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## Rates and Correlates of Well-being among Youth Experiencing Homelessness

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### Abstract

**Aims:** Mental health concerns have been well studied among youth experiencing homelessness, yet few studies have explored factors that contribute to well-being in this population. The current cross-sectional study examined rates and correlates of well-being among youth experiencing homelessness.

**Methods:** This is a descriptive, secondary analysis of the baseline data from a clinical intervention study. Ninety-nine youth (aged 16-25) who were experiencing homelessness were recruited in Chicago.

**Results:** Approximately 40% of the sample reported average or above average well-being relative to existing benchmarks. Having medical insurance, a mobile phone, and a history of more severe childhood trauma were unique cross-sectional predictors of worse well-being (all  $p$ s < .034).

**Conclusion:** A significant portion of our sample experienced well-being. Having access to certain resources may be counterintuitive indicators of poorer well-being among youth experiencing homelessness, perhaps because they are indicators of greater need or increased social comparison among these youth.

### Keywords

homeless; youth; young adult; subjective well-being; resilience; child abuse

### Introduction

Youth homelessness is a significant problem in the United States. A recent nationally representative phone-based survey estimated that over a 12-month period, almost three and

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half million youth between the ages of 13 and 25 were homeless or unstably housed (Morton et al., 2018). Risk of homelessness is particularly high among young parents, black and Hispanic youth, and lesbian, gay, bisexual, or transgender (LGBT) youth (Morton et al., 2018). Youth experiencing homelessness face both stressors that contribute to homelessness (e.g., family conflict, abuse, parental substance use), as well as stressors that result from homelessness (e.g., academic problems, barriers to health care). Not surprisingly, these stressors contribute to elevated rates of mental health concerns, substance use, and suicidal ideation in homeless youth compared to their housed peers (Narendorf, Cross, Santa Maria, Swank, & Bordnick, 2017; Rew, Taylor-Seehafer, & Fitzgerald, 2001). These challenges exacerbate the difficulties of homelessness, often prolonging the length of homelessness and further intensifying its comorbid issues (Narendorf, Cross, Santa Maria, Swank, & Bordnick, 2017; Rew, Taylor-Seehafer, & Fitzgerald, 2001).

Although it is important to study psychopathology among youth experiencing homelessness, it is equally important to study well-being in this population. While well-being and psychopathology are related, evidence suggests that they are not unidimensional (Greenspoon & Saklofske, 2001; Keyes, 2007). The study of well-being may illuminate novel interventions that improve the quality of life of youth experiencing homelessness. There is mounting evidence that subjective well-being is associated with a host of objective benefits such as good physical health, productivity and prosocial behavior (DeNeve et al., 2013; Western & Tomaszewski, 2016). The existing literature on subjective well-being typically examines two types of well-being: evaluative and affective well-being (Biswas-Diener et al., 2004). Affective well-being focuses on the frequency of positive emotions (i.e., positive affect) and infrequency of negative emotions (i.e., negative affect), whereas evaluative well-being focuses on a global, cognitive evaluation of one's satisfaction with one's quality of life (Biswas-Diener et al., 2004; Pavot & Diener, 2008). Proponents of evaluative well-being argue that measures of evaluative well-being provide a more holistic assessment of subjective well-being beyond momentary affective states (Pavot & Diener, 2008). The current study assessed evaluative well-being.

Overall, studies have shown that persons experiencing homelessness tend to report lower well-being (i.e. subjective quality of life, personal meaning, and life satisfaction) compared to housed persons (Bearsley & Cummins, 1999; Hubble et al., 2014; Rew et al., 2019). However, a few studies have reported samples of marginally housed persons who report surprisingly high levels of well-being in certain domains. For example, although samples of persons experiencing homelessness from the U.S. and India reported low satisfaction with material resources, they also reported high satisfaction with their own intelligence, morality and physical appearance (Biswas-Diener & Diener, 2006).

A small but growing body of literature looks at strengths among youth experiencing homelessness and their quality of life. Prior research has shown that youth experiencing homelessness have greater self-awareness and are better at adapting to certain difficult situations than housed youth (Nott & Vuchinich, 2016). Youth experiencing homelessness are able to use street smarts, personal strengths, and informal resources to overcome challenges as well (Bender et al., 2007). Furthermore, many homeless youth cultivate relationships with natural mentors, which is associated with higher reported social support

and less frequent engagement in risky sexual behaviors (Dang et al., 2014). In a sample of 255 marginally housed young adults in the Netherlands, most participants reported neutral or even positive assessments of their quality of life (Krabbenborg et al., 2017). These findings suggest that homeless youth may have unique strengths and strategies for cultivating well-being despite housing insecurity.

