemologies.

**Social Constructivism**

Social constructivism is a type of constructivism that emphasizes the importance of social context and culture for understanding what occurs in society and constructing knowledge grounded in this understanding (Derry, 1999). Specific assumptions about reality, knowledge, and learning provide a basis for applying social constructivism to research. Social constructivists believe that reality is constructed through human activity. Together, members of a society create the properties of their world (Kukla, 2000). Reality cannot be discovered; it does not exist prior to its social invention. To social constructivists, knowledge is also a human product, and is socially and culturally constructed. Individuals create meaning through their interactions with each other and with the environment they live in. Finally, in social constructivism, learning is viewed as a social process. The most meaningful learning occurs when individuals are engaged in social activities (McMahon, 1997).

A major advantage of using social constructivism as a basis for homeless youth research is its philosophical commitment to the unique perspectives and social contexts of a population who lack voice in society. An inquiry founded on this philosophy represents
and preserves what is most significant to the participants, and is less likely to reflect the researcher’s preconceptions and those of others who are not the participants.

**Narrative Theory**

In this study, narrative is recognized in two ways; as a phenomenon useful for understanding life as temporal experience, and as a qualitative research methodology (Clandinin & Connelly, 2000). Conceptually, narrative is the structured quality of the experience studied, or the "story”. Narrative inquiry is a methodology for studying “stories lived and told” (Clandinin & Connelly, 2000, p. 20). In the following section, I will describe narrative as a conceptual framework, drawing on the ideas of Dewey (1933) and Clandinin and Connelly (2000).

Individuals tell stories; nature and the rest of the world do not. How individuals tell their stories, what they say or do not say, and the connection that people make with their audience all become part of their narrative. When experiences are framed in the form of stories or narratives, their meanings and reality are revealed to both the storyteller and the audience. The personal narrative is used by people to construct identities and promote how they want to be known (Rosenwald & Ochberg, 1992). We cannot know "the ultimate essence of things," but only that which we perceive (Sternberg, 1998, p. 18). All we can know is the reality that we construct. Therefore, reality is best expressed in the structure of a story (Sternberg, 1998).

John Dewey’s (1933) idea of continuity in experience explains how human experience unfolds into further experiences on a temporal continuum. Current experience does not exist in isolation, but grows out of our past. According to Dewey (1938), "In a certain sense, every experience should do something to prepare a person for later
experiences of a deeper and more expansive quality" (p. 47). Therefore, experiences appreciated in the present are those that are in continuity with past and future.

Drawing on the work of Dewey (1933), Clandinin and Connelly (2000) describe a metaphorical "three-dimensional inquiry space" (pp. 2-3, 60) as a way to understand narrative and the experiential continuum of past, present, and future in relation to a particular situation and social interaction. They define this three-dimensional space as "temporality along one dimension, the personal and social along a second dimension, and place along a third dimension" (p. 50). “Narrative threads coalesce out of the past and emerge in the specific three-dimensional space we call our inquiry field” (Clandinin & Connelly, 2000, p. 70).

Clandinin and Connelly (2000) further describe the qualities of experiences that inform narrative:

...inward and outward, backward and forward. By inward, we mean toward the internal conditions such as feelings, hopes, aesthetic reactions and moral dispositions and so on. By outward, we mean toward the existential conditions, that is, the environment. By backward and forward we refer to temporality - past, present, future.... to experience an experience - that is, to do research into an experience - is to experience it simultaneously in these four ways and to ask questions pointing each way. (p. 50)

In summary, narrative theory, as influenced by social constructivism, maintains that realist assumptions from natural science prove limiting for understanding social life (Riessman, 1993). This concept implies that multiple realities exist. Research that is guided by these ideas ascribes to the notion that there are truths that are held by the
participants, truths of the researcher, and truths held by those who are interpreting the results of a study. By thinking about narrative as existing in a three-dimensional space and being influenced by experiences moving inward, outward, back and forth, inquiry is deeply contextual, never static, and always shaped by what has happened and what will happen next (Clandinin and Connelly, 2000).

**Ecological Model**

In addition to social constructivism and narrative, this study on homeless street youth is influenced by the ecological model. Ecological models increase understanding about the nature of people’s transactions with their physical and sociocultural surroundings (Stokols, Grzywacz, McMahan, & Phillips, 2003). From an ecological standpoint, behavior is multifaceted. This position considers the environment and its relation to individuals at numerous levels, including intrapersonal (biological, psychological), interpersonal (social, cultural), organizational, community, physical environmental, and policy as potential sources of influences on behavior and decision making (Glanz, Lewis, & Rimer, 1997; McLeroy, Bibeau, Steckler, & Glanz, 1988).

In particular, ecological models have been useful to nursing and other health sciences for providing comprehensive frameworks for understanding the multiple and interacting determinants of health behaviors (Sallis, Owen, & Fisher, 2008). Ecological models propose that health is not only a function of individuals but also of the environments in which they live.

Applying an ecological model to narrative inquiry research aimed at understanding homeless street youth, their time perspective, and how time perspective might influence their health and health promotion is necessary for several reasons. First,
environment is a relevant concern for a population who live unsheltered, on the streets, engaging in risky survival strategies that compromise health. According to the ecological model, the decisions and behaviors of homeless street youth are a result of the interaction of many factors that cannot be well understood without viewing the context in which the decisions and behaviors occur (Grzywacz & Fuqua, 2000). Secondly, time perspective has been identified as an important intrapersonal factor that influences all of human behavior (Zimbardo & Boyd, 1999). Therefore, in order to understand the time perspectives of homeless youth, a comprehensive model, such as the ecological model is needed (Sallis et. al, 2008). In addition, ecological models reflect the holistic values of nursing and can inform research and interventions more effectively by systematically targeting mechanisms of change at many levels of influence. Finally, integrating individual and external levels of influence in a single framework adds strength to the argument that causes of behavior are usually multifactorial, not limited to one source. Applying an ecological model to vulnerable populations, such as homeless youth, helps to reduce the tendency to blame victims for harmful behaviors and may, perhaps in some way, contribute to greater human dignity (Sallis et al., 2008).

Significance to Nursing

The American Nurses’ Association Social Policy Statement posits that the goals of nursing are “to protect, promote, and optimize health; to prevent illness and injury; to alleviate suffering; and to advocate for individuals, families, communities, and populations” (ANA, 2010, p. 11). Additionally, the discipline’s focus on facilitating humanization (Willis et al., 2008) and holistic and culturally competent caring (Benner & Wrubel, 1989; Leininger, 1984; Oulton, 2000; Saewyc, 2000; Swanson, 1993; Watson,
2002) indicates that nursing is well suited to be a leader in the healthcare of homeless youth. However, due to the complex causes and consequences of youth homelessness, as well as a lack of effective interventions, more knowledge of this population is needed. According to Rew (2008), efforts to improve health in the homeless youth population are needed and should focus on increasing knowledge about the population that can support health promoting behaviors. Using narrative inquiry, this study is aimed at understanding the time perspectives of homeless street youth through their storied experiences. This information is necessary to improve nursing care and will provide valuable insight that lays the foundation for future nursing research. Research regarding homeless youth is needed for multiple reasons: to develop evidence-based interventions with regard to health promotion that will improve youths’ overall health status and quality of life; and to develop prevention and early intervention strategies that will reduce youths’ risk of ever becoming homeless or remaining chronically homeless (Rew, 2008; Toro et al., 2007).

**Summary**

Homeless youth constitute a large and vulnerable group that suffers from poor health and engages in risky behaviors for survival. This study addresses a gap in the scientific literature by providing a rich understanding of homeless street youth, specifically with regard to their time perspective, and the connection it may have on their health and health promotion. A narrative inquiry methodology was used to analyze the stories of thirteen homeless street youth. Storytelling allows people to understand their past, present and future and is considered a primary way by which people make sense of, give meaning to, and share their experiences (Duffy, 2007).
A thorough review of the literature pertaining to homeless youth and time perspective is provided in chapter two. The methodology for this study, including a detailed description of narrative analysis, is described in chapter three. Chapter four contains the research results – the stories of homeless youth participants and an analysis of story similarities and uniqueness. A discussion of the results, implications, and suggestions for future research are presented in chapter five.
CHAPTER 2: REVIEW OF THE LITERATURE

In this chapter, the literature on essential topics to support the study of homeless street youth and time perspective will be reviewed. A historical perspective of youth homelessness is provided first, followed by population estimates and definitions relevant to youth homelessness. Characteristics of the homeless youth population are described and include studies focused on physical and psychosocial health, survival strategies, and victimization. Finally, the strengths and resources of homeless youth are described.

Time perspective is then reviewed in the chapter including historical and theoretical developments, time perspective measurement, and studies examining the relationship between time perspective and health. The chapter concludes with a review of the pertinent literature on adolescent development and adolescent time perspective.

Youth Homelessness

Historical Perspective

Prior to 1974, youth who ran away from home and lived on the streets were considered criminals. The problem was viewed narrowly as “a form of delinquency characterized by disobedience and acting out” (Hyde, 2005, p. 172). Although significant strides have been made to address the problem of runaway and homeless youth in the US during the last 40 years, homelessness in this age group is not unique to our society. Going as far back to the nation’s earliest history, youth have been homeless (Smollar, 1999).

Since the initial immigration to North America and settlement of the “Wild West”, adolescents and young adults have left home to escape family problems or seek independence, excitement, and opportunity for economic advancement (Libertoff, 1980;
Wells & Sandhu, 1986). Nineteenth century literature depicts youth that were forced to leave their families because of circumstances such as poverty, abuse, neglect, and exploitation, as well as rejection from the workforce due to immigrant status (Bremner, 1974; DeMause, 1988).

During the Great Depression of the 1930s, when homelessness was prevalent across the entire population, a significant number of teens left home with the approval of their struggling parents, often hopping freight trains to find work or for mere adventure (Libertoff, 1980). At the height of the Depression, it is estimated that 250,000 young “hoboes” were roaming America (Uys, 2003). In fact, transient adolescents were a target group of the Federal Emergency Relief Administration of 1933 under President Roosevelt that provided state assistance during this challenging time in our country’s history (Bradley, 1997).

The 1960’s “hippie” movement inspired a new group of homeless individuals to emerge. Rejecting popular political, social, and cultural norms, youth and young adults left middle and upper class homes and became “flower children”. In this subculture, they could experiment with alternative life styles involving drugs, sex, music, and transient living arrangements on the streets, out of vans, or on the couches of acquaintances (Gurvis, 2006; Smollar, 1999).

It was not until the early 1970’s, when the number of runaway and homeless youth grew, that there was national attention focused on the welfare of the population. During this time it was reported that approximately one million youth had left home without the permission of parents or guardians (Cooper, 2006) and 40 to 60% were estimated to have fled “to escape a growing epidemic of once unspeakable crimes—
incest and child abuse” (“Why Children are Running Away in Record Numbers?,” 1977, p. 72). As a result of the increasing problem, two historical pieces of legislation were passed: 1) the 1974 Juvenile Justice and Delinquency Prevention Act (JJDPA) that established a system to provide financial help to states to improve treatment for at-risk youth and 2) the Runaway Youth Act (RYA) (as Title III of the JJDPA) that provided assistance to youth who had run away from home (Cooper, 2006). By 1976, an estimated two million young Americans had run away, double the number reported five years earlier (“Why Children are Running Away in Record Numbers?,” 1977). In 1977, the Runaway Youth Act was expanded and renamed the Runaway and Homeless Youth Act (RHYA) (Cooper, 2006; Moses, 1978).

Since the 1970s, there has been a constant increase in the number of homeless youth (Cooper, 2006; Smollar, 1999). Family disintegration and dysfunction have been cited as the main reasons for this increase (Paradise & Cauce, 2002; Rew, 2008). Subsequent revisions of the laws described above have led to the expansion of services and creation of critical new programs to help this vulnerable population. These programs include the following: Transitional Living Program of 1988, for older homeless youth; Street Outreach Program of 1994, to help youth living on the streets; and the Runaway, Homeless and Missing Children Protection Act (RHMCPA) of 2003 that reauthorized and amended RHYA and the Missing Children’s Assistance Act (Cooper, 2006).

Population Estimation

Youth homelessness is a distressing national social problem occurring in all communities – urban, suburban, and rural (Martinez, 2006; Robertson & Toro, 1999; Toro et al., 2007). Unfortunately, precise numbers of the total population do not exist.
At any given time, estimates in the US of the number of runaway and homeless youth are between 500,000 and 2.8 million (Cooper, 2006). Homelessness among young persons is considered more common than for older adults (Ringwalt, Greene, Robertson, & McPheeters, 1998). According to Robertson and Toro (1999), the age group most at risk of becoming homeless in the US may be the youth.

Empirical evidence about the prevalence and incidence of youth homelessness varies widely (Greene et al., 2003). Challenges in studying this population, due in large part to homeless youths’ marginalized status, have resulted in population estimation and sampling methods that are limited and flawed (Greene et al., 2003; Toro et al., 2007). Factors associated with this problem are summarized below.

First, one of the main problems with identifying the population of homeless youth is defining who they actually are. Because homelessness is such a complex problem in all age groups, especially for youth, there are a multitude of terms and criteria that are used by governmental agencies, researchers, and advocacy groups, as well as the youth themselves. These definitions often overlap and, in some cases, are contradictory (Ensign & Bell, 2004). In addition to being called homeless youth, individuals may be classified in a number of ways such as runaways, throwaways, street kids, couch-surfers, unaccompanied minors, homeless adolescents, corrections youth, and systems youth (National Network For Youth [NN4Y], 2010; National Runaway Switchboard [NRS], 2010; Thompson, Safyer, & Pollio, 2001; Toro et al., 2007). Other terms used by homeless youth to self-identify have been noted by this author in recent clinical experience: “drifter”; “squatter”; “nomad”; “worker” (sex industry worker); “camper”, and “a nobody”. 
Another problem affecting population estimation is that the age range used to identify youth who are homeless varies causing further definitional confusion (Greene et al., 2003; Toro et al., 2007). While the term “youth” is often synonymous with “adolescent”, the age of adolescence spans 11 years and is divided into three stages (early 10-13 years; middle 14-17 years; late 18-21 years) (Rew, 2005). The United Nations (UN) (2010) defines “youth” as people between the ages of 15 and 24 years. Further distinctions by the UN are made for teenagers (13-19 years) and young adults (20-24 years). Toro et al. (2007) use a definition of “homeless youth on their own” between the ages of 12 and 25 (p.3). In summary, without a single, explicit definition that is inclusive of all homeless youth, it is impossible to accurately know the size of the population (Greene et al., 2003; Staller & Kirk, 1997). A more complete discussion of definitions pertaining to homeless youth is provided later in this chapter.

In addition to problems with defining homeless youth, population estimation and sampling methods are affected by the fact that the majority of these youth are considered “hidden” (Raleigh-DuRoff, 2004). Their concealed status is due to two factors. First, homeless youth cannot be differentiated from the general youth population by appearance alone. Second, this group is highly mobile. They spread through communities typically unnoticed and may not stay in one place long enough to be surveyed (Greene et al., 2003; Link et al., 1995; Raleigh-DuRoff, 2004).

Overall, the usual methods of counting the homeless population tend to be biased toward identifying adults and families who are chronically homeless, non-transient, and staying in shelters (Greene et al., 2003). In contrast, youth experiencing homelessness are typically unsheltered and living on the streets because very few shelters exist for this
age group (National Coalition for the Homeless [NCH], 2007). This is the case even in large cities where there are a significant number of homeless youth. For example, in Boston there are hundreds to thousands of youth living on the streets and only one emergency shelter available (with a maximum stay of 72 hours only) (G. Perchik, personal communication, September, 2010).

Instead of going to shelters, youth who are homeless tend to gather in places that are not generally used in traditional survey methodologies such as the streets, subway and bus stops, and abandoned buildings (Greene et al., 2003; Toro et al., 2007). Data on youth homelessness that is based on shelter census, therefore, is not representative of the total population (Thompson, Pollio, Constantine, Reid, & Nebbitt, 2002). Likewise, point prevalence methods, that identify a certain point in time (usually a typical day) to estimate the number and characteristics of individuals, are not an accurate measure for a highly transient population such as homeless youth (Greene et al., 2003).

Lack of trust among homeless youth is another factor affecting accurate estimation of the population. Youth may avoid interviewers or not admit to their homeless status for fear that people who approach them may be from criminal justice or social service agencies (Ringwalt, Greene, & Robertson, 1998; Taylor, Lydon, Bougie, & Johannsen, 2004). Legally requiring parental consent for homeless youth to participate in research is also a barrier to obtaining accurate estimates of the population (English, 1995). Rew, Taylor-Seehafer, and Thomas (2000) warn that because many homeless youth come from families that were abusive, obtaining parental consent may compromise safety. Interestingly, despite the fact that some youth do self-identify as being homeless and are willing to be interviewed by researchers and other advocates, information
obtained is not always properly relayed because of concern about confidentiality and potential adverse consequences related to homeless youths’ identification (Kidd & Scrimenti, 2004).

Finally, studies of homeless youth tend to be conducted in urban areas (Greene et al., 2003; Link et al., 1994). Whereas homeless youth exist in all geographic areas, data obtained only from large cities is not representative of the total population. The challenges in conducting homeless youth research described above have led to inaccurate estimations about the size and characteristics of the population (Greene et al., 2003; Ringwalt, Greene, Robertson, McPheeters, 1998). Still, existing evidence suggests that the population of homeless youth is large and growing (Rew, 2002; Toro et al., 2007).

A 1995 study conducted for the US Department of Health and Human Services reported that 2.8 million youth ages 12 to 17 years experienced at least one runaway episode (Greene, Ringwalt, Kelly, Iachan, & Cohen, 1995). To date, this is the highest number that has been identified in the US literature. In the US, statistics for homeless youth are estimated by the National Incidence Studies of Missing, Abducted, Runaway, and Thrownaway Children (NISMART), conducted by the Office of Juvenile Justice and Delinquency Prevention, US Department of Justice (Flores, 2002). The most recent study, the NISMART-2, was published in 2002. Based on data collected in 1999 from three different surveys (National Household Survey of Adult Caretakers, National Household Survey of Youth, and Juvenile Facilities Study), this study estimated that 1,682,900 youth nationwide were missing due to a runaway or throwaway episode. The majority of these youth (68%) were 15 to 17 years old and overall there were equal numbers of males and females (Hammer et al., 2002).
Ringwalt and colleagues analyzed data collected as part of the Youth Risk Behavior Survey (YRBS) from approximately 6,500 youth who were ages 12 to 17. They found that roughly 7.6% had been homeless for at least one night during the past 12 months (Ringwalt, Greene, Robertson, & McPheeters, 1998). This figure is equal to approximately 1.6 million homeless youth each year (Toro et al., 2007) and consistent with the NISMART-2 results.

A later study supported by the Substance Abuse and Mental Health Services Administration (SAMHSA) reported similar figures as well (Office of Applied Studies, 2004). Based on data from the 2002 National Survey on Drug Use and Health, it was estimated that 1.6 million youth (7% of the entire population) ages 12 to 17 ran away from home during the past 12 months and slept on the streets. Runaways were more likely to be male (55%) than female and almost half (46%) were ages 16 or 17 (Office of Applied Studies, 2004).

The most recent data available on the homeless youth population are from the National Runaway Switchboard (NRS), a federally designated national communication system for runaway and homeless youth. The 2010 NRS Crisis Caller Trends Report documented crisis calls from 2000-2009. The number of homeless youth calling NRS has been increasing every year since 2000. In 2009, calls increased 98.9% from 739 calls to 1,470 calls (Benoit-Bryan, 2010).

Definitions of Youth Homelessness

Homeless youth are a heterogeneous population. A wide variety of terminology and definitional criteria based on backgrounds, pathways to homelessness, and other factors are used by government, advocacy agencies, and researchers to describe this
group. The large number of labels suggests the complexity of the problem (Staller & Kirk, 1997) and makes it difficult to deliver optimal services and determine funding necessary to care for this vulnerable population.

Most often, “homeless youth” is an overarching term for a diverse group of adolescents and young adults who lack regular housing. The one characteristic that homeless youth have in common is that they are “unaccompanied”, meaning that they are on their own without the supervision of an adult caretaker (Haber & Toro, 2004). Additionally, homeless youth can be differentiated from two other homeless populations: single adults, who do not have children in their custody; and homeless families, typically comprised of a mother and her children (Toro et al., 2007). Historically in the US, relatively few homeless families (12 to 20%) included children age 12 or older (Buckner, Bassuk, Weinreb, & Brooks, 1999; Burt, Aron, Lee, & Valente, 2001), and children under age 12 were rarely found homeless on their own (Robertson & Toro, 1999). However, due to the recent economic crisis, the profile of homeless families and children may likely be shifting.

In addition to being unaccompanied, homeless youth tend to fit into one or more of the following descriptions: a “runaway” who has left a dangerous or undesirable home; a “throwaway” whose parents or guardians forced them to leave home; a “former foster” youth who has aged out of foster care with no place to go; and a “systems” or “correctional” youth who has been in the care of child protective services or the juvenile justice system. Youth may also be identified according to where they usually reside or hang out such as the street, shelter, or episodically at the homes of friends and acquaintances as a “couch surfer” (Thompson et al., 2001; Toro et al., 2007).
There is no single federal definition of “homeless youth”. However, the Runaway and Homeless Youth Act (RHYA, 42 U.S.C. 5601 note) (Title III of the Juvenile Justice and Delinquency Prevention Act of 1974, as last amended by the Reconnecting Homeless Youth Act of 2008 (P.L.110-378 ) is cited most often. The RHYA defines “homeless youth” as individuals under age 18 who are unable to live in a safe environment with a relative and who lack safe alternative living arrangements, as well as individuals ages 18 to 21 years without shelter (U.S. Department of Health and Human Services, 2008). The RHYA defines “street youth” as an individual who is a runaway youth; or indefinitely or intermittently a homeless youth; and spends a significant amount of time on the street or in other areas that increase the risk to such youth for sexual abuse, sexual exploitation, prostitution, or drug abuse. (U.S. Department of Health and Human Services, 2008, SEC. 387.)

Another statutory definition of homeless youth is provided by the McKinney-Vento Homeless Assistance Act, the primary piece of federal legislation dealing with the education of students experiencing homelessness (U.S. Department of Education, 2004). The Act defines an unaccompanied, homeless youth as a youth whose living situation is not “fixed, regular, and adequate,” and who is not living in the physical custody of a parent or guardian. It provides examples of living arrangements that would be considered homeless including: living on the street; in a car, abandoned building, bus station, or emergency and transitional shelters; or living doubled-up with others (National Association for the Education of Homeless Children and Youth, 2008; U.S. Department of Education, 2004).
When defining the homeless youth population, NN4Y (2010) uses the term “unaccompanied youth” and includes children and youth through age 17 who are living apart from their parents/guardians and young adults ages 18 to 24 years who are economically and/or emotionally detached from their families and experiencing homeless situations. Unaccompanied youth are further classified as runaway, homeless, and street youth using similar definitions previously described above. Additionally, NN4Y (2010) describes “thrownaway” youth as children who were directly told to leave the household; abandoned or deserted; not allowed to return to home after leaving for any reason; or actual runaways but their parents or guardians made no effort to find them. It’s important to note that NN4Y (2010) does not routinely use the term “thrownaway” because of its disparaging nature, unless they are quoting directly. Instead, the terms “expelled youth” or “pushed out youth” are often used.

One of the most comprehensive definitions of homeless youth can be found in the nursing literature. According to Taylor-Seehafer et al. (2007):

Homeless youth are adolescent males or females under the age of 18 years from every racial/ethnic background who, lacking a fixed, regular, and adequate nighttime residence, live with friends or acquaintances, in shelters or other system-based institutions, in unstable residences, or on the street; they often are called “unaccompanied youth” (p. 38).

Limitations to this definition exist, however. Because young adults who are age 18 and a few years older are omitted, they may go unidentified and not be able to access appropriate services, inevitably “falling through the cracks” (J. Kaplan, Director of Youth Outreach, personal communication, February, 2010).
The many definitions of homeless youth described above may be useful for the purpose of enacting laws, providing services, and conducting research. However, hearing how homeless youth view and label themselves, in their own words, is critical for understanding this population and partnering with them to improve their health (Freire, 2000; Jolly, Weiss, & Liehr, 2007; Rew, 2008).

Recent research conducted by the NRS (2010) highlights the problems of defining or labeling homeless youth. In the study, individual interviews \( N = 83 \) with runaway homeless youth between the ages of 14 and 17 years took place in Chicago \( n = 40 \) and Los Angeles \( n = 43 \) from October, 2008 to January, 2010. Participants resided in shelters \( n = 40, 20 \) at each location or lived predominantly on the street \( n = 43 \). Only half of the youth interviewed, who reported that they indeed ran away, actually considered themselves a “runaway”. One-third considered the term “runaway” to be an accurate description of their behavior, but stated that the term was judgmental and suggested that they were a bad person and someone who did not appreciate having a home and family. Younger youth and males were more likely to consider themselves as runaways than older youth and females. Heterosexual youth identified with the label runaway significantly more often than lesbian, gay, bisexual, transgender, or queer/questioning (LGBTQ) youth. Those who considered themselves “thrown out” did not consider themselves as runaways. Similarly, only half of those who described their episode as a combination of running away and being thrown out, considered themselves as a runaway (NRS, 2010).

When asked to describe themselves, runaway homeless youth who participated in the NRS (2010) study provided close to 30 terms and statements. These descriptions
support the diversity of views among homeless youth and include the following terms: a lost child in need of help; a person that needs space; a rebellious teenager; a runaway with permission; an independent person; drifter; gypsy; homeless; I feel like I wasn’t accepted; I was disowned; living on my own; lock out; looking for a better chance; neglected; squatter; street kid; traveler; and vagabond (NRS, 2010).

**Factors Influencing Youth Homelessness**

Youth homelessness appears to affect both genders equally. In the most recent federal study, the NISMART-2, researchers found that among a sample of greater than 1.6 million homeless youth nationwide, equal numbers of males and females were represented (Hammer et al., 2002). Between 20 and 40% of all homeless youth identify as GLBTQ (Ray, 2006). Most often, family conflict over a youth’s sexual orientation or gender identity is a significant factor that related to homelessness (Clatts, Davis, Sotheran, & Atillasoy, 1998). However, there are other causes of homelessness among youth and these will be described in the following section.

Youth leave home willingly or are forced out (thrownaway) often because of family conflict (Rew, 2008). Paradise and Cauce (2002) have identified a process of “familial disintegration” beginning in homeless youths’ early childhood involving poor parenting habits, an unstable or unhealthy family environment, and violence. Youth describe environments of disorganization, dysfunction, neglect, and violence including physical, sexual, and emotional abuses (Hyde, 2005; Martijn & Sharpe, 2006; Martinez, 2006; Rew, 2008; Safyer, Thompson, Maccio, Zittel-Palamara, & Forehand, 2004; Thompson & Pillai, 2006). Antecedents include the following: frequent arguing; independence and control issues; substance use and abuse; changes in family structure;
sexual activity and sexual orientation; pregnancy; school problems; and behavioral and mental health disorders (Fernandes, 2007; Hyde, 2005; Mallett, Rosenthal, & Keys, 2005; Martinez, 2006; Rew, Whittaker, Taylor-Seehafer, & Smith, 2005; Thrane, Hoyt, Whitbeck & Yoder, 2006; Tyler, 2006, Tyler & Cauce, 2002).

There is a strong correlation between physical and sexual abuse of youth and their subsequent homelessness (Bao, Whitbeck, & Hoyt, 2000). Approximately 15 to 60% of adolescents who are homeless have experienced parental physical violence (Haber & Toro, 2004). In an ethnographic study of 50 homeless youth ages 18 to 23 years, Hyde (2005) found that most youth left home due to severe family threat and physical abuse. Over 20% of youth in the NISMART-2 reported being physically or sexually abused at home in the prior year or feared abuse upon returning home (Hammer et al., 2002). In a study by Ryan, Kilmer, Cauce, Watanabe, & Hoyt (2000) that used a nonprobability sample of 329 homeless Seattle adolescents, 22% of participants identified nonviolent conflict as the reason for leaving home. Other reasons were violence (18%), physical abuse (11%), neglect (10%), a family member’s drug use (5%), and sexual abuse (4%).

As stated previously, sexual orientation appears to be a factor in youth homelessness. Whitbeck, Chen, Hoyt, Tyler, & Johnson (2004) studied 428 runaway and homeless adolescents across 4 Midwestern states. Adolescents who self-identified as gay, lesbian, or bisexual were thrown out of their homes due to conflict over sexuality or sexual behaviors more often than heterosexual participants. Ginsburg et al. (2002) found that more than one third of youth who were experiencing homelessness, or in the care of social services, reported a history of being physically assaulted by a family member due to disclosing their sexual orientation as gay, lesbian, or bisexual.
It is not surprising that economic issues play a role in youth homelessness. Homeless youth are likely to come from low-income or impoverished families and communities (Sanchez, Waller, & Greene, 2006; Thompson, Kost, & Pollio, 2003; Wolfe, Toro, & McCaskill, 1999) where a high incidence of parental unemployment has been noted (Hagan & McCarthy, 1997). Robert, Pauze, & Fournier (2005) warn against misinterpreting risk factors for youth homelessness as solely related to being homeless when they might be more appropriately attributed to an impoverished family background. In a comparison between samples of homeless adolescents and non-homeless adolescents from impoverished family backgrounds, both groups were found to have dysfunctional family backgrounds. However, a greater proportion of homeless participants cited family-related adversity, such as conflict and violence. In addition, the homeless sample had a greater number of behavioral disorder diagnoses (Robert et al., 2005).

Residential instability has also been cited as a contributing factor to youth homelessness. First, families of homeless youth tend to experience more residential moves than those of their housed peers (Hagan & McCarthy, 1997; Toro et al., 2007; Toro & Goldstein, 2000). In addition, while there is no known research regarding an association between the number of individual foster care placements and youth homelessness, it is known that many homeless youth are currently and formerly part of the foster system (NCH, 2007; NN4Y, 2010) and have experienced multiple residential placements. Finally, according to Wright, Rubin, & Devine (1998), living “doubled-up” or couch-surfing is one of the stages of residential instability that can lead to a total lack of housing and life on the streets.
The longer youth are on the streets, the more likely they are to suffer negative consequences. Length of homelessness appears to be related to the places youth predominantly stay while homeless. Ensign and Bell (2004) found significant differences between youth on the streets and in shelters. For street youth, the average length of homelessness was three years (range 1 month to 3 years), and for sheltered youth, the average was four months (range 1 to 9 months). Given the extraordinarily high number of homeless youth, coupled with the fact that most of these youth are unsheltered (Wilder Research, 2005), it is easy to see why poor health is so prevalent within this population.

According to the NRS (2010), assault, illness, and suicide claim the lives of approximately 5,000 runaway and homeless youth every year. It is well known that youth experiencing homelessness have poor access to healthcare and increased incidence of acute and chronic illness, early pregnancy, sexually transmitted diseases, and HIV (Bontempo & D’Augelli, 2002; Ensign, 2000; Greene & Ringwalt, 1998; Rew, 2008). In addition, homeless youth appear to be at elevated risk for a variety of mental health problems, including mood disorders, suicide attempts, and post-traumatic stress disorder (Cauce et al., 2000; Haber & Toro, 2009; Stewart et al., 2004). According to Rew (2008), factors related to the health status of homeless youth may be related to both the causes and consequences of their homeless lifestyle.

