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"I'd rather injure somebody else than get injured": An introduction to the study of exposure to physical violence among young people experiencing homelessness

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ABSTRACT

Homeless young people are at risk for a range of negative health and behavioral outcomes, and they commonly report exposure to physical violence, as both perpetrators and victims. Semi-structured interviews focusing on exposure to physical violence were conducted with 18 homeless young people in Victoria, Australia. Results showed perpetration of physical violence occurred as a form of self-protection. Painful experiences of physical victimization were also described. Injuries were sustained as a result of both physical violence perpetration and victimization. Results suggest an important duality exists between homeless young people's acceptance of exposure to physical violence as normal and requiring emotional detachment at the time of its occurrence, and later reflection about exposure to physical violence with emotional engagement and problematizing the necessity of normalization and detachment. Shame, stigma, and unequal power relationships were described in relation to interactions with health professionals. Future research exploring violence as a response to vulnerability and subsequent feelings of shame and stigma in homeless young people is especially warranted.

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'The amount of shit that goes on': an introduction to the research

Young people's experiences of homelessness are complex, and can result in feelings of helplessness, fear, anxiety, and distress. Amidst these complexities and feelings, young people must pool their personal and external resources to reduce their vulnerability and survive their homelessness experience. For many young people, homelessness is both preceded and followed by an absence of connections with and support from trusted adults, disconnection from education and employment, a lack of safe and affordable housing, poor health and detrimental social outcomes (e.g. Bearsley-Smith et al. 2008). Childhood abuse is also commonplace for young people who experience homelessness (Bearsley-Smith et al. 2008; Kendall-Tackett 2002).

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Experiencing homelessness places young people in an environment where societal values and behavioral norms may be contradictory to their survival, and conventional opportunities to adhere to social laws and norms that prohibit offences are not afforded (Baron 2003; Heerde and Hemphill 2018; Heerde, Hemphill, and Scholes-Balog 2014; Kipke et al. 1997). That is, engagement in behaviors which are considered socially unacceptable (e.g. threatening another person, engaging in group fights) is often not the result of a malevolent disregard for mainstream social and cultural norms, but rather behavior enacted as a means of survival, to meet ones' needs, and in response to vulnerability, social exclusion and marginalization (Baron and Hartnagel 1998; Ferguson et al. 2011; Gaetz 2004; Heerde, Hemphill, and Scholes-Balog 2014; Kipke et al. 1997; Watson 2017). Consequently, these young people are at increased risk for engagement in, and victimization from, risky behaviors such as violence and crime (Baron 2003; Kipke et al. 1997). Traumatic experiences (i.e. those which pose 'threats to life or bodily integrity, or a close personal encounter with violence and death'; Herman 1992, 33) such as street-based exposure to physical violence may be directly and indirectly responsible for some of the short- and long-term harmful and pervasive effects of homelessness.

Contemporary Australian research investigating exposure to physical violence among homeless young people is particularly lacking. Prior Australian studies have investigated victimization experienced by homeless young people (e.g. Alder 1991; Alder, Sandor, and Clunne-Ross 1989). More recent Australian research has examined sexual victimization and survival sex among young people experiencing homelessness (Watson 2011, 2017). This article presents a qualitative exploration of exposure to physical violence, as both perpetrators and as victims, among homeless young people in Victoria, Australia. Injuries sustained because of this exposure and young people's resultant interactions with health professionals are also explored. Three research questions were investigated: (1) How do homeless young people experience physical violence, both as perpetrators and victims? (2) What types of injuries are incurred because of exposure to physical violence? and (3) How do homeless young people seek help from health professionals for injuries sustained because of exposure to physical violence?

