Comment on Dennis P. Culhane et al.'s "Testing a Typology of Family Homelessness Based on Patterns of Public Shelter Utilization in Four U.S. Jurisdictions: Implications for Policy and Program Planning"

Ellen L. Bassuk
National Center on Family Homelessness

Abstract

A comprehensive typology of homeless families would help us understand how to provide services and supports appropriate to particular subgroups. In their attempt to establish such a typology, Culhane and his colleagues employ administrative data sets to correlate shelter use with behavioral indicators. These data sets are limited in that they fail to incorporate the complex, intense, and sometimes traumatic experiences that characterize the lives of homeless families, causing this study to fall short of what is required to create an accurate typology.

Among the areas overlooked by this approach are the high levels of traumatic stress and violence in the lives of homeless families, children's needs, and the interactions between parents and children. When only limited research is available, there is a danger that even modest findings will be used to support broad policy directions. Further research is needed to arrive at a defensible typology.

Keywords: Families and Children; Homelessness; Traumatic stress

Introduction

This comment discusses strategies for developing typologies that accurately reflect the real-life experiences of homeless families, as well as the specific issues raised by Culhane et al. in their article. A comprehensive typology would be valuable because people who are homeless comprise a highly heterogeneous population with diverse characteristics and service needs. If we

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can delineate subgroups of homeless families, we can begin to understand which combination of services and supports they need to escape homelessness, become stable in permanent housing, and have a reasonable quality of life.

Using the methodology developed in a previous work on subtyping homeless single adults (Kuhn and Culhane 1998), Culhane et al. have contributed to the field by attempting to correlate shelter utilization patterns among homeless families with various behavioral indicators. Their findings are limited, however, by the variables in administrative data sets that tend to capture only a small part of the real-life experience of homeless families. Despite extensive research to the contrary, their study assumes that the mental health needs of families are the same as those of single adults. It fails to consider the very high prevalence of traumatic exposure and its often lifelong aftermath, as well as the distinct needs of children of different developmental ages and their families as a unit. Hence, the policy implications of this study overstep the limitations of the data sets. Any conclusions drawn from this work must be filtered through the lens of trauma and shaped by the complex needs of the children and their interactions with their parents.

Developing multidimensional typologies

Typologies or classification systems have long been used in fields such as alcoholism, psychiatry, and criminology. Jahiel and Babor (2005) have reviewed this research tradition and its potential application to homeless families. They discuss its theoretical, clinical, and practical applications, highlighting its potential usefulness in matching clients with services and understanding which families need supports and services in addition to housing subsidies. Drawing from the literature on alcoholism, they describe how clinical subtyping using single domains (e.g., gender, psychopathology) dates back to the 19th century and has evolved into a search for subtypes based on multiple characteristics within seemingly homogeneous groups. In part, they credit this evolution to the development of sophisticated measurement strategies such as multivariate statistical techniques, as well as a better understanding of the complex variables that may contribute to distinct behavior patterns. For example, Babor et al. investigated five classification systems that described subgroups of alcoholics and "hypothesized that empirical clustering techniques that search for naturally occurring commonalities among alcoholics may be a better way to identify homogeneous subtypes" (1992, 1415).

In their review, Jahiel and Babor (2005) describe how early typologies were based on factors such as the characteristics of homeless persons (e.g., dis-

affiliation) and pathways into homelessness. The results of this work seemed similar to the work in the alcoholism field that distinguished between "low severity, low vulnerability vs. high vulnerability, high severity subgroups" (Jahiel and Babor 2005, 9). Kuhn and Culhane (1998) extended this work by investigating patterns of shelter use based on the number of shelter days and episodes and associating these with different characteristics (e.g., age, physical and mental problems). Kuhn and Culhane (1998) developed a typology for homeless single adults in which they convincingly demonstrated that this population has distinct patterns of shelter use correlated with consistent population characteristics and, hence, service needs of varying intensity. They defined three subgroups of homeless single adults and found that those who were chronically homeless used a disproportionate number of shelter beds and services and often had immediate and desperate needs. This research mobilized policy support for ending chronic homelessness within the next decade (Culhane, Metraux, and Wachter 1999; Kuhn and Culhane 1998).