Several reasons suggest that the promotion of well-being may help to alleviate the consequences of housing instability among youth experiencing homelessness. Research has shown that measures of evaluative well-being are associated with important health behaviors among youth, including substance abuse (Zullig et al., 2001), risky sexual behaviors (Valois et al., 2002), engagement in violence (MacDonald et al., 2005; Valois et al., 2001) and risk for suicide (Valois et al., 2004). Youth experiencing homelessness are more likely to engage in risky health behaviors compared to their housed peers (Baron, 2003, Greene, Ennett & Ringwalt, 1997; Solorio et al., 2008). These risky health behaviors are likely to negatively impact youths' ability to participate in activities that would promote greater stability (i.e., work, school) and may directly contribute to outcomes that further instability (e.g., early pregnancy, engagement with the justice system). Additionally, research shows that among youth experiencing homelessness, life satisfaction is associated with greater hope and optimism (Rew et al., 2019), which may promote engagement and persistence in positive activities such as work or school. Although longitudinal research is needed to evaluate the direction of these relationships, the existing evidence suggests that the promotion of well-being among youth experiencing homelessness may be a valuable intervention approach that could also be more engaging and less stigmatizing for youth.

In order to effectively promote well-being among youth experiencing homelessness, it is important to first understand the degree to which these youth experience well-being and what factors are associated with well-being among youth experiencing homelessness. Most research examining quality of life among youth experiencing homelessness has focused on internal attitudes and beliefs that may be resistant to change (e.g., autonomy, competence, hope and self-esteem; Bearsley & Cummins, 1999; Krabbenborg et al., 2017; Rew et al., 2019; Stewart & Townley, 2019). More research is needed to identify the potentially modifiable social-contextual characteristics of marginally housed youth that may promote or inhibit evaluative well-being. This line of research has the potential to advance a new set of strength-based interventions for youth experiencing homelessness that aim to support well-being. This contrasts with current efforts that are largely based on a deficit approach and emphasize the treatment of psychopathology.

The current study is a secondary analysis of baseline (pre-intervention) data collected as part of the Stepping Stone 2.0 project, which examined the feasibility and acceptability of delivering fully-automated mobile mental health interventions to youth experiencing homelessness (Glover et al., 2019). The current study seeks to (a) characterize the degree of evaluative well-being (hereafter referred to as well-being) as measured by self-reported satisfaction with life and flourishing among marginally housed youth, and (b) examine potential factors associated with enhanced or diminished well-being among youth experiencing homelessness, particularly contextual and psychological resources. Because this was an exploratory analysis, we did not develop any a priori hypotheses.

## Methods

### Participants and Procedures

Participants (53 male, 39 female, 7 transgender<sup>1</sup>) included youth recruited from December 2017 to January 2019 in Chicago as part of a study designed to determine the feasibility and acceptability of delivering fully-automated mental health interventions via smartphone apps to youth experiencing housing instability (Glover et al., 2019). Youth were recruited from homeless shelter agencies; potential participants were referred to the study by their case manager, responded to flyers posted in shelters, or were recruited from in-person information sessions held by study staff in shelters. In order to participate in this study, participants were required to meet the following inclusion criteria: (a) aged 16-25, (b) English-speaking, (c) experience housing instability or imminently leaving the foster care system (hereafter referred to as youth experiencing homelessness), and (d) willingness and ability to comply with study protocol requirements. All interested youth were screened by study staff at a shelter, and a total of 101 youth signed consent and enrolled in the program. After consenting to the study, participants completed a baseline (pre-intervention) assessment of self-report questionnaires and were provided with a smartphone and three-month data plan. Even if the participant already had a smartphone, they were given a new device and asked to use this device for the duration of the study.