Consistent with the overall homeless population, homeless youth suffer from increased rates of health problems (Rew, 2008; Taylor et al., 2004) and yet almost half do not have a regular source of healthcare (Sneller et al., 2008). Conditions such as traumatic injuries, infectious disease (including HIV, hepatitis B and C, and other sexually transmitted infections), dermatologic disorders, sleep disorders, and unplanned
pregnancy are common (Halcon & Lifson, 2004; Toro et al., 2007; Van Wormer, 2003). Poor diet, diminished sleep, substandard hygiene practices, and victimization are factors that impact the status of homeless youths’ health as well (Martinez, 2006; Rew, 1996). It is generally understood that homeless youth encounter many, if not all, of the same risks as homeless adults. For example, given that TB rates are up to 20 times higher for homeless individuals than for the general population, the risk is significant for homeless youth (Brewer et al., 2001).

Decreased access to healthcare is another factor affecting the health status of homeless youth. In addition to not having insurance, barriers such as insufficient knowledge of healthcare resources, lack of transportation, distrust of healthcare providers, and fear of social service agency notification and legal consequences have been documented in this population (Ensign & Panke, 2002; Geber, 1997; Klein et al., 2000).

Youth experiencing homelessness suffer from high rates of mental health problems. Depression, mood disorders, post-traumatic stress, self-harm suicide, aggressive, and delinquent behaviors, conduct disorder, and poor school adjustment have been identified in the literature (Haber & Toro, 2009; Kidd, 2003; Moskowitz et al., 2012; Thompson et al., 2002). Furthermore, mentally ill homeless youth who use alcohol and drugs, as well as those who engage in risky sexual practices, are known to face additional negative psychological effects (Stanton, Kennedy, Spingarn, & Rotheram-Borus, 2000).

In a longitudinal study of 428 runaway adolescents in the Midwest conducted by Whitbeck, Johnson, Hoyt, & Cauce (2004), the risk of having two or more mental health
disorders was six times higher than a national representative sample of youth. Cauce et al. (2000) examined mental health disorders in the homeless youth population. They found that post-traumatic stress disorder was identified in close to 24% of females and 16% of males. In addition, Klee & Reid (1998) found that 82% of homeless youth and young adults, ages 14 to 25 years, reported psychological symptoms including severe and chronic depression, anxiety, and aggression. In addition, 43% reported that they had attempted suicide at least once.

Runaway and homeless youth often have a constellation of behavioral, emotional, and family problems that contribute to stress and maladaptive behaviors, which, in turn, can lead to self-harming and suicidal behaviors (Moskowitz et al., 2012). Moskowitz and colleagues (2012) examined the mediating roles of stress and maladaptive behaviors on self-harm and suicide attempts among homeless youth in a sample from Los Angeles County \( N = 474 \), age 12–24, 41% female, 17% White, 32.5% African American, 21.5% Hispanic/Latino). Females and LGBTQ youth were more likely to have self-harmed and to have attempted suicide than males and heterosexual youth, and younger participants reported more self-harming than older youth.

While risk-taking in adolescence is a normal developmental process (Romer, 2003), living a homeless lifestyle can increase the frequency and severity of unsafe behaviors (Busen & Engebretson, 2008; Martinez, 2006; Toro et al., 2007). It has been suggested that the primary need of homeless youth is survival (Dachner & Tarasuk, 2002; Fest, 1998; Rew, 2008). The general meaning of survival is to remain alive. Although survival has not been operationalized in the homeless literature, it is commonly used to describe an individual’s efforts to obtain basic needs including food, clothing, shelter,
medical care, and personal hygiene (Dachner & Tarasuk, 2002; Greenblatt & Robertson, 1993).

The majority of homeless youth, alienated from the dominant culture, have developed a marginalized subculture that guides life and survival on the streets (Oliveira & Burke, 2009). Culture is a significant aspect of context and has been described as a community and individual resource, a potential source of strength, and a buffer against the effects of marginalization and lack of access to vital resources (Trickett, 1996). Often, the culture of youth homelessness includes the formation of street families who provide social capital and instruction on survival strategies (Oliveira & Burke, 2009; Smith, 2008).

Given the limited resources of homeless youth, daily survival strategies typically involve adopting “deviant” behaviors to meet physical, safety, economic, and emotional needs (Shane, 1996). The survival strategies of homeless youth include the following: panhandling; dumpster diving (obtaining food from dumpsters); selling drugs; prostitution (commonly referred to as “survival sex”) and commercial sex industry work (stripping, pornography, etc.); participating in scams/cons; stealing; mugging; and selling stolen goods (Kipke, Unger, O’Connor, Palmer, & LaFrance, 1997; Rew, 2008; Robertson & Toro, 1999; Stephens, Braithwaite, Lubin, Carn, & Colbert, 2000).

Whitbeck & Simons (1993) compared the adaptation strategies of homeless adults and homeless adolescents and found that homeless adolescents were more often involved in active survival strategies (selling drugs, stealing, and engaging in survival sex), whereas homeless adults use more passive strategies such as panhandling and dumpster diving. According to Johnson and colleagues, the likelihood of adopting street values
that encourage high-risk behaviors, including those associated with survival strategies, increases in direct proportion to the amount of time one is homeless (Johnson, Aschkenasy, Herbers, & Gillenwater, 1996).

The majority of homeless youth are sexually active and infrequently use condoms (Clements, Gleghorn, Garcia, Katz, & Marx, 1997; Halcon & Lifson, 2004). Compared to their housed peers, youth on the streets engage in more risky sexual behaviors and are more likely to have multiple sex partners (Kral, Molnar, Booth, & Watters, 1997). Survival sex is the most widely discussed survival strategy in the homeless youth literature and is defined as the performance of sexual acts in exchange for money, shelter, food, clothing, or other basic needs (National Alliance to End Homelessness [NAEH], 2009). According to Greene, Ennett, & Ringwalt (1999), about 25% of homeless youth have exchanged sex for money, drugs, food, or shelter. In a summary of 19 studies on homeless youth and sex work between 1987 and 2006 (including both survival sex and commercial sex industry work), involvement ranged from 2 to 46% with a cluster of research showing an involvement rate of 15 to 30% (NAEH, 2009). Kipke, O’Connor, Palmer, & MacKenzie (1995) found that among homeless youth engaging in survival sex, 48% reported exchanging sex for housing or food, 22% traded sex for drugs, and 82% traded sex for money.

Homeless males and females of all ages engage in survival sex and this behavior has been documented in all geographic locations, not just in big cities (Halcon & Lifson, 2004). Survival sex behavior of the homeless youth population has been correlated with the following: sexually transmitted diseases, including HIV; unintended pregnancy; drug use; victimization; and suicide attempts (Greene et al., 1999). Other factors associated
with engaging in survival sex in this population include the following: multiple sex partners, history of suicide attempt, drug and heavy alcohol use, and pregnancy (Greene et al., 1999; Halcon & Lifson, 2004). In addition, the risk of involvement in sex work increases among runaway youth who have a history of sexual abuse (Rotheram-Borus, Mahler, Koopman, & Langabeer, 1996). It is suggested that youth who are sexually abused by adults learn to use their bodies to meet their physical and psychosocial needs, and are often coerced to take excessive sexual and safety risks to achieve shelter and respite from the streets (Halcon & Lifson, 2004; Tyler & Johnson, 2006). Further, the risk of survival sex increases the longer the time that youth remain homeless (Greene et al., 1999; Unger et al., 1998).

Identification as gay, lesbian, bisexual, transgender, and queer/questioning (GLBTQ), especially among the youngest homeless youth, is related to involvement in survival sex (Reaves, 2001; Unger et al., 1998). Homeless youth who are GLBTQ are more likely to use sex as a survival strategy than their heterosexual homeless peers (Kipke et al., 1995).

Homeless youth experience increased rates of pregnancy and are at high risk for acquiring HIV and other sexually transmitted diseases due to risky sexual behaviors (Haley, Roy, Leclerc, Boudreau & Boivin, 2004; Slesnick, Bartle-Haring, Glebova, & Glade, 2006). Rates of HIV in homeless youth are estimated to be 2 to 10 times higher than adolescents in general (Beech, Myers, Beech, & Kernick, 2003; Gwadz et al., 2010). This number is staggering given the fact that young Americans ages 13 to 29 years are disproportionately affected by HIV (Hall et al., 2008) with more new cases of HIV
occurring in this age group than any other (Centers for Disease Control and Prevention, 2008).

Alcohol and drug use by homeless adolescents is common and is likely a way to cope with previous trauma and the stress of being homeless (Farrow, 1995; Rew, 2008; Toro et al., 2007). In a study by Greene, Ennett, & Ringwalt (1997), substance abuse was consistently higher for homeless youth compared to stably housed youth. In addition, youth living on the streets were more likely to be substance users compared to those in a shelter. Substance use is highly linked with risky sexual behavior in homeless and runaway youth (Rew, Taylor-Seehafer, & Fitzgerald, 2001) and appears to be more prevalent for those identifying as GLBTQ (Cochran, Stewart, Ginzler, & Cauce, 2002).

For homeless youth, victimization is often a consequence of life on the streets (Tyler, Hoyt, Whitbeck, & Cauce, 2001). Frequently, the family situations that youth have tried to escape are similar to what they face in their new lifestyle (Noell, Rohde, Seeley, & Ochs, 2001). Around 80% of sampled homeless youth report being victimized physically or sexually after leaving home (Stewart et al., 2004). Victimization among homeless adolescents was studied by Whitbeck, Hoyt, & Ackley (1997) in four Midwestern states. On more than one occasion while homeless, 18% of males and 12% of females had been beaten; 11% of males and 7% of females had been robbed; and 11% of males and 4% of females had been assaulted by a weapon (Robertson & Toro, 1999).

The majority of studies conducted about the homeless youth population have been disease or problem oriented. Consequently, more is known about the deficits of homeless youth than their strengths and resources (Rew, 2008). According to Levy (1998), a strengths-based approach is needed to empower youth to focus on their future and
transition out of homelessness. Several studies that have focused on the protective factors and health promoting behaviors of homeless youth will be reviewed next.

Williams et al. (2001) used a multiple case study design to determine key factors that distinguish resilient homeless youth from those that continue to engage in risky behavior. The data were analyzed using qualitative methods described in Strauss and Corbin (1998). Four key themes served as distinguishing characteristics: 1) determination, 2) meaning and life purpose, 3) caring for self and help from others, and 4) support. Meaning and purpose in life had several subcategories that included spiritual connection, hope and gratitude, and concern for others with a commitment to give back to the community. Self-care was described in terms of recognizing and meeting one’s own needs, asserting one’s autonomy, and the development of problem solving skills.

Using a grounded theory design, Rew (2003) explored self-care attitudes and behaviors in a sample of homeless adolescents seeking health and social services from a street outreach program in Texas. Fifteen youths (7 males, 6 females, and 2 transgendered), who were an average of 18.8 years old, participated. Participants described a basic social process of Taking Care of Oneself in a High-risk Environment. This process was supported by three categories, each with two processes of their own: 1) Becoming Aware of Oneself included gaining self-respect and increasing self-reliance; 2) Handling One’s Own Health included interacting with other people and confronting obstacles; and 3) Staying Alive with Limited Resources included engaging in self-preservation and planning for self-protection. In particular, self-preservation not only included activities such as personal hygiene, drinking fluids, and getting exercise, but also panhandling to get food and getting into fights (Rew, 2003). Homeless youth in this
study described survival lifestyles that include health promoting behaviors. In addition, behaviors that may be labeled by outsiders as deviant, such as panhandling and fighting, can alternatively be viewed as ways to take care of oneself in order to stay alive.

In research conducted by Rew & Horner (2003), findings from 3 qualitative studies on homeless adolescents were synthesized to identify strengths that might serve as motivators for health promoting behaviors. Two types of strengths were discovered: resources and self-improvement. Resources served as the foundation for survival and included 1) Knowledge of the Environment (knowing resources; developing streetwise skills; learning who to trust; and adapting to the situation) 2) a Community of Peers (building a new family; relying on others; being accepted by peers; and having traveling companions), and 3) Internal Motivators for Self Improvement (having a sense of freedom; being responsible for others such as friends and pets; recognizing consequences; feeling good about doing healthy things; and setting goals for the future) (Rew & Horner, 2003). Self-improvement served as a process that enabled youth to consider a more healthy future and included the following: 1) Enacting Healthier Behaviors (eating a healthier diet; increasing physical activity; using natural remedies; employing stress-reduction strategies; and reducing or eliminating tobacco, alcohol, and other drug usage) 2) Gaining Emotional Maturity (developing self-respect; increasing self-confidence; accepting a range of emotions; and learning one’s limits) and 3) Mastering Skills for the Future (using computers; practicing assertive communication; and preparing for job interviews). The findings from this study support the claim by Pender (1996) that the motivation for engaging in health promoting behaviors comes more from positive factors or strengths such as the desire for growth and human potential.
than from negative factors. Future time perspective was identified as a resource for motivation to engage in self-improvement in this sample of homeless youth.

In other studies of homeless youth, “street families” have also been identified as a valuable resource that provide companionship and promote survival on the streets (McCarthy, Hagan, & Martin, 2002; Smith, 2008) homeless youth contrasted their positive feelings with homeless peers to the rejection they had felt from their families of origin and other adults they encountered when seeking services. Formation of a family while being homeless on the street is a rather unique aspect of the homeless youth culture and has implications for further research and intervention (Smith, 2008).

Kidd & Davidson (2007) obtained “resilience narratives” from over 200 homeless youth in New York City and Toronto (p. 219). Self-reliance, supporting other youth, caring for others, and spirituality were themes identified in three phases of homeless life labeled as “coming to the streets”, “living on the streets”, and “exiting the streets” (p. 230).

In an attempt to distinguish variability within the homeless youth population, Milburn, Liang, Lee, and Rotheram-Borus (2009) designed a typology for homeless adolescents to describe which homeless youth do well and why. The authors distinguished between newly homeless youth as opposed to chronically homeless youth and found that newly homeless youth had the following characteristics: more likely to be younger, attending school, not engaged in high risk sexual practices, not using drugs, and without a history of attempted suicide. This typology placed newly homeless youth into three distinct categories: homeless adolescents who are protected, those who are at risk
(possessing more risks factors than protective factors), and those who are risky (possessing no protective factors) (Milburn et al., 2009).

In this study, protected youth typically were still attending school, were employed, and had good health, positive friends, and survival skills (Milburn et al., 2009). By contrast, at risk youth and risky youth exhibited such factors as emotional distress, unprotected sex, smoking, alcohol use, drug use and hard drug use. Risky newly homeless adolescents are more likely to use alcohol and hard drugs than the other groups. The authors asserted that the newly developed typology might contribute to more appropriate services that are more specific to the diverse needs and strengths of the homeless youth population (Milburn et al., 2009).

**Time Perspective**

Time is an omnipresent concept relevant to nursing that touches all cultures and all dimensions of life (Fitzpatrick, 1989; Jones, 2001). Time is fundamental to every physical, psychological, social, and spiritual process, and, according to Heidegger (1962), is vital to the notion of existence itself. Though the role of time in people’s lives may often go unnoticed or taken for granted, the psychology literature supports that a person’s time perspective can greatly influence many aspects of their life, including health.

Time perspective is a psychological construct that has been shown to be a significant factor in coping, adjustment, and health behavior decision making across the lifespan (Zimbardo & Boyd, 1999). The formation of time perspective is related to one’s cultural values, religious orientation, socio-economic status, gender, age, education, and occupation (Boniwell & Zimbardo, 2004). According to Zimbardo & Boyd (1999):
“Time perspective may be one of the most powerful variables influencing all of human behavior: judgment, decisions, affect, relationships, choices...” (p. 1).

**History and Theoretical Development of Time Perception**

Albert Einstein's theory of relativity (1931) established the subjective nature of the physical interpretation of time. The significance of this relative phenomenon has been studied over the years by philosophers, physical scientists, psychologists, and nurses to a small degree as well. Time perspective is one concept in the study of time.

The term time perspective was first introduced by Frank in 1939. He believed that all human conduct was conditioned by the time perspectives of the individual and his or her culture (Hoornaert, 1973). In defining the concept of time perspective, Frank (1939) theorized that an individual’s present is shaped by both their past experiences and perceptions of future events, and perceptions of the future may result from his or her current behavior. Additionally, an individual’s present beliefs, needs, and emotional states can also moderate his or her interpretation of past events. Frank (1939) further believed that since culture and religion dictate behavior in various situations, they play an important role in the formation of time perspectives.

Lewin (1951) defined the term time perspective as “the totality of the individual’s views of his psychological future and his psychological past existing at a given time” (p. 75). Lewin’s view that all aspects of time are incorporated within the present moment is similar to the circular concept of time in Zen (Ornstein, 1975). Lewin (1951) later integrated time perspective into his conception of an individual’s life-space, which he described as “the person and the psychological environment as it exists for him,” (p. 57).
In this model, Lewin (1948) proposed that the actions, emotions and morale of an individual, at any given time, are dependent on the individual’s time perspective.

Both Frank (1939) and Lewin (1951) believed that time perspective changes with age and addressed, to some extent, the developmental issues related to time perspective. Frank (1939) emphasized the early development of time perspective. His main argument was that the regulation of physiological functions marks the onset of the "human career" whose two essential characteristics are the acceptance of values and the consideration of future consequences. Lewin (1939) believed that the development of time perspective in adolescence is marked by an increase in "the scope of time ahead" (p. 879). He proposed that “The time dimension of the life space of the child grows with increasing age; more and more distant future and past events affect present behavior” (Lewin, 1951, p. 75).

During the early study of time perspective, a variety of terms were used by researchers including “time sense”, “time orientation”, “time perception”, “time experience”, and “psychological time”. These terms were used inconsistently and interchangeably with minimal or no definition of their meaning (Nuttin & Lens, 1985). Later, however, attempts were made by researchers to more clearly define the time perspective related concepts they studied. Building upon the work of Frank (1939) and Lewin (1948), a large amount of research focused exclusively on the future dimension of time perspective.

For example, Wallace (1956) expanded the definition of future time perspective to include what he called extension and coherence. He defined extension as the length of the future time span conceptualized, and coherence as the degree of organization of the events in that time span. Wallace and Rabin (1960) later suggested that the concepts of
extension and coherence may also apply to the past dimension of time perspective.

Kastenbaum (1961) further defined future time perspective by introducing the concept of density. Density can be thought of as the quantity of objects, events, or experiences populating a particular time perspective (Hoornaert, 1973; Kastenbaum, 1961; Nuttin & Lens, 1985).

In 1973, Hoorneart conducted a comprehensive review of the literature and defined time perspective as a multidimensional concept consisting of a number of formal aspects that included attitude toward time and time dimensions, differential direction, density, extension, and, coherence. He noted that an individual’s attitude towards time and time dimensions can be optimistic or pessimistic, positive or negative, and active or passive with different degrees (Hoornaert, 1973).

Like Hoorneart, Nuttin & Lens (1985) believed that density and extension were aspects of time perspective. However, they saw time orientation, time attitude, and time perspective as clearly separate research topics. Nuttin & Lens (1985) further identified two additional aspects of measuring time perspective. One aspect was the degree of structuration, defined as the presence or absence of ties between objects or groups of objects. The second aspect referred to the degree of vividness and realism of objects in time perspective as they are perceived by the individual and as a function of their distance in time.

In addition, the role of cognition in the formation of time perspective was explored by Nuttin & Lens (1985). They noted that since time perspective is constituted by objects or events existing in the representational or cognitive level of behavioral functioning, acknowledging the effect of time perspective requires the recognition of the
role of cognitive processes. These cognitive processes categorize events that are experienced, perceived, and anticipated into three distinct representational segments that respectively correspond to the three dimensions of time – the past, the present, and the future. Thus, “From the point of view of its content, time perspective consists of mentally represented objects localized in different time periods” (Nuttin & Lens, 1985, p. 32). Arguing that some time perspectives are more adaptive than others in particular situations, Nuttin & Lens (1985) coined the term time competence to describe the fit between time perspective and the particular domain that is under consideration.

**Time Perspective Measurement**

An extensive number of different methodologies have been used over the years to study time perspective. Early time perspective measurement is characterized by instruments that demonstrated the complexity of time perspective through abstract graphical representations, short story, imagination, personal events, and scales (Cottle, 1967; Cottle, Howard, & Pleck, 1969; Greaves, 1971; Henik & Domino, 1975; Landau, 1976; Lessing, 1972; Rizzo, 1967; Ruiz, Reivich, & Krauss, 1967). In general, these measures lacked validity and reliability, making it difficult to compare results across studies.

**Current time perspective measurement and research.**

Current time perspective research is governed by two sets of measures. The Consideration of Future Consequences scale (CFC) (Strathman, Gleicher, Boninger, & Edwards, 1994) and the Zimbardo Time Perspective Inventory (ZTPI) (Zimbardo & Boyd, 1999) were both developed in the late 1980s/early 1990s to provide standard, reliable, and valid methods of measuring time perspective.
Consideration of Future Consequences Scale.

The Consideration of Future Consequences (CFC) Scale (Strathman et al., 1994) is designed to assess the extent to which people emphasize short-term or long-term consequences. It includes twelve items developed from factor analyses, reliability testing, and validity testing across seven samples of college students. Cronbach’s alpha ranged from .80 to .86 across four samples, and temporal stability was demonstrated through testing and retesting of participant groups after two and five week intervals. Individuals who are low on CFC are expected to focus more on immediate needs and concerns, and to act accordingly. Individuals high on CFC are expected to focus more on the future implications of their behavior and use these longer term outcomes as guides to their behavioral decision making. One criticism regarding the CFC is that it assumes that present and future time orientations exist only on a mutually exclusive continuum.

Theoretical assumptions of the CFC related to health posit that behaviors performed to protect health typically involve delayed benefits and immediate costs. If an individual disregards future outcomes, it might be predicted that the likelihood of performing a health-related behavior will depend upon the individual’s evaluation of the inconvenience, loss of pleasure, or psychological costs that are incurred in the short term (Chapman, 2005). The CFC scale has been used to show inverse relationships between present and future time orientation and behaviors such as: academic achievement (Joireman, 1999), gambling (Toplak, Liu, Macpherson, Toneatto, & Stanovich, 2007), impulsive sensation seeking (Joireman, Anderson, & Strathman, 2003); sexual behavior (Appleby et al., 2005); substance use (Webley & Nyhus, 2006), and youth delinquency (Cauffman, Steinberg, & Piquero, 2005; Modecki, 2008).
Two studies (Orbell & Hagger, 2006; Orbell, Perugini, & Rakow, 2004) have examined the implications of CFC for information processing and persuasion in relation to health screening behaviors. Consistent with hypotheses, low-CFC people were more persuaded (generated more positive relative to negative thoughts) by a message in which positive outcomes occurred in the short term, whereas high-CFC people were more persuaded by a message in which positive outcomes occurred in the longer term.

*Zimbardo Time Perspective Inventory.*

Most recently, a popular view of time perspective is found in the work of Zimbardo and colleagues who view time perspective as a dimension of psychological time resulting from cognitive processes that partition human experience into past, present, and future temporal frames (Boniwell & Zimbardo, 2003; Boniwell & Zimbardo, 2004; D'Alessio, Guarino, De Pascalis, & Zimbardo, 2003; Zimbardo & Boyd, 1999). These cognitive temporal frames are used to encode, store, and recall experienced events that shape the development of expectations, goals, contingencies, and imaginative views (D'Alessio et al., 2003; Zimbardo & Boyd, 1999). The formation and modification of time perspective is primarily influenced by a variety of personal, social, and institutional factors such as one’s cultural values, religious orientation, education, socio-economic status, career, and family background (Boniwell & Zimbardo, 2004; Zimbardo & Boyd, 1999). In this model, time perspective is believed to have a significant impact on an individual’s attention, perception, judgment, decision making, and actions (Boniwell & Zimbardo, 2004; D'Alessio et al., 2003; Zimbardo & Boyd, 1999).

Zimbardo and Boyd (1999) argued that the study of time perspective should be approached multidimensionally because a one dimensional approach, that focuses
exclusively on the past, present, or future, may lead to incorrect conclusions. For example, scoring low on a scale of future orientation is not equivalent to scoring high on a scale of present orientation (Zimbardo & Boyd, 1999). Thus, the Zimbardo Time Perspective Inventory (ZTPI) (Zimbardo & Boyd, 1999) was developed to measure individuals’ orientations to the past, present, and future.

The first version of the ZTPI, known as the Stanford Time Perspective Inventory, was created in 1985 using a convenience sample of more than 12,000 respondents to a Psychology Today questionnaire (Gonzalez & Zimbardo, 1985). It had multiple future factors and was refined over time with various samples, ultimately resulting in the current version. The ZTPI (Zimbardo & Boyd, 1999) underwent vigorous exploratory and confirmatory factor analyses, convergent and discriminant validity testing, and reliability testing across six samples consisting of over 1,000 college students. Reliability, as indicated by Cronbach’s alpha, ranged from .74 to .82 and test-retest reliabilities ranged from .70 to .90 for the various subscales of the instrument. Fifty-six items are included in the five separate scales that make up ZTPI (Zimbardo & Boyd, 1999): two scales measure different dimensions of past orientation, two measure different dimensions of present orientation, and one scale measures future orientation. A brief description of these scales will be provided below.

The past-negative scale reflects a generally aversive attitude toward the past that may include trauma, pain, and regret. It is associated with negative rumination, depression, anxiety, unhappiness, and low self-esteem (Zimbardo & Boyd, 1999). A strong relationship was found with measures of the Buss and Perry Aggression Questionnaire (Buss & Perry, 1992 as cited in Zimbardo & Boyd, 1999). In contrast, the
past-positive scale is characterized by a warm, sentimental, positive construction of the past. It is negatively correlated with depression, anxiety, and aggression and it is positively correlated with self-esteem (Zimbardo & Boyd, 1999). The present-hedonistic scale represents an orientation toward present pleasure with little concern for future consequences. It is characterized by a risk-taking attitude and is negatively correlated with measures of the CFC (Zimbardo & Boyd, 1999). The present-fatalistic scale indicates a helpless and hopeless attitude toward the future as well as an absence of a focused time perspective. It is positively correlated with depression and anxiety, and negatively correlated with the CFC (Zimbardo & Boyd, 1999). The future scale reflects behavior that is characterized by setting future goals, rewards, and planning. It is positively correlated with conscientiousness, consideration of future consequences, preference for consistency, and it is negatively correlated with novelty seeking, and sensation seeking (Zimbardo & Boyd, 1999).

A tendency to habitually favor one time perspective over the others results in a cognitive temporal bias toward being past, present, or future oriented (Zimbardo & Boyd, 1999). According to Zimbardo & Boyd (1999), “When chronically elicited, this bias becomes a dispositional style, or individual-differences variable, that is characteristic and predictive of how an individual will respond across a host of daily life choices” (p.1272). They note that while the bias is considered to be a relatively common and stable personal characteristic, it can be modified by situational factors such as a status change, trauma, or an altered state of consciousness. Zimbardo and Boyd (1999) claim that the ideal situation is a balanced time orientation. This balance represents a mental framework
under which an individual is able to flexibly switch temporal frames as most appropriate to the behavioral situation at hand (Boniwell & Zimbardo, 2004).

Studies using the ZTPI scales have measured a number of variables including academic achievement (Adelabu, 2007), gambling (MacKillop, Anderson, Castelda, Mattson, & Donovick, 2006), and duration of adult homelessness (Epel, Bandura, & Zimbardo, 1999). In addition, several studies using the ZTPI have examined the relationships between time perspective and health behaviors and will be summarized below.

**Time Perspective and Health**

Overall, present time perspective is a predictor of risky health behaviors. Zimbardo, Keough, and Boyd (1997) found that present time perspective was positively related to risky driving and Rothspan and Read (1996) reported associations with frequent sexual behavior and more sexual partners. Wills, Sandy, and Yaeger (2001) and Keough, Zimbardo, and Boyd (1999) found positive relationships between present time perspective and substance use.

Researchers have also examined the influence of future time perspective on health behaviors using the ZTPI. In general, individuals with a stronger future time perspective tend to report fewer risk behaviors, including less risky driving (Zimbardo et al., 1997), delayed onset of sexual activity with fewer number of sexual partners (Rothspan & Read, 1996), and less substance use (Wills et al., 2001). Moreover, future time perspective correlated positively with health protective behaviors such as condom use (DiLorio, Parsons, Lehr, Adame, & Carlone, 1993), exercise, and healthy eating (Mahon, Yarcheski, & Yarcheski, 1997).
Future time perspective has been identified as a predictor of participation in health promotion activities. Yarcheski, Mahon, Yarcheski, & Cannella (2004) conducted a meta-analysis of predictors of positive health practices and the magnitude of the relationships between each of the predictors and positive health practices. Positive health practices were conceptually defined as participation in health promotion activities, and operationally defined in the Personal Lifestyle Questionnaire (PLQ) (Brown et al., 1983). The PLQ is a 24-item 4-point summated rating scale that measures six self-reported health-related practices of exercise, nutrition, relaxation, less substance use, safety, and health promotion. Higher scores indicate more positive health practices for the total scale or for each of the six subscales. The questionnaire shows content and concurrent validity. Test-retest reliabilities for 3 and 4 week periods were .88 and .78, respectively (Brown et al., 1983). Using 37 total studies in the meta-analysis, 14 predictors of positive health practices were identified, including future time perspective that appeared in five studies. Three of the five studies involved adolescents. A quality index score for each study was assigned based on the criteria proposed by Beck (2001) (as cited in Yarcheski et al., 2004) with 23 being the highest score. Quality index scores for FTP studies ranged from 12 to 15 (mean = 13). Effect sizes ranged from .29 to .32 indicating a medium effect for the relationship between future time perspective and positive health practices. Loneliness had the most powerful (negative) influence on positive health practices followed by social support. Perceived health status, self-efficacy, self-esteem, and hope were other predictors of positive health practice that demonstrated a medium effect size.
Time Perspective and Nursing Theory

In the discipline of nursing, time perspective (referred to as temporal perspective) has been identified as one of the foundational concepts in Fitzpatrick’s (1989) life perspective rhythm model. In this model, temporal perspective is defined as temporal patterns that exist within the life rhythm as a spatial concept of time. Temporal patterns are considered the perceptions of past, present, and future and are embedded in the meaning of life. The model posits that temporal patterns influence behavior and decision making, and therefore may have an impact on health (Fitzpatrick, 1989).

Although research using the life perspective rhythm model is limited, recently Thompson & Fitzpatrick (2008) used the model as a basis to describe health promoting behaviors and temporal perspective in a convenience sample of low-income adults. The sample consisted of 75 subjects, 61 women (81%) and 14 men (19%). Positive health practices were measured using the Personal Lifestyle Questionnaire (Brown, Muhlenkamp, Fox, & Osborn, 1983). Temporal variables of future dominant temporal perspective and continuous temporal relatedness were measured with the Circles Test (Cottle, 1967). For the Circles Test, participants were instructed to draw three circles of any size and any relationship to one another that represent the past, present, and the future (Thompson & Fitzpatrick, 2008).

Scoring for temporal dominance as future dominant or non-future dominant was based on the size of the future circle compared with the past and the present circles. Scoring for temporal relatedness as continuous-related or non-continuous-related was based on the overlap of the circles. Circles Test validity
was assessed by asking each subject to describe the circles drawing. (Thompson & Fitzpatrick, 2008, p. 1712)

Positive health practices in the low income adult sample were relatively high (mean = 70 out of a possible score of 96) and similar to those reported in other samples using middle class adults. Forty three percent of the subjects expressed future temporal dominance, a finding consistent with other samples studied in the past using the Circles Test. A large number, 80%, of the subjects expressed non-continuous temporal relatedness. This suggests that the perception of the relationship between past, present, and future times may be different in this low-income sample compared to other samples (Thompson & Fitzpatrick, 2008).