Rog, Holupka, and Patton (2007) have started to conceptualize a multidimensional typology of homeless families based on activities designed to inform its development, including reviewing the literature on typology development and homeless families, reviewing and reanalyzing data (e.g., a sample at high risk for homelessness), identifying data sets that might be modified to contribute to this effort, convening an expert panel, and determining future directions. The panel recommended developing multiple typologies, particularly one that focused on prevention ("ranking families according to levels of risk for homelessness and probability of a quick exit") and another on resource allocation ("identifying factors that impeded their exit from homelessness and their ability to maintain housing and self-support") (Rog, Holupka, and Patton 2007). They also emphasized the importance of considering the interplay between family characteristics and context, environmental characteristics, and resource availability.

Given these diverse activities, Rog, Holupka, and Patton (2007) suggest a staged approach to developing a typology of homeless families. They concluded that existing studies were of limited application in the creation of a useful classification system because of their variable design and their limited capacity for generalization. In the short-term, they recommended studying local triaging efforts and analyzing existing Homeless Management Information Systems, but concluded that the strongest data sets would emerge from enhancing existing surveys (such as the American Community Survey) and designing a longitudinal study of shelter requests and exit patterns of homeless families.

A new typology for homeless families

Working from the typology developed by Kuhn and Culhane (1998) for homeless single adults, Culhane et al. explore whether a parallel typology might have similar validity among homeless families. Building on the research to date that has generally viewed these families as either homogeneous or as having special needs (Bassuk and Geller 2006), they used large administrative data sets in multiple locales and a typology that investigates the relationship between duration of shelter stay and the particular characteristics of the families. Variables included shelter use patterns over time (two to three years), histories of intensive social service involvement in multiple systems (indicators of mental health or substance use issues, child welfare involvement), and evidence of disability (receipt of supplemental security income [SSI] and employment status). On the basis of findings from cluster analyses, they then attempted to define differences among subgroups that could be used for developing programs for homeless families and planning policy.

The authors focus on identifying family members with “a history of service involvement indicative of a need for significant or ongoing service engagement” (6). Although the completeness of the data varied considerably across the four jurisdictions, Culhane et al. analyzed the following variables to determine service needs:

1. Demographic characteristics
2. Length of stay in publicly funded shelters and some transitional facilities
3. History of mental health and substance abuse treatment, which varied by jurisdiction, including records for Medicaid-reimbursed inpatient care for mental or substance use disorders (using International Classification of Diseases–9 codes in Massachusetts and Philadelphia that do not include posttraumatic stress disorder [PTSD]) or, in one jurisdiction, additional Department of Mental Health data stating that clients received “acute treatment services” (9)
4. Employment status and receipt of SSI
5. Families with a child in an out-of-home placement (foster care) at any time

Using a large sample from multiple locales followed over a long period, data sets from multiple service systems, and cluster analyses, the authors combine these elements into a strong methodological design to track the dynamics of homelessness as well as patterns of service use among homeless

families. By considering several components of a family's experience, they have made a laudable attempt to move the field forward. However, the challenge in developing a robust classification scheme is to incorporate multiple dimensions of experience—a particularly difficult task given the composition of homeless families (the family unit, parents, children of different developmental ages), their diverse needs, their complex pathways onto the streets, and the differences in resource availability across communities.

While Culhane et al.'s approach represents a good beginning, it has significant limitations that involve the risk of underestimating and misunderstanding the needs of many homeless families by not incorporating a full and accurate picture of their experiences. The variables analyzed are too narrow and are limited by the nature of administrative data sets. The data gathered in this study do not adequately reveal the complex needs of family members and do not contain critical information that can come only from direct interactions with homeless families and children. Richer data sources are needed. The challenge in moving forward is to integrate the methodology with knowledge generated from the field, clinical experience, and the families themselves.

The distinct needs of homeless families

The experiences of homeless single adults and families are different in many respects and require a different approach toward developing a typology. Most homeless families are composed of an adult parenting alone—most often a female head of household caring for two or more young children. Against a backdrop of minimum subsistence, motherhood (and single parenting especially) may jeopardize a woman's ability to maintain a home. Given extreme poverty as well as insufficient child support and the virtual lack of government-sponsored child care, it is not difficult to understand why motherhood for single parents is a risk factor for homelessness. Often, these women must combine the role of primary breadwinner with that of caregiver and homemaker, a challenge even for women with enough financial resources and social supports. This situation is exacerbated by service sector jobs that do not pay a living wage or provide adequate benefits or flexible work hours. Within this context, poverty chips away at buffers, leading to catastrophic consequences in the lives of women and their children (Bassuk 1995).