The fully-automated intervention involved loading the phone with 15 apps designed to promote mental health wellness and provide real-time resources (see Glover et al., 2019 for details). One app specifically designed for the study sent a daily survey and a daily coping skills-focused tip via push notification and offered brief cognitive behavioral interventions. Other apps included on the phone offered access to an online emotional support platform, cognitive-behavioral skills, information about local resources, a telephone hotline, and a crisis text line. Participants were shown how to use a selection of the 15 apps downloaded on the phone and were given a handout describing the uses of all 15 apps. Glover et al., 2019 have reported findings on the feasibility and acceptability of this phone-based mental health intervention; the present study is a secondary analysis of the baseline data. Of those who signed consent, two participants did not complete the baseline questionnaires, and thus 99 participants are included in the present analyses. Participants were 20.03 years old on average ( $SD = 1.83$ , range = 16-24), were mainly Black or African American (57.6%), and the majority had a minimum of a high school diploma or GED (68.7%). For more detailed demographics, see Glover et al., 2019.

### Measures

**Demographics.**—A demographic questionnaire assessed age, sex, sexual orientation, race/ethnicity, educational status, employment status, pregnancy/parenting status, homelessness status, physical health and mental health history, treatment history, current medical insurance, and access to mobile technology.

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<sup>1</sup>Transgender men and women were collapsed into a single group due to small sample size.

**Childhood Trauma Questionnaire (CTQ-15; Bernstein et al., 2003).**—Exposure to childhood trauma was assessed using the Physical Abuse, Emotional Abuse, and Sexual Abuse subscales of the Childhood Trauma Questionnaire. Each sub-scale contained 5 items, with the total scale containing 15 items. Total scale scores range from 15 to 75, with subscale measures ranging from a possible 5 to 25. In our sample, the total CTQ-15 scale ( $\alpha = .94$ ) and each of the subscales (physical abuse  $\alpha = .89$ ; emotional abuse  $\alpha = .91$ ; sexual abuse  $\alpha = .94$ ) exhibited excellent internal consistency.

**Satisfaction with Life Scale (SWLS; Diener et al., 1985).**—The SWLS is a widely used 5-item questionnaire assessing an individual's global judgment of their life satisfaction. A 7-point Likert-type scale is used for each item from Strongly Disagree (1) to Strongly Agree (7). The possible range of scores for the SWLS scale is 5 to 35, with higher scores indicating higher satisfaction with life. According to developers of the measure, scores from 5-9 indicate extreme dissatisfaction with life, scores from 10-14 indicate dissatisfaction with life, scores from 15-19 indicate slightly below average life satisfaction, scores from 20-24 indicate average life satisfaction, scores from 25-29 indicate high satisfaction with life, and scores from 30-35 indicate very high satisfaction with life (Diener, 2006). In the current study, the SWLS scale exhibited good internal consistency ( $\alpha = .85$ ).

**Flourishing Scale (FS; Diener et al., 2009).**—The FS is an 8-item questionnaire assessing flourishing, as indicated by perceived success in relationships, self-esteem, meaning, purpose, and optimism. This scale has demonstrated good reliability and validity with diverse groups of participants including Canadian adolescents, Indian adults, and Iranian older adults (Romano et al., 2020; Singh et al., 2016; Fassih-Ramandi et al., 2020). The measure has also been used to evaluate mental health disparities in a large study of college students that included over 13,000 minority participants (Lipson et al., 2018). A 7-point Likert-type scale is used for each item from Strongly Disagree (1) to Strongly Agree (7). The items are summed to create a total score with scores ranging from 8 (lowest possible flourishing) to 56 (highest possible flourishing). In a large sample of U.S. college students, the average score was a 44.97 (Diener et al., 2010). In a nationally representative study of adults in New Zealand scores from 8 to 45 represented individuals in the lower 50<sup>th</sup> percentile and scores from 46 to 56 represented individuals in the top 50<sup>th</sup> percentile (Hone, Jarden, & Schofield, 2014). Therefore, a cutoff score greater than or equal to 45 was used to represent average or above average flourishing for the current sample. In the current study, the FS scale exhibited excellent internal consistency ( $\alpha = .90$ ).

## Data Analysis

Data analyses were conducted using SPSS version 26. Descriptive statistics (means and standard deviations) were calculated to characterize rates of satisfaction with life and flourishing within our sample. Independent samples t-tests and ANOVAs were conducted to compare mean differences in satisfaction with life and flourishing for categorical predictors. Spearman and Pearson correlations were conducted to examine bivariate relationships among ordinal and continuous predictors of satisfaction with life and flourishing. Significant predictors at the bivariate level were then included as simultaneous predictors in a multiple regression model to evaluate unique predictors of satisfaction with life and flourishing.