**Adolescent Developmental Theories**

The purpose of this study is to gain an understanding of the time perspectives of homeless street youth by exploring the meanings of their storied experiences. The following section will summarize adolescent neurological development followed by a discussion of adolescent development and time perspective.

**Neurological Development**

Neuroscience researchers contribute critical data related to adolescent brain development and the process of decision-making that have importance relevance to health behaviors and time perspective. Briefly, because the brain, cognitive, and behavioral systems all mature at different rates, adolescence is often a period of increased vulnerability and adjustment (Steinberg, 2005). Part of adolescent vulnerability may be linked to biological changes in neural systems that appear to increase tendencies toward risk-taking, sensation-seeking, and heightened emotional expression (Martin et al., 2002).
Although this is considered a normative process, some adolescents may be developmentally inclined to engage in more risky behavior if they are unable to mediate arousal, emotion, and new sensations.

Steinberg (2004) stated there are two observations regarding adolescent brain development that are particularly important: First, much of brain development during adolescence is in the particular brain regions and systems that are essential to the regulation of behavior and emotion, and to the perception and evaluation of risk and reward. Second, it appears that changes in arousal and motivation brought on by pubertal maturation precede the development of regulatory competence in a manner that creates a disjunction between the adolescent’s affective experience and his or her ability to regulate arousal and motivation (p. 69).

This neurologic development can be linked to Elkind’s theory of adolescent cognitive development (1967) in which adolescents express behaviors associated with egocentrism and invulnerability. The inability to regulate emotion and motivation may result in the inability to recognize the risk and potential harm associated with various behaviors. Therefore, acknowledging the existence of gaps between emotion, cognition, and behavior is fundamental to understanding differences in adolescent judgment, risk-taking, decision making, and sensation seeking behaviors (Steinberg, 2004).

**Adolescent Cognitive Development and Time Perspective**

Individuals are not born with the ability to conceive of time. Rather, they develop this ability during early childhood (Blum & Resnick, 1982; Gonzalez & Zimbardo, 1985). Prevailing psychological theories posit that younger adolescence is dominated by concrete, present-oriented thinking that lacks consideration of potential consequences of
behavior. Abstract and futuristic thinking develops during later adolescence and early adulthood, although some individuals may never reach this level of formal cognition (Inhelder & Piaget, 1958). Egocentric behavior, feelings of invulnerability (Elkin, 1967), formation of an individual identity beyond that of parents (Erikson, 1968), expansion of cognition to incorporate complex information (Perry, 1999), and the ability to make meaning from experiences (Marcia, 1989) are all hallmarks of adolescent development.

Erikson (1968) believed that changes in adolescents’ time perspective are vital to the process of identity formation. He argued that during this time of prolific ego development, establishing a mature time perspective was needed for the adolescent to acquire self-certainty as opposed to self-consciousness and self-doubt. Through this process, the adolescent can anticipate achievement and experience success instead of being paralyzed by feelings of inferiority or a time perspective that is inadequate. According to Erikson, “The young person, in order to experience wholeness, must feel a progressive continuity between that which he has come to be during the long years of childhood and that which he promises to become in the anticipated future” (1964, p. 91).

In addition, Erikson (1968) described the need for a “psychosocial moratorium” (p. 156), that provides the adolescent with a time to slow down and think about future plans while considering both their past and present situation. Time perspective crises during adolescence were described by Erikson (1968) as “moving in molasses” and “simultaneous very young, and in fact baby-like and old beyond rejuvenation” (p. 169).

More recently, a detailed outline of how adolescents develop their abilities to think about and plan for the future is provided by Nurmi (1991). First, when faced with normative age-specific tasks set forth by parents, teachers, and peers, adolescents can
begin to consider their future lifespan development. Second, adolescents begin to recognize that their future oriented decisions will significantly influence future family, career, and lifestyle outcomes. Finally, the way in which an adolescent envisions his or her future affects their identity formation and their subsequent discovery and commitment to future-oriented interests/milestones (Nurmi, 1991).

In summary, time perspective is an important interpersonal variable of adolescence. Individuals in this age group are seeking to establish a clear sense of self through the often challenging time of identity formation and are developing cognitive and abstract thinking skills. In general, adolescent time perspective is characterized by an orientational shift from the nearness of the present and the fascination of the past, to a considerable interest in the future (Greene, 1986). Future time perspective is a person’s model of the future which provides a foundation for exploring options, goal setting, planning, and making commitments (Zimbardo & Boyd, 1999).

**Adolescent Time Perspective Studies**

There is a substantial amount of psychological research on adolescents’ time perspective (Kauffman & Husman, 2004), with the majority of the studies focusing on future time perspective (McInerney, 2004; Nuttin & Lens, 1985; Simons, Dewitte, & Lens, 2000; Simons, Vansteenkiste, Lens, & Lacante, 2004; Wyman, Cowen, Work, & Kerley, 1993). Meaningful relationships have been found between future time perspective and variables such as academic achievement (Honora, 2002; Shell & Husman, 2001), delay of gratification (Bembenutty & Karabenick, 2004), delinquency (Oyserman & Markus, 1990a, 1990b), and motivation (Greene & DeBacker, 2004; Miller
Several studies have explored the relationship between future orientation and cognitive skills. However, no relationships have been found between future orientation and Piagetian formal operations reasoning or standardized measures of intelligence/cognitive skill (Greene, 1986; McCabe & Barnett, 2000). In a study examining the hopes and fears of Finnish adolescents by Nurmi (1989), 11 year olds were already competent planners and expressed interest in the domains of occupation and family. This finding further confirms that formal operations are not a requisite for having a well-developed future orientation (Nurmi, 1989).

In a study by Krietler & Krietler (1987), the capacity for planning for the near future fully developed by age 9 and the capacity for planning for the distant future peaked at age 11. At age 11, children transitioned from being concerned about the here-and-now to being concerned about future achievement, personal future, and society at large. Nurmi (1989) found that, in general across cultures, adolescents expect to meet educational goals by age 19, occupational goals by age 23, and family goals at age 29.

Additionally, Nurmi (1989) observed the following in his sample of Finnish adolescents: 1) occupation and education were the domains most mentioned by adolescents when asked about future orientation, 2) adolescents with high socioeconomic status (SES) were more optimistic than low SES adolescents, and 3) adolescent thinking did not extend beyond the fourth decade of life. Recognizing that adolescence is shaped by the socio-cultural context in which it occurs (Crockett & Silbereisen, 2000), and much
has changed for the youth population in the last 20+ years, these findings should be interpreted prudently.

Wyman et al. (1993) found that positive expectations for the future differentiated between resilient and non-resilient children exposed to high levels of stress. Early positive future expectations predicted enhanced socio-emotional adjustment in school and a more internal locus of control 2.5-3.5 years later. In addition, early positive future expectations acted as a protective factor in reducing the negative effects of high stress on self-rated competence.

Future orientation has been linked to several cognitive outcomes. McCabe & Barnett (2000) found that younger adolescents’ future orientations about the career domain were significantly more detailed than within family or romantic relationship domains. Studying a sample of African-American high school students, Kerpelman & Mosher (2004) found that girls had higher future orientation regarding both career and education than boys, and maternal and paternal level of education correlated with levels of their teenagers’ future orientation.

Future orientation has further been linked to behavioral outcomes, particularly those measured for at-risk populations. Robbins and Bryan (2004) studied probated adolescents and found that the more positive an individual’s future orientation was, the less likely the following behaviors occurred: marijuana usage, hard drug usage, sex while drinking alcohol, and unprotected sex. Peters et al. (2005) studied a sample of 974 alternative school students between 7th and 12th grade. Logistic regression analyses showed that lower levels of future orientation were significantly associated (OR = 0.88, 95% CI = 0.81-0.97) with thirty-day substance use after controlling for age and gender.
In addition, lower levels of future orientation were found to have a significant association with students' lifetime substance use (OR = 0.93, 95% CI = 0.87–0.99) after controlling for age, race, and gender. Several studies of African American teenaged girls have linked future planning capabilities to a reduced likelihood of teen pregnancy (Aronowitz & Morrison-Beedy, 2004; McCabe, 1997; McCabe & Barnett, 2000).

Although the ZTPI (Zimbardo & Boyd, 1999) has been the most widely studied time perspective measurement tool during the last 25 years, it has mainly been used for adult populations, particularly college undergraduates, and has not been considered appropriate for adolescents. To date, only one peer-reviewed article about administering the ZTPI to adolescents was found. Mello and Worrell (2006) used the ZTPI (Zimbardo & Boyd, 1999) to examine the relationship between time perspective and the following variables: age, gender, and academic achievement. The study sampled 722 academically talented adolescents ages 11-18 years who were attending a 6-week summer program at a research university in a Western state. Findings were as follows: 1) academically talented students did not demonstrate particularly positive or negative attitudes toward the past, present, or the future, 2) age predicted time perspective, with older adolescents reporting more present hedonistic attitudes than their younger counterparts, 3) females had fewer negative thoughts about the future than males, 4) adolescents emphasized the present time dimension more often than the past and the future time dimensions, and 5) academic achievement was negatively associated with a present fatalistic orientation and positively associated with future positive orientation. Researchers noted that small effect sizes were partially due to the ZTPI not providing valid and reliable scores for an adolescent population.
In a doctoral dissertation, Cooper (2010) recognized the potential of studying time perspective in the foster youth population. Based on the ZTPI (Zimbardo & Boyd, 1999), he developed and validated a self-report instrument to measure adolescent time perspective called the Adolescent Time Perspective Inventory (ATPI). Initial instrument development involved subjecting the ZTPI to critical review by several focus groups: high school students, foster youth, clinicians, and teachers who work with adolescents. After item modification, the resulting ATPI was administered to 333 high school students and 53 foster youth. The foster youth also completed the Snyder Children's Hope Scale as well as a second administration of the ATPI four weeks after the initial administration. After removing 10 problematic items, the five factors of ATPI (Past-Positive, Past-Negative, Present, Future-Positive and Future-Negative) demonstrated strong internal consistency with Cronbach’s alpha reliabilities ranging from .75 to .80. Study findings included the following: seventeen year olds were significantly more future-positive than 14, 15 and 16 year-olds; females were significantly more future-positive and less future-negative than males; and the hope scale scores of foster youth correlated significantly with their future-positive and past-negative scores. In addition, the ATPI subscales demonstrated moderate levels of test-retest reliability with coefficients ranging from .49 to .74.

Recommendations for future research by Cooper (2010) included determining the temporal biases present within foster care populations, determining whether certain time perspectives put foster children at heightened risk for adverse developmental and life course outcomes, and, if indicated, development and testing of interventions to improve foster children's time perspective.
Homeless Youth and Time Perspective

Despite the theoretical and research support for time perspective as an important variable in human behavior, especially for risk-taking and health promotion, there have been no qualitative or quantitative studies dedicated to examining the time perspective of homeless youth. Still, there are two quantitative studies in the homeless youth literature that examined future time perspective as a sexual health variable and these will be described below.

In a convenience sample of homeless youth receiving street outreach services in central Texas, Rew, Fouladi, & Yockey (2002) examined relationships among cognitive-perceptual variables, including future time perspective, and behavioral factors on sexual health practices. The sample consisted of 414 homeless young men (244) and young women (170) aged 16-20 years. The majority of the sample was Anglo American. Thirty-five percent reported homosexual or bisexual orientation, and sexual orientation was reported as a reason for leaving home. Over half reported a history of sexual abuse and nearly one in four had been treated for gonorrhea. Safe-sex behaviors were related to age, time away from home, assertive communication, social support, future time perspective, connectedness, perceived health status, intentions to use condoms, and condom self-efficacy. Further, the only direct paths to safe-sex behaviors were future time perspective, intentions to use condoms, and self-efficacy to use condoms. Direct paths to sexual self-care behaviors were from assertive communication, social support, and self-efficacy to use condoms.

Johnson, Rew, & Kouzekanani (2006) explored how gender and a history of sexual abuse influence cognitive-perceptual and behavioral factors associated with sexual
health practices of homeless adolescents. This study was a secondary analysis and included data from the above study by Rew et al. (2002). The sample consisted of 414 youth (104 males who reported sexual abuse and 124 who did not; and 95 females who reported sexual abuse and 75 who did not; 16 youth did not provide data). Homeless adolescent females with a history of sexual abuse scored higher (indicating a shorter perspective) on a measure of future time perspective than females with no history of sexual abuse.

Summary

This chapter has provided a review of the literature on homeless youth and time perspective. Homeless youth are considered one of the most vulnerable groups due to their age, unaccompanied status, socioeconomic level, poor health, risky behaviors, and survival strategies. Both the causes and consequences of youth homelessness appear to be intricately related and have serious negative implications for this population’s health. Nevertheless, the strengths and resources of homeless youth are beginning to emerge within the research literature. Time perspective is a psychological construct that has been shown to be a significant factor in coping, adjustment, and health behavior decision making across the lifespan. Time perspective is related to a variety of personal factors but has not been studied in the homeless youth population. Examining this construct along with its possible connection to health in this high-risk group may provide valuable information that will lay the foundation for future nursing research.
CHAPTER 3: METHOD

After a thorough review of the literature related to homeless youth, health, and time perspective, I have recognized that this is a complex phenomenon with multiple contributing factors. The gap in the extant literature is the absence of homeless youth stories related to their experiences of homelessness, health, and time perspective. To address this need, a descriptive study design was employed with narrative inquiry as the chosen qualitative research methodology to guide this research process. The overall purpose of this study was to gain an understanding of the time perspectives of homeless street youth. Specific aims of the research were to:

1. Conduct a narrative analysis of the stories of homeless street youth;
2. Describe the meanings that homeless street youth give to their experiences;
3. Identify the time perspectives of homeless street youth and examine what past, present, and future mean to them;
4. Determine if and how the time perspectives of homeless street youth influence their health and health promotion

Qualitative Research

The interpretive nature of this study is grounded in the field of qualitative research. According to Denzin and Lincoln (2005), qualitative research is:

…a situated activity that locates the observer in the world. It consists of a set of interpretive, material practices that make the world visible…This means that qualitative researchers study things in their natural settings, attempting to make sense of, or interpret, phenomena in terms of the meanings people bring to them. (p. 3)
Qualitative research approaches are an appropriate choice for an area of study when the voice of the group has been unexplored (Cohen, 2000); such is the case for homeless youth and time perspective. As articulated by Lincoln (2005):

Tests and measurements, while useful for some purposes, do not permit us to ask how individuals and groups make sense of their worlds. Only by observing and communicating with them face to face, can we understand the meaning making apparatuses that individuals bring to, and create from, a dynamic stream of events. Both of those tactics are qualitative methods. (p. 225)

**Narrative Inquiry**

Narrative inquiry has been identified as the most appropriate methodology to explore the meaning of homeless street youths’ experiences in order to gain an understanding of their time perspectives. Narrative inquiry is a form of qualitative research in which the stories of participants are the focus of analysis. Stories provide an organizational platform that exposes one’s perception of reality. Additionally, they provide “rich data for understanding interpersonal interaction, individual bias, social expectations and cultural values” (Horrocks & Callahan, 2006, p. 72). Knowledge acquired through stories sheds light on human behavior and emotion and helps to explain why individuals act and feel as they do.

All people are storytellers (Lincoln, 2000). Human beings are storytellers by nature as storytelling is a fundamental way of expressing ourselves and our world to others (McAdams, 1993). People’s lives are compiled of stories lived and told in social situations (Clandinin & Connelly, 2000). The telling of stories is considered a primary
way by which people make sense of, give meaning to, and share life experiences (Duffy, 2007; Riessman, 2002).

The sharing of stories both provides insight into and also impacts the storyteller’s personal identity (Holstein & Gubrium, 2000), including their time perspective. Personal identity, the answer to the riddle of ‘who’ people are, takes shape in the stories we tell about ourselves. Such stories may not necessarily be the ones we tell to others or to the public at large; they are the narratives that we construct as we orient our present choices and actions in light of our imagined futures and the version of our past that fits...” (Hinchman & Hinchman, 1997, p. xvii)

According to Polkinghorne (1988), the temporal sense of one’s life has an effect on present actions and future goals. In telling stories, time becomes an enhanced awareness of past events and a state of future experiences into the present. As a result, people can organize and understand their lives in created ways to explain and justify those events and experiences (Richardson, 1990). In summary, narratives may provide some clarity about the significance of past and present events which the storyteller is sharing by paying attention to the outcomes and future plans that follow. Based on the unique temporal feature of storytelling, narrative inquiry is an appropriate methodology for this study that seeks to understand the time perspectives of homeless youth.

It’s important to point out that the terms story and narrative are often used interchangeably. However, some important distinctions should be noted. While story is generally considered a person’s account or testimony, narrative is the created structure chosen by the storyteller for the telling of their story. Narrative is associated with reflection, organization, and formality (Parker & Wiltshire, 2003) and is used by
researchers who study stories. Polkinghorne (1988) defines narrative as “the kind of organizational scheme expressed in story form” (p. 13), and views the story as focusing on a person’s life history.

Contemporary narrative inquiry is described by Chase (2005) as a combination of multiple disciplinary lenses, diverse approaches, and traditional and innovative methods that all revolve around an interest in biographical particulars that are narrated by the ones who live them. When engaging in narrative inquiry, the researcher uses a collection of stories as the source of data (Duffy, 2007) and examines the personal accounts of individuals’ motives, experiences, and interpretations of their actions (Holloway & Freshwater, 2007). Through first person narratives, the researcher is able to gain insight into the ways in which individuals construct their worlds. The environment becomes the filter through which individuals perceive and attach meaning to their experiences and become active agents in building their perceptions of social reality (Holloway & Freshwater, 2007). Considered a social process, the storytelling of narrative inquiry gives participants the power to define their own identities and experiences rather than having their reality shaped by the researcher (Sandelowski, 1991).

According to Patton (2002), stories give us the opportunity to view cultural and social meanings through a translucent window.

Narrative inquiry is a way of understanding experience. It is a collaboration between researchers and participants, over time, in a place or series of places, and in social interaction with milieus. An inquirer enters this matrix in the midst and progresses in this same spirit, concluding the inquiry still in the midst of living and telling, reliving and retelling, the stories of the experiences that make up
people’s lives, both individual and social. … Simply stated narrative inquiry is stories lived and told. (Clandinin and Connelly, 2000, p. 20)

**Representation of Experience**

Riessman (1993) views narrative as a means of gaining access to experiences. Because we do not live the experiences of another person, we are actually getting a representation of those experiences through their telling of them. She proposes five levels of representation of experience: 1) attending to experience, 2) telling about experience, 3) transcribing experience, 4) analyzing experience, and 5) reading experiences (Riessman, 1993). These representations are useful for understanding the narrative inquiry process and are described below.

The experience is where representation begins. Attending to the experience occurs as the person embeds what is happening in their mind (Riessman, 1993). Naturally, things can be missed as one reflects upon the whole picture of the experience. Just as two people in the same place at the same time, and seemingly in the “same experience”, may have different recollections of the experience, people remember the things in an experience that are most important to them.

Telling about the experience is the second level of representation (Riessman, 1993). During the process of telling the story, it will not be related exactly as the experience itself. This may occur because some things may have changed as time passed since the experience was lived. In addition, because the telling of the experience is a translation of one’s own self, telling will be what the teller wants others to hear or know with certain details told to one person and not another.
The third level of representation is transcribing experience (Riessman, 1993). Although transcribing has the potential for being very exact as to what was recorded, it is the decision of the transcriber as to what is important to keep and what can be omitted. This subjective assessment has profound implications for the subsequent two levels of representation.

Analyzing experience is the fourth level in the representation of experience where the researcher makes decisions as to what is important in the transcribed account, what has meaning, and how to convey the meanings through their own writing (Riessman, 1993). The researcher’s own views form the basis of how the original story is represented. The final level of representation of experience is reading. This is when others read about the experience as told by the person and interpreted and represented by another (Riessman, 1993). The reader then, in turn, interprets this representation according to their own viewpoint.

**Research Procedure**

**Sample Selection**

Unlike quantitative studies that aim to provide generalizability in a positivist empirical sense (Denzin & Lincoln, 2005; Sandelowski 1995), this study sought to achieve profound meaning in order to gain an understanding of homeless street youths’ time perspectives. According to Holloway and Freshwater (2007), “Sampling in narrative research can rely on a very small number of people as depth rather than breadth in data collection is sought” (p. 70). While prepared to recruit and interview as many participants as needed, it was anticipated that between ten and fifteen homeless street youth meeting the inclusion criteria described below would be sufficient (Morse, 2007;
The process of sample selection continued until saturation (the point of redundancy, when no new information is revealed) was reached (Lincoln & Guba, 1985). A total of fifteen participants were interviewed. However, the final analysis included only thirteen participant stories as two stories were not included for the following reasons. One of the participants did not meet the study criteria because he had never spent a night on the streets and another participant appeared to be severely mentally ill expressing thoughts that were scattered and illogical.

According to Sandelowski (1995), people participate in qualitative studies because they have direct and personal knowledge of a phenomenon and wish to communicate it. Participants were selected because they met both experiential fit (experts undergoing the experience of interest) (Morse, 2007) and were willing to participate in the study.

While convenience sampling is considered a weakness in quantitative studies, and few qualitative researchers have argued against its use (Patton, 1990), there are situations in which convenience samples are an acceptable method. For example, convenience samples may be appropriate when studying marginalized populations that are difficult to access, instances in which a population is rare, or for populations and phenomenon that have not been studied previously (Phua, 2004). In this study, homeless street youth are considered a marginalized population that is very difficult to access.

Research participants in this study were recruited using two strategies. The first strategy was a purposive criterion based method (Patten, 2005) seeking participants who fulfilled the inclusion criteria as described below. A second strategy, commonly referred to as “snowballing”, was also used to obtain more participants who fit the inclusion
criteria. In this strategy, initial participants were asked to share study recruitment information with peers who may be eligible (Patten, 2005), but only if they were comfortable doing so. As stated previously, I sought to interview ten to fifteen participants who met the criterion. An attempt was made to include approximately equal numbers of female and male participants and also include youth who considered themselves to be transgender. The rationale for this was that an equal gender distribution of homeless youth would reflect the characteristics of this population in the U.S. (Hammer et al., 2002). In addition, an attempt was made to obtain a sample that reflected the full age range per the study inclusion criteria for the purpose of eliminating bias toward one or more ages.

**Research participant inclusion criteria.**

Participants were included in the study if they (a) spoke English; (b) considered themselves homeless; (c) identified the street (or other outdoor locations such as parks, train stations etc.) as a significant place where they lived or stayed at least 50% of their time; and (d) and were ages 16 to 21 years old.

It should be noted that for convenience, the age criteria in this study was limited to a five year span representing only middle and late adolescents. As discussed in chapter two, the homeless youth population is comprised of adolescents younger than age 16. In order to enroll in the study, participants did not have to show identification, proof of homelessness, or any documentation to verify age.

**Research participant exclusion criteria.**

Participants were excluded from the study if they (a) did not speak English; (b) were stably housed; (c) considered themselves homeless but did not identify the street (or
other outdoor locations such as parks, train stations etc.) as a significant place where they lived or stayed at least 50% of their time because they were with family, friends, acquaintances, or lived in a shelter, group home, or other residential facility; or (d) were less than 16 years or older than 21 years of age.

**Human Subjects Protection**

This study aimed to study a highly vulnerable population, homeless street youth between the ages of 16 and 21 years. Therefore, ethical and legal considerations were of paramount importance. Prior to conducting the research, approval from the University of Hawai‘i Committee on Human Studies was obtained.

**Adolescent health research guidelines.**

The Society for Adolescent Medicine (Santelli et. al, 1995, 2003) provides published guidelines for interdisciplinary research in adolescent health based on several general principles. These principles are summarized below and describe the standards which guided the current study.

1. There is currently a critical need for research in biomedical and behavioral sciences to enhance the health and well-being of adolescents.

2. Adolescents are distinctly different from children and adults in terms of their developing cognitive abilities and judgment.

3. Adolescents are most likely to achieve full maturity and identity when a loving family supports them. Adolescents need the security of a caring adult to provide the framework for exploring attitudes, values, and beliefs of society at large. Moreover, “the role of the parent in protecting the adolescent’s interests must be
honored and facilitated whenever possible and appropriate” (Santelli et al., 1995, p. 264).

4. In evaluating any research proposals involving adolescent subjects, the risks and benefits to individuals and groups associated with conducting or not conducting the research should be addressed.

5. Current federal regulations (45 CFR Part 46) and the ethical principles of beneficence, justice, and respect for people provide the framework for evaluating research involving adolescents as subjects.

6. Members of internal review boards and investigators who lack knowledge about adolescent research would benefit from guidance in interpreting and applying regulations to adolescents.

**Waiver of parental consent.**

This study sought and obtained a waiver of parental consent from the University of Hawai‘i CHS for participants who were less than 18 years old. It was felt that requiring underage youth to obtain parental consent would compromise their safety (Rew et al., 2000). Many youth are currently homeless due to unhealthy relationships with their parents or guardians. Knowledge of a youth’s lifestyle might have increased the risk of parental/guardian abuse – emotional, physical, or sexual. Because participation in this study was voluntary and involved minimal risk, it was important to maintain homeless youths’ privacy within the limits of the law. In addition, the need to obtain parental consent would have discouraged potential participants from taking part in a study that would otherwise be of some benefit to the population.
The ethical standards for research involving children as human subjects have been disseminated by the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research in two published reports: 1) Research Involving Children (National Commission for the Protection of Human Subjects of Biomedical Research, 1977) and 2) The Belmont Report (National Commission for the Protection of Human Subjects of Biomedical Research, 1978) (Santelli et al., 2003). The Code of Federal Regulations, 45 CFR Part 46.408 allows institutional review boards (IRBs) to waive parental consent in those studies of adolescents that do not pose more than minimal risk; when the requirement for such permission is not reasonable; and when the waiver is not inconsistent with state or local laws (Rew et al., 2000).

I took several steps to ensure that all state laws pertaining to research with high-risk minors would be followed. First, I contacted the IRB at the local research university where I was employed and verified that a waiver of parental consent was not inconsistent with any laws in the state where the study was conducted. Secondly, I met with a faculty member of the university’s law school to identify any statutory regulations that might inhibit collection of data from a sample of local homeless street youth without parental consent. A computer search found no statutory regulations requiring parental consent.

Thirdly, in order to have a thorough understanding of the child abuse reporting requirements in the state in which the study was conducted, I reviewed relevant sections of state law. In addition, I consulted with two local professionals with expertise in the subject area: a senior nursing faculty member at the nearby research university who is considered an expert in ethics and is also a member of the IRB; and a staff member and attorney at the same university’s juvenile justice program. Findings from these efforts
confirmed that in my capacity as a nurse researcher, I was required to be a mandatory reporter. Therefore, while conducting this study on a population with a high incidence of abuse, I anticipated the possibility of receiving information that would require reporting and explicitly described the limits of confidentiality to the participants during the informed consent process. During the study, no information was shared with me that required mandatory reporting.

**Informed consent.**

All participants who participated in this research were required to provide informed consent per the Agreement to Participate form (see Appendix A). Informed consent is a vital part of the research process and, as such, entails more than obtaining a signature on a form. Investigators must educate potential subjects to ensure that they can reach a truly informed decision about whether or not to participate in the research. Their informed consent must be given freely, without coercion, and must be based on a clear understanding of what participation involves. In this research, consent (agreement to participate) was not considered to be an event but rather a process that involved a reciprocal relationship between the participant and researcher that continued for the duration of the study. In the current research, this relationship began during initial contact with potential participants, developed during the interviews as trust and good will were built, continued through the analysis, and will be sustained through and beyond the dissemination of findings.

Participants were given verbal and written information that explained about the study and the informed consent process. Specifically, a thorough description and explanation of the study procedure, benefits, risks, privacy, and confidentiality was
provided. Voluntary participation was reinforced. To address the potential issue of participants being illiterate or having a visual impairment, the Agreement to Participate form was placed before the participant and read as they followed along.

**Risks.**

This study posed no major risks, physical or otherwise. However, it was anticipated that some participants may experience a variety of emotional responses such as discomfort, worry, embarrassment, and anger after revealing personal information. Participants were informed before and during the interview session that they could refuse to answer any question or topic, end the interview session whenever they wish, and reschedule or drop from the study without explanation. Participants were encouraged to talk about any feelings and concerns they had as a result of the study with a professional provider or other responsible adult if it was safe to do so. In addition, a document with the names, addresses, and phone numbers of multiple local health and social services organizations that work with homeless youth was provided to each participant.

The interview would end if the participant appeared to be emotionally upset or fatigued. Because the researcher has considerable experience assessing the physical and mental health of youth, it was felt that she would be able to determine if a participant’s health was becoming compromised during the course of an interview. At any time indicated or requested, the participant would be given referral information for local homeless youth service providers or emergency care.

During the informed consent process, participants were notified that a second interview may be requested if, based on the initial interview, information needed to be clarified or expanded and findings needed to be validated. At the end of the consent,
before the signature section, participants were asked to indicate whether or not they gave permission to be contacted for a second interview; and if so, how to contact them.

**Recruitment**

Participants in the research were recruited from three organizations that provide services to homeless youth in a large metropolitan area on the east coast of the United States. One of the organizations is a health center that provides comprehensive medical, behavioral, and psychiatric health services to marginalized, high-risk adolescents and young adults ages 12 to 29 including the following populations: homeless, gang-involved, HIV positive, GLBTQ, and sex industry workers. The center is located across the street from two popular gathering places for homeless youth. It is licensed as a health center, mental health clinic, and substance abuse center by the state. The other organization is a drop-in center that provides a welcoming and non-judgmental environment for homeless and street-involved youth. It is open five days a week and serves young people between the ages of 14 and 24. The center offers basic necessities including onsite hot meals, clothing, showers, and laundry facilities. It also provides weekly medical care, mental health counseling, referrals to community resources and information on the prevention of HIV, STDs, Hepatitis C and other diseases associated with high-risk behavior. The third organization provides comprehensive services to homeless youth including street outreach, counseling, educational, medical, career services, emergency shelter and transitional housing. Permission to recruit for the study was obtained from program directors at each of the organizations.

Recruitment was accomplished by posting research study recruitment flyers (see Appendix B) throughout the organizations. Flyers were placed in lobbies, exam rooms
and common areas. In addition, I was given permission by each organization to come on site and approach youth about the research in common areas where they congregate and are staffed by professionals. Because there was a low response to the flyer, I went several times to each organization to recruit. In total, two participants contacted me because of the flyer and thirteen participants were recruited directly on site.

Participants could receive a $25 iTunes, CVS pharmacy, or Dunkin’ Donuts gift card for their participation. Participants who agreed to a follow-up interview received another $25 gift card of their choice. Most participants chose the CVS pharmacy gift card stating that they needed to purchase food, including pet food, or personal hygiene items.

**Interview Setting**

All interviews were conducted by the principal investigator and took place on site and during normal business hours at the organizations where participants were recruited. Spaces that ensured privacy during interview were provided including conference rooms and clinical examination rooms. For safety purposes, professional staff from the organizations were always within shouting distance during the interview in the event that help was needed. The signed Agreement to Participate (Appendix A) was thoroughly reviewed with the participant prior to beginning the interview.

**Demographic Data**

During their story telling, it was anticipated that participants would be providing sensitive details of their life. Basic demographic data was considered important for enriching understandings of the stories told. In keeping with this study’s approach of
respect and sensitivity while studying a vulnerable population, and so as to avoid unnecessary intrusion, it was decided that a standard demographic questionnaire would not be given to participants to complete. Rather, a minimal set of demographic data (see Appendix C) was obtained during the interview as participants shared their stories. In cases when demographic data was not shared during a participant’s story, questions were gently asked at the conclusion of the interview.