'*It's a bad world out there*': defining homelessness and exposure to physical violence

Homelessness

Conceptualizations of homelessness vary internationally (Busch-Geertsema, Culhane, and Fitzpatrick 2016), meaning definitive prevalence estimates for the number of homeless young people are difficult to obtain (Chamberlain and Mackenzie 1992). In line with the most recent global framework and conceptualization for measuring homelessness, young people experiencing homelessness in this study include those without accommodation (suitable and permanent), who may be unsheltered (living directly on the streets or other spaces not intended for habitation), or in temporary or emergency accommodation that is reserved for homeless persons (i.e. at-risk of homelessness) (Busch-Geertsema, Culhane, and Fitzpatrick 2016). This global conceptualization is congruent with the way in which homelessness is defined in Australia (Australian Bureau of Statistics 2019; Mallett 2004). In Australia, the most recent Census

estimated 27,680 young people (12–24 years old) were homeless (Australian Bureau of Statistics 2018).

Exposure to physical violence

Variation exists in methodological approaches to quantifying the types and rates of physical violence to which young people experiencing homelessness are exposed (Heerde, Hemphill, and Scholes-Balog 2014). In this research, *perpetration of physical violence* is the intentional and unwanted physical handling or threat of physical harm performed by an individual(s) against another person without consent (e.g. physical assault, mugging and robbery, use of weapons, threats to harm using weapons, threatening gestures, aggressively accosting another person) (Heerde, Hemphill, and Scholes-Balog 2014). *Physical victimization* is the physical handling or threat of physical harm experienced by an individual at the hands of another person (e.g. assault, being threatened with harm with or without the use of weapons, being mugged or robbed) (Heerde, Hemphill, and Scholes-Balog 2014). Herein, unless otherwise specified, *exposure to physical violence* includes both perpetration and victimization. Internationally, estimates of physical assault by homeless young people reportedly range from 10% (Gaetz 2004) to 45% in the seminal paper by McCarthy and Hagan (1991), while rates of having been physically assaulted are estimated to range between 27% (Ferguson et al. 2011) and 54% (Whitbeck et al. 2001). There is limited contemporary research on exposure to physical violence among Australian young people (e.g. Alder 1991; Alder, Sandor, and Clunne-Ross 1989).

Precursors for exposure to physical violence

Opportunities to reduce homeless young people's exposure to physical violence can be afforded through increasing understandings of potential influences on their violence perpetration and victimization. Across the international literature, experiencing homelessness is frequently posited as a precursor of exposure to physical violence (Baron 2003; Heerde, Hemphill, and Scholes-Balog 2014; Schreck, Wright, and Miller 2002). Having experienced childhood abuse is also a risk factor for aggressive behaviors and vulnerability to victimization while homeless (Hamilton, Poza, and Washington 2011; Heerde and Hemphill 2018; Kendall-Tackett 2002). Social norms and situational circumstances encountered by young people while homeless also contribute to violence exposure (Heerde, Hemphill, and Scholes-Balog 2014; Kipke et al. 1997; McCarthy and Hagan 1991). Perceptions that perpetrating violence is needed for survival (Baron 2003), the need for food, shelter or money (Kipke et al. 1997), exposure to others' violent behavior (Baron, Forde, and Kennedy 2007) and subsequent vicarious trauma in witnessing violence (Dominguez 2017) are commonly cited factors in homeless young people's violence exposure. Victimization has also been consistently perceived as a normative experience while homeless (Kipke et al. 1997). Among young people experiencing homelessness violence perpetration and victimization are interconnected (Bender et al. 2015; Gaetz 2004; Heerde and Hemphill 2018; Heerde, Hemphill, and Scholes-Balog 2014) and are increased through entrenchment in the homelessness culture (Baron 2003; Bender et al. 2015; Gaetz 2004; Heerde, Hemphill, and Scholes-Balog 2014; Schreck, Wright, and Miller 2002).

Injury resulting from exposure to physical violence and help-seeking behavior

Internationally, homeless young people experience higher morbidities (e.g. mental health disorders), mortality, and barriers to health care (Bearsley-Smith et al. 2008; Hwang et al. 2005) than their housed peers, however few studies have examined injury resulting from exposure to violence. An earlier US study by Kipke et al. (1997) found 23% of homeless young people had been seriously hurt as a result of a violent attack, while Cauce et al. (2000) reported 31% of homeless young people had spent time in hospital as a result of an assault. Receiving consistent medical care and opportunities for recuperation are hindered by the transient nature of homelessness and financial instability. Furthermore, commonly reported barriers to seeking help are related to: a lack of support from trusted adults; prior negative experiences with and low trust in support services; insufficient knowledge regarding navigating the health system; fear of contact with authorities (e.g. child protective services, police); and shame, stigma, embarrassment (Darby, Henniger, and Harris 2014; Dickerson, Gruenewald, and Kemeny 2004; Ensign and Bell 2004; Harris and Darby 2009; Hudson et al. 2010).