## Results

### Rates of Satisfaction with Life and Flourishing

Overall, participants reported an average of 17.62 (SD = 8.12, range 5-35) on the SWLS, which is in the slightly below average life satisfaction range (Diener, 2006). The distribution of scores for the SWLS indicated that 20.2% ( $n = 20$ ) of participants reported being extremely dissatisfied, 21.2% dissatisfied ( $n = 21$ ), 16.2% slightly below average ( $n = 16$ ), 12.1% ( $n = 12$ ) average, 25.3% ( $n = 25$ ) high satisfaction with life, and 5.1% ( $n = 5$ ) very high satisfaction with life (see Figure 1). This means that overall, 42.5% of participants reported average or above average satisfaction with life.

Participants reported an average of 40.78 (SD = 10.53, range 12-56) on the FS, which is below the average score of a sample of U.S. college students (44.97; Diener et al., 2010) and falls within the lower 50<sup>th</sup> percentile of a nationally representative sample of adults in New Zealand (Hone, Jarden, & Schofield, 2014). Using a cutoff score greater than or equal to 45, 40.4% of participants reported average or above average flourishing relative to these samples.

### Predictors of Satisfaction with Life and Flourishing

Bivariate relationships among the predictors of interest and outcomes of satisfaction with life and flourishing are reported in Table 1 (categorical variables) and Table 2 (ordinal and continuous variables). Results showed that participants with medical insurance ( $d = .59$ ,  $p = .005$ ), participants who had a mobile phone ( $d = .53$ ,  $p = .011$ ), and participants who previously received therapy for emotional problems ( $d = .65$ ,  $p = .004$ ) reported lower satisfaction with life. With respect to flourishing, sexual minorities (lesbian, gay, bisexual, pansexual, queer); ( $d = .59$ ,  $p = .015$ ), those with medical insurance ( $d = .60$ ,  $p = .005$ ), those with a mobile phone ( $d = .76$ ,  $p < .001$ ), those who had previously taken medication for emotional problems ( $d = .61$ ,  $p = .003$ ), and those who previously received therapy for emotional problems ( $d = .47$ ,  $p = .036$ ) reported lower levels of flourishing. Childhood trauma severity was significantly negatively associated with both satisfaction with life ( $r = -.38$ ,  $p < .001$ ) and flourishing ( $r = -.27$ ,  $p = .006$ ).

Based on these results, multiple regression models were conducted using the variables that were significant at the bivariate level as simultaneous predictors. For the flourishing model, taking medications for emotional problems was excluded because of high multicollinearity with having ever received therapy for emotional problems. Both models explained a significant proportion of variation in satisfaction with life and flourishing ( $R^2_{SWL} = .290$ ;  $R^2_{FL} = .260$ ). For both models, having medical insurance, having a mobile phone, and more severe childhood trauma were unique predictors of worse satisfaction with life ( $b = -3.84$ ,  $p = .011$ ;  $b = -3.28$ ,  $p = .029$ ;  $b = -0.16$ ,  $p = .001$ ) and flourishing ( $b = -4.12$ ,  $p = .034$ ;  $b = -5.42$ ,  $p = .007$ ;  $b = -0.15$ ,  $p = .009$ ). See Tables 3 and 4 for all potential cross-sectional predictors examined.



## Discussion

Our findings showed that a substantial minority of the youth experiencing homelessness in our sample reported experiencing relatively high levels of well-being as measured by satisfaction with life and flourishing. This is in spite of the various difficulties and challenges such youth face with unstable housing. Over 40% of our participants reported average or above average satisfaction with life and flourishing based on published norms (Diener, 2006; Diener et al., 2010; Hone, Jarden, & Schofield, 2014). These findings are consistent with previous literature showing that marginally housed individuals report having a positive quality of life and well-being, particularly in certain domains (Biswas-Diener & Diener, 2006; Krabbenborg et al., 2017). Indeed, Rew et al. (2019) observed that 49.8% of youth experiencing homelessness reported being “satisfied” or “highly satisfied” with life. Collectively, these studies demonstrate that youth experiencing homelessness can experience well-being in spite of material lacking, and highlight the entangled, yet unique, contributions of objectively difficult circumstances and perceived well-being to overall flourishing and a full life.