Parents' mental health

Homeless parents have different mental health needs than homeless single adults, in addition to the different environments they live in. Psychoses, such

as schizophrenia, are not overrepresented in homeless mothers, and their rates of hospitalization for mental illness are extremely low. With de-institutionalization and the commitment to comprehensive community care, inpatient care is a last resort and is often driven by stringent predictions of dangerousness and the availability of inpatient beds (Anderson et al. 1998). Further, although the overwhelming majority of people with serious mental illness are never hospitalized, this does not invalidate their need for services. PTSD, while sometimes very disabling, is unlikely to be a cause for inpatient care in the public mental health system. Depression may lead to severely impaired functioning and is often associated with extreme poverty and exposure to severe stressors (including homelessness itself), but it is underrecognized and undertreated in homeless women. With a lifetime prevalence among all women of 20 percent, depression occurs disproportionately among homeless women (at twice the rate in the general female population), but leads only infrequently to inpatient care (Bassuk et al. 1996, 1998). In addition, not only are substance abuse beds for women sorely lacking in most states, but also very few admit women with children—and most women would resort to almost any other option before being separated from their children.

Since homeless families have distinctly different mental health issues than homeless single adults who do not fall under the rubric of "severe" mental illness (Bassuk et al. 1998), these issues are not likely to be captured by the indicators used in this study. Instead, some individual family members have serious mental health needs that may not require inpatient care, but are nevertheless significant enough to warrant ongoing community-based treatment and support. The distinction between "severe" and "serious" is one of degree that has not been readily objectified, but both terms imply significant difficulties requiring some intervention. These may include problems such as PTSD and clinical depression that may interfere with a parent's capacity to maintain housing and become self-supporting, but most likely would not require inpatient hospitalization. Further, they do not capture the complex and often devastating experiences of the heads of households or the children who have lost their homes. Even among homeless single adults, it could be asked whether these variables taken together provide a sufficient proxy to define service needs.

Because Kuhn and Culhane (1998) applied a methodology previously used to investigate the needs of single adult homeless people whose mental health profile is markedly different from that of families, I contend that this study should be applied only to the very small numbers of families headed by an adult with severe mental illnesses that are similar to those experienced by single adults (e.g., schizophrenia and other psychoses, and some co-occur-

ring disorders). I question the application of this approach beyond the small percentage of homeless families (2 to 4 percent) that fall into the episodic cluster and both have repeated spells of homelessness and meet the authors' definition of intensive service histories. This small percentage may well support my contention and perhaps represents the small numbers of homeless families with disorders that can be considered severe or even psychotic. Inpatient mental health and substance use treatment and the receipt of SSI are extremely limited ways of assessing the need for services.

Further, in their analyses, Culhane et al. used SSI income and employment status as a proxy for disability—a questionable selection since SSI receipt mainly assesses work history and clients must stringently prove medical disability against challenging odds. Experience has demonstrated that to receive SSI, people must be persistent, navigating bureaucratic systems over many months and even years, have an address and adequate identification, and receive help from a willing case manager. Even then, the process often fails (Rosen, Hooey, and Steed 2001).

Traumatic stress and its aftermath

Culhane et al. view domestic violence as a "predicament" (4) that may possibly contribute to some of the differences in length of shelter stay and recidivism. They do not mention the documented histories of extreme physical or sexual assault experienced by the vast majority of homeless women over their lifetimes or the long-term adverse consequences that may ensue (Bassuk et al. 1996; Guarino, Rubin, and Bassuk 2007). When violent victimization is repetitive, is of long duration, or is perpetrated by a family member, the long-term effects can be especially severe. Multiple lifelong experiences of traumatic exposure may lead to disrupted relationships, inability to work, parenting difficulties, posttrauma responses, severe depression, suicidal behavior, and sometimes self-medication. Homelessness itself further exacerbates this picture (Bassuk et al. 1996; Guarino, Rubin, and Bassuk 2007). The high prevalence of PTSD among these young mothers attests to the devastating impact of their earlier traumatic experiences. These are also associated with a sharply increased risk of comorbidity with various anxiety disorders, depression, and substance abuse (Bassuk et al. 1998).