**Interview**

In this narrative inquiry, the aim of the interview session was to bring out stories (Kahn, 2000) about homeless street youths’ lives. The stories were a product of a "given moment in time, of sociocognitive activity which takes form in the narrative" (Ville & Khlat, 2007, p.1004) rather than the facts of the experience. The feelings, images, thoughts and meanings that are significant to the homeless youth storytellers were conveyed in the text of the interview. According to Patton (2002), interviewing in research enables us to:

…enter into the other person’s perspective. Qualitative interviewing begins with the assumption that the perspective of others is meaningful, knowable, and able to be made explicit. We interview to find out what is in and on someone else’s mind, to gather their stories. (p. 341)

According to Mishler (1986) narrative is a collective process with the interviewer and interviewee both sharing in the control; a discourse with give and take. Therefore, a conversational interview approach was used in this research for dialogue aimed “toward encouraging expression, elucidation, and disclosure of the experience being investigated .... Dialogue involves cooperative sharing” (Moustakas, 1990, p. 47). Reinharz (1992)
advocates for a semi-structured or unstructured interview format that allows for a free exchange between the interviewer and the interviewee. “One of the ways to get at subtleties is to be interviewee guided, which means focusing less on getting one’s questions answered and more on understanding the interviewee” (p. 24).

In order to allow a sample of homeless street youth participants an opportunity to tell their story, the following broad opening question (Chase, 2003) was asked: *Please tell me your story, in your own words, any way you want to tell it.* It’s was expected that with such permission to tell their stories, participants would be allowed to “hold the floor for a lengthy turn in the interview conversation and [be] interrupted only for clarification” (Riessman, 1997, p. 156). The less number of interruptions, the longer stories with meaning are produced, resulting in less fragmented data which can suppress the story.

An interview guide (see Appendix C) was used in all initial interviews to help direct a conversational style interview. The use of open ended questioning, a technique widely used in qualitative inquiry, helped participants to bring their stories forward. Although narrative researchers have noted that very little prompting of participants is usually required (Riches & Dawson, 1996), additional general questions were developed to help homeless street youth tell their stories if needed. Neutral, open-ended probes were used if participants need to illustrate their answers with additional stories or to provide evidence for particular conclusions they draw. Finally, participants were given an opportunity to provide any information that they wish to share at the conclusion of the interview (see Appendix C, Part III.).
“Self” as Instrument

Since the characteristics of clinical interviewing and qualitative research both rely strongly on the interviewer as the main instrument for gathering data, it is necessary to note that my own background and experience working as a nurse, and specifically with the homeless, influenced this research. The idea of "bracketing" or setting aside all prejudgments during the interview process was originally conceptualized by Husserl (1963) in regards to the study of phenomena. It is understood as the suspension of the researcher’s own experiences and beliefs in order to allow the subjects essential meaning to be brought forth. In contrast, Heidegger (1982) theorized that an investigator's own views and beliefs cannot be suspended and should be acknowledged as part of qualitative investigation (Moran, 2000). My personal narrative and preconceptions related to this area of inquiry have been previously discussed in chapter one. Reflexivity, as described below, provided a mechanism to address any biases.

Reflexive Journaling

Reflexivity is an attitude of attending systematically to the context of knowledge construction, especially to the effect of the researcher, at every step of the research process. It is a necessary element of quality and assists in establishing the trustworthiness of the study (Holloway & Freshwater, 2007). Reflexivity is important because: "A researcher's background and position will affect what they choose to investigate, the angle of investigation, the methods judged most adequate for this purpose, the findings considered most appropriate, and the framing and communication of conclusions" (Malterud, 2001, pp. 483-484). A reflexive journal was kept during the research process to record methodological decisions and the reasons for them, the
logistics of the study, and reflection upon what was happening in terms of my own values, interests, and biases (Lincoln & Guba, 1985).

Field Notes

Field notes are recommended to enhance the quality of data obtained in the research. They were taken throughout the study, during and after interviews and other times when I was in contact with homeless youth (Kahn, 2000). Notes included the following: date, time, place of observation, specific facts and details in the field, sensory impressions, and specific words and summaries of conversations.

Data Management and Security

Explicit, strict data management and security processes were employed during the study to maintain organization for analysis, increase trustworthiness, and ensure participant confidentiality. Agreement to Participate forms (informed consents) containing names and other contact information were kept in a locked cabinet in my work office. Interview transcripts, demographic information, field notes, reflexive journal entries, and analysis documents were stored in a locked portable cabinet in my home office. These documents did not contain participants’ names, only an alias/code name. Any proper names in the text (names of family members, friends, service providers, or institutions etc.), specific locations, and other unique identifying data were extracted and/or changed to neutral terms (for example “my partner” instead of the individual’s proper name).

With participants’ informed consent, all interviews were digitally audio-recorded. Recordings were immediately transferred and stored as files on a secure computer server at the university where I work and the original recordings were deleted. Interviews were
transcribed verbatim by a professional transcriptionist as soon as possible after the interview and data was checked for accuracy by listening and comparing it to the transcribed notes. When the audio files were no longer needed during analysis, they were permanently deleted.

All data were locked at all times except when they were being used. Only I, as the researcher, have direct access to the data. All data will be destroyed by shredding three years after completion of the study.

**Narrative Analysis**

In narrative inquiry, the stories of participants are the focus of the analysis. Storytelling is a creative act. Storytellers choose the details, events, characters, and perspectives for the stories they tell about their lives (Holloway & Freshwater, 2007). These decisions reflect the meanings that they give their stories. According to Riessman (2006), narrative analysis is the method that is used to analyze text that occurs in storied form, with plot sequences that are ordered, connected and meaningful. Through the use of narrative analysis, nuances are constructed within the context of the participant’s story, and the sequential, temporal order of events determines the “plot” of the narrative.

The researcher’s own story.

As previously discussed, prior to the commencement of the narrative interviews and analysis, I wrote a narrative of my own experience relevant to the topics of inquiry, time perspective and homeless youth. Munhall (2007) described how important it is for researchers to take time to “reflect on your own beliefs, preconceptions, intuitions, motives, and biases so as to decenter” (p.170). Writing my narrative enabled me to be
more open to listening to and hearing the stories of the participants and also better able to focus on the analysis.

Narrative analysis, as a research approach, does not have a theoretical framework or standard methodology (Emden, 1998a; Priest, Roberts, & Woods, 2002). The development of data analysis procedures used in narrative analysis have been influenced by scholars across many disciplines (Emden, 1998a; Priest et al., 2002; Riessman, 1993). This has led to a variety of approaches and uses of narrative in qualitative research (Priest et al., 2002). While McLeod and Balamoutsou (2001) argue that researchers should be able to generate their own data analysis method, Priest et al. (2002) recommended that beginners should follow an established procedure. Polkinghorne (1995) provides phases of the analytic process as a guide. He notes, however, because the analysis is an iterative and interpretive process, the researcher should not be overly burdened with using the guidelines.

As a novice researcher, I chose to adapt Polkinghorne’s narrative analysis approach by incorporating procedures from a number of narrative sources (Dollard, 1949; Emed, 1998a, Goodfellow, 1997; Polkinghorne, 1995; Riessman, 1993; Seidman, 1991). The resultant procedure fit within my own interpretive process of gaining an understanding of the time perspectives of homeless street youth and included the following steps which I carefully followed for each participant:

Step 1: Transcription

Step 2: Connecting with the Participant’s Story

Step 3: Identification of the Denouement

Step 4: Examination of Dollard’s Criteria for Life History
Step 5: Chronological Ordering of Events and Experiences

Step 6: Core Story Creation

Step 7: Verification of Core Stories

Step 8: Story Emplotment

Each of the steps is described in detail below.

**Transcription.**

Once all of the data including printed transcripts, demographic information, field notes and reflexive journal entries were organized, the first step in narrative analysis was to transcribe the audio-file interview. A professional transcriptionist was hired.

**Connecting with the participant’s story.**

Beginning with the first interview, I simultaneously read each transcript while listening to the audio-file. This allowed me to reconnect with the participant’s story and gain an overall understanding of the experiences of homeless street youth. I analyzed the field notes and reflexive journal entries that corresponded to the interview. I then re-read the transcript several times to enable me to engage in the data and to gain an overall understanding of the experiences of the participant. A technique of narrative analysis known as overreading (Kermode, 1981) was used. This is a deliberate act of interpretation (Poirier & Ayres, 1997) where the investigator looks for meaning that is implicit rather than only explicit in the interview text (Ayres, Kavanaugh, & Knafl, 2003). Through overreading, it was possible to demonstrate a sensitivity to unspoken or indirect statements and attend to inconsistencies, endings, repetitions, and silence (Poirier & Ayres, 1997).
During this step I was totally immersed in the data, allowing the data to “talk to me” so that I could reflect on the following questions: “What is this homeless street youth telling me?”, “What do they want me to know about them?”, “What is the story she/he is trying to communicate?”, and “What is the significance of the story?”. It was during this time that I also read the transcript to gain my initial understanding of the participant’s time perspective and how it may be connected to their health and health promotion.

**Identification of the denouement.**

According to Polkinghorne (1995), the narrative configuration process begins with identifying the denouement or the story’s outcome. In order to determine the denouement, I studied each transcribed interview and carefully followed the events in the plot to arrive at the resolution that took place for the participant.

**Examination of Dollard’s criteria for life history.**

During this step, I used Polkinghorne’s adaptation of Dollard’s criteria for the components of a life history (Polkinghorne, 1995) as a lens for looking at the data. Although Dollard (1949) developed a tool for assessing a life history, Polkinghorne (1995) suggested the criteria could be used in narrative analysis as a guide for the development of the narrative (pp 16–18). I re-read the transcripts with Dollard’s criteria in mind and this allowed me to have an additional perspective of the data that could potentially deepen my understanding of the participants’ stories.

The criteria (Polkinghorne, 1995) included the following:

1. The contextual features including ‘cultural context . . . values, social rules [and] meaning systems’ (p. 16)
2. The ‘embodied nature’ of the central character including factors that may influence their ‘personal goals’ and ‘life concerns’ (p. 17)

3. The influence of ‘significant other people in affecting the actions and goals’ of the character (p. 17)

4. The ‘choices and actions’ of the character and their movement ‘toward an outcome’ (p. 17)

5. The ‘historical continuity’ of the character and their cohort (p. 17)

6. A requisite ‘bounded temporal period . . . it needs a beginning, middle and end’ (p. 17)

7. The provision of a plot that configures ‘data elements into a meaningful explanation of the [character’s] responses and actions’ (p. 18)

**Chronological ordering of events and experiences.**

Stories are organized within a temporal framework and they usually contain a beginning, middle, and end (Polkinghorne, 1995; Riessman, 1993). Most of the participants did not share their story in chronological order. Instead, they moved back and forth between the past, present, and future. Therefore, it was important that the data elements of each of the participant’s transcripts were arranged chronologically (Polkinghorne, 1995). To create an organizing template, headings relevant to time perspective (past, present, and future) were used to sort the data. Within each of the headings I chronologically ordered the data. This step produced a new data item which was called “chronologically restructured transcript”.

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Core story creation.

According to Emden (1998b), creating a core story is useful because it reduces full-length stories to shorter ones to assist in the data analysis process. Therefore, the next step in the narrative analysis process was for each of the newly chronologically restructured transcripts to be reduced significantly down to the “core story”; a product that reflected the necessary elements for story completion (Mishler, 1986; Polkinghorne, 1988).

To produce the core story, all interviewer questions and comments were deleted from the transcript. All words that detracted from the major idea of each of the participant’s sentences were deleted. This process was repeated several times until only the key ideas were retained.

Verification of core stories.

Once completed, an attempt was made to return the core stories to the participants for verification or “member checks”. Each of the participants had given consent to be contacted for a second interview. Each was contacted through email, phone, or in person and invited for a second interview meeting to review the core story that had been reconstructed. They were asked to read or listen to the core story and to correct, delete, or develop any part of their story (Emden, 1998b). Of the 13 participants, 5 who were contacted in person agreed to verify their core stories. The remaining eight participants, who had been contacted through email or phone, did not respond.

Story emplotment.

In the sixth and final step, I focused on emplotting the story. Emplotment is a process of working with the plots in a story in a way that reveals the significance of the

During this step full-length core stories were reduced to shorter emplotted whole narratives. This allowed there to be a distinct focus of each story’s events, actions, and outcome. Unlike the core story verified by the participant, the emplotted whole narrative is a narrative construct that gives meaning and understanding to the data.

**Final story.**

The final stories that were co-created from the participants and I, as the researcher, should reflect the complex, interwoven, character of human experience as it unfolds through time (Heidegger, 1962). Rather than simply reordering data chronologically, the events of the story were made whole and the storied product is a “temporal gestalt in which the meaning of each part is given through its reciprocal relationships with the plotted whole and other parts” (Polkinghorne, 1995, p. 18).

**Trustworthiness**

The narrative researcher is entrusted with participants’ stories and therefore must recognize the responsibility attached to this privilege. It is imperative to provide an interpretation that is trustworthy, or true to each participant’s unique story (Ayres & Poirier, 1996). Researchers trying to establish the validity of a narrative analysis are faced with a challenge. It is what Sandelowski (1991) refers to as “the inherently contradictory project of making something scientific out of everything biographical” (p.
161), and what Ayres and Poirier (1996) call attempting to “make science out of stories” (p. 164).

Traditional conceptions of validity, techniques, and typologies as standards for judging the importance and value of a study are situated in positivist assumptions underlying quantitative and experimental realms of research (Maxwell, 1992). Riessman (2002) argues that these standards do not resonate with those of understanding and purpose as keys for evaluating qualitative research and, therefore, should not be applied to narrative inquiry.

Validation, the process through which we make claims for the trustworthiness of our interpretations, is the critical issue. “Trustworthiness” not “truth” is a key difference (Riessman, 2002, p. 258). According to Riessman (2002), a social constructionist perspective places less emphasis on the verification of “facts” and more on the perception of those events from the view of the participant. Thus, understanding the changing details of events for the individuals involved, and how these events are located in a social context, is a main component of validity. This is also supported by Polkinghorne (2007) who stated “storied texts serve as evidence for personal meaning, not for the factual occurrence of the events reported in the stories” (p. 479).

Validity in narrative research is the believability of a statement or knowledge Claim and its believability is a function of intersubjective judgment and consensus within a community of scholars (Polkinghorne, 2007). The purpose of the validation process is to convince readers that there is enough support for the research claim and that it represents understanding of human action. Narrative research results in a composite story that provides insight and understanding about life events for individuals and how
these individuals understand themselves, others, their context, and situations (Polkinghorne, 2007).

In this research, using the original interview data, the participants’ stories were re-storied. Writing the story was an iterative process that consisted of movement back and forth between the constructed story and the narrative elements. This process validated the story as being true to the narrative elements and clarified the plot as plausible.

Ayres and Poirier (1996) argue that a clear and transparent description of all methods and means used to come to the final presentation is the best evidence for demonstrating the trustworthiness of the work, given the potential for multiple interpretations and meanings. The ability for the findings of the study to be confirmed or substantiated by other people is referred to as the study’s confirmability. An audit of the study’s data and ultimate findings by an outsider is one way to ensure confirmability of the study. In this study, an audit trail is accessible for confirmation of the study findings and details my “trail” as a researcher. Interview transcripts, field notes, reflexive journal entries, and a record of narrative analysis procedures have been maintained. With this process, an outside “expert” can look at the information critically and be able to distinguish work that is of high quality (Patton, 2002).

Verisimilitude is the sense of authenticity that the reader feels in response to the narrative. If the text resonates with a reader’s experience, they are likely to find value in the story. Connelly and Clandinin (1990) describe a good narrative as being one that feels like an invitation to participate. They cite Peshkin (1985) who wrote:

When I disclose what I have seen, my results invite other researchers to look where I did and see what I saw. My ideas are candidates for others to entertain,
not necessarily as truth, let alone Truth, but as positions about the nature and meaning of a phenomenon that may fit their sensibility and shape their thinking about their own inquiries. (p. 280)

Authenticity has been maintained by accurately representing the participants’ perceptions, and by allowing each participant to direct the flow of the interview to capture the story that is important to them.

As described earlier, after the core stories were formed from the interview transcripts, study participants were contacted for a second interview. Rigor was maintained through these “member checks” by allowing participants \( n = 5 \) to validate the content descriptions and/or correct any areas they felt were inaccurate, misleading, or missing. This technique was crucial for establishing the validity and credibility of the participants’ accounts (Lincoln & Guba, 1985). Furthermore, it allowed them to be the experts of their stories, and this was congruent with the overall importance of staying true to the study purpose.

**Summary**

Storytelling provides insight into a person’s identity including their time perspective. Narrative inquiry was selected as the most appropriate methodology for this research and was used to gain a rich understanding of homeless street youth, their stories, their time perspective, and health. In this chapter, I provided details on the research method, sample, procedures, and data analysis. The rigorous and iterative process leading to a participant’s final story was delineated step-by-step. In the following chapter, I will present the results of this research, a collection of stories developed through narrative analysis.
CHAPTER 4: RESULTS

The outcome of the narrative analysis described previously is a collection of thirteen stories that answered the following research questions:

1. What are the stories told by homeless street youth?
2. What meanings do homeless street youth give to their experiences?
3. What are the time perspectives of homeless street youth and what meaning do past, present, and future have to them?
4. Does time perspective influence the health and health promotion of homeless street youth? If so, how?

In this chapter the collection of stories will be presented followed by an analysis of story similarities and uniqueness. Participants in the study were between the ages of 18 and 21 years old. There were six females, five males, and two female to male transgender individuals. Each participant considered themselves to be homeless and identified the street as the place they live at least half of the time. A semi-structured, interview guide was used in each case to allow the participant to contribute their own ideas. All participants were initially asked to tell their story, in their own words, any way they wanted to tell it. Additional questions were designed to invite the research participants to discuss being homeless and their time perspectives, health, and health promotion.

As a collection, the individual stories offer greater insight and understanding than any one story could (Polkinghorne, 1995). This allowed me to shift my focus “to look at cultural narratives more broadly” (Emden, 1998a, p. 32). According to Bruner (1987), to understand what is told, ‘life stories must mesh . . . within a community of life stories” (p.
The sequencing of the stories in the collection was determined purposively and does not reflect the actual chronological order of the participant interviews. After reflecting on each story and its uniqueness, the stories were ordered in such a way to that the reader might be able to appreciate the uniqueness of the stories. For example, in most instances, I alternated between female, male, and transgender participant stories.

Collection of Stories

Anna

Anna is a 19 year old female who describes herself as “5 foot 3, smart and strong, with never the same hair color”. She graduated from high school with a 3.9 GPA and considers herself a “homeless junkie alcoholic with lupus.”

Anna was a “DSS kid my entire life”. Her biological mother had had four children before she had Anna. “She kept having them because they kept getting taken away and dumbass thought maybe if I have one more, I’ll get to keep it. That’s not how it works.”

Anna’s not sure who her biological father is. Each of her siblings has different fathers. The father that she remembers was very abusive to Anna’s mother and all the children. “I have a scar on my forehead because he threw me at 2 1/2 into a coffee table.” Because Anna’s mother refused to leave her husband, Anna and her siblings were put in the custody of the Department of Social Services. At the age of six, Anna was placed in a foster home along with her younger sister and eventually they were adopted.

When Anna was 11, she was diagnosed with bipolar disorder and “kicked out” of her adoptive parent’s home. She bounced between group homes, residential facilities, and psychiatric wards. During this time she ran away many times, often staying on the streets.

When Anna was 17 years old she reunited with her biological mother and moved in with her and her “boyfriend person thing”. She graduated from high school with excellent grades and tried going to college for a couple semesters but then quit. She started drinking heavily and got hooked on drugs. “I am now identified as an alcoholic and a junkie.” At some point she moved back in with her adoptive family who could not tolerate her behavior and gave her an “eviction notice”. She left that home and has been homeless now for about four months ago.

On the streets Anna considers the group of homeless youth she hangs out as her “street family”. Anna sleeps in the park with a sleeping bag and a blanket. Her day generally consists of going to Dunkin Donuts with money that she received from spanging (panhandling for spare change) the day before. When the homeless youth drop-in center
opens up at 11am, Anna goes there to shower, eat, use the computer, and do laundry. “It’s pretty normal when we’re at the center. It’s like having a house. But when they close, it’s back out to the cold.” In the evening, she spanges some more for money to buy alcohol and hangs out with her friends and parties all night.

Anna is currently using marijuana, having most recently smoked a “bowl” several minutes before sharing her story. She had been clean for three months from cocaine and heroin but had a slip up a few days ago and is trying hard not to use again. Anna drinks alcohol daily, and gets the shakes about two hours after she stops drinking.

Anna uses a sign when she spanges that says “Homeless, hungry and broke, please help.” She always includes a smiley face on her sign. She believes that when people see the smiley faces, it makes their day better. Anna never makes eye contact with people because, based on her experience, they will run right past her and not read the sign. On average she receives $100 per week panhandling.

“Panhandling is all I do for money.” Anna doesn’t steal and believes that is why she is the “most broke homeless kid in the park”. Even though she has many friends that are “working the track”, she believes “It’s the worst things a woman can do. It is degrading and you have to have some really shitty self-respect to be doing that.”

Anna wears glasses and has braces. Her adoptive mother sent her $100 to get new prescription lenses recently. She has not seen the dentist in over a year. Anna describes her health as “bad”. She has lupus, juvenile arthritis, and asthma. In terms of her mental health, Anna was diagnosed with schizophrenia this year “but I still have bipolar.” She also has been told over the years that she has the following disorders: PTSD, reactive detachment disorder, ADD, ADHD, OCD, ODD, MPD, “and a couple of others that I cannot remember, like the whole book”. Anna is not seeing a psychiatrist she believes she needs to.

In the last year Anna has been to the emergency room between 20 and 30 times for various medical, psychiatric, and drug related conditions. Of those visits, she was admitted overnight about ten times for several days to one week. Anna has state medical insurance, Medicaid, but has been moving around for so long she doesn’t remember who and where a lot of her doctors are. She has an upcoming appointment with a new primary care provide to get help with her lupus and asthma which have been bothering her. She was recently tested for HIV and was negative. “I’m safe, when I do shoot up, I use clean needles that I get from my grandmother who is a diabetic.”

Anna’s health has little meaning to her at this time. “As long as I’m slightly alive, that’s all I really need.” Slightly alive means being able to “somewhat function”. “I’ve reached the point where I’m just like, alright I’m homeless, I’m doing what I can to get out. If I die trying, at least I was trying. Living outside is a lot harder than people think.” Anna has had several suicide attempts over the years. She is not feeling suicidal today but says “There are definitely days I wish I would die because I’m sick of everything.”
Thinking of the past helps Anna to cope. “Going through the things I have, I can go through just about anything. Even though I’ve hit a low now, I’ve been worse. I can get out of it.”

Anna defines the present as this week. “I live hour to hour, or more accurately minute by minute.”

Anna believes she is smart and strong. She puts effort into getting off the streets “more than anyone I know”. She fills out housing and job applications and is trying to get into drug rehab programs. Anna realizes the importance of getting off of the streets. “There’s too much coke and heroin around here. I need to get out of it. If I’m sitting here all day, it’s going to happen.”

To Anna, the future means what she is doing in about five minutes from now. She also believes in reincarnation and having another life and attributes this to being a Pagan. “Instead of worshiping a single God, Pagans see God as two halves male and female, the lord and lady. It’s nature based.” Although Anna says that a Pagan is not supposed to take modern medication but rather use natural things, she will occasionally take medicine but is “cautious”.

Anna’s message to healthcare providers about homeless youth is that more clinicians are needed onsite at homeless youth centers for psychiatric disorders and substance abuse treatment. She also thinks that one of the biggest barriers to getting healthcare is a lack of transportation. “How can I get to my appointments if I don’t have a car or bus or subway pass?”

**Todd**

Todd is a 21 year old male who wears a black leather strap around his ankle. It’s resembles a video game character named Ryu who is a street fighter.

Todd and his mother have never gotten along. As a child, they constantly argued and he felt she didn’t listen to how he was really feeling inside. “She thought whatever helps me is the best for me and there’s one thing I hate about guardians and mothers to their people or their children or whatever, you’re not supposed to think what’s best. You’re supposed to see how they feel inside before it’s best given.”

Todd was physically abused occasionally as a child but is most concerned about the significant amount of mental abuse. “I’ve been mentally tortured from people including my mother.” Todd started running away and staying outside for a day or two when he was 11.

Todd is currently diagnosed with schizophrenia and bipolar disorder. His past diagnoses have included ADHD and personality disorder. He has been hospitalized at local psychiatric hospital “too many times to count”. Todd is on medication which he says
helps “50/50 but not really’. He doesn’t like want to talk about when the last time he saw
the psychiatrist.

Todd describes his psychiatric problems in the following way. “It was a spiritual
encounter that I dug into something deep in the house that I shouldn’t have and it affected
me around the whole areas. Like jumping out of a hole of a track that shouldn’t have
been released and I was released. Stop man, it was horrible. Running around like doing
all these crazy things. People would say what is wrong with him.”

About three years ago, Todd left home. He has been continuously homeless since then.
He stays mostly on the streets, at the parks, and also in train stations. “Wherever I’m
stuck at, I just deal with it.” Sometimes when he has money he stays at the YMCA.
Although he likes getting off the streets every now and then, the Y doesn’t allow visitors
“so what’s the point of being there?”

Todd gets $680 per month in social security disability for his mental health disorders, but
it’s not enough for an apartment. He gets food stamps and also can eat at the homeless
youth drop in center.

Todd has learned from being on the streets. “I learned I could survive without people
telling me what to do and I used to think I won’t survive in this world.”

To get his needs met, Todd says he tries to be a hero on the streets and protect people.
“I always figure things out. I am a smart dude and I have a dangerous mind.” Todd
describes his dangerous mind by saying: “Let’s just say instead of shooting people for
killing, why don’t we just have fun giving them pain. Torturing is better than killing
people. At least that person lives for the rest of their life with that pain and your
vengeance is complete, you don’t want to kill them so that’s they’re problem. They can’t
handle the pain but as a matter of fact you got your payback in that feeling.”

Currently, Todd is using marijuana. Over the last two weeks he also been using cocaine,
heroin, methamphetamine, and taking prescription Klonopin and Suboxone pills he gets
from friends. To get off of drugs, Todd believes he should just stay away from people.
He doesn’t want to go to a drug rehabilitation facility. “I already got the steps. I already
read the steps so why should I go again? They only want to help you. Help me with
what?”

Todd has attempted suicide once. “I thought about it and I was like this ain’t worth it,
life, and just ending right there and being trapped in a hole. Sorry to say that’s being
trapped in a hole. You can’t be free from that stuff.”

Todd believes he could improve his health if he could “listen to people, use my head, and
stop being impulsive.” He’s is connected with a community health center for primary
care and mental health services but does not go regularly despite having some problems
to deal with. “I have half of it met as I speak. Most of them I saw also, I need a quarter of
that to meet and I should be all set, but spiritually that’s what I need help with the most. It
has nothing to do with psychiatry or psychology. It’s part psychology but in a spiritual way, but therapy and psychiatry is not going to help my problem.”

In terms of getting his spiritual needs met, Todd wants to know “Who am I really on the inside?” Todd describes his spiritual and religious beliefs as being “neutral”. “I have a positive attitude but I’m neutral to beliefs. I’m not on nobody’s side. I believe in everything but I don’t choose a side.”

Todd says he thinks about time a lot. “The past is something to learn but not to look back into. The future is a plan, but never to step forward to and the present is always the ground you stand on and the gift you receive every day of the moment.” He learned about past, present, and future from a Buddhist book.

Todd’s goal is to be a super hero of the universe, not the planet. “There’s already super hero for this planet, but I want to be something to make peace on the other side of the universe called the cosmos, the stars because they are at peace more than the universe. The universe is in its own peace, got to make its own way but that side is unbalanced and need a balance on both sides of the expanding universe to complete the peace of all time the end of time. The end of time just means peace of all time.”

When Todd was a child, he had “unexplainable abilities that people consider as powers”. “But they’re really not powers. Ability is a power, but the real power is a virtue to the ability. So it’s all about here (pointing to his forehead). That’s where the powers come from is your third eye.”

Todd feels like he is a spirit machine. “It’s like I came from the future from my spirit but my body’s used as a puppet to continue a sequence. People are like you’re crazy. They don’t understand the knowledge about truth about high learning.”

Todd’s message to healthcare providers about homeless youth is “Feel them from inside.”

Oli

Oli is a thin 21 year old with short blonde hair and large blue eyes who considers his story “hell”.

His mother had a placental abruption and he was born two pounds, fifteen ounces. “That was the first health issue in a long list of problems I have had.” As a child, Oli’s mother used to bring him for a lot of psychological testing. “She thought I was crazy, that I had bipolar and was insane. It turns out I’m autistic. It turns out I have Asperger’s.”

Oli was born a female. He lived as a female until he was 16 years old and made the transition to being a male. “I guess I never really believed I was a girl. I was forced into drag for a bunch of years. Well my mother was like you’re a girl, wear girl clothes and I was like okay. I don’t really understand what you mean by girl but… because gender is still a really confusing thing for me.”
Oli’s parents divorced when he was twenty-one months old. He lived with his mother “even though she didn’t want me” and was not allowed to see his father much even though he feels that if he was raised by his dad he would have been doing a lot better and not homeless.

Oli’s mother married a man who owns a multi-million dollar catering company and they had two children when Oli was 8 and 10 years old. Oli recalls being physically abused by his stepfather. He cannot recall ever being sexually abused. “I’ve tried to unlock that many times, but it’s not there.”

When Oli was 16 his stepfather kicked him out of the house and he has been homeless since staying in the park, along side of the river, and in the doorway of the church. “I was on a slew of psychiatric medications at the time. My mom was convinced I was crazy.” Oli recalls being on a complex psychiatric medication regimen before leaving home. “Effexor XR Adderall, Seroquel, Respiradone, and Abilify. And my parents kicked me out of the house, cold, dead turkey right out. I could have died. I didn’t’ die. But I could have died. Mind you most of those medications conflict. You do not pull a Judy Garland with a sixteen year old child. I’m sorry, up, down, up, down, dead. Kicked me out of my house.”

Oli lists his diagnoses as “PTSD, ADHD, OCD, ODD, X, Y, Z, L, M, N, O, P, anything you can diagnosis a teenage girl with is what they diagnosed me with.” At that time Oli was dealing with gender identity issues. “I tried to tell my parents before when I was a lot younger, like when I was still prepubescent, that something wasn’t right, but I just didn’t know… they don’t give you the words.”

Oli identifies as a “mostly heterosexual gender queer male. I’m a feminine guy but I’m not gay. I am not gay. I tried this, it didn’t work. Like being in a relationship with a man, holding hands with him, it did not work for me. Could not fucking do it. So I am a transsexual, but my gender is queer and male and I like girls the best. Born girls, biological girls.” He believes that being with biological girls is safe.

Oli has been raped “between eight and fifteen times”. “Never anally, astoundingly.” He has suffered damage to his cervix but has never contracted any STDs. “I’ve never been raped by a woman of the born woman variety. I’ve been raped by a transwoman, a transman and multitudes of men. Most of my rapes have been by white males. I have a lot of fear of white males, which is really fucking funny because I happen to be one now.”

Oli’s transition to being a male was necessary or he would have killed himself. Oli has been taking testosterone shots for a couple years and has noticed some side effects. “Sex and food, sex and food, sex and food. Just immediately was the only thing I could think of for the longest time, horrible.” He is starting to get used to the side effects of the testosterone and feels a bit calmer.
Oli is irritated that he still has breast tissue. Grabbing his chest he states “I don’t even know what you call this, something, less than a handful. Just enough to be irritating. Not enough for people to want me to get surgery though.” He would like to get surgery to “speed up the transition” but his physician has not been supportive of that.