Experiencing more severe childhood abuse was negatively associated with well-being in our sample. Although this finding was not wholly unexpected, it is significant to note that despite the many current objective disadvantages facing marginally housed youth, that a history of severe childhood abuse was one of the few clear predictors of well-being in our sample. Childhood abuse disrupts principle attachment relationships and may make it more difficult for youth experiencing homelessness to maintain meaningful relationships through impairing conflict resolution skills even after youth have left an abusive home environment (Styron & Janoff-Bulman, 1997). Furthermore, youth who have experienced physical and sexual child abuse are even more likely to be revictimized on the streets than those who have not (Tyler & Schmitz, 2018). This likelihood of revictimization may have contributed to the lower well-being reported among abused youth in our sample. Interventions to bolster well-being among youth experiencing homelessness should pay special attention to youth with a history of child abuse, particularly severe abuse.

A surprising finding of our study was that having the resources of medical insurance and a mobile phone were both unique predictors of worse well-being, even after accounting for childhood trauma. Although one might expect that having a phone and access to medical care would enable better well-being, there are several potential interpretations of why these resources may actually be associated with lower well-being among youth experiencing homelessness. In terms of owning a mobile phone, most of the youth in our sample who had a phone reported having a smartphone. Although smartphones and social media might promote well-being for some people through providing important connections to resources or other people, they may be detrimental for others, especially those who are vulnerable or disadvantaged (Odgers, Schueller, & Ito, 2020). Youth with smartphones have easier access to social media, which may contribute to negative social comparisons. Some research has even found an association between increased social media and worse well-being as well as self-harm behaviors and suicidality among housed youth (Abi-Jaoude et al., 2020), and it is possible these associations hold for youth experiencing homelessness as well. Additionally, phones may allow these youth to maintain social contacts or be put into situations that have



a negative impact on their well-being. Given the role of technology in the lives of youth (Smith et al., 2018), understanding the impact of technology and social media use among youth experiencing homelessness is an important area of study.

In terms of our counterintuitive findings with respect to medical insurance, this may be due to selection bias whereby marginally housed youth that have medical insurance obtained it because of a greater need for health or mental health care services. Additionally, the difficulty of obtaining public health insurance (held by most of the youth with insurance in our sample), or the need to interact with potentially abusive family members to use health insurance, may contribute to poorer well-being for these youth. Finally, it is possible that youth with these resources may have come from backgrounds with greater means prior to becoming homeless and therefore may experience a larger discrepancy between their current and prior life circumstances, leading to greater dissatisfaction with life. Losing income or moving to a lower socioeconomic status has been associated with lower well-being, even among very low-income populations (Burchardt, 2005; Reyes-García et al., 2016). Our findings suggest that further research aimed at understanding the relationship between access to resources and well-being among marginally housed youth is needed.

Being a sexual minority was associated with lower well-being among our sample, although this did not remain a unique predictor when examined alongside the other predictors identified in our sample. While this finding should be interpreted cautiously, it is possible that a lack of power contributed to our inability to find a significant relationship between sexual minority status and well-being when examined alongside other predictors. Being gay, lesbian, bisexual, or queer has been associated with increased rates of distress, psychopathology and suicidality among both housed and unhoused youth (Kann et al., 2016; Moskowitz et al., 2013), and it is estimated that 8% - 40% of unhoused youth identify as queer (Ecker, 2016; Moskowitz et al., 2013; Rew et al., 2001). Further research on the potentially unique experiences of well-being among sexual minority youth experiencing homelessness is warranted.

Having received previous therapy or psychiatric medication was also associated with lower well-being among our sample of youth experiencing homelessness, although these were not unique predictors of well-being. These findings are likely explained by the fact that previous therapy and psychiatric medication are typically associated with experiencing psychopathology, and psychopathology has consistently been linked to lower well-being (Bartels et al., 2013; Bos et al., 2016). Youth experiencing homelessness are more likely to experience psychopathology than their housed peers, including depression, anxiety, substance abuse disorder, psychosis and PTSD (Edidin et al., 2012). Experiences of psychopathology may not only impact marginally housed youths' perceived well-being, but may also impede their ability to improve their objective situation (e.g. obtain housing, maintain employment).

It is noteworthy that homelessness-related variables were not associated with youth well-being in our sample. We examined several objective measures of homelessness including age at which homelessness was first experienced and total time experiencing homelessness. It may be that the factors that lead to youth homelessness may have a stronger effect

on marginally housed youths' experiences of well-being than objective differences in experiences of homelessness (i.e. length of homelessness experience). It may also be important to assess youths' subjective experiences of homelessness, such as level of perceived stress as a result of experiencing homelessness, in future studies.