PTSD is one of the most severe outcomes of interpersonal and other forms of traumatic stress. Many factors determine who develops PTSD, but most people exposed to trauma do not go on to develop this disorder. PTSD is characterized by intrusive thoughts that may be triggered by current, often symbolic reminders of the earlier trauma. At such a time, a person may relive the trauma and have vivid, disturbing, and sometimes disorganizing flash-

backs of the earlier experience just as if it were occurring in the present. These experiences are often accompanied by severely dysphoric feelings, increased arousal and startle responses, and terror and hopelessness. Periods of hyperarousal may be interspersed with periods of numbing, constricted activities and behaviors, and difficulty with functioning as usual (Guarino, Rubin, and Bassuk 2007). "For women still in abusive relationships or in threatening environmental surroundings, responses to the cumulative effects of past trauma are maintained and exacerbated by the realities of present dangers" (Bassuk et al. 1996, 645). Although most people with PTSD could benefit from an array of community-based services and supports, they generally do not qualify for inpatient care (van der Kolk, McFarlane, and van der Hart 1996).

Bessel van der Kolk (2005) recently described how children who have experienced pervasive traumatic stress during their critical developmental years often receive a mixture of labels that are treated as separate conditions. Further, van der Kolk (2005) has questioned whether a PTSD diagnosis captures the ongoing impact of pervasive trauma characterized by an extensive system of internal disorganization and emotional dysregulation. Using the term "complex trauma," they describe developmental delays that affect all aspects of functioning and behavior. In particular, people who have had these experiences see the world as unsafe and threatening and tend to develop insecure attachments. This is reflected in the difficulty such people have in forming and maintaining supportive relationships with providers and peers and in accessing health care (Cook et al. 2005). Various field reports have described how some homeless mothers seem unmotivated to receive help (Bassuk et al. 2006)—a set of behaviors that alternatively could be interpreted as resulting from the effects of complex trauma.

People who have endured complex trauma also tend to have problems with affect regulation, reflecting an imbalance in the body's stress response that may lead to chronic hyperarousal, hypervigilance, and an inability to relax or moderate emotional responses. Given our knowledge of the early life experiences of many homeless mothers and the information we have about homeless children, it is likely that many are suffering from complex trauma (Guarino, Rubin, and Bassuk 2007). Such a view is consistent with anecdotal reports from providers and the field. Not only are administrative data sets unlikely to accurately document diagnoses such as PTSD, they cannot capture the lifelong disturbances and subsequent functional impairment associated with complex trauma for both parents and children. To date, no studies have investigated van der Kolk's (2005) distinction between PTSD and complex trauma in homeless mothers and children.

The physical and mental health of homeless children

Most of the members of homeless families are children, and almost 40 percent of them are under the age of six. Researchers have extensively documented the impact of homelessness on children, citing health, behavioral, and educational problems (Bassuk et al. 1997a; National Center on Family Homelessness 1999). Determining the service needs of homeless children by looking at a single variable—out-of-home placement—does not account for their complex experiences and needs. Homeless children have higher rates of acute and chronic medical problems than their housed counterparts. Studies have also described the high rates of exposure to violence and traumatic stresses, including the experience of homelessness itself. The impact can be long-term and devastating. By age eight, approximately one-third of homeless children of school age have at least one major mental disorder. These problems are mirrored in their generally poor school performance: An estimated one-third have repeated a grade (Bassuk et al. 1997b; Buckner, Beardslee, and Bassuk 2004; Buckner et al. 1999).

Compared with their housed counterparts, children in homeless families are much more likely to be separated from their immediate families. Most live with other family members, but a significant minority have been placed in foster care (Shinn and Bassuk 2004). Researchers have also repeatedly shown that many homeless adults had a history of foster care placement during childhood. Burt, Aron, and Lee (2001) found that more than a quarter of homeless people 18 and older had been in foster care, supporting the importance of this variable. However, they followed families for 2 to 3 years, suggesting that they are likely to identify only a very small proportion of the children affected by family separation. Finally, most homeless children do not experience out-of-home placement, making the use of this variable alone inadequate.

The need to consider the family unit

The proposed typology based on patterns of public shelter utilization does not adequately account for the service needs of the family as a unit or the interactions between children and their parents. However, neither is there any other study that I am aware of in the literature on family homelessness that considers the family as the primary unit of analysis.