There’s been some support on the streets with other transsexual youth. “There has been one trans woman who has slept out with us, one other trans guy who is my friend, I brought him here from the south because it was better here and there’s about seven bisexual men.”

Oli gets most of support, however, from his dog who he considers his “baby” and “the only man I’ll ever love.” The dog is a service animal, something that Oli feels keeps him healthy and sane. “He’s trained to do compressions, bring you out of PTSD or panic attacks, reassociate you. He’s trained to sleep between me and any other person, and he’s trained to hear the door for me because I’m half deaf.”

Oli has been doing a variety of hard core drugs over the last few years. Recently he started using a new drug called bath salts, or “madman”. “When you live on the street, sometimes you need to do drugs or sometimes you need to numb yourself in some way.” “I’m a transsexual. I live on the street. I’m disrespected. I don’t scream. I’m probably the quietest person in here and the only time I yell is when I get too autistic for myself.”

Oli also does acid which affects his perception of time. “It elongates times. It can take like two hours and turn it into six.”

For Oli, “The past means shit. It’s over, it’s done, I’m through with it. I prefer not to return it.” The present means “working my ass off to make my life better”.

Oli plans to move to a city in the south west and live in a commune with a girl that he met and fell in love with. “In ten years I hope to be with her.”

Oli describes the meaning of health in the following way: “It’s just like when you realize you have nothing, almost nothing to fear and nothing to lose and everything to gain, you start realizing yourself is pretty damn important and if you don’t keep yourself healthy and you watch the other people outside overdose and die.” Oli believes he will be working on his health for the rest of my life. He wants to be healthy enough to go get off all of his psychiatric meds.

Although he has done sex work “from time to time”, Oli has never gotten a sexually transmitted disease. The worst thing I’ve caught from someone I’ve slept with is fleas.” In addition, he has never had any “inhabitants living in me”, or been pregnant.

Despite his own drug use, Oli tries to help other homeless youth stay safe. “At the peak of the summer I will have two sets of Narcan in case of an overdose and I will carry extra weight in order to be carrying band-aids, alcohol swabs, Neosporin, cough drugs, Benadryl.”
Oli’s message to healthcare providers about homeless youth is “It’s usually not our fault.”

Karen

Karen is a 19 year old female who does a lot of speaking engagements on behalf of the homeless youth organizations she gets services from. She shares her story with politicians and donors and talks about what homeless youth need.

Karen was adopted at birth through an arranged adoption. She was the “third of five accidental children” in her birth family. Her biological father was addicted to “meth”. Karen’s adoptive parents had arranged two adoptions because their lawyer told them one would likely not go through. However, “Neither my brother nor I fell through and at the last minute they tried to cancel me but couldn’t do anything about it. They were kind of stuck.” Karen’s adoptive parents are wealthy and she grew up in a big home with eight bedrooms in a neighborhood two blocks from where she usually stays on the streets. Her parents are still there.

Karen’s parents hired a nanny to take care of the kids when she was an infant. The nanny’s husband began sexually abusing Karen at the age of five until twelve years. The nanny and her husband lived in the house and their bedroom was across from Karen’s room. Karen was “not totally raped, but everything else”. She did not tell her parents at time the abuse was going on. When she was twelve, her parents fired the nanny “because when you’re twelve, you’re old enough to take care of yourself”.

When Karen was 14 she started staying out on the streets regularly and began drinking a lot. She tried to explain to her parents that she was drinking because she was abused “and trying to make it all go away with the alcohol” but her parents did not believe her. “They were like well that kind of thing doesn’t happen to rich kids. We don’t believe you. We checked our sources on that nanny. I was like the nanny was fine. You didn’t check your sources on the husband.”

When Karen was 17 her parents told her she could no longer live at home. She dropped out of high school but got her GED. She has been homeless for two years. Being homeless for Karen “sucks”. She has a van she sleeps in but does not have much money for gas. In addition, she has a difficult time finding a place to park during the day and at night because of the meters and parking restrictions in the area.

Recently she has found a place to park that car during the day “way out of town” and takes the bus back and forth from the homeless drop in center and park where the youth hang out. In order to get money for the bus, she panhandles.

At night, Karen sleep with her dog, cat, and a car mate, a transgender male. The dog is service trained and helps to protects her and the cat is “trained to snap people out of flashbacks and ground people”.
Often Karen opens her van up to more people. “Anybody that asks as long as I’ve known them for more than a couple of days. Because of the sexual abuse, I’m really submissive. I have a really hard time saying no. So when people ask me if they can stay in my car, I pretty much always say yes unless there is no way to jam in another person.” Karen admits that she “gets walked on and used a lot”. “For my van, sexually, whatever they want.”

Karen recently applied for social security disability due to the PTSD and borderline personality disorder that she has been diagnosed with. While waiting for her disability, she gets transitional assistance in the amount of $80 a month. When the monthly disability check begins, Karen will not be able to get an apartment but plans to live more comfortably in her car. “I’ll probably get everything fixed and maybe even upgrade, that sounds so fancy. Probably upgrade some stuff on the car but I’ll still be living in my car.” Specifically she looks forward to buying yoga mats for the floor so there will be more of a cushion to sleep and also always having a full tank of gas. This is especially important in the winter so she can heat the car before going to sleep.

In the winter Karen tries to stay warm with her sleeping bag and also with the heat produced from her friend and the pets. “I have a really good sleeping bag and I tempt the cat in there with me and my friend sleeps in his sleeping bag with the dog and we squash together and we put one blanket over both the sleeping bags and we survive the night.”

Karen tries to be fair about staying warm. “A cats’ normal body heat is about 105. So they’re hot, warmer than humans. However a cat is smaller than a dog so there’s not as much heat spread out. I’m with the cat which helps a little but I have the better sleeping bag so my friend sleeps with the bigger animal.”

Karen has been seeing a therapist since she was sixteen. “It’s one of those things my mom is still willing to pay for so I see my therapist once in a while.” Karen’s parents pay for three things. In addition to therapy, they pay for her car insurance and cell phone. Karen feels “I guess it’s helpful”.

Karen says that her health and the health of all of her friends are poor because they are exposed to so many things living outside. “We share everything. We smoke cigarettes that we pick up off the ground. We eat leftovers that people hand us when we’re panhandling. We pick up everything.” In order to get food, Karen and some of her friends dumpster dive. “That’s a cheap way to get food. Why wouldn’t we do it?”

Karen doesn’t do drugs because her biological father killed himself on them. However, 90% of her friends are addicted “and wake up shaking and withdrawing”. Karen tries to help her friends. “I have to run around and panhandle and bring them beer so they don’t die.”

“If I lose a friend, I lose one of the people that protects me. I lose one of the people that has my back and somebody I trust. I also lose body heat at night and the more people I
have in my car, the warmer the car is. The street kids are my family. If my mother was
shaking and needed a beer because she was dying, of course I would go get her one.”

The only medical problem Karen has is anemia. She goes to the clinic every three
months to be checked for STDs. “I’m really paranoid about STD’s. I’ve only ever had
one thank God.”

Last year Karen was diagnosed with Chlamydia. She her and her partner were treated
four times because they continued to sleep together and were passing it back and forth.
Karen says this was “probably not the smartest thing”.

Karen gets regular rapid HIV tests. She is paid $10 from the health center each time she
tests. Karen describes her sexual orientation as “opportunistic”. She sometimes engages
in survival sex for money.

Karen doesn’t think about the future. “There’s not really much of a point because this is
my now and there’s too much for me to worry about right now. So I’m not going to
worry about a week from now.”

One to two weeks is as much into the future as Karen can think of. “If I have a therapy
appointment in two weeks, I usually can remember that but no, we have to be very in the
present because there’s just too much to do right now. How am I going to eat tonight?
Where am I going to shower? The drop in center is closed on the weekend so what will I
do for two days?”

Still, there are things Karen wishes for. “There’s things I think about when I’m falling
asleep at night like oh I wish that were me, I’d really, really love to be a counselor or a
social worker or something helping other people like me. I would have loved if
somebody could have saved me between five and fourteen. That would be great but it’s
not going to happen so I’m not going to spend all day thinking about it.”

Karen can’t imagine how she could ever go to college. “First, I don’t have the money, I
wouldn’t be able to get to class even if I did. How do you do homework out of your car.
Everybody wants typed papers now. I can’t have a printer in my car. There’s just so
many things between now and that.”

If Karen was to be offered housing, she would not accept it if she couldn’t bring her pets.
“So I’m supposed to house myself up and leave the animal that I have been with 24/7 for
the last two years outside or in a shelter somewhere where he could get put down, I don’t
think so. That’s not going to happen.” She describes the bond that is developed once you
go through living on the street with a person or an animal. “The bond you have with
them is way more intense than any other bond you will have with anything else because
you rely on each other not just for companionship but to live.”
Karen describes her dog as her “baby”. “He gives me a reason to get up and do it all over again every day and I probably wouldn’t without him. I’d probably just lay there, I would die or something.”

Karen hates her past. It causes her to have flashbacks and keeps her awake at night. In addition to thinking about the sexual abuse she experienced and the consequences of that, she wonders about her biological family. “Why couldn’t I stay with my biological mother?”

For Karen, the past affects her future. “I can’t go to college because of what I did in the past. My parents won’t pay for it.”

Karen would like for healthcare providers to think of homeless youth as individuals. “I feel we get clumped together a lot. All street kids are not drunken and crazy and wild and deserve to be on the street. That’s not true. Some of us just ran into some bad situations and our families didn’t want us. Now we’re on the street.”

“It’s totally untrue that every street kid breaks all the laws. I don’t. If I can avoid breaking laws, I do. I mean sometimes I can’t because I live on the street and I have to survive but I never hurt anybody with what I do.”

**Biggie**

Biggie is a 20 year old black male who has been homeless for almost a year “but happy to be living and not dead or locked up”. He describes himself as big, enthusiastic, and bold, and also believes that he is a “down to earth, and a cool, loving, caring dude that just cares about everybody. I can’t let people go to ruins. I’m always helping people even when I’m not helping myself.”

When he was three months old he was removed from his mother and put into the Department of Social Services system. He was placed with a biological aunt and her husband and remained in the system.

Biggie’s family kept secrets from him. They would not tell him the truth about his birth family. “The only thing they would tell me is that my mother was a drug addict, alcoholic and all this other stuff and basically I was born into all of that, basically a drug baby, alcoholic baby, whatever. I had all of that in my system.”

Biggie had a “really destructive childhood”. He says it wasn’t his fault and was beaten every day. Biggie grew up with his cousin who was two years older. “I learned by example from him.” Together they got into a lot of trouble and Biggie got whippings every day from his aunt and his cousin, who was in his twenties. “Not just with belts, but with cords and switches from outside and belts with metal castings on it.” Biggie was also hurt by his aunt “every once and a while”. “She would use her hands and hit me in the face.”
Biggie was picked on a lot and bullied at school. “I would come with a black eye, bloody lip, or bloody nose almost every day.” One day in the third grade had enough. “I couldn’t take it anymore from being beaten at home to being bullied at school and always getting into trouble. I tried to tell somebody but nobody would listen.” That was the day he “blew up” and beat up five kids who were in the fifth grade. Biggie says although he almost got arrested, “It was amazing because I got everyone off of me that day.”

The physical abuse by his aunt and his cousin continued throughout high school. “I was big by then and sometimes retaliated.” Biggie was sent to live with other family members and often would run away from any home he was in.

Biggie says that because of all the trauma that he’s had throughout his childhood, he has a lot of anger inside. “I try to keep it to a certain level so that I will not be a destructive young man.” Biggie does “blow up from time to time” when something is going wrong and he feels that he’s either being threatened or someone is disrespecting him.

Biggie has been homeless for a little over a year. He had a previous homeless experience a few years ago lasting eight months. “I’m hurting right now because I don’t have a place to stay. I don’t have a job. I don’t have any type of anything. Food stamps got cut off. so I have to go back and reapply for those, but I’m going to get me a job. All I have to do is get a state ID and I will have several jobs if I want.”

Although Biggie is homeless, he still believes he’s in a good situation. “I’m not going to sulk and be sad because I got my life. I’m still breathing. I get to see all my beautiful friends every day and I get to see more beautiful faces every day. I don’t discriminate, I don’t pick on people. I don’t like that because I’ve been through it so I know what it’s like.”

He stays at night in the subway stations and underground. To earn money he panhandles. His approach to panhandling is to give compliments to try to make them smile. “I say good morning beautiful, hope you have a nice wonderful day today. For the fellows, if they’re wearing like nice cool sunglasses, I say hey those are hot sunglasses, can I have those?”

Once he gets an ID, Biggie is looking for a job in sales or in a restaurant. He likes to work because it helps him to forget his past. “Like I need to be working. I need to really get a job and just forget about the past and just move on because it’s messing with my life.”

Biggie believes he may have bipolar disorder. He hasn’t been evaluated but because he’s “blown up too many times”, he’s concerned. “So it’s like I’m a ticking time bomb but how many times can a bomb blow up? It’s supposed to be one time and so it’s kind of bearing on my life and messing with my head more and more and I just can’t shake it.”

Biggie has thought about seeing a psychiatrist but is scared. “Sometimes I think I’m going crazy.” “I had a job, I was in school, I was working on a place to stay and it just
was moving way too fast and everything just got jumbled up together. I was missing dates and missing appointments and just forgetting and showing up at the wrong time and I was just like wow, this is not working for me.”

Other than being concerned about having bipolar disorder, Biggie believes his health is good. He does not have any chronic medical problems although sometimes his blood pressure is elevated. He was almost 300 pounds and would like to lose weight.

Biggie describes health as “my life”. “I want to stay breathing, I want to be on earth and see everything. I’m that type of person that likes to see everything. Sometimes I won’t go to bed because I’ll be thinking I’m missing out on something, something very cool and important, nothing negative because I don’t do those negativity scene. I do all positive things.”

Biggie has state medical insurance, Medicaid, but worries that he would get billed if he used the clinic or hospital. He recently had a physical and all his vaccinations are up to date.

Biggie tries to have peace by praying. “I’m a Christian, but I’ve dipped and dabbled into spiritualism.” He is able to “sit back and meditate and just be free of everything.” Biggie has experienced seeing the future and knows it will turn out great. “I actually have foreseen my future and there’s going to be some trials and tribulations in there but I’m going to get through it and I’m going to be successful. I may not be the richest person in the world, but I will be pretty wealthy, not like extremely wealthy, like a millionaire, but I’m going to have money to where I could do whatever I want, when I want, but also do what I need to do.”

Biggie’s goals include finishing his GED and going to culinary school so he can be chef and have a TV show. He believes he can accomplish this through “hard work, sweat, and tears”.

Biggie’s message to healthcare providers about homeless youth is “Have an outreach team.” He believes this would help him get access to healthcare without having to go to the clinic or hospital, which is difficult because he doesn’t have any transportation.

**Nicole**

Nicole is a 21 year old African American female who “wants more for myself and I feel like I can do it.”

Nicole was born and raised in a large east coast city by grandmother since she was one or two years old. Her mother was only 17 when she had her. Nicole has heard two different stories about why she went with her grandmother: her mother gave her away and her grandmother took her away.
Nicole’s mother was homeless on and off for years but occasionally she would see her on weekends. At some point her mother ended up moving to the south and getting married. When she was 13 Nicole tried to live with her mother for four months, but things “didn’t work out”. Nicole attributes this to her stepfather being abusive to both she and her mother. When she was 15, she tried again to live with her mother but “it didn’t work out” because of her stepfather’s continued abuse.

Nicole talks about some “mistakes” when she was in her teens, around 14 and 15. Though overall she says she was a “pretty good kid”, she “kind of rip and ran the streets a little bit.” She dropped out of high school at one point but went back to an alternative high school and received straight As and graduated as valedictorian of her class. Nicole was given a four year scholarship to attend a local state school. At college she studied social work while living in the dormitory during the academic year.

Towards the end of her second year of college “ things kind of took a turn for the worse”. During that time she says she “sort of came out of the closet”. The girl she was dating was her best friend for a year before they became sexually involved. “So we were really close friends and then eventually I just told my family we’re more than friends now.” Her family practices Judaism and Nicole believes her sexual orientation was unacceptable to their religion. She recalls it was March when her grandmother called and said “You’re going to have to find somewhere else to go when May comes because I can’t afford to have you come back with me.” Nicole believes that her grandmother’s decision had to more to do with her sexual orientation than finances.

Nicole did not want to label herself at that time as a bisexual or homosexual because labeling is one her “pet peeves” and “ labels are for clothes not people”. She didn’t know if it was a phase or what she was going through. She thinks that labeling leaves room for stereotypes and recalls studying that topic in a sociology course. “I got really into the way society makes certain groups look like and things like that.”

Nicole says she felt comfortable with the fact that her grandmother was going to “disown” her because she had a girlfriend. When the semester ended and she had to move out of her dorm, she had nowhere to go and tried again to move down south with her mother and stepfather. However, “things didn’t work out again”. She ended up coming back to her home city but had nowhere to go. She went to a shelter and wasn’t able to attend college anymore.

Nicole has a difficult time understanding how she could become homeless. “I have load of family, plenty of people with space. I can’t really understand why nobody wanted to take me in at the time.”

Several months after staying in the shelter, Nicole and her girlfriend were both working odd jobs and were able to get an apartment. That lasted for almost a year but then “the relationship started to go downhill that’s when everything kind of started to go back downhill again.” When Nicole and her girlfriend broke up, Nicole became depressed and
anxious was not able to work and so she could not afford the apartment on her own. She has been homeless ever since.

Nicole has suffered with depression and anxiety since was a young child. These feelings make it hard for her to work. Nicole feels like she is “really smart, I have the knowledge” but can’t hold a job. She has had nine or ten jobs that she could not keep because “the anxiety would kick in, either that or the depression would kick in” and then she would either quit or get fired for “blowing up or losing it.”

Nicole believes that growing up she had a lot materialistically but she doesn’t feel like she had the attention that she needed or the closeness. Her family “never hugged each other or things like that.” They hardly said they loved each other. Nicole thinks that these types of things are really important to a child’s growth and that she “missed out on a lot of those things and it sometimes holds her back.”

Nicole believes that not getting her needs met as a child is why she is still homeless. Since losing her apartment she has been sleeping mostly in the park. Occasionally she stays at the shelter or tries to sleep at the airport. She describes how difficult it is to get rest at the airport because the State Police wake homeless people up and say that it’s trespassing and the chairs are uncomfortable to try to sleep in. However, “it’s better than being outside where it’s freezing cold.” Sleeping in the park is scary for Nicole because “You never know who’s going to come and do what to you. You never know.” She says she just tries to deal with it because she doesn’t have any other choice.

Nicole describes having a good support system presently with a male friend, as well as her boyfriend and a couple of other homeless youth. She describes being in a “tight circle” because most of the homeless youth don’t have family that they can depend on for support. “We kind of have grown this bond together for the past six months and become really close and we just try to support each other through everything because it’s really hard going through this situation as it is and so to try and do that without a support system is really hard.”

Nicole tries to get some of her needs met through two youth homeless programs in the city. There she can get a meal, do laundry, and use the computer. She says the hardest thing to come by is transportation. She has a difficult time getting where she needs to go and sometimes tells subway staff that she is homeless and has no money, and asks if she can ride for free. However, she says that she feels embarrassed and most of the time it doesn’t work.

Nicole admits that in order to get her needs met she had to steal, beg, and lie “and do other things too”. While she knows many homeless youth that engage in survival sex, she has never done that. However, “I have definitely had serious thoughts about doing it.” Nicole knows people in her family that have been involved in “prostitution”. For her, the decision to not engage in survival sex is based on the fact that even though it’s easy, fast money, she wouldn’t be comfortable with herself and thinks it would probably lower her self-esteem. Nicole can understand why other girls have sex for money, drugs,
and shelter. “We’re out here trying hard to do things in a legitimate way. There’s so many barriers and things that are blocking us from doing that and sometimes you get to the point where it’s like you know what, there’s no other options for me. This is all I know or this is what I have to do to make it.

Nicole doesn’t do drugs, “other than occasional marajuana”. She was exposed to drugs growing up and made the decision not to get involved with it.

Nicole describes how many people treat in a way that is degrading because she is homeless. This is especially when she has to ask for things, which she hates to do. “I only ask for help if there’s like no other option and I just had no choice.” She find that people often do not believe that she has a real need and think she’s faking. This is hurtful and embarrassing to her.

In Nicole’s experience of being homeless, “a lot of people give up in this situation and I’m just not at that point where I’m done.” She says that “to survive you got to figure out something and the human instinct figures something out. You’re going to find a way to get food unless you’re just totally done. I’m just not at that point where I’m done trying.”

Nicole remains optimistic every day and wakes up with the idea that “I’m going to keep going. Something is going to work out.”

She believes that homelessness is a lifestyle and she has seen the older adults in the shelters who are very comfortable being in this situation, living in a shelter every day, and having to beg for food. “I’ve come to the conclusion that that’s the way they’re going to be for the rest of their lives and I’m not comfortable with that for me.”

Nicole says that being homeless has been very humbling. She says that she’s not looking for a mansion, or anything like that. She just wants “the basic needs”. “If I want to eat something, I want to be able to go in the kitchen, pull something out of the fridge, heat it up or cook it. Simple things like that. Like the bare essentials. I want to be able to take a shower in the comfort of my own home, not share a shower with people because it’s unsanitary.”

Nicole wants to enjoy her life, be around positive people because she feels like she spends a lot of her life being around negativity, being unhappy and “life’s too short”.

To Nicole, health means “taking care of yourself”. Being in good health means “doing the things that you know that are healthy for you physically and emotionally”. She gets her health needs met through her state health insurance, Medicaid. “That’s one thing I’ve always been able to do is get the things I need. I know when something’s wrong with my body.”

However, Nicole is unsure about psychiatry and has had some bad experiences with getting help for her depression and anxiety. She hasn’t seen her psychiatrist lately because she feels worse leaving the appointment compared to when she goes in. She has
tried two doctors recently that she didn’t get along with and knows she needs to find someone else.

For Nicole, the past is “everything that happened before right now”. “Past affects how you think, your lens, the way you view the world, everything.” She feels the past definitely can affect a person’s future “in a major way”, either positively or negatively and that “it depends on your story.” Depending on how a person is brought up, the past can affect how well he or she does in the future. Having the support you need when you’re a child plays a big role on how your past can affect your future, according to Nicole. Nicole believes she has a choice on whether she’s going to let her past affect her present negatively or positively. However, not everybody has a choice and she gives the example of people with mental illness.

For Nicole, tomorrow is still considered the present. Future makes her think more of her long term goals. Nicole would like to have children someday. Her main goal is to be a better parent than her mom. Nicole believes that this is possible. “Because I’ve been through what I’ve been through, I’ve learned.”

Nicole’s message to healthcare providers about homeless youth is the following: “Every individual is different. Every situation is different. Don’t listen to the stereotypes that you hear. It’s true, there are people that way, but it’s not everybody…Just treat every individual in this situation as an individual. Don’t judge them because of this situation.”

**Jay**

Jay is a 19 year old who comes from a town “where we are all illiterates and degenerates”. He feels this way because people in his town “all drop out of school by the age of twelve, and we’re really not good for anything except for gang banging, hustling and impregnating women, like rats and skunks everywhere and people get shot a lot.”

He moved there when he was twelve and believes he was a good kid “until you put one good apple in a barrel with a bunch of bad apples, you just turn bad.” Jay was involved with alcohol, taking and selling drugs, gangs, “and a whole bunch of other stuff” in high school. At age 17 his parents “got sick of it, filed a restraining order on me, and kicked me out”. He went into the custody of Department of Child and Family Services moved in with a foster family.

At age 17 “with a 4.0 GPA”, Jay dropped out of high school to further his rap career”. He got his GED but questions his choice to pursue rap by saying “And look, where did it get me?”

Growing up, everyone knew Jay was “weird” and when he was nineteen, he was diagnosed with “delusions of grandeur, bipolar, schizophrenia, and ADHD. He became eligible for services from the Department of Mental Health and was placed in a group home. “I was eighteen living with fifty year old people, really far gone.”
Jay left the group home and has been homeless and living on the streets mostly ever since. While Jay acknowledges his struggles being homeless, he is proud that he’s not a “bum”, “I do things with my life.”

Jay has tried one of the other homeless youth programs in the city but found the rules to be too strict. “They’re trying to help people from the streets that have been through the worst parts of life, but they expect us to act like we’re just fresh out of high school. No swearing, take your hat off, no you can’t use your phone. It’s ridiculous how many rules they have. You can’t play pool until the afternoon. They abuse their power.”

Jay came to the youth drop-in center because “there aren’t many rules, just no weapons.” He can take a shower, do his laundry, use the computer, eat, and “chill”.

Jay describes being homeless as being out in the “jungle” and “survival of the fittest”. Jay will get his needs met “by any means necessary really”. Jay sells drugs, has stolen and sold iPhones a few times, and “catches vics”. “Like you find somebody stumbling out of a bar and you knock them and take their money and stuff like that. I keep coming back to it because I’m from a town where this is like a pastime. You know you’re twelve years old, hey what do you want to do? I don’t know. We need money for weed. Let’s go catch that drunk guy.”

Jay doesn’t panhandle. “Like I will rather steal or rob or jump somebody than beg for money. I don’t know, maybe it’s a really messed up sense of ego or something, but it’s just how I am. Like I would rather get my money than beg people for money.” He believes the people who beg for money are “unkempt, they’re derelicts, their clothes are torn up, they sit up with a cup and spare change with signs like oh just trying to survive, please help me.”

Jay doesn’t rob females and describes some of his street rules: “There’s a certain fucked up moral code. Like I’m not going to ask for spare change, but I’ll rob somebody. At the same time I’m not going to rob a female. Like I never put my hands disrespectfully on anyone of the opposite sex no matter how much. Like if she’s pissing me off, I’ll just leave it alone. So it’s different.”

Despite his moral code, Jay admits that his actions aren’t always moral. “It works for me but I know sometimes what I do is wrong, but it’s a moral code that I feel like I can dip into my bad side without submerging myself fully.” Jay’s involvement in crimes depends on how bad he is hurting and how bad he has to “flip into grimy mode”.

While being homeless, Jay has gained weight and that surprises him because he thought he was going to get skinnier. He attributes the weight gain to all the churches that feed the homeless and the open refrigerator at the homeless drop in center.

Jay describes health as “Lots of things, not just physical health – spiritual and mental health”. Jay believes his physical health could be better if he got in shape, his mental
health is “where it needs to be for my type of person”, and his spiritual health is not very
goood because he doesn’t have many good relationships.

While taking about health, Jay pulls out a picture of himself. “I love myself. My upper
body is still showing the muscles that I’ve had, you know what I’m saying. It’s my lower
body is like deteriorating and it pisses me off but whatever, but it’s still cool.” Jay’s plan
for his health is to start working out more and lifting weights.

For Jay, the past “sucks” but made him who he is today. “Like people that I thought were
there for me ended up not being there for me. Like women that I fell in love ended up
using me.”

Jay feels that today is just another day because “The present sucks.” “I don’t have any
money and I have some nice clothes, I have connections, but I’m not really doing
anything, you know what I’m saying. Like I’m making phone calls and putting wheels in
motion for tomorrow.” Putting the wheels in motion for tomorrow refers to Jay’s goals to
try to get an apartment by saving his disability checks once he starts getting them. Jay’s
future plans are focused on “taking over the world” through his rap music.

Jay’s message to healthcare providers about homeless youth is “Don’t underestimate
somebody because of the situation that they’re in.”

Raven

Raven is a 21 year old female who is married and wears a Pentacle necklace in place of a
wedding band. She describes herself in the following way: “I’m someone who has had
rough life, but I didn’t give up.”

Raven’s parents divorced when she was eight years old. She experienced physical and
sexual abuse by her mother who was an alcoholic and also physical abuse by her brother
who is 2 years older. Raven recalls being 13 and going into “DSS”, the Department of
Social Services. A teacher noticed she had come to school “too many times with marks”
and so they put her in a foster home.” She ran away from the foster home and her mother
was given custody again. After that, she ran away from home often, sleeping at her
friends and then eventually her car.

Raven graduated from high school and attended college for criminal justice for 1 ½ years.
During Raven’s freshman year she was “gang raped” and moved out of the dormitory and
into an apartment for safety. In order to pay her bills, she was working three jobs but got
too tired and was unable to continue with school. “There’s been ups and downs through
life I guess.”

Raven has been on the streets for a little over six months. She met her husband through
some new friends three months ago and they got married soon after. Along with their
four pit bulls that she would do “anything” for, Raven and her husband live on the edge
of the river. Raven’s husband is 25 and is not able to go to the homeless youth program. Raven, her husband, and four dogs usually sleep down by the nearby river.

Raven has no identification. Her license was suspended due to driving with an expired license and she doesn’t have the $300 needed to have it reinstated. She has a birth certificate but can’t get a Social Security card without an ID.

Raven does not use any drugs and drinks alcohol rarely. She attributes this to her both her parent’s problems with alcohol, her brother’s drug problem, and a former boyfriend who overdosed on heroin once.

Raven has “Chiari”. Chiari malformation is a condition in which brain tissue protrudes into your spinal canal. She has “lots of health problems because of it”. However, she is putting off dealing with it because “I’m not a big fan of medicine”. Raven’s balance has become unsteady and she is starting to lose sensation in her limbs and can’t keep a grip anymore. This makes taking care of the four dogs very challenging.

Raven has had four knee surgeries. The knee problems are a result of her brother being violent and “tearing through all my cartilage and a couple of tendons and my knee cap.” Once he threw Raven down five stairs, another time he crushed her knee under a chair, and also ran over her with a four wheeler.

Raven had state medical insurance, Medicaid, until about four months ago when she lost of some reason. She has stopped seeing her neurologist and primary care provider and has not been able to get her migraine and asthma medicine.

Raven has been diagnosed with ADHD as a child and had been medication until recently when she lost her insurance. Raven was taking birth control but when she ran out and could not afford to see a provider and get a refill she and her husband talked and decided “If a baby happens, it happens. We’re going to keep it and going to raise it.”

Recently Raven was in the hospital for one week due to internal bleeding because her liver was “acting up”. She became aggravated in the hospital, took out her own IVs, and left against medical advice. Despite not having insurance, she wanted to make a follow-up appointment with her doctor but could not because her husband was arrested and she has been trying to help raise money for his bail through panhandling.

Raven has tried to get help from the homeless youth program staff with getting insurance again. However she believes that if she reapplyes and gets it, she could end up losing it again. She wonders “Is it worth the frustration?”

Raven believes “The past made me who I am today. It can either break you or make you stronger.” I may not speak to my mother anymore, but I also don’t wish her dead.” She has moved on from problems with her family members as best she can right now and has plans to deal more with the issues as time goes on. “But I’m not going to let it affect my present or my future and won’t let it ruin my life.”
For Raven, the present means living each day “just making sure we have what we need
day to day to survive, whether it’s dog food, water or food”.

In terms of survival, the most important thing for Raven is that she always has enough
money from panhandling to get dog food and food for her husband. Because she comes
to the homeless youth program, she has access to her own food. Raven feels judged for
panhandling. “People assume that I either have a drug problem or I’m just lazy. And
some even comment that I look like a student so why am I out here? It’s not because I
have a habit. It’s because I physically can’t hold a job.”