Another important consideration when examining our findings is that most of the youth in our sample reported less than average satisfaction with life and flourishing relative to normative samples. This finding is unsurprising, as youth experiencing homelessness face many barriers and challenges that impact their objective circumstances and may also negatively impact their sense of well-being. However, these results also highlight the potential value of interventions aimed at promoting well-being in this population. The fact that some of the youth in our sample reported relatively high levels of well-being demonstrates that it is possible to cultivate subjective well-being despite housing instability. A growing number of intervention approaches focus specifically on increasing aspects of well-being including positive psychological interventions (Koydemir et al., 2021), Positive Affect Treatment (Craske et al., 2019), and well-being therapy (Fava & Runi, 2003). There is also increasing evidence that well-being focused interventions can be effectively used to promote well-being among youth (Manicavasagar et al., 2014; Tejada-Gallardo et al., 2020). These treatment approaches are distinct from approaches that focus on alleviating psychopathology. Positive Affect Treatment, for example, has been directly compared to Negative Affect Treatment with unique impacts on positive affect in addition to sustainable improvements on psychopathology such as depression, anxiety, and suicidal ideation (Craske et al., 2019). Therefore, investigating such intervention approaches in youth experiencing homelessness could be a beneficial avenue for further research. Additionally, findings from the intervention aspects of the current study showed that the intervention component that youth liked the most was receiving a daily tip (Glover et al., 2019). These tips offered both coping skills and motivational messages; the highest rated tips acknowledged challenges and provided motivational messages about overcoming and moving past struggles. This may suggest that youth experiencing homelessness may prefer and engage better in interventions that are focused on positive growth rather than distress.

Our findings should be considered in light of their limitations. First, the data examined here were cross-sectional and therefore we cannot infer causality. Longitudinal research is needed to identify individual and sociocontextual factors associated with well-being among youth experiencing homelessness in order to identify important intervention targets. The generalizability of our findings is also limited due to our non-random sample of youth experiencing homelessness who self-selected to participate in an intervention study. It is possible that youth who would choose to participate in an intervention study may be in more need of services and therefore have poorer well-being than the general population of youth experiencing homelessness; alternatively, youth who choose to participate in an intervention study may be more motivated or have more resources and therefore may report higher rates of well-being than the general population. Since we defined youth experiencing homelessness as youth experiencing housing instability or imminently leaving the foster care system, it is also possible that findings would differ with a different, more specific population (e.g., only youth currently living on the streets). Although we were able to examine several different potential predictors of well-being among youth experiencing

homelessness, we did not have any social measures, which may be particularly associated with well-being among adolescents (Chu et al., 2010; Ciarrochi et al., 2017). For example, we were not able to examine whether social desirability may have led to inflated ratings of subjective well-being. Additionally, we were not able to examine a fully comprehensive list of contextual factors that may be associated with well-being. We also focused on contextual factors and did not include many individual potential predictors of subjective well-being such as optimism or resilience, and so we cannot rule out the possibility that individual factors may be more important predictors of subjective well-being than contextual factors when experiencing homelessness. The cut-off we selected for the Flourishing Scale was based on a U.S. college sample and nationally representative study of adults in New Zealand; this may not represent the average rates of flourishing among U.S. youth, particularly within a predominantly ethnic/racial minority sample. Lastly, our measurements of well-being focused on evaluative well-being. Future studies should also examine affective well-being in order to gain a more comprehensive picture of the subjective well-being of youth experiencing homelessness.

Despite these limitations, our findings have important implications for interventions targeting youth experiencing homelessness. Marginally housed youth who have experienced severe child abuse may be particularly important to target in interventions aimed at improving subjective well-being. Additionally, much of the previous literature on youth experiencing homelessness has focused on the difficulties these youth face. Yet, a substantial number of youth in our sample reported average and even high levels of well-being despite housing instability, challenging the assumption that youth experiencing homelessness inherently have poor well-being. Our findings speak to the resilience of youth facing significant adversity and suggest that a strengths-based approach to intervention, rather than one focused on psychopathology, may resonate with youth experiencing homelessness.