Families headed by women alone are the poorest of the poor; mothers parenting alone are quintessentially stressed and face unusual challenges in raising children without adequate resources and supports. Even mothers who parent alone but have significant resources require adequate income, flexible work situations, employment benefits, and a social support system to sur-

vive. When children have medical, developmental, emotional, or academic problems, a family's stability may be further compromised. For example, an extremely poor mother who is working at a service sector entry-level job, has fragmented social supports, and has a young school-aged child with asthma may be at high risk for becoming homeless if her child has repeated asthma attacks. It may not be long before she loses her job. This picture may be even more complicated if the mother has PTSD. Such a scenario and many others are not well accounted for in the Culhane et al methodology.

Creating a multidimensional typology: Next steps

In my view, the authors' conclusions overstep the bounds of their research design and the limitations of their data sources. For example, they conclude that "[h]alf of the system's resources are being used by a relatively small group of long-staying families, at a very significant cost per unit, although these families do not have a compellingly distinct profile of need relative to the other clusters" (22). They go on to state that "the vast majority of households followed here do use the shelter system on a relatively short-term basis, and most of them (and most of the homeless families overall) do not have intensive behavioral health or social service histories that might represent a significant barrier to exit and housing stability"(22). Given the significant limitations of the data sets, it is possible that the long-stay cluster with the lowest proportion of intensive service users was part of the group with extensive traumatic exposure and serious long-term sequelae. This possibility is supported by clinical and field experience. To be accurate, they might rather conclude that the long-stay cluster does not have the same profile of need as homeless single adults with severe mental illness.

Another murky issue complicating this and other studies is the lack of a definition of "ongoing services." What do the authors mean when they describe service needs? They do not delineate the types or frequency of services needed by the small subgroup of families that meet their criteria. This lack of clarity allows policy makers to fill in the blanks, possibly creating policies that may not meet the needs of parents and their children. Prior studies of the service needs of homeless families have not clearly defined the nature of these services or the amount and intensity required to be effective. Terms such as "case management" or "advocacy" have been used without defining what the service consisted of, how it was delivered, or what its frequency and duration were. For example, engaging homeless families and forming trusting relationships are often the linchpins of any effective intervention. Engagement is frequently carried out through informal contacts that are not

reimbursable and, therefore, not captured in large data sets. But these very interactions may be the critical determinants of positive outcomes that are more cost-effective in the long run (Bassuk and Geller 2006).

Although Culhane et al. acknowledge that their approach was only partially successful since it identified shelter use patterns associated with specific characteristics among only some heads of household (episodic users), they still concluded that program and policy factors are the primary driver of shelter use among families. They go on to argue that the results are consistent with a "system effect" (21) in which family shelters serve as "queuing systems and proving grounds for housing placement opportunities" (20). Although this system effect may be a factor, their conclusion goes well beyond the data. Additional research is required to understand how the system effect interacts with some of their conclusions. Nor does their typology address all homeless families, but rather only those who are in shelters. This categorization of homeless families is underdeveloped, since a majority of single adult women on the streets are also parents and many other homeless families are doubled up in precarious, overcrowded situations. What about the children and the family as a unit? Again, this is largely ignored. At the very least, the limits of their research design and data sources should have been adequately discussed in the article.

The danger of this proposed typology and its conclusions—even those that are stated more tentatively—is that they could be used to make a public policy case to further limit services for homeless families and children. We know from experience that when there are gaps in our knowledge base, people are quick to fill them with biases and misperceptions. Defining service needs on the basis of several variables that reflect only a narrow slice of the experience of homeless families does all of us a grave disservice. It is only by fully understanding the real challenges facing homeless families that we can develop responsive and effective programs and policies that can change and renew their lives.

Despite its limitations, the work of Culhane et al. represents an important step in moving toward a multidimensional typology of homeless families that can help us prevent homelessness and allocate resources appropriately. By their attention alone, these authors have advanced this neglected matter. This study can also be viewed as an urgent call to modify the variables in administrative data sets and Homeless Management Information Systems to ensure that they better reflect the true experience of parents, children, and families. As Rog, Holupka, and Patton (2007) suggested, additional information drawn from national surveys and longitudinal studies may be necessary to understand the distinct needs of subgroups of homeless families. Only

then can we develop a stratified typology that truly reflects the service needs of homeless parents and children.

Author

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