From panhandling, Raven can earn between $5 and $100 a day. She holds a sign and it
says “family”. The dogs eat twice a day and getting enough dog food for four dogs is
difficult. The nearest place that she can buy the dog food is at a CVS Pharmacy store and
they only sell the four pound bags that are $7 each and four bags are needed per day. In
addition to spending about $28 per day on dog food, Raven and her husband spend about
$16 on food. If they are short on money for food, they “dumpster dive”.

Raven doesn’t rob people because she would not want to be robbed. “I’m not going to
turn around and do it to someone else.” However, if she could not find a way to get dog
food or food for she and her husband, she would shoplift. “I would not take from a
person. I would not steal money, I would shoplift. I would take that risk if it meant I had
no other way to feed my dogs and my husband.” She feels okay about shoplifting
because of her experience working in stores like CVS Pharmacy. “I know they have loss
prevention and I know they get their money back. Whereas you rob a person, you don’t
know how much damage you’re causing them. You don’t know if they can get it back.
Stealing is not right in general but shoplifting, they have their resources. They do.”

Raven describes the future as “a lot of wide open space, and you don’t know what’s
coming.” This makes her feel curious. Raven’s future plans include getting an apartment
which thinks is possible because the dog kennel her husband works at is starting to
expand. Eventually she would like to go back to school or do something with music.
Although she studied criminal justices, it’s not something she wants to do anymore.

Raven believes in Paganism, also called “Wicca” and describes it as “anyone has their
own God or goddess but we really define more with anything natural.” Paganism plays a
role in her health as Pagans believe people can heal themselves. “You don’t need any
medication or anything, maybe surgery.” She believes being a Pagan affects her
perspective of time. “My husband and I live for today.”

Raven’s message about homeless youth to healthcare providers is “Just because we live
outside and don’t have the same opportunities or luck that you do doesn’t mean that you
should treat us different.”
Mike

Mike is a 19 year old well-dressed Haitian male who had a 3.8 GPA at college before becoming homeless for eight months after he got out of jail. He describes himself as “motivated and ambitious”.

Mike was home visiting his mother during a college break. He met a friend downtown and “Little did I know he was making a drug transaction, selling to an undercover police officer. So we got both nabbed.” He is angry that his friend “was determined to not go down alone even though I had nothing to do with it.” Upon release from jail, he was sentenced to two years of probation.

When Mike came out of jail he had nowhere to go. His mother had moved to Haiti. His father and four older would have taken him in but they all lived out of state and due to his probation, he could not leave the area.

While homeless, Mike has been staying on the streets. He frequents the airport, train station, and was at an “Occupy event” for about a month. He tried the shelters but was “disgusted” as there are “so many horrible people and sex offenders there”.

Mike’s homeless experience has taught him “about how to survive, how to live day to day without certain necessities”. He defines survival as staying alive long enough to make it to tomorrow morning. In order to survive, Mike admits “I’ve done a lot of grimy shit in this situation that I’m not proud of but I mean you’re so hungry it drives you to do it. I’ve robbed a lot of people, been involved in home invasions, ran scams, and other shit that I would never ever have envisioned doing in my life.” Mike describes being hungry as “my stomach eating itself type of hunger, hunger I only experienced in jail”. Mike is not proud of what he has done but states “You just get so desperate.”

Mike has found that applying to jobs and “trying to do it the right way” doesn’t work in his case. “Every application I have to write drug felony and as soon as they see that, they don’t even give me a chance to speak to them.”

Mike has not gotten involved with sex work but knows that many homeless do and that he could make “a ton of money”. “Because the shelters are all full of sex offenders, that’s usually where most of the males in my situation go.”

Mike has gone dumpster diving a few times. “There’s all these little produce stores and stuff, meat markets, they’ll take product that they’ll just have too much and instead of just giving it away, they’ll just throw it out.” However, Mike is quick to point out that dumpster diving is not something that homeless people do. “My sister is a psychologist, her husband’s a college professor, and they be going dumpster diving.” Rather than dumpster diving, Mike says he would rob someone. Though he says he tries to stay away from females.
Mike says that the homeless youth he has become friends with are like family. “There are seven of us and we’re like a really tight knit group. We look out for each other as a family, as if we’re brothers and sisters. We break bread together, what’s mine is yours.”

Mike’s health means “a lot to me”. He says that being homeless has taken a toll on his health. Prior to being in jail he was never sick. “I’ve been to the emergency room six times since in eight months for various different reasons, whether it was food poisoning, just being sick, ulcers from stress.” Homelessness has also been “mentally draining”. For Mike, health is top priority, after staying alive. “I need to be healthy so I can fulfill my goals and my dreams and aspirations.”

Mike describes the experience of being homeless as “the most enriching experience in my life, like gold to me.” When he was in college he was just a boy but “after this situation, jail, homelessness, I feel like I become a man. I really feel like I earned my manhood in this situation.”

“I thank God I was in this situation because now it’s even more motivation to go out there and get a degree and try to turn around and help people in this situation.” He appreciates the people who he has met while being in jail and on the streets. They have given him “words of wisdom that I would have never learned from my parents or being in college or a sheltered home environment.” Mike believes the streets things he’s learned on the streets will be useful in the long run and help him to succeed in life.

Mike describes his past as “where I’m from” and believes “You can’t have a future without knowing your past and really embracing your past.” His present is what is going on right now, homelessness, which he describes as “the lowest you can get before death, the bottom”. However, homelessness has taught him about “strength, courage, fortitude, keeping motivated, and keeping your ambition in the right place.” He believes all of these things are the key to his future which will include success and prosperity, what everyone hopes for”.

Mike is in a program to help the homeless get housing. He currently works for a catering company “because someone gave me a shot and realized that despite my record, I am a good kid, well spoken.” That meant a lot to Mike and has not only allowed him to save up money, but also eat a meal when is working. Mike intends to go back to school in the fall. He’ll enroll in a local community college for a semester or two in order to demonstrate that “things have cooled down and I’m trying to do the right thing. Like that jail situation was just a hiccup. That wasn’t me.”

Six weeks after Mike shared his story, he reported that he was still working at the catering company and that his mother was recently diagnosed with cancer and has been given only six months to live. She will be returning back to the US soon. Mike is planning on living with his mother soon and although he is sad about her health feels “this is my ticket to getting out of this situation.”
Mike’s message to healthcare providers about homeless youth is: “Don’t be fooled by what you see.” “People have a certain stigma about what homeless people are supposed to look like. Because most people they see me dressed like this with khakis, Polo, in the street and would never think I’m homeless. Whenever I tell people, if someone’s talking shit out there, you know I’m homeless. Don’t be fooled by the image. It goes a lot deeper than that.”

Allison

Allison is a 20 year old female who describes herself as “very headstrong, very set in my ways, very devout in my beliefs, very secure in who I am, and nobody’s going to change that.”

Allisons says that her story is “actually really, really simple”. One month before she gave birth to her twins, she found her husband dead in their bed. He had died from a chemical overdose from taking Methadone for chronic back pain and alcohol. When her husband died, she lost her housing and moved back in her parents.

A few months ago, Allison left her children, who are now two years old, with her parents to take a job in the city as a live-in patient care assistant. She was sending money home for her kids while she was saving up enough money to get her own apartment. The job lasted for about two months until she was fired because “the patient started pulling the feeding tube and his sister wanted me to restrain him, tie him to the bed and I don’t have training for that. There weren’t any doctor’s orders for that so I wouldn’t do that.”

Since being fired three weeks ago, Allison has been homeless and living outside. She decided not go to back her parent’s house because it is only a two bedroom and in addition to her parents and children, a brother and a dog live there. “So there’s no room and if I went there that’s one more person and then the landlord will kick them out. So I can’t jeopardize everybody else’s living situation because my living situation isn’t very great.”

This is the first homeless experience Allison has had. The first day she was on the streets she was “absolutely petrified”. However, she believed that there is no reason why she couldn’t find another job quickly. She has been to a few interviews and has another one coming up. “It’s all a matter of riding it out.”

Her first day being homeless, she rode the subway and decided to get off at a particular subway stop in the area of prestigious college “just to look around”. She has stayed in this area ever since after meeting a group of homeless youth. “Most of them are really friendly though some of them are hobo-esque.” Hobo-esque means “They are dirty, wear torn clothes, get high and drunk, and are falling all over the place and sleeping everywhere.”

One of the things that has surprised Allison about being homeless is all the food that is available. “I can safely tell you that no homeless person out here will ever starve. You
sit down on the ground anywhere around here and people just walk up to you and give you food. Last night somebody brought four pizzas over to five or six of us.”

Allison does not panhandle but one night, after not sleeping for two days, she fell asleep on a park bench and woke up and her coffee was dumped out and there was $16 stuffed in the cup. She was very confused and “I felt kind of degraded a little.” She has had a job since she was twelve and up until recently, always had a place to live. “I’ve always provided for myself. I’ve always provided for my children. I’ve always provided for my family and the fact that people feel it necessary to give stuff to me when I’m so used to doing that, my pride is too big for that.” Allison describes how her grandfather, who had a big hand in raising her, taught her to “never take nothing for nothing”.

Most of Allison’s day involves walking around, hanging out with other homeless youth, and looking for a job. The search for a safe place to sleep at night begins in the afternoon.

“It’s really scary to sleep on the streets. Anybody can come along at any point and do whatever they want to you when you’re sleeping. I don’t drink. I don’t smoke weed. I don’t do drugs. I’m just a heavy sleeper. You can be sleeping and anybody can come along and God forbid somebody comes along and pees all over you. Or rape or kill you while you’re sleeping.”

To find a safe place to sleep, Allison walks up and down residential streets outside of the busy downtown area and looks for a wooded area or places underneath stairs.

“I’ve slept in somebody’s bushes. They came out they’re like are you alright, do you need anything? I’m like no, I’ll all set, I’ll leave in a minute, sorry.” She chose that location because it was dark and she would not be “sticking out like a sore thumb”.

One of Allison’s safety strategies is to “set up a whole bunch of things in front of me, like branches and put them in between the bush so if anybody was to walk that way, I would hear them walking that way.” She grew up hunting and learned “survival skills that come in handy being homeless”. Allison is proud that she has been able to teach other girls some of her “homeless tactics”. “I’ve actually shown three girls how to set up little booby traps.”

Allison is not picky about jobs. “I don’t even care what they’re doing because I guarantee you I can probably do it if they showed me how.” She has identification and can provide references. When applying for a job she has an appropriate set of clothing – dress slacks, a turtleneck, and a black short sleeve sweater wrap.

Allison doesn’t believe in robbing or stealing. She doesn’t understand why many of the homeless youth are “too proud to go out there and ask somebody for something when a lot of people are more than happy to give it to you” and says “It’s not cool to rob somebody instead knowing that you hurt somebody and damaged them in some way.” She has not needed to dumpster dive either because of all the food that restaurants are willing to give to the homeless and the many meals provided by churches in the park.
Allison is aware that many of the homeless girls prostitute but she does not agree with it. “If you’re sick, you’re making somebody else sick. If they’re sick, you’re making yourself sick and then you’re making other people sick. So it’s just a whole mess of nastiness.”

Allison states that her health “sucks”. She has a ruptured back disc and after sleeping on the ground, she can barely stand up and walk. Waking up in the morning is hard for Allison because “you generally feel like shit”. Also her feet hurt because of blisters and sores from walking around so much. Presently she has a bad cold and is coughing quite a bit due to heavy rain that got into her tent. However, Allison is optimistic that this situation is only temporary “so I can push through.”

Allison describes the future as “everything”. She wants her children to be proud of who she is. “Maybe ten, fifteen years down the road this is going to be a funny story. Like oh yea, I was homeless for a few weeks actually.”

The present is “right now and temporary” for Allison. She believes “Everything’s an experience so I see this as a way for me to grow.” “A lot of people would think that it would be over at this point and I still see a lot of options. I haven’t given up.”

Allison is looking forward getting an insurance settlement worth almost $50,000 from a car accident she was in. The check should arrive in a few weeks and she will then get an apartment for she and her children. In the meantime, she continues to look for work.

“The past is nothing but a learning experience. I take everything from my past and I always apply it to my future, but I never let my past stop me from my future.”

Although Allison describes herself as a Protestant Christian, she doesn’t base a lot of her life on religion. Rather she feels, “Life only has to do with what you do with it. Like if you don’t try, you’re not going to get nothing. If you do try and you try and try, you might get something and it’s a big might but it’s still a might.”

Allison’s message to healthcare providers about homeless youth is: “Stop treating everybody like an addict.” She recently had an experience when she went to the emergency room for her foot wounds and immediately a nurse told her that she wasn’t going to get any pain pills. “I never wanted pain pills. I wanted the doctor to look at my feet and either bandage them or put some liquid stitches on them and the nurse goes where do you sleep? I said on the street. She goes you’re not getting pain pills. I didn’t want pain pills. I’d don’t take them. Even my previous back doctor wanted me on Oxycontin and I refused to take them because I do not want to get addicted to anything.”

Allison knows that a lot of homeless go to the ER “pill hunting” but believes “treats everybody the same is messed up.” “Somebody that is supposed to be helping you should not automatically be judging you.”
Six weeks after Allison shared her story, she was off the streets. She found another live-in patient care assistant position in the neighborhood. She was caring for “a sick drug addicted son of a wealthy professor”. She is still waiting for her insurance settlement check. Allison remains connected to her homeless youth friends and is “taking the lead role in the area with the police related to the homeless kids.” She has participated in homeless youth police trainings, sharing her story with them which she summarizes as “I’m a daughter, I’m a mother, I’m a friend. Six months ago I was just like you.”

**Muhammad**

Muhammad is a 20 year old male who describes himself as Muslim and black. He was born to an Arabic father and a mother from the Caribbean.

After his parents divorced, his father was deported back to the Middle East and he was left to take care of his mother for many years until she remarried.

Muhammad grew up in a Muslim household and “didn’t follow all the rules and stuff.” In high school he smoked marijuana and would drink sometimes which made his mother furious. When he was 15, his mother kicked him out of the house. “I was doing stuff that normal kids in America do but they just looked at it was like it was the worst thing in the world.”

At that time, Muhammad was placed in the custody of the Department of Social Services. He was in a group home and found it to be a difficult environment to practice his faith. “It was even less Islamic than home and I rarely got to pray when I was supposed to. It was just a bad environment for me to be in.”

Muhammad got out of the group home when he was seventeen and found a job. He had his own apartment for a year until he was “incarcerated by the Federals for conspiracy of terrorism”. He believes that he was under suspicion for terrorism because he is Muslim and “We don’t have the best ties with America”.

Muhammad describes why he was arrested in this way: “Allegedly somebody in a mosque was talking to me about stuff that’s not good and, according to the government, he was a federal informant and basically he said that he had me saying certain stuff on tape and then when they brought the tape to court it didn’t make any sense. It was just nonsense so they threw it out but that’s after I served almost two years for that.”

His case eventually dropped and when he was released from federal custody, his family disowned him. Muhammad has been homeless, sleeping mostly on the streets for months. Sometimes he sleeps at the mosque. He has tried to get a job but no one will hire him. “It’s hard to get a job because of my name. They see that I’m Muslim and I’m young and they think, oh he’s trouble.” Muhammad is willing to do any basically any job but he can’t work in restaurants where alcohol is served because it is against his religion.
Being Muslim is hard for Muhammad. “I can’t party. I can’t date. I can’t do a lot of things. And we have to deal with being harassed by America. So it makes it two times as hard.”

Islam is very important to Muhammad. His life revolves around praying. Muhammad makes every attempt to pray during the five calls to prayer, called adhān. He prays in public areas including truck stops. He prayed last night in front of the shelter in a long line to get in. “I had to pray outside in a place where people piss. You have to do it.”

During his time in federal prison, Muhammad prayed a lot. “It just actually was a blur. I was just non-stop praying.” It couldn’t eat much because most of the food was not allowed. He describes how he had to fulfill Islamic expectations about grooming in prison. “We’re expected to trim our armpit hair and our pubic area at least every forty days and that’s obligatory. We had razors most of the time but if there was an instance where you didn’t have a razor, it’s permissible to refrain from trimming. I mean I doubt Allah wants you to pull your hair out.”

He thought about Allah “the whole time” in prison. “We believe that Allah puts you through tests and I look at it this way, my life’s not as bad as Muslims in other countries. I could live in a poorer part, part of Afghanistan and Bangladesh and not have anything.”

Although Muhammad usually sleeps outside, last night he stayed in a shelter because it was pouring rain. He hates to go to shelters because “Right when you walk in you smell people’s body odor, booze, alcohol, just noxious smells. It just makes me break down inside like wow, I’m really in this type of place. Do I deserve to be here, why am I am here? I have all this in me and I have to live here. It’s frustrating.”

Muhammad describes himself as healthy. “I jog.” He has a bandage on his hand because he got jumped by two people leaving the mosque and punched one man in the mouth and his tooth bit his finger. He was seen in the emergency room.

Muhammad does not smoke, drink alcohol or use drugs. He is not sexually active. “I’m proud I can answer no.” “We believe that Allah is always watching us and what we do every day is being recorded. We have one angel on the right side and one of the left. The one on the left writes down our bad deeds and the one on the right writes down our good deeds. So at the end of the day if we’re doing more bad stuff than good stuff, on the day of judgment we’ll be judged on that and it would be subjected to hell fire if we didn’t do what we had to do.”

Health is important to Muhammad. “We have to take care of ourselves because we have to be healthy to worship Allah. You must be healthy.” Everything Muhammad does is for Allah. “Like when we eat, we believe that we’re not eating because we’re hungry, we eat because we have to have strength so we can pray. Everything is for Allah. That’s how we think.”
Muhammad explains that Islamic medicine is different than Western medicine. For example, Muslims use black seed oil, an herb discussed in the Koran that is taken three times a day. “When you’re sick or you have a headache, you have a deficiency with your immune system somehow, there’s something off about your system and that stuff actually fixes it. Like right now I wish I had some. I can speak with conviction. I had a bronchitis. I took it and one day later it went away.”

As a Muslim, Muhammad believes “The past is not worth dwelling on. The present is just an illusion and the future is the real life.” He believes that this world that we’re living in is just a short life, temporary one, compared to the afterlife. “Being in this life is equivalent to walking in the front of your house and walking out that back door of your house.”

Muhammad does not stress over things because this life is short. “We get whatever Allah intends for us. We try hard to get somewhere in life and if it happens and it’s meant for you. If it doesn’t then it just wasn’t meant for you.”

Muhammad is more concerned with the afterlife than this life. “I’m trying to do the right thing because you get rewards and stuff for good deeds and it’s like the afterlife is so long. You want the all reward you can get.” The afterlife is beautiful. “You can get whatever you want in the afterlife.”

During this life, Muhammad hopes to get married. Before he went to prison, he intended to marry a girl in a close by state who is the sister of a friend of his. She still is not married and he hopes she is waiting for him.

Muhammad has a GED and also some credits as a medical assistant. He doesn’t intend to continue to pursue medical assisting because “I learned it’s a big scam. It’s like paying twenty thousand dollars just to go to school. It’s a very common job and they don’t pay you that much anyway.” Through various odd jobs, he feels he makes enough to get by but needs to save up money for his goals.

Muhammad was glad he could tell his story. “Muslims in the future who are in my situation, maybe they’ll get some help.

**Kelly**

Kelly is a very thin 18 year old female who is addicted to heroin.

Kelly moved to this city about two years ago. “I didn’t run away. My parents let me come.” They gave her all of her personal documents including her social security card and birth certificate. Kelly hasn’t seen or talked to them since.

Kelly had a friend who lived in the city and so she decided to get on a train “even though I didn’t know where I was going”. Without a place to live, she began hanging out at the
large city park and “started sleeping with people to earn money”. Soon she started using
drugs and then found a pimp.

Kelly works during the day on certain high demand streets in the city. “I walk up and
down and I’ll watch the cars go by and I’ll try to catch someone’s eye. If I see someone,
they turn the corner and they come back around again.”

Kelly is cautious about who her customers are. Her former pimp taught her about who
not to get in a car with. “My pimp was black but he taught me never to get into a car
with a black man.” Kelly only goes into cars with white men. “I am Latino and don’t
even go with them them guys.”

Once in a customer’s car, Kelly introduces herself and asks if the man is a police officer.
“I ask them if they would like any service today and they’ll tell me, they’ll ask me how
much it costs, and then usually we just go find an empty parking spot.”

Kelly says this lifestyle is hard. “All you do is suffer. I mean that’s all you do.”
“Sleeping under a bridge and waking up every morning. I’m eighteen years old, I didn’t
think it would be like this. I really didn’t. I thought I’d be married, at least have a kid or I
don’t know but now here I am with a forty-seven year old guy waking up under that
bridge every morning. Kelly’s boyfriend is almost 30 years old than she is. He is a
heroin user also and has hepatitis C and advanced liver disease. “He’s pretty much
dying.”

Being homeless has affected Kelly’s health. Kelly has had STDs in the past for which
she was treated with antibiotics. She gets colds often and has had strept throat several
times. She is gets skin infections easily “from shooting up and rarely taking a shower”.

Kelly was diagnosed with hepatitis C a few months ago and wasn’t surprised because she
and her boyfriend share needles. They both get tested for HIV regularly and so far have
been negative. Several months ago Kelly was with a customer multiple times before she
found out he had AIDS. A friend told me “Kelly, you know, he’s got the bug. I was like
what are you talking about? You know he’s got the bug. Well what do you mean the
bug? He’s got AIDS. He’s got full blown AIDS and I couldn’t tell. I was like oh well
that’s okay. I don’t care. I didn’t actually sleep with this guy, just do other things, but
inside I felt like cold, like sweat because I was scared. Like oh my God, you know. I
went to the doctor’s and I got my rapid HIV and they told me you’re going to need a test
later in four months.” Kelly says she tries to always use condoms and practice safe sex.

For Kelly, the present is about “survival”. “It’s a struggle out here because you know
you want to survive. You got to do what you got to do to survive. It’s hard.”
Everything in Kelly’s life right now is about being an addict. Every minute revolves
around her use and that of her boyfriend.

In addition to sex work, Kelly gets money to pay for heroin for herself and her boyfriend
by cashing in her food stamps and selling prescription pills. “I get $200 per month for
food stamps and take them to this guy who runs a store and he makes us wait two, three, four hours to see him but ends up giving me $140.”

Kelly is going to a clinic for Suboxone for heroin addiction treatment. However, instead of taking the Suboxone, she sells the pills. “When I first started them, I was like I can’t believe they came up with this. It’s like a miracle, like a little orange pill that can last you for a few days and where you don’t have to shoot heroin and get sick. I would take a Suboxone and it would be crazy, I wouldn’t even have to shoot heroin for like two days. It was amazing the whole Suboxone thing.”

Although she kicked her heroin habit with Suboxone in three days, she discovered that she could sell each pill for between 5 and 7 dollars, sometimes up to 10. The money helps to buy heroin for she and her boyfriend. On a weekly basis, Kelly gets prescribed 14 Suboxone pills that she sells and earns about $100 a week. Her heroin habit is almost $200 a day, as is her boyfriends. Therefore, Kelly still must earn about $350 dollars a day doing sex work. Kelly hopes that one day when her boyfriend stops using she can start taking the Suboxone for herself.

Kelly believes that everything she is going through presently will be a learning experience someday, “something I can use to do good”. “I can use what’s happening now in the future for whatever I’m supposed to do.” Kelly hopes that someday she can use her experiences to help young women like herself stop using drugs and get a home.

Kelly is ambivalent about her past. She was adopted from South America and says that she loved her adoptive father but her mother “thought he loved me too much and was with me”. Kelly is starting to go into withdrawal while she is sharing her story. The story suddenly ends and Kelly excuses herself saying that she needs to go to work.

Alex

Alex is a 21 year old male who describes himself as being very strong, patient, and indecisive. He moved to the city “on a whim, very impulsive whim” from his parents’ house in the south where he was attending college and had a job.

Alex met his boyfriend online and was offered a plane ticket to come here. This was appealing to Alex who wanted to move out of his state and “have the opportunity to go to a more progressive city.” Alex’s boyfriend has been homeless on and off for almost seven years but they were optimistic about finding a place.

Alex transferred his previous job at a clothing store to the area and started living in a tent with his boyfriend and his dog by the river. “Snow was completely new to me so it was tough.” After two weeks they found an apartment and lived there for a few months, but could not afford it anymore. Alex and his boyfriend ended up breaking up and Alex has been continuously homeless for a year.
Alex says being homeless was a complete shock to him, “very scary, a completely different culture”. He carries a large, heavy pack around with all day with his belongings including two pairs of shoes, three pairs of pants, shirts, blankets, tarps, rope, and food. In addition to these supplies, Alex carries medical supplies for weekly testosterone shots he takes.

Alex says that another challenge he has is that he is transgender. “That’s something, being transgendered, homeless, and gay.” Alex was born a female and then came out as being transgender when he was 18, then started his transition soon after. He had the support of “everyone in my family and all of my friends”. Despite all of the support he had at home, he did not like living in a “very backwards, ignorant culture” and needed a change.

Alex is employed part-time and earns between $80 and $140 per week. He does not qualify for health insurance at work but gets Medicaid. Medicaid doesn’t cover dental, however, and Alex has some teeth that are painful which he needs to get pulled. He receives medical and mental health services at a health center for GLBTQ and homeless youth.

Alex suffers from major depression and anxiety and is taking Prozac and Klonopin. He uses marijuana and has been drinking heavily recently.

Alex is thankful that his former boyfriend and other homeless youth taught him to live outside and learn about “street smarts”. Street smarts include how Alex carries himself and how he stays dry at night and safe.

To get to work, Alex gets up at 7 a.m. in order to have enough time to take the two trains he needs to get to work. He stops in a restaurant on the way to wash up and brush his teeth “and try to look presentable after living in a tent”. Knowing he is homeless, trans and gay, Alex’s boss is concerned for his well-being and gives him numbers for shelters.

However Alex says he would never go to a shelter. “That would be like absolute horror. I would honestly rather sleep outside than sleep in a shelter.” Alex feels he would be at risk of being victimized due to his gender transition and sexual orientation. “There are a lot of older people in shelters. Most of them are alcoholics, drug addicts, junkies, whatever and a lot of them are kind of crazy.” There are no GLBTQ shelters in the city.

For Alex, the past is something that was mostly positive. Although high school was lonely for Alex because he felt like an outsider, he had a good childhood with parents that always made sure he and his sisters had everything they need. Alex came out to his mother at age thirteen, while he was a female, as being bisexual. “She was like I know, that’s fine, whatever. Let’s go swimming. It was just like nothing.” He and his mother got through a rough patch during high school “and now she’s my best friend”.

The present is difficult for Alex. He is trying to deal with everything and “just trying to basically survive”. “Being homeless, how much lower does it get?” Alex tries to keep
positive about the future and keeping his job and getting an apartment. For the future, Alex would like to see himself back in school, working part-time, and “just living a good healthy life on my feet”. “I’m trying to be positive and just take care of myself because mentally I don’t think I’m stable at all. I see a therapist once a week.”

Alex has suicidal thoughts every day but no plan to end his life. “I just want to be gone.” “Things would be so much easier if I were just gone because it’s so hard and I’m trying to do this all on my own because I don’t ask my parents for help at all. Alex doesn’t want to ask his parents, who are now divorced, for financial help because he feels they have too much going on in their life. “My dad’s fifty years old and has a six month old child who has severe health problems and he’s a police officer also and the only one working in his house right now with six people living there. They have horses and animals and all this stuff and my dad’s in debt up the ass with the IRS.”

Alex has thought about moving home but figures his financial situation would be worse than now. “I know it doesn’t really make sense, but I think it would cost me way more because I would have to get a car. They don’t have good public transportation whatsoever. I’d have to get a car and that means I would have to pay for insurance and gas and that would be my whole paycheck.” In addition, Alex would not be able to get state health insurance back home and therefore would not be able to see his therapist at the health center for “free whenever I want”.

Alex has been told by many people that he has many strengths. “I really want to believe it, but there’s lots of parts of me that says that I don’t because I guess that’s where my depression comes in because I honestly don’t like myself.” One of the strengths is that he is a very caring person. His mom tells him that ever since he was a little kid he would put everyone else before himself. Alex agrees with that. “Like with Henry, my friend’s dog, I’m going out of my way to help him because he’s in pain. He was bit by another dog a couple of days ago. So I’m trying to find him a clinic because he needs surgery and I took off work today for this. But work told me I couldn’t come in and get my check to pay for the surgery because I called out. It’s a lot to deal with.”

Alex’s message to healthcare providers about homeless youth is the following: “We really need healthcare really bad, like whatever kind of healthcare we can get, we need it.”

**Analysis of Story Similarities and Uniqueness**

**Similarities**

While each of the stories shared by homeless youth in this narrative inquiry was unique, there were also many similarities across the stories. Similarities included issues related to childhood family conflict, violence, drugs and alcohol, survival, social support,
and health; the meanings of youths’ experiences; the time perspectives of youth -- past, present, and future; and the influence of time perspective on youths’ health and health promotion.

Viewing similarities across the participants’ stories through the lens of an ecological framework previously discussed in chapter one was considered a way to increase understanding of homeless street youth by identifying and examining the multiple and interacting levels of influence that individual, relationship, community, and societal factors have in their lives (Glanz et al., 1997; McLeroy et al., 1988). Similarities of these thirteen stories were examined by levels of influence included in the ecological model.

At the individual or intrapersonal level, similarities existed among biological and personal history factors of participants such as health status, substance use and abuse, exposure to violence and victimization, personal meanings of experiences, and time perspectives. At the relationship or interpersonal level, participants’ relationship experiences with family, peers, and pets were similar. Similarities among homeless street youth were also noted at the community level. Participants’ stories included settings in which their social relationships occurred such as on the streets and at homeless youth support facilities. Additionally, similarities among participants were identified with regard to the societal level in which broad factors such as social and cultural norms, health, economic, educational, and social policies were commonly found in homeless youth participants’ stories.
In the following section, a discussion of the specific similarities of the thirteen participant stories organized using the research questions is provided. This is followed by a discussion of each of the story’s uniqueness.

**What are the stories told by homeless street youth?**

*Childhood family conflict.*

The stories of homeless youth in this study provided insight into childhood family conflict. Many youth described growing up with parental or guardian discord and being “thrown out”, “kicked out”, or “evicted” from their home. Conflict was related to alcohol, drugs, gang involvement, gender identity, and sexual orientation issues. Five youth had a history of running away as a child. Seven youth were involved in the Department of Social/Family Services at some point and lived in foster care or a group home. Four youth were adopted either at or close to birth or while in foster care.

*Exposure to violence & victimization.*

A history of exposure to violence and personal victimization prior to homelessness and during homelessness was common for the youth. Two participants described witnessing intimate partner violence in their home. Seven youth reported histories of physical abuse from family members or guardians. Sexual assault was described by three homeless youth. Prior to being homeless, one female was sexually assaulted by her nanny’s husband between the ages of 5 and 12 and one female was gang raped at college. While homeless, one female to male transgender youth was raped between 8 and 15 times as a young adult by men. A fear of sexual assault was also described by a few youth in terms of being at increased risk while sleeping outdoors and also in the shelters. It should be noted that the female who was raped in college was one
of the participants who reported sexual abuse by her mother and physical abuse by both her mother and her brother.

**Substance use and abuse.**

Alcohol and drug use and abuse were prevalent among the participants. Eight participants admitted to using alcohol and/or drugs, five of whom described having an addiction. Drug use included marijuana, cocaine, heroin, acid, and bath crystals. Among those who used drugs, one considered herself a “junkie” and wanted to go to drug rehabilitation and one was a heroin user who was involved with sex work to purchase heroin for she and her boyfriend.