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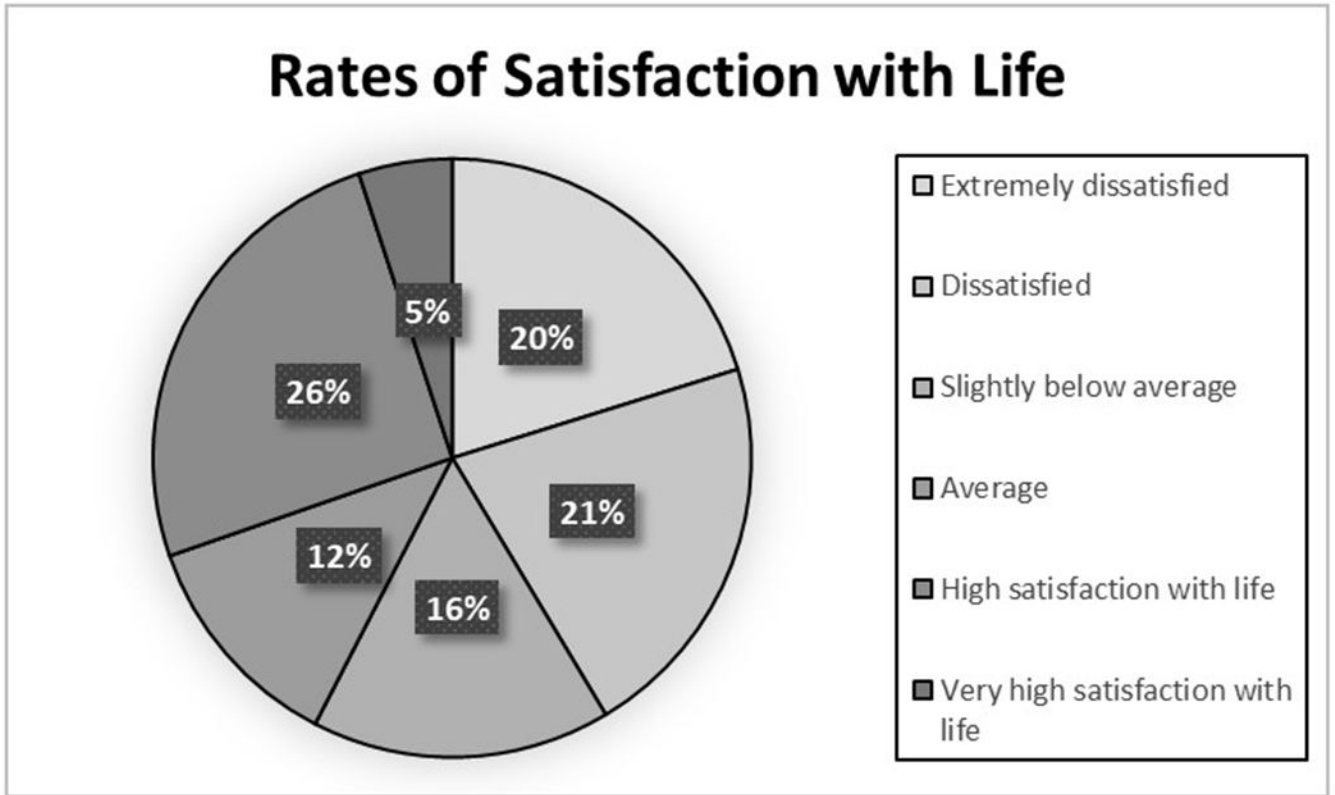
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**Figure 1.**  
Rates of Satisfaction with Life

**Table 1.**

Categorical predictors of satisfaction with life and flourishing.