**Survival.**

All thirteen youths’ stories included descriptions about needing to survive on the streets. Specific survival strategies included carefully choosing a location to sleep, setting up “booby traps” to stay safe, and knowing “homeless tactics” such as how to pack a backpack with all day gear. One participant discussed how she is strategic about her sleeping arrangements to stay warm during the winter, calculates dog and cat body heat production, and considers the types of sleeping bag she and her friends use. Panhandling, stealing, robbing, and selling drugs were also described in the participant stories as behaviors necessary for getting food, alcohol and drugs, and taking care of friends and pets. A few youth engaged in dumpster diving and three were involved in sex work or “survival sex”.

**Social support.**

Social support was considered important for the majority of homeless youth. Stories revealed two key types of supports, street families and pets. Youth discussed how
important establishing relationships and “tight bonds” with other homeless youth were. Seven youth referred to having a street family. Stories revealed how youth looked out for one another’s health, helped take care of one another’s pets, and shared resources. Pets were also noted to be important. Four participants described how much they value their pets or the animals that they spend time with. Two of these youth explained how they wouldn’t mind sacrificing what they had for their animals and how they would never abandon them.

**Health.**

Six youth considered their health status as being poor. Reasons for this included chronic diseases such as lupus, asthma, Chiari malformation, arthritis, and anemia; side effects related to testosterone injections for gender transition; back problems; skin infections; and mental health problems and substance abuse. For many of the participants, health and health promotion was a positive concept described in the following way: taking care of yourself; doing the things that you know are healthy for you physically and emotionally; a top priority after staying alive; important for worshipping Allah; lots of things, not just physical health – spiritual and mental health.

Additional health promotion strategies found in the stories included jogging, black seed oil, getting glasses, HIV and STD testing, getting clean needles, using condoms and practicing safer sex, not using drugs, trying to get appointments with a provider, taking testosterone shots, and including spirituality in health.

In terms of mental health, nine participants discussed having multiple psychiatric diagnoses. Of the nine participants, only two were on medication. Two were actively receiving mental health services and three had a history of being admitted to a psychiatric
ward or going to a residential facility. Two participants had a history of attempting suicide and one participant had suicidal thoughts at times.

In response to an interview question about what message should healthcare providers hear about homeless youth, participants expressed a need for healthcare professionals to do the following: respect homeless youth as individuals; stop stereotyping; embody fairness, equality, and humanization in their interactions; and increase access to services for homeless youth. Finally, limited access to healthcare was noted in several of the stories. While many participants had Medicaid, they did not have transportation to go to appointments and relied heavily on the emergency room for medical attention.

**What meanings do homeless street youth give to their experiences?**

All thirteen homeless street youth provided stories that gave insight into the meanings of their experiences. For the majority, the experience of being a homeless street youth was difficult – physically, mentally, and in some cases spiritually. For many youth, the experience of homelessness was also valuable and they felt that they were learning important lessons. Additionally, homeless youths’ descriptions of their past, present, and future time perspectives provided understanding into the meanings of experiences.

**What are the time perspectives of homeless street youth and what meaning do past, present, and future have to them?**

A major focus of this research was uncovering the time perspectives of homeless youth. In this section, the description of similarities will include selected participant’s names and quotes.
For three participants, Raven, Anna, and Muhammad, their time perspective was influenced by their religious or spiritual beliefs. Although Raven and Anna were both Pagans they shared different views. For Raven, Paganism has had an impact on her present. “My husband and I live for today.” For Anna, the opportunity to have another life through reincarnation is part of her future. As a Muslim, Muhammad believes: “The past is not worth dwelling on. The present is just an illusion, and the future is the real life.” He believes that this world that we’re living in is just a short life, temporary one, compared to the afterlife. “Being in this life is equivalent to walking in the front of your house and walking out that back door of your house.”

**Past.**

Several of the participants’ stories revealed negative perspectives about the past. The past is something Karen hates because it causes her to have flashbacks of trauma she’s experienced and she can’t sleep. In addition, the past is affecting Karen’s future. “I can’t go to college because of what I did in the past. My parents won’t pay for it.” Biggie would like to work because he believes it will him help him forget the past. He would like to “just move on because it’s messing with my life.” Oli believes that the past is finished. “It’s over, it’s done, I’m through with it. I prefer not to return it.” As stated above, Muhammad believes that the past is not worth dwelling on.

Stories also revealed positive perspectives about the past, about how it makes people who they are, and how it can impact the future. Jay believes that although the past “sucks”, the past made him who he is today. According to Raven, “The past made me who I am today. It can either break you or make you stronger but I’m not going to let it affect my present or my future and won’t let it ruin my life.” Similarly, Nicole stated
“The past affects how you think, your lens, the way you view the world, everything.” She feels the past definitely can affect a person’s future “in a major way”, either positively or negatively and that “it depends on your story. It’s your choice.” For Allison, the past is a learning experience. “I take everything from my past and I always apply it to my future, but I never let my past stop me from my future.” According to Mike, “You can’t have a future without knowing your past and really embracing your past.”

**Present.**

Present time perspective was described as short-lived and temporary in several stories. For Allison, the present is right now and temporary, “so I can push through.” Muhammad believes the present is only a short life and temporary. Mike described the present as “what is going on right now”.

Several participants described positive attitudes towards the present. Biggie is “just happy to be living and not dead or locked up.” Biggie went on to say “I’m not going to sulk and be sad because I got my life. I’m still breathing. I get to see all my beautiful friends every day and I get to see more beautiful faces every day.” For Todd, “The present is always the ground you stand on and the gift you receive every day of the moment.” Allison believes that “Everything’s an experience so I see this as a way for me to grow.” Mike believes that the present is about teaching him and it effects the future: “I thank God I was in this situation because now it’s even more motivation to go out there and get a degree and try to turn around and help people in this situation.” Mike believes the things he’s learned on the streets will be useful in the long run and help him to succeed in life. Kelly believes that everything she is going through presently will be a
learning experience someday, “something I can use to do good”. “I can use what’s happening now in the future for whatever I’m supposed to do.” Kelly hopes that she can use her experiences to help young women like herself get out of sex work and drugs and get a home.

Many participants related the present with the need to survive. Alex stated he is “just trying to basically survive”. Karen described how she needs to be completely focused in the present because “There’s just too much to do right now. How am I going to eat tonight? Where am I going to shower? The drop in center is closed on the weekend so what will I do for two days?” To Raven, the present means living each day “just making sure we have what we need day today to survive, whether it’s dog food, water or food”. Nicole shared the following: “A lot of people give up in this situation and I’m just not at that point where I’m done; to survive you got to figure out something and the human instinct figures something out. You’re going to find a way to get food unless you’re just totally done. For Kelly, the present is about “survival”. “It’s a struggle out here because you know you want to survive. You got to do what you got to do to survive. It’s hard.”

**Future.**

Participants’ stories revealed positive future time perspectives. Nicole states she wants more for herself and “I feel like I can do it.” The future makes her think of her long term goals. Nicole believes she can change. “Because I’ve been through what I’ve been through, I’ve learned.” Nicole would like to have children someday. Her main goal is to be a better parent than her mom. She would like her basic needs to be met and doesn’t need a “mansion”. Raven describes her future as “a lot of wide open space, and
you don’t know what’s coming.” This makes her feel curious. Raven’s future plans include getting an apartment which she thinks is possible because the dog kennel her husband works at is starting to expand. Eventually she would like to go back to school or do something with music.

For Allison, the future means “everything”. She wants her children to be proud of who she is. Mike believes that the future is about “strength, courage, fortitude, keeping motivated, and keeping your ambition in the right place.” He believes all of these things are tools and the key to his future which will be “success and prosperity, what everyone hopes for”. Consistent with his Muslim beliefs, Muhammad believes in the afterlife and says that the future is the real life.

While none of the participants were suicidal during their storytelling, the issue of suicide was described in three stories. These descriptions may shed light on future time perspective, or the lack of a future perspective, for some youth. Anna has had several suicide attempts over the years. She is not feeling suicidal during her story but says “There are definitely days I wish I would die because I’m sick of everything.” Todd has attempted suicide once. “I thought about it and I was like, this ain’t worth it, life, and just ending right there and being trapped in a hole. Sorry to say that’s being trapped in a hole. You can’t be free from that stuff.” Alex has suicidal thoughts every day but no plan to end his life. “I just want to be gone. Things would be so much easier if I were just gone because it’s so hard and I’m trying to do this all on my own…”
Does time perspective influence the health and health promotion of homeless street youth? If so, how?

None of the participants directly discussed how their time perspectives influenced their health and health promotion. However, as previously described, many youths’ stories related their need to survive with the present.

Uniqueness

In narrative analysis, the search is for the remarkableness of each of the narratives that is unique. According to Polkinghorne (1995), the “power of a storied outcome is derived from its presentation of a distinct individual, in a unique situation, dealing with issues in a personal manner” (p. 18).

Despite the numerous similarities between the participants described above, each homeless youth had a unique story that separates them from the commonalities they have. Thirteen stories written about homeless street youth recognize their significant contribution to the study. In this section, a summary of the special characteristics of each participant’s story will be provided. Participant stories will follow the same order as the collection of stories. (Jan--this section does not follow the subheadings as they don’t apply; the uniqueness of each participant’s story is shared on its own)

Anna’s story is unique because of her severe substance abuse problem, mental health conditions, and lupus. In the last year, she has been to the emergency between twenty and thirty times. Anna is the only participant with a drug problem who expressed an interest in drug rehabilitation. She uses clean needles which she takes from her grandmother who is a diabetic. Also, Anna wears braces but has not seen a dentist in a
year and was recently she was given $100 from her mother to buy new prescription
glasses.

Todd’s story is unique because his goal is to become a super hero of the universe.
He is severely mental ill and uses drugs.

Oli’s story is unique because he is a transgender female to male youth who has
been raped between 8 and 15 times. In addition to mental illness, he abuses a variety of
drugs, including bath salts, considered a new designer drug similar to amphetamine. Oli
carries a first-aid kit and Narcan, a medication to treat overdoses, so that he can help his
friends who are using drugs and homeless. Oli describes the challenges of growing up
with gender identity confusion and says gender is still unclear to him.

Karen’s story is unique because she is the only participant to have an automobile
and she shares her van with as many people as can fit. Her wealthy parents live near
where she hangs out and they pay for three things: her therapist, cell phone, and car
insurance. Karen was sexually abused for many years by her nanny’s husband and turned
to alcohol to cope when she was 14 and later was told to leave home. Karen shares her
story with politicians and funders at speaking engagements on behalf of the homeless
youth organizations where she receives services from.

Biggie’s story is unique because he was born a drug-addicted baby, raised by
family members who physically abused him and was bullied at school. Biggie says he
tried to tell someone about what was going on “but nobody would listen”. Biggie’s anger
led to retaliation at home and he ended up having to leave. Biggie is worried he has
bipolar disorder. He would like to be a chef someday.
Nicole’s story is unique for several reasons. She is a young woman who after being valedictorian of her high school alternative school and getting a college scholarship, studied social work for two years before not being allowed to return to her grandmother’s house possibly because at that time she was romantically involved with a female. Nicole is bright and articulate and raised the following issues in her story: the problem of stereotypes and labeling others; homelessness as a lifestyle; and the importance of children getting their needs met in order to succeed. Additionally, Nicole is the only participant who stated that her goals included having children and being a better mother than her mom.

Jay’s story is unique because he recognizes that the community he lived in had an impact on how he developed. He attributes his alcohol and drug use and gang involvement to the environment. He has been diagnosed with delusions of grandeur, bipolar, schizophrenia, and ADHD and receives services from the Department of Mental Health. His goal is to take over the world with his rap music.

Raven’s story is unique because she is married, has a Chiari malformation (a structural defect in the cerebellum which affects her balance), and struggles to care for her husband and four dogs while living outdoors. Feeding her dogs is a priority for Raven and she panhandles to earn money for their food, often at the expense of her and her husband’s needs. Additionally, Raven attended college for over year to study criminal justice and while living in the dorm was gang raped.

Mike’s story is unique because he is notably a very clean cut, well dressed young man who was doing well in college but during a school vacation was arrested and later convicted on a drug-related crime which he states he is innocent of. Upon being released
from jail he was on probation and could not leave the state. Because he didn’t have any family nearby, he became homeless. Mike is appreciative of his homeless experience, describing it as “enriching” and “like gold”. He is working for a catering company and getting help from a housing program so he can get an apartment and go back to college.

Allison’s story is unique because, at the time of her interview, she had only been homeless for 2 months and when the member check was done she had already found a job and place to stay. Additionally, Allison is a widow. Her husband overdosed on pain medication. She has toddler age twins who are staying with her parents until she can earn enough money to get her own place. She had been fired from a job as a live-in patient care assistant because she refused to restrain the client given there were no doctor’s order to allow this. She has found another live-in patient care position in the immediate area of the homeless youth drop-in center. She is expecting an insurance settlement related to a car accident she previously had and believes she will have enough money to get her own apartment and live with her children again. Allison has an interest in helping the homeless community and has started working with the police department and educating them about homeless youth. Allison is the only participant that shared she had children and believes it’s important that her kids are proud of who she is.

Muhammad’s story is unique because of his devotion to Islam and being held in federal prison for two years related to suspicion of conspiracy of terrorism. Despite being homeless, Muhammad’s lifestyle is unlike most youth on the streets. He does not smoke, drink, or do drugs; he is not sexually active; and he follows the Muslim rules and prays five times a day among other things. Muhammad’s time perspective is based on his
faith and he believes that “The past is not worth dwelling on. The present is just an illusion and the future is the real life.”

Kelly’s story is unique because she is a sex industry worker who lives under a bridge with her 47 year old boyfriend and they are both heroin addicts with Hepatitis C. She provided a detailed description of her experience doing sex work and shared how one of her clients had AIDS. Kelly goes to a substance abuse clinic and receives prescription Suboxone for her addiction but sells it to earn money for heroin. Kelly hopes to someday use her experiences to help other women who are in her same situation.

Alex’s story is unique because he is a female to male transgender youth who left college and a supportive family to relocate over 1,500 miles away to be with a new boyfriend he had at the time. He works part-time at a clothing store, is taking testosterone injections, suffers from major depression and anxiety, as well as uses alcohol and marijuana.

Summary

In this chapter the product of the narrative analysis was provided as a collection of thirteen stories of homeless street youth. Additionally an analysis of story similarities and uniqueness was given. The stories provided information about youths’ experiences and perspectives regarding childhood family conflict, violence, drugs and alcohol, survival, social support, health, and also their past, present, and future time perspectives.
CHAPTER 5: DISCUSSION

Narrative analysis was used in this research regarding homeless street youth to gain a better understanding of this highly vulnerable and growing population. Chapter five begins with a discussion structured around each of the research questions and subsequent findings from the collection of thirteen participant stories provided in chapter four. Research findings will be compared to the current literature. Implications for nursing, policy, clinical practice, education, and future research will then be addressed, followed by concluding remarks.

What Are The Stories Told By Homeless Street Youth?

The first research question sought to gather and understand the stories of homeless street youth. Thirteen homeless street youth participants shared deeply personal and rich stories of their lives -- past, present, and future. Their stories shed light on the following: childhood family conflict, exposure to violence and personal victimization, substance use and abuse, survival, social support, health, health promotion, and time perspective. Each of these topics will be discussed below.

Childhood Family Conflict

Childhood family conflict played a significant role in the lives of homeless street youth and in their becoming homeless and remaining homeless. Study findings are consistent with the literature that reports that youth are often forced out of their home or leave willingly because of family conflict (Rew, 2008) and they also tend to experience more family conflict than their peers who are housed (Toro & Goldstein, 2000). In addition, familial disintegration that begins in homeless youths’ early childhood is common and involves poor parenting habits, an unstable or unhealthy family
environment, and violence (Paradise & Cauce, 2002). These conflicts tend to reflect longstanding patterns rather than problems that arise just before youth leave home (Smollar, 1999). Conflicts related to step-parent relationships, sexual activity, pregnancy, sexual orientation and gender identity, school problems, and alcohol or drug use seem to be the most common (Rew, 2005; Robertson & Toro, 1999; Whitbeck & Hoyt, 1999) and were largely present in the stories of homeless street youth who participated in this study.

Sexual orientation and gender identity appears to be a causal factor for youth homelessness (Whitbeck et al., 2004). Three study participants described how their sexual orientation and gender identity had led to and impacted their homelessness. In the October 2011 through March 2012 Lesbian, Gay, Bisexual, and Transgender Homeless Youth Provider Survey (a web-based survey of over 350 homeless youth agencies) the number of homeless youth agencies serving LGBTQ youth had grown over the past ten years, particularly those serving transgender youth (Durso & Gates, 2012). Youth who are LGBTQ comprised approximately 40% of the clientele served by agencies represented in the sample. Family issues were the primary reasons why LGBTQ clients were either homeless or at-risk for homelessness. Respondents indicated that 68% of their LGBTQ homeless clients have experienced family rejection. Running away from home because of family rejection was the most frequently cited reason (46%) and a similar portion of respondents (43%) said that LGBTQ youth had been kicked out of their homes. More than half (54%) have experienced physical, emotional, or sexual abuse in their family (Durso & Gates, 2012). Overall, providers in this survey indicated that a lack of funding is the biggest barrier to addressing the needs of LGBTQ youth who are homeless or at-risk of becoming homeless. Working with limited resources clearly
impacts the ability of agencies to provide LGBTQ youth with services that may help them change their homeless situation.

**Exposure to Violence & Victimization**

In addition to childhood family conflict, many homeless youth in this study were exposed specifically to violence in their families and were victimized themselves. Although the percentage of homeless youth who report a history of maltreatment varies widely across studies, research using comparison groups has found that homeless youth are more likely to have been abused and/or neglected than their peers who are housed (Wolfe et al., 1999). This may also explain why homeless youth are more likely to have been verbally and physically aggressive toward their parents compared to their housed peers (Toro & Goldstein, 2000). Homeless youth often cite physical or sexual abuse as their reason for leaving home (Rew, 2008). As recently discussed, over 50% of LGBTQ youth have experienced physical, emotional, or sexual abuse in their family (Durso & Gates, 2012).

Child maltreatment is an urgent national problem. In 2010, U.S. state and local child protective services (CPS) estimated that 695,000 children (9.2 per 1,000) were victims of maltreatment. Of the child victims, 78% were victims of neglect; 18% of physical abuse; 9% of sexual abuse; and 8% of emotional abuse (U.S. Department of Health and Human Services, 2010). Reports of child maltreatment by CPS may underestimate the true occurrence. Non-CPS studies estimate that 1 in 5 U.S. children experience some form of child maltreatment in their lifetimes and that rates range from 15 to 43 per 1,000 children (Finkelhor, Turner, Ormond, Hamby, 2009). Child maltreatment has significant economic consequences. The total lifetime economic
burden resulting from new cases of fatal and nonfatal child maltreatment in the United States is approximately $124 billion (Fang, Brown, Florence, & Mercy, 2012).

Childhood family conflict and exposure to violence and victimization can be understood as “adverse childhood experiences” (ACEs). ACEs include the full spectrum of family dysfunction (arguments, intimate partner violence, divorce, etc.) as well as verbal, physical, or sexual abuse. Experiences described as ACEs have been linked to a range of adverse health outcomes in adulthood, including substance abuse, depression, cardiovascular disease, diabetes, cancer, and premature mortality (“Adverse Childhood Experiences”, 2010). Furthermore, in data collected from a large sample of health maintenance organization members, a history of ACEs is common among adults and ACEs are themselves interrelated (“Adverse Childhood Experiences”, 2010).

Between 3.3 and 10 million children are exposed to domestic violence (DV) each year and child maltreatment is estimated to occur in 30-60% of homes where DV is present (Zink, Jacobson, Regan, & Pabst, 2004). Several studies have linked cumulative childhood stress with poor health outcomes in children, adolescents and adults. Children exposed to DV can experience a variety of adverse effects such as behavior disorders and developmental delay (Siegel, Hill, Henderson, Ernst, & Boat, 1999). During the early transition to adulthood, the impact of childhood adversity can be evident in the association with depressive symptoms, antisocial behavior, and drug use (Schilling, Aseltine, & Gore, 2007). These effects may last well into adulthood and may include chronic pain (Wuest et al., 2008), depression and physical symptoms (Bonomi, Anderson, Rivara, & Thompson, 2007) including autoimmune diseases in adults (Dube, Anda, Felitti, & Williamson, 2002). There is a critical need for prevention and intervention
strategies to decrease the effects of ACEs and increase the number of positive influences in childhood (Chung, Mathew, Elo, Coyne, & Culhane, 2008; Schilling et al., 2007).

Strengthening families and preventing ACEs and child maltreatment in particular requires a shared commitment of individuals and organizations in every community. Successful ACE/child maltreatment prevention and intervention strategies must reduce risk factors and promote protective factors to ensure the well-being of children and families (Fang et al., 2012; U.S. Department of Health and Human Services, 2010). Protective factors are conditions that, when present, increase the health and well-being of children and families. They are attributes that serve as buffers, helping parents who might otherwise be at risk of abusing their children to find resources, supports, or coping strategies that allow them to parent effectively, even under stress. In summary, ACEs and child maltreatment play a role in youth homelessness. Prevention & intervention strategies are critically needed in order to strengthen families and improve the health and well-being of children. Successful efforts could likely reduce the risk of youth homelessness.

**Substance Use and Abuse**

Consistent with the literature on youth homelessness (Kidd, 2012), participants in this study exhibited high rates of substance use disorders, including the use or abuse of alcohol and/or drugs. Use of tobacco products was not discussed in the interviews but the majority of the homeless youth in the interview locations were observed to be smoking. Substance use and abuse is likely a way to cope with previous trauma and the stress of being homeless (Rew, 2008; Toro et al., 2007). In homeless and runaway youth,
substance use is highly linked with physical and mental health problems, as well as risky sexual behavior (Rew et al., 2001).

Across the lifespan, the prevalence of tobacco, alcohol, and illicit drug use and abuse is highest among adolescents and young adults (Sussman & Ames, 2008). By grade twelve, an estimated 71% of youth in the U.S. have tried alcohol, 42% have tried cigarette smoking, 43% have tried marijuana, and 25% have tried an illicit drug other than marijuana (Johnston, O’Malley, Bachman, & Schulenberg, 2011). Consequently, substance misuse is among the most prevalent causes of youth morbidity and mortality in the United States, and approximately 5–8% of adolescents in the United States qualify for a diagnosis of substance abuse disorder (Ozechowski & Waldron, 2010). Youth substance use-related disorders are associated with poor academic performance; job instability; crimes such as stealing, vandalism, and violence; teen pregnancy and sexually transmitted diseases; and a relatively high prevalence of driving under the influence, and other related accidents (Sussman & Ames, 2008).

In our efforts to lower the morbidity and mortality caused by adolescent substance use, it is important that we focus our attention on preventing youth from using substances in the first place. In fact, some researchers and practitioners believe that prevention programming ought to be applied to very young children to enhance social and emotional learning while the brain is still rapidly developing (Fishbein, 2000). For those whom have not been exposed to nor had success with prevention programming, providing treatment and support to youth who are in recovery is essential. Further, because co-occurring substance use and mental disorders often exist in the same individual
(Ozechowski & Waldron, 2010), substance abuse treatment programs must integrate both aspects of care.

**Survival**

Survival is a primary need of homeless youth (Dachner & Tarasuk, 2002; Fest, 1998; Rew, 2008) and the participant’s stories support this. Alienated from the dominant culture, homeless youth develop a marginalized subculture that guides life and survival on the streets (Oliveira & Burke, 2009). Survival strategies that participants engaged in included the following: panhandling; dumpster diving; selling drugs; survival sex; participating in scams/cons; stealing; mugging; and selling stolen goods (Kipke et al., 1997; Rew, 2008; Robertson & Toro, 1999; Stephens et al., 2000). While many of these strategies can be considered risky and deviant, youths’ stories in this study described the use of survival strategies to meet physical, safety, economic, and emotional needs (Shane, 1996). Research regarding survival strategies and health (in its broadest form) is lacking but would be insightful towards understanding how youths’ desire to survive could be used for improved health, health promotion, and ending homelessness.

**Social Support**

For the last three decades, there has been a growing interest in social support as a coping resource. Social support has been defined as information from others that one is loved and cared for, esteemed and valued, and part of a network of communication and mutual obligations (Cohen & Wills, 1985). Social support is considered a positive attribute consisting of interactions between individuals and groups which can provide varying degrees of connection, resources, and affirmation (Bates & Toro, 1999). In addition, social support can be conceptualized as “a social ‘fund’ from which people may
draw when handling stressors” (Cohen, Underwood, & Gottlieb, 2000, p. 64). In this study, homeless youth spoke of the importance of receiving social support from other homeless youth whom they referred to as their street family, as well as from animal companions who they claimed as members of their family. Often, the culture of youth homelessness includes the creation of street families which is considered a valuable resource that, in addition to companionship, helps promote survival on the streets (McCarthy et al., 2002; Oliveira & Burke, 2009; Smith, 2008). Additionally, youth stories revealed the importance of pets to homeless youth. This finding is supported by Rew and Horner (2003) who identified that, among other things, taking care of a pet was an internal motivator for self-improvement that might serve as a motivator for health promoting behaviors. Social support provides people with part of the emotional and practical resources they need to get through life. The effect of perceived social support can be observed in adjustment to chronic pain (Valente, Ribeiro, & Jensen, 2009), academic adjustment in young adults (Rueger, Malecki, & Demaray, 2010), depression in adults and HIV patients (Brown, Andrews, Harris, Adler, & Bridge, 2009; Li, Lee, Thammawijayab, Jiraphongsab, & Rotheram-Borus, 2009), smoking cessation (Westmaas, Bontemps-Jones, & Bauer, 2010), physical activity in elementary students (Springer, Kelder, & Hoelscher, 2006), nutritional behaviors in international students (Anderson, Winett, & Wojcik, 2007), and drinking behavior among women in poverty (Mulia, Schmidt, Bond, Jacobs, & Korcha, 2008). Conversely, lack of social support during traumatic times can be very distressing, especially for vulnerable populations who are unable to obtain it (Sorkin, Rook, & Lu, 2002). Furthermore, social isolation and exclusion are associated with increased rates of premature death, mental illness such as
depression, higher levels of pregnancy complications, and higher levels of disability from chronic illness (Wilkinson & Marmot, 2003).

According to the IOM (2001), positive health does encompass high-quality personal relationships. Positive relationships that provide some degree of social support have been identified as strengths and resources of homeless youth in the literature (Rew, 2003; Williams et al., 2001). Interpersonal and animal relationships appear to be a key source of support, protection, and guidance for homeless youth as they negotiate life on the streets (Rew, 2002). These findings lay the foundation for future studies focused on social support for homeless youth that can lead to innovative, evidence-based approaches (including animals) to improve the health and well-being of this population. Additionally, given that families with low social support are at increased risk of child maltreatment (Li, Godinet, & Arnsberger, 2010), and this could contribute to the risk of youth homelessness, there is a strong need for research examining social support interventions aimed at prevention.

Health

A large number of homeless youth in the study described their health status as being poor due to a variety of medical, mental health, and substance use disorders. These findings are supported by the literature. Approximately 5,000 runaway and homeless youth die each year due to illness, assault, and suicide (NRS, 2010). Youth experiencing homelessness have decreased access to healthcare and increased rates of acute and chronic illness, sexually transmitted diseases, and HIV (Bontempo & D’Augelli, 2002; Rew, 2008). Additional factors associated with poor health have been identified and
include exposure to the elements, inadequate nutrition, and mistrust of medical providers (Kelly & Caputo, 2007).

Homeless youth who identify as LGBTQ seem to face increased risk of poor health. In a recent study of homeless youth service providers 54% of providers reported that the overall health of their LGBTQ homeless youth clientele was worse than other homeless youth (Durso & Gates, 2012). Nearly 25% of homeless youth service providers thought that the overall health of their transgender clients was “much worse” than other non-LGBTQ homeless youth. Also, relative to other homeless youth, transgender homeless youth had suboptimal physical and mental health. The lack of funding, in particular government funding, has been identified as a primary barrier to improving services related to reducing LGBTQ homelessness (Durso & Gates, 2012). In the current study, the stories of homeless street youth revealed that two transgender youth perceived their health status as poor and recognized the importance of better healthcare. More research is needed about both the unique healthcare needs of LGBTQ of homeless street youth and the knowledge and attitudes of service providers who work with this group.

Many youth in this study described having multiple psychiatric diagnoses but not receiving mental health treatment. This is consistent with the literature. Homeless youth are at elevated risk for a variety of mental health problems depression, mood disorders, post-traumatic stress, self-harm, and suicide (Haber & Toro, 2009; Kidd, 2003; Moskowitz et al., 2012; Thompson et al., 2002). The risk of mental health problems may be particularly high among street youth, who tend to have experienced more stressful events and exhibit more psychological symptoms than homeless youth who have not spent time on the streets (Robertson & Toro, 1999; Whitbeck & Hoyt, 1999). Further, a
substantial proportion of youth (including those who are not homeless) with severe mental disorders do not receive mental healthcare (Merikangas et al., 2011).

Approximately 20% of youth overall are affected by a severe mental disorder (Merikangas et al., 2011). In a recent study, Merikangas and colleagues analyzed data from the National Comorbidity Study-Adolescent Supplement, a nationally representative, face-to-face survey of more than 10,000 teens ages 13 to 18. Only 36% of youth with any lifetime mental disorder received services, and only half of these youth who were severely impaired by their mental disorder received professional mental health treatment. The majority (68%) of the children who did receive services had fewer than six visits with a provider over their lifetime. The researchers concluded that despite recent programs designed to improve mental health services for youth, such as the State Children’s Health Insurance Program and the federal Children’s Mental Health Initiative, many children in need of mental healthcare still do not receive it. In addition, the relatively low number of treatment visits suggests that the few who are getting treatment may not have sufficient professional follow-up. Finally, ethnic disparities in mental healthcare, especially of mood and anxiety disorders, are still widespread.

Unfortunately, the reason for the high prevalence rates of mental illness among homeless youth is not clear (Robertson & Toro, 1999). Mental health and behavioral disorders contribute to family conflict and thus to homelessness. However, causality could also be in the opposite direction (MacLean, Embry, & Cauce, 1999). In any case, it is clear that efforts are needed to increase awareness of the importance of promoting mental health. Specifically, there is a need for increased access to preventative services, early identification and treatment, and supportive services for those identified.
Health and health promotion was a positive concept for many of the homeless street youth in this study. Their stories described a wide variety of health promoting behaviors noted in the homeless youth literature (Kidd & Davidson, 2007; Rew, 2003; Rew & Horner, 2003). Youth spoke about self-care behaviors, surviving with limited resources, self-protection, seeking out resources, and knowledge of the environment, adaptation, social support, caring for friends and animals, and setting health goals. These health promoting behaviors can be considered strengths and resources of homeless street youth and help to shift the literature on this population which has been largely disease and problem oriented (Rew, 2008). Evidence-based strengths approaches are needed to empower homeless street youth to focus on their future and transition out of homelessness (Levy, 1998).

Homeless street youth participants described a number of barriers to their health and gave recommendations for health professionals. Issues that were raised by youth centered on limited access to healthcare and also treating youth individually and respectfully. These problems have been identified in the literature as well as insufficient knowledge of healthcare resources and distrust of healthcare providers (Ensign & Panke, 2002; Geber, 1997; Klein et al., 2000). Findings from this study demonstrate the need for health policies aimed at increasing access through medical coverage and supportive services including transportation. In addition, there is an opportunity to improve the knowledge and training that service providers of homeless youth receive with regard to culturally sensitive care.
What Meanings Do Homeless Street Youth Give To Their Experiences?

What Are The Time Perspectives Of Homeless Street Youth And What Meaning Do Past, Present, And Future Have To Them?

The second research question sought to understand the meanings that homeless street youth give to their experiences. The third research question aimed to understand the time perspectives of homeless street youth and the meanings that past, present, and future have to them. The second and third research questions are tightly interwoven in the stories and will be answered together.

As stated previously, the stories shared by homeless youth revealed that their time perspectives shed light on the meanings they gave to their experiences. This is not surprising given that time perspective is a psychological construct representing an individual’s way of relating to the past, present, and future; a psychological construct which influences all of human behavior (Zimbardo & Boyd, 1999). Zimbardo and colleagues posit that time perspective is a dimension of psychological time that develops from cognitive processes that divide human experience into past, present, and future temporal frames (Boniwell & Zimbardo, 2003; Boniwell & Zimbardo, 2004; D'Alessio et al., 2003; Zimbardo & Boyd, 1999). These cognitive temporal frames are used to encode, store, and recall experienced events which then shape individuals’ attention, perception, judgment, decision making, and actions, expectations, goals, and imaginative views (Boniwell & Zimbardo, 2004; D'Alessio et al., 2003; Zimbardo & Boyd, 1999). Factors that influence the formation and modification of time perspectives include personal, social, and institutional factors such as family background, socio-economic status, education and employment, and cultural and spiritual values (Boniwell &
Zimbardo, 2004; Zimbardo & Boyd, 1999). As discussed in chapter two, the Zimbardo Time Perspective Inventory (ZTPI) (Zimbardo & Boyd, 1999) was developed to measure individuals’ orientations to the past, present, and future. Although homeless street youth participants were not given the ZTPI, time perspective findings from this study will be examined in light of this measurement tool.

**Past**

For homeless street youth in this study, the past had both negative and positive meaning. Some participants reported that the past was traumatic and resulted in flashbacks, difficulty sleeping, anxiety, depression, and substance use and abuse. This finding is supported by Zimbardo and Boyd (1999) who found that the past-negative scale of the ZTPI reflected a generally aversive attitude toward the past including trauma, pain, and regret, as well as negative rumination, depression, anxiety, unhappiness, and low self-esteem (Zimbardo & Boyd, 1999).

Alternatively, many homeless street youth described the past as having a positive meaning in that it made them who they are today. Youth talked about learning from the past and not letting the past get in their way of obtaining goals in the future. In the ZTPI, the past-positive scale is characterized by a warm, sentimental, positive construction of the past, increased self-esteem, and negatively correlated with depression, anxiety, and aggression (Zimbardo & Boyd, 1999).

**Present**

Homeless street youth described the present as both temporary and also important to survival. These finding are somewhat congruent with the ZTPI present-hedonistic scale that is characteristic of risk-taking and an orientation toward present pleasure with
little concern for future consequences. However, participants linked the survival strategies they engaged in more to meeting basic needs than pleasure needs. With regard to the ZTPJ present-fatalistic scale, youths’ stories were not generally compatible. The present-fatalistic scale characteristics indicate helpless and hopeless attitudes toward the future as well as an absence of a focused time perspective (Zimbardo & Boyd, 1999). In this study, homeless street youth clearly articulated hopeful attitudes for the future. This will be described in more detail in the following section.

Future

The majority of the participants had positive future time perspectives. Homeless street youth were hopeful that they could obtain their goals and many believed that past and present have an impact on their future. Their descriptions of the future were congruent with characteristics of the future scale of the ZTPJ including setting future goals, rewards, and planning (Zimbardo & Boyd, 1999). Findings from this study do not support the claim made by Fest (1998) that homeless youth have little regard for the future.

It’s important to emphasize that study findings related to participants’ meanings of their experiences and their time perspectives are based on the stories of a sample of homeless street youth whose stated ages ranged from 18 to 21 years. Therefore, the findings may have been different if the sample contained younger adolescent participants. As previously discussed in chapter two, the ability to make meaning from experiences is a hallmark of adolescent development (Marcia, 1989) and the ability to conceive of time is developed during early childhood (Blum & Resnick, 1982; Gonzalez & Zimbardo, 1985).
Time perspective is an important interpersonal variable of adolescence and, in general, adolescent time perspective is characterized by an orientational shift from the nearness of the present and the fascination of the past, to a considerable interest in the future (Greene, 1986). Differences exist between younger and older adolescence with regard to time perspective. Specifically, younger adolescence is dominated by concrete, present-oriented thinking that lacks consideration of potential consequences of behavior. In later adolescence and early adulthood, thinking that is more abstract and futuristic develops although some individuals may never reach this level of formal cognition (Inhelder & Piaget, 1958).

In summary, findings related to participants’ meanings of their experiences and their time perspectives should be interpreted carefully in light of the older adolescent/young adult age range of the sample. Furthermore, there are many factors that may affect adolescents’ meaning making abilities, their conceptions of time, and their time perspectives. Specifically, multiple and interacting factors affecting individuals at interpersonal, intrapersonal, community, and societal levels (Glanz et al., 1997; McLeroy et al., 1988), as described in ecological theory, may play a role.

Does Time Perspective Influence the Health and Health Promotion of Homeless Street Youth? If So, How?

The fourth research question aimed to understand the possible connection between time perspective and health and health promotion. As discussed in chapter four, participants did not describe a direct relationship between their time perspective and health and health promotion. However, based on the following findings from this study, a connection between time perspective, health, and health promotion may exist:
homeless street youth value health; homeless street youth engage in health-promoting behaviors; homeless street youth express a strong desire to survive and sometimes must resort to unpleasant and high-risk strategies to meet their needs; homeless street youth have positive attitudes towards the future, identify goals, and indicate that their past and present situations are learning opportunities that are useful for achieving their future plans.

Perhaps, this possible connection between time perspective, health, and health promotion is best summarized by recounting several of the voices of the study participants themselves:

- The future means “everything” to Allison.
- Nicole wants “more” for herself and believes “…I can do it.”
- The future is about “strength, courage, fortitude, keeping motivated, and keeping your ambition in the right place” for Mike.

Findings from this study that a connection between time perspective, health, and health promotion may possibly exist for homeless street youth are promising for many reasons. First, a person’s time perspective can impact one's current course of action (Zimbardo & Boyd, 1999). Children and adults with positive future orientation tend to experience better life outcomes than those with a negative future orientation (Aronowitz & Morrison-Beedy, 2004; Robbins & Bryan, 2004; Vankineeste et al., 2004). Secondly, adopting health promoting behaviors requires a time perspective focused on the future in order to imagine, anticipate, and plan for anticipated change (Bandura, 1991). By valuing the future, health benefits in the future can be valued (Adams & Nettle, 2009). Until now, the role that time perspective plays in the lives of homeless youth had not
been explored. Findings from this study offer hope for improved health and well-being for a young, marginalized, almost invisible population, who through their stories clearly stated that their future is important. In conclusion, future studies aimed at examining time perspective, health, and health promotion are necessary.

**Implications**

The findings from this narrative inquiry of homeless street youth, their stories, time perspective, and health and health promotion have significant implications for nursing. These include suggestions for nursing, policy, clinical practice, education, as well as for future research. This section includes the study implications followed by limitations and strengths of the study, and concluding remarks.

**Nursing Implications**

The topic of this study and the subsequent research findings have major implications for nursing, especially in terms of caring for vulnerable populations and promoting social justice. In the United States, nursing’s social mandate to care for vulnerable populations has been outlined in ANA's *Social Policy Statement* (2010). This responsibility is also acknowledged by the International Council for Nursing (ICN, 2006) which represents nurses globally and by numerous scholars internationally (Flaskerud & Nyamathi, 2002; Spenceley, Ruetter, & Allen, 2006; Tripp-Reimer, 1999). "The nurse shares with society the responsibility for initiating and supporting action to meet the health and social needs of the public, in particular those of vulnerable populations" (ICN, 2006, p. 2). The basis for asserting this as an ethical responsibility of the profession is that nursing cannot fulfill its 'promises' to promote a good for society (Grace, 2001) if
there are social conditions that cause recurring problems or other obstacles to well-being anchored in societal arrangements.

Societal conditions that lead to dehumanization for certain populations have a profound bearing on human health and well-being. Many of the social factors linked to youth homelessness previously described in this paper, such as lack of housing, poverty, child maltreatment, lack of education, untreated substance abuse and mental illness, and unemployment, exist for many other vulnerable populations as well. The World Health Organization’s Commission on Social Determinants of Health (WHO, 2008) explicitly links health inequities with social inequalities in power distribution, earnings, shelter, access to education, healthcare, climate change and other living conditions. Without attending to the root causes that lead to disparities in health, nursing cannot fulfill goals of optimizing human health (Grace, 2009). The Commission argues that unequal social conditions can be remedied and that remediating these inequalities is an issue of social justice—and presents the global community with associated ethical imperatives.

Social justice is a matter of life and death. It affects the way people live, their consequent chance of illness, and their risk of premature death. . .avoidable health inequalities, arise because of the circumstances in which people grow, live, work, and age, and the systems put in place to deal with illness. The conditions in which people live and die are, in turn, shaped by political, social, and economic forces. (WHO, 2008, para 1)

The profession of nursing has a critical potential—and mandate—to advance social justice in order to further health for vulnerable communities (Willis, Perry, LaCoursiere Zuccheri, & Grace, 2012). Nursing’s mandate to advance social justice emerges from
the ontological, epistemological, and ethical foundations of the profession, as well as its own historical development. Nursing responsibility includes recognizing and addressing social injustices.

Nursing’s Social Policy Statement (ANA, 2010) calls for nursing to influence public policy to promote social justice. Nursing actions to optimize health cannot be achieved within the confines of a healthcare institution. A growing body of research makes clear that the sources of suboptimal physical, mental, and social well-being lie in the social structure itself. In order to assist populations to maximize health and well-being in the fullest sense we must, as a profession, move our attention beyond the boundaries of the healthcare infrastructure to the broader society as a whole. Chinn & Kramer (2008) have suggested a new pattern of knowing in nursing called “emancipatory knowing”. Emancipatory knowing critically examines social injustices and identifies the changes needed to effect social and structural change. Similarly, Butterfield (2002) calls for nursing to expand its knowledge base and use strategic advocacy to advance from individual to collective public interests at an “upstream” level. The actions of social-reforming nurses, like Florence Nightingale and Lillian Wald, significantly influenced how people in their time lived and died. They took whatever means necessary to pursue good solutions to immediate health problems and addressed the social determinants of health, or what contemporary public health scholars term “upstream” determinants of health; that is, those social, educational, economic, environmental, and political factors that influence the health of individuals, families, communities, and populations (Butterfield, 2002; Gehlert et al., 2008). Using a narrow definition of health, social determinants of health determine whether individuals stay healthy or become ill.
However, using an expanded definition of health, such as the one provided in chapter one, social determinants of health also determine the extent to which an individual, family, community, and population possesses a multitude of necessary resources to identify and achieve personal aspirations, satisfy needs, and cope with the environment. In summary, vulnerable populations, social determinants of health, and social justice issues are inter-related concepts and a focus of nursing. Involvement in health policy is one way that nurses and other professionals can contribute to these important causes.

**Policy Implications**

Policy refers to decisions, plans, and actions that are undertaken to achieve specific healthcare goals within a society. One of the most significant factors related to youth homelessness, and confirmed in the study participant’s stories, is the problem of childhood maltreatment. Every individual has the right to health and a life free from violence. Each year, though, thousands of children and older youth in the U.S. are the victims and witnesses of physical, sexual and emotional violence. Child maltreatment is a huge global problem with a serious impact on the victims’ physical and mental health, well-being and development throughout their lives – and, by extension, on society in general.

Unfortunately, despite the scale of the problem and increasing awareness of its high social costs, preventing child maltreatment has not been a political priority. A lack of understanding of the serious, life-long health repercussions of child maltreatment, the burden on society, and associated costs of health services all contribute to this problem. Maltreatment and other trauma in infancy and childhood are associated with a broad spectrum of health-risk behaviors (Stroud & Petersen, 2012). In this way, maltreatment
contributes directly and significantly to some of the leading causes of death and chronic diseases. Furthermore, there is a lack of awareness of how powerful strategies for preventing disease and promoting public health can prevent child maltreatment. These prevention strategies focus on underlying causes and risk factors at the level of the individual, family, community and society. They aim to reduce the incidence of child maltreatment in the population (Stroud & Petersen, 2012). However, investment in child maltreatment is laden by a widespread demand for immediate returns on public investment and this demand cannot always be met by prevention programs, which sometimes take years to yield their anticipated effects. Intensifying child maltreatment prevention, therefore, requires that the gravity of the problem be understood. This can be achieved through good epidemiological studies that point to where and how maltreatment takes place; that measure its consequences and costs; and that, with this information, set up, carry out and evaluate prevention programs addressing the underlying causes and risk factors.

While detailed health policy recommendations are beyond the scope of this paper, health policy efforts related to child maltreatment must address multiple level factors. These levels include the following: individual level factors (a child with special needs, unplanned pregnancy, parental alcohol and drug abuse, etc.); relationship level factors (intimate partner violence, family breakdown, etc.); community level factors (lack or inadequate housing, lack of services or barriers to services to support families to meet specialized needs, etc.); and societal level factors (social, economic, health, and education policies that lead to improved living standards, etc.).
A second important area for health policy based on the findings from this study on homeless street youth involves housing. While successful housing programs exist for families, the elderly, Veterans, and other vulnerable groups, there are very few housing initiatives for the young adult homeless population ages 18 to 24 years. Health policy should include the development and accessibility of supportive transitional and permanent housing that use proven approaches for success. For example, permanent supportive housing programs typically utilize comprehensive case management services to advocate for and assist the resident. In addition, many supportive housing programs are based on a nationally successful model called Housing First that maintains an immediate and primary focus on helping homeless people quickly access and then sustain permanent housing (Tsemberis, 2010). As opposed to programs that work with clients only before they are housed, to help them to become ‘housing ready’, the Housing First approach helps clients find housing and then provides services for as long as necessary to ensure residential stability. Services are provided in the home, at agency offices, and, when necessary, in the community.

Third, policy is needed to separate legislation pertaining to children who run away from legislation for homeless and street youth. Although it is true that many homeless youth are initially runaways, approximately 70% of youth who run away from home for less than 6 months do return home (Milburn et al., 2007). Therefore, the needs of short term runaways are very different from chronic homeless youth who cannot nor will not return to their families of origin.

Policy is also needed to meet the needs of homeless youth with regard to homeless education legislation (McKinney Vento Act) and foster care legislation. The
reintegration of homeless youth back into educational institutions is still plagued with difficulties in most school systems. There also needs to be recognition of where foster care laws do not meet, or stop meeting, the needs of youth, so that they prevent rather than add to homeless youth populations.

Additional opportunities for policy aimed at increased funding and programs to improve the health and well-being of homeless youth include the following: access to healthcare; substance abuse prevention and treatment programs; mental health prevention and treatment programs; transportation vouchers so that youth can attend health and other service appointments; employment assistance and job training; access to GED program and higher education.

**Clinical Practice & Educational Implications**

The findings of this research could potentially affect the clinical practice and education of nurses and other health and social service professionals who work with homeless youth. Specifically, it is hoped that findings from this research will help to positively transform the attitudes of professionals who work with homeless youth and consequently improve their practice. Professionals may recognize the importance of providing homeless youth with the opportunity to share their stories, rather than limiting their communication to traditional health and social history elements. In addition, professionals may appreciate the role that time perspective has in homeless youths’ beliefs, choices, and actions. By incorporating a question about time perspective into their assessments or intakes, professionals may be able to obtain valuable information that can affect homeless youths’ plan of care and outcome. With the understanding that the meanings of homeless youths’ experiences may be affected by their time perspective,
professionals can provide informed and individualized care that takes these factors into account. For example, if a nurse is aware that a homeless youth is living day to day in “survival mode”, the nurse may be better able to tailor health promotion education to issues that the youth is immediately facing rather than providing education that is geared toward health benefits not realized until the distant future. Also, if a nurse is aware that a homeless youth has a positive orientation toward the future, goals and a plan can be made. Alternatively, with knowledge that a homeless youth has a negative or absent perspective of the future, a nurse can do further assessment, particularly investigating for depression and suicidal ideation, and then create an appropriate plan of care.

In addition to clinical implications, this research has many implications for educating nurses and other professionals. Content on topics such as child maltreatment, substance abuse, mental health disorders, social determinants of health, and homelessness across the lifespan could increase the knowledge and skills among professionals who work with at-risk families and youth. Secondly, introducing the topics of time, temporality, and time perspective may be valuable to theoretical, philosophical, and clinical curriculum in nursing and other disciplines. Finally, education about the value of subjective experience and the nurse/professional-patient relationship as a vehicle for creating meaning and insuring wholeness is needed to support the central unifying focus of nursing – facilitating humanization, meaning, choice, quality of life, and healing (Willis, et al., 2008).

**Implications for Future Research**

Research regarding homeless youth has recently been described as “stagnant” and “an extension of the exploitation of these young people” (Kidd, 2012, pp. 533, 539).
Nursing research relating to the health needs of homeless youth is necessary to revitalize this area of scientific inquiry and do so justly. Continued lack of knowledge potentially undermines optimal healthcare for this population, making it difficult to prevent and eliminate health disparities.

Using narrative analysis, the current research has given voice to the stories of homeless street youth. This research has laid the groundwork for future research aimed at learning more about the population’s strengths, needs, time perspectives, health, and health promotion. Given the lack of research to date on the topic and its significance (in terms of the health and well-being of homeless youth, as well as economic, policy, and service delivery implications for society and the current healthcare system), descriptive exploratory studies are necessary as a starting point. However, it is the intent of this study to raise questions about the health of homeless youth that can be explored in other descriptive studies and ultimately in intervention studies.

Forthcoming research related to this study could include 1) a narrative analysis of time perspective, health, and health promotion with a more heterogeneous sample of homeless youth including youth from various geographic areas, sheltered youth, youth not connected with a homeless youth program, and youth that represent the full age range of the population; 2) development of a time perspective measurement tool for homeless youth; 3) qualitative studies aimed at understanding the unique needs of LGBTQ homeless youth; and 4) intervention studies. Specific intervention studies could be aimed at the following: expanding homeless youths’ time perspective, particularly in terms of future orientation; improving health promotion using novel approaches that are pertinent to this population based on their survival lifestyle and time perspectives; child
maltreatment prevention for at-risk families; homelessness prevention for high-risk youth including those with histories of child maltreatment and involvement in the social services, foster and correctional system.

In addition, Kidd (2012) proposes three major culturally-bound dimensions from which researchers should construct understanding of and responses to youth homelessness. These dimensions are scope of responsibility, the location of moral responsibility, and the amount of agency held by the youth. While a detailed discussion is beyond the focus of this paper, it is important to emphasize that Kidd’s framework offers hope for a much needed coordinated strategy for youth homelessness given that “contemporary social responses are failing” (Kidd, 2012, p. 534). Therefore, future research on homeless youth should consider these dimensions.

Furthermore, it is imperative that increased research funding and efforts be aimed at studying the underlying factors of homelessness among youth, adults, and families including ACEs and child maltreatment, which are major causes of youth homelessness. This can lead to experimental studies for prevention and early intervention.

**Limitations of the Study**

There are several limitations to this study. First, only one major interview was completed for each participant. The amount of time for each interview ranged from 35 minutes to 1 hour and 15 minutes. Time spent with the participants was affected by youth needing to leave and, in one case, an interview was ended when the participant began to experience drug withdrawal symptoms. These factors may have limited the research as it reduced both the time a participant could tell their story and the opportunity
to probe deeper into areas that needed clarification. At least one additional interview would have been valuable given the complexity of the homeless youths’ stories.

A second study limitation is that only five out of thirteen participants completed member checks and verified their core story. All five of these participants were contacted directly by me in person. None of the eight participants who received an email and/or phone call from me responded for a member check. Thirdly, the ages of the participants are questionable. Although the study aimed to sample 16 to 21 year olds and the final sample included homeless youth who were 18 to 21 years old, it is possible that the participants in this study did not meet the age criteria (they were younger than 16 years or older than 21 years). Participants were not asked to show any identification to participate in the study and may have not been truthful about their age in order to meet the study criteria.

In addition, as stated earlier, narrative analysis, as a research approach, does not have a standard methodology (Emden, 1998a; Priest et al., 2002). The procedure I used was an adaptation of narrative analysis by Polkinghorne (1995) that incorporated procedures from several narrative scholars (Dollard, 1949; Emden, 1998a, Goodfellow, 1997; Riessman, 1993; Seidman, 1991). Although detailed steps of my analysis plan have been provided, the fact that this exact procedure has not been used before may weaken the study. Finally, the study sample was homogeneous in terms of the following characteristics: geographic location, involvement in a homeless youth program; age range; English-speaking youth only; and the exclusion of sheltered youth.
Strengths of the Study

This research has a number of noteworthy strengths. First, this research identified and sought to close a gap in the literature with regard to a highly vulnerable and inaccessible population, homeless street youth, and their time perspectives. Findings from this study have laid the foundation for future research aimed at increasing understanding of homeless street youth and using innovative approaches to improve the health and well-being of this population. Secondly, because conducting qualitative research with vulnerable populations is often a challenge, obtaining thirteen deeply personal stories of homeless street youth can be considered a strength of this study. Additionally, the sample of homeless street youth included six females, 5 males, and two transgender individuals. This represents a level of diversity in the sample. Another strength of the study is that a very rigorous and transparent narrative analysis method was used to increase trustworthiness of the research. Finally, and perhaps most importantly, through this study homeless street youth were given an opportunity to give voice to their deeply personal stories. As the research findings, the collection of stories makes visible the often invisible stories of an invisible group.

Conclusion

Prior to the current research, time perspective, a psychological variable that has been shown to impact an individual’s course of action (Aronowitz & Morrison-Beedy, 2004; Robbins & Bryan, 2004; Vankineeste et al., 2004, Zimbardo & Boyd, 1999), appeared to be absent in literature on youth homelessness. Homeless youth represent a highly vulnerable population whose numbers are increasing, whose health is steadily deteriorating, and who suffer disproportionate risk of mortality from their circumstances
Given their serious plight, along with a need for innovative research, this study sought to uncover the time perspectives of homeless street youth and the connection time perspective may have with health and health promotion. Using narrative inquiry methodology, I conducted a narrative analysis (Polkinghorne, 1995) on the stories of thirteen homeless street youth from a metropolitan area on the east coast of the United States. Each participant was asked to tell me their story, in their own words, any way they wanted to tell it. Additional questions about time perspective and health were asked. Narrative inquiry was chosen as the methodology for this research because storytelling is considered a primary way by which people make sense of, give meaning to, and share their experiences (Duffy, 2007). Stories allow people to understand their past, present and future and this has an effect on present actions and future goals (Polkinghorne, 1988). Each participant’s final story, or “restoried story”, fit the interview data while at the same time bringing about an order and meaningfulness that was not originally apparent in the data itself (Polkinghorne, 1995, p. 16).

As a collection, the stories provided rich information to answer the research questions and revealed specific details about childhood family conflict, violence exposure and victimization, alcohol and drug abuse, survival strategies, health and health promoting behavior, and time perspective and its possible connection to health. Through their stories, homeless youth participants provided meaningful insights into a very complicated phenomenon, street life. Two important findings in this study are: 1) many homeless street youth possess positive future time perspectives; and 2) a possible connection between time perspective, health, and health promotion may exist.
This study provides clinicians, educators, and researchers with significant information about the homeless youth population. By making a contribution to the literature, this research will guide the development of further studies and possible interventions to improve healthcare for this population. From this study there is a potential for expanding nursing knowledge in multiple ways including: the development of theories; practice innovations; research; health promotion education; and policies for addressing the needs of homeless youth for optimal health and well-being.
Appendix A: Agreement to Participate

University of Hawai‘i at Mānoa Agreement to Participate in
The Stories of Homeless Street Youth
Terri LaCoursiere Zucchero, RN, PhD(c), Doctoral Student, SONDH

My name is Terri LaCoursiere Zucchero and I am a nurse and doctoral student at the University of Hawai‘i at Mānoa School of Nursing and Dental Hygiene in Honolulu, Hawai‘i. As part of my dissertation, I am conducting a research study to learn more about homeless street youth. I am asking adolescent and young adult females and males, who are ages 16 to 21 years and live on the streets most of the time, to participate in this study by telling their personal story during an interview process.

**Activities and Time Commitment:** If you agree to participate, I will interview you at a safe, public meeting place that provides privacy and is convenient and comfortable for you. The interview will last about 1 hour and be informal and conversational so that you may feel as comfortable as possible sharing your story. You will receive a $25 iTunes, CVS pharmacy, or Dunkin’ Donuts gift card for participation the interview.

In order to remember what you said, I will be asking for your permission to record the interview using a digital audio recorder. After the interview, a professional transcriptionist will transcribe the file from the digital audio recorder so that I will have a typewritten record of the interview. Then I will check and edit the transcription for accuracy and permanently delete the audio file. Your name will NOT appear anywhere on the file, on the transcription, or in my notes. It will be a confidential interview with a code name and your age.

If you give permission at the bottom of this form, I may contact you by phone, email (or possibly another way that you choose) to inquire about your interest in participating in a second interview. The purpose of the second interview will be to clarify (or be sure that I understand) things you told me in the first interview which I might be unclear about; and/or to share my research findings with you and see if what I have learned makes sense to you. The 2nd interview is optional and you do not have to participate. If you choose to participate, we will make arrangements to meet for no longer than 1 hour at a safe and public meeting place that provides privacy and convenience (such as a conference room at Sydney Borum Health Center or Youth on Fire Drop-in center, or individual study rooms at the Boston Public Library). I will ask you to you sign and date this same form again. You will receive another $25 gift card for your participation.
Voluntary Participation: Your participation in this project is voluntary and you may withdraw from participation at any time, up to the completion date of this project, which is expected in August 2012. During the interviews, you can choose to not answer any question(s), at any time, for any reason. If you disapprove of, wish to change, add to, delete, or otherwise change the transcripts or the audio file of the interviews, you may do so at any time up to the completion of this project. If you decide that the transcripts and/or audio files should not be used in the study, you may contact me and your information will not be used.

Benefits and Risks: There is no direct benefit to you in participating in this research project. However, your participation will contribute to helping professionals better understand homeless street youth. This is important so that better services can be provided based on the voices of homeless youth who may need the services. There are no known physical risks to you in this study. However, a potential risk when telling your story is that some topics you discuss during the interview may be sensitive, resulting in a variety of emotions. Specifically, it’s possible that some topics might bring back painful or unpleasant memories. In such cases, we can take a break, skip that topic, and/or you may choose to stop participating in this research study altogether. In addition, if you have any concerns during or after the interview, you are encouraged to share these with a helping professional. I will provide a list of professionals who work with homeless street youth so that you can obtain assistance.

Privacy and Confidentiality: The information you reveal in the interview will be kept strictly confidential (private). However, there are a few exceptions to confidentiality that you must be aware of. As a nurse, I have an ethical and legal responsibility to contact an appropriate helping professional (such as the police or Department of Children & Families (DCF)) who can provide assistance if you tell me the following: you intend to harm yourself or you are harming yourself; you intend to kill yourself; you intend to harm another person or have harmed another person; or that a person under 18 years old (including yourself) is being neglected or abused physically, sexually, or emotionally. The digital audio files, transcripts, my notes, and the final project will not contain your name. The information you provide will be coded with a number or pseudo name. Study documents will be stored securely in a locked file cabinet and destroyed 3 years after the study has been completed.

Questions: Please contact me, Terri LaCoursiere Zucchero, at (617)990-2638 or terrizucchero@gmail.com if you have any questions regarding this project. If you have questions about your rights as a research participant, please contact the University of Hawai‘i Committee on Human Studies at (808) 956-5007 or uhirb@hawaii.edu.
“I certify that I have read and that I understand the information in this consent form, that I have been given satisfactory answers to my questions concerning the project, and that I have been told that I am free to withdraw my consent and to discontinue participation in the project at any time without any negative consequences to me. Therefore, I give my consent to participate in this project with the understanding that such consent does not waive any of my legal rights.”

Audio taping

☐ I give my permission to have my interview audio taped.
☐ I DO NOT give my permission to have my interview audio taped.

Contacting for 2nd interview

☐ I give my permission to be contacted for a possible 2nd interview. I may be contacted by:
  ☐ Phone: _______________
    ☐ It is OK to leave a message on my phone saying “Terri” called and my phone number
    ☐ It is NOT OK to leave a message on my phone.
  ☐ Email: _______________
    ☐ It is OK to send me an email that says “Hi, This is Terri. Please contact me at this email address or call me at 617-990-2638 if you want to talk again soon.
    ☐ The email should say: ________________________________________
  ☐ Other: __________________________
☐ I DO NOT give my permission to be contacted for a possible 2nd interview.

_________________________________________  __________________________
Printed Name of Interviewee                  Signature of Interviewee

________________________
Date

☐ Copy of this consent form provided to the participant
Appendix B: Research Recruitment Flyer

YOUR STORY

I’m nurse & doctoral student at the University of Hawai‘i doing a research study to learn more about homeless youth and their stories.

If you are 16 to 21 years old, mostly staying on the streets, and may be interested in sharing your story…

Please contact Terri Zucchero for more information
at terrizucchero@gmail.com or (xxx) xxx-xxxx
terrizucchero@gmail.com617

You’ll receive your choice of a $25 iTunes, CVS pharmacy, or Dunkin' Donuts giftcard for participating in an initial interview (approximately 1 hour) and another gift card if you choose to do a 2nd, follow-up interview.

University of Hawai‘i, Committee on Human Studies IRB Approval: 1/31/2012
Appendix C: Interview & Demographic Data Guide

Interview strategy: Interviews will be conducted using a conversational, semi-structured style using open-ended questions. The main interview will begin with a broad opening question and based on the participant’s response and story, a flexible format will be used to obtain specific information per the general and additional questions related to day to day life on the streets, time perspective, and health. Demographic data not obtained during Part I. will be asked at the conclusion of the main interview, in Part II. All participants will be given an opportunity to provide concluding thoughts in Part III.

Part I. Main Interview

- Broad opening question:
  - Please tell me your story in your own words, any way you want to tell it.

- General questions:
  - Please tell me your story of living on the streets.
  - How did you end up being out on the streets?
  - How are things going for you? What’s happening?
  - How do you manage or get by on the streets?
  - What does a typical day consist of?

- Additional questions about time perspective and health to be asked if/when appropriate during interview:
  - Discuss the past and its meaning to you.
  - Discuss the present and its meaning to you.
  - Discuss the future and its meaning to you.
  - Does your view of past, present, and future affect your health in any way? If so, please explain.

- Probes:
  - Please tell me more about...
  - What happened then?
  - What was that like?
  - Can you tell me a story about your experience with...
  - Can you elaborate on...
  - Could you clarify...
Part II. Demographic Data

You have shared a lot of personal information with me. Thank you. I would now like to ask you a few more questions about topics that were not previously discussed. This is optional but would help me to learn more about you. If you are comfortable, could you please answer the following:

- What is your age?
- What is your gender?
- What race, ethnicity, or culture do you identify with?
- How would you describe your sexual orientation?
- Please describe your educational experience (high school, GED, post high school training/college):
- Please describe your employment experience:
- Please describe your income (daily, weekly, monthly, or annually from all sources):
- Often times, youth who are experiencing homelessness have a history of:
  - Foster care
  - Corrections/juvenile detention
  - Gang involvement
    Would you like to comment on these situations?

Part III. Concluding Questions

- Is there anything else you would like to share with me today?
- What do you think people who help homeless youth should know?
References


Kidd, S., & Davidson, L. (2007). “You have to adapt because you have no other choice”: The stories of strength and resilience of 208 homeless youth in New York City and Toronto. *Journal of Community Psychology, 35*(2), 219-238.