	<i>n</i>	SWL <i>M (SD)</i>	<i>F(df)</i>	FS <i>M (SD)</i>	<i>F(df)</i>
Gender			0.70 (2, 96)		0.80 (2, 96)
Male	53	16.56 (7.75)		40.64 (10.85)	
Female	39	18.53 (8.32)		41.49 (9.70)	
Transgender	7	16.71 (9.05)		36.14 (14.80)	
	<i>n</i>	SWL <i>M (SD)</i>	<i>t(df)</i>	FS <i>M (SD)</i>	<i>t(df)</i>
Sexual orientation			-1.07(96)		-2.47(96)*
Straight / heterosexual	75	18.23 (7.95)		42.44 (9.09)	
LGB+	23	16.17 (8.48)		36.61 (12.27)	
Enrolled in School			-0.44(97)		-1.20(97)
Yes	35	18.11 (6.94)		42.49 (9.34)	
No	64	17.36 (8.74)		39.84 (11.08)	
Race			-0.83(97)		-1.85(97)
Black	57	18.21 (8.21)		42.44 (9.33)	
Not Black	42	16.83 (8.03)		38.52 (11.70)	
Ethnicity			-0.69(97)		0.65(97)
Hispanic / Latino	23	18.65 (7.76)		39.52 (9.57)	
Not Hispanic / Latino	76	17.32 (8.25)		41.16 (10.83)	
Currently Employed			-0.86(97)		-0.06(97)
Yes	27	18.78 (8.36)		40.89 (8.84)	
No	72	17.19 (8.05)		40.74 (11.15)	
History of Head Injury			0.16(97)		0.45(97)
Yes	27	17.41 (8.41)		40.00 (10.38)	
No	72	17.71 (8.07)		41.07 (10.64)	
Currently Pregnant			-0.37(97)		-0.77(97)
Yes	6	18.83 (6.49)		44.00 (9.01)	
No	93	17.55 (8.24)		40.57 (10.62)	
Parent			0.62(97)		-0.52(97)
Yes	18	16.56 (7.38)		41.94 (8.35)	
No	81	17.86 (8.30)		40.52 (10.98)	
Medical Insurance			2.88(97)**		2.89(97)**
Yes	60	15.80 (7.69)		38.40 (11.29)	
No	39	20.44 (8.06)		44.44 (8.08)	
Mobile Phone Ownership			2.60(97)*		3.71(97)***
Yes	41	15.17 (7.85)		36.39 (11.55)	
No	58	19.36 (7.92)		43.88 (8.56)	
Phone can Download Applications			-1.41(39)		-2.01(39)

	<i>n</i>	SWL <i>M (SD)</i>	<i>F(df)</i>	FS <i>M (SD)</i>	<i>F(df)</i>
Yes	36	15.81 (7.97)		37.69 (10.99)	
No	5	10.60 (5.59)		27.00 (12.29)	
Psychiatric Medication (Lifetime)			1.73(97)		3.01(97) **
Yes	42	16.00 (8.35)		37.21 (11.69)	
No	57	18.82 (7.80)		43.40 (8.79)	
Psychotherapy (Lifetime)			2.93(97) **		2.12(97) *
Yes	70	16.14 (8.01)		39.36 (11.35)	
No	29	21.21 (7.34)		44.21 (7.28)	
Psychotherapy (Current)			0.91(97)		0.85(97)
Yes	38	16.68 (8.13)		39.63 (10.94)	
No	61	18.21 (8.12)		41.49 (10.29)	

Note. LGB+ = lesbian, gay, bisexual, pansexual, and queer.

\*  $p < .05$

\*\*  $p < .01$

\*\*\*  $p < .001$

**Table 2.**

Ordinal and continuous predictors of satisfaction with life and flourishing.

Variable	<i>n</i>	SWLS	FS
Age	99	-.08	-.09
Age First Homeless	95	.13	-.02
Times Homeless, Lifetime <sup>a</sup>	99	-.04	-.08
Childhood Trauma Questionnaire	99	-.38**	-.27**

Note. SWLS = Satisfaction with Life Scale, FS = Flourishing Scale.

<sup>a</sup>Spearman's rho correlations were calculated because this variable is ordinal.

\*  
 $p < .05$

\*\*  
 $p < .01$

**Table 3:**

Multiple regression predicting satisfaction with life.

Variable	Unstandardized Coefficient B	Std. Error	Standardized Beta	<i>p</i>
Medical Insurance	-3.84	1.49	-.23	.011
Mobile Phone Ownership	-3.28	1.48	-.20	.029
Psychotherapy (Lifetime)	-3.07	1.64	-.17	.064
Childhood Trauma Questionnaire	-0.16	0.04	-.33	.001

*Note.* Total *N* = 99. Std. Error = Standard Error.

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**Table 4.**

Multiple regression predicting flourishing.

Variable	Unstandardized Beta	Std. Error	Standardized Beta	<i>p</i>
Sexual Orientation	2.79	2.28	0.12	.223
Medical Insurance	-4.12	1.92	-0.20	.034
Mobile Phone Ownership	-5.42	1.96	-0.26	.007
Psychotherapy (Lifetime)	-1.84	2.16	-0.08	.397
Childhood Trauma Questionnaire	-0.15	0.06	-0.25	.009

*Note.* Total *N* = 98. Std. Error = Standard Error.

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