'*You learn not to trust them*': shame, stigma, and homelessness

Shame and stigma theorists assert that under certain conditions, socially stigmatized individuals might develop shame for aspects of their stigmatized identity and subsequent actions or behaviors (Benedict 1934; Goffman 1963; Heatherton et al. 2000; Link and Phelan 2001). These theories lack substantial application in the development of a framework for understanding the emotional reactions that young people experiencing homelessness may have when they are at risk of, or are exposed to, violence. Goffman (1963) defined social stigma as an attribute, behavior, or reputation which is socially discrediting, causing an individual to be classified by the so-called social normative in an undesirable, rejected stereotype. Young people experiencing homelessness who perceive themselves to be members of a stigmatized group may experience psychological distress and view themselves contemptuously due to social stigma, both external and internalized. Goffman (1963) and more recent theorists such as Smith (2009) state that members of stigmatized groups are subsequently disadvantaged in sectors such as education, housing, health, and access to medical treatment (see also Dickerson, Gruenewald, and Kemeny 2004; Weiss, Ramakrishna, and Somma 2006).

Shame is theorized as an unpleasant self-conscious emotion and an alienating and isolating experience that involves negative evaluation of the self such as being 'bad', inadequate or contemptuous (Benedict 1934; Broucek 1991; Dolezal and Lyons 2017). It involves a comparison of the self's action with the self's standards of ethics, and equally from comparison of the self's identity and actions with the ideal standards of behavior and action with normative social contexts (Benedict 1934; De France et al. 2017). Theorists have also endeavored to differentiate between shame and guilt, with the former being a violation of cultural or social values while the latter, guilt, arises from violations of one's internal values (McNamee 2015; Tangney et al. 1996). Thus in relation to young people experiencing homelessness and their exposure to violence (as both perpetrators and as victims), shame may result from the negative evaluation (whether real or imagined) of their actions against the social normative, while guilt may arise from their own negative

evaluation of their actions when their behavior or experience is contrary to their own values or ideas of one's self. Indeed, as Dolezal and Lyons (2017) point out, shame 'creates a bind for the person experiencing it, as revealing that one is experiencing shame is itself shameful' (258). Pertinent to young people experiencing homelessness, this 'intensification or multiplication of itself' (Dolezal and Lyons 2017, 258) means that while shame needs to be addressed in clinical (therapeutic) encounters, it remains under-theorized and usually unacknowledged in health service provision (Darby, Henniger, and Harris 2014; Harris and Darby 2009).

'Thank you so much. Thank you': research materials and methods

This study is part of larger qualitative research examining exposure to physical violence among young people experiencing homelessness. The Australian Catholic University Human Research Ethics Committee provided study approval, the institution with which the first author was affiliated at the time of data collection. Permission to conduct the study was also obtained from the Chief Executive Officers of the participating organizations in a metropolitan region of Victoria, Australia. These organizations provide a broad range of youth services, including homelessness outreach and support, addiction services, housing assistance and crisis accommodation, transitioning from out-of-home care, and intensive case management for young people with high treatment needs, on statutory orders, or for whom other services have been ineffective.

Decolonizing research practices

Decolonizing research practices, which foreground the concerns, perspectives, knowledge and recommendations of participants (i.e. standpoint theory; Moreton-Robinson 2013), originated as resistance to the universalism, positivism, researcher-as-expert, and exploitation of 'the researched' within Western colonial research practices imposed on First Peoples such as Indigenous communities in Australia (Smith 2013). These methods are increasingly used in research involving marginalized groups such as LGBTIQA+ communities and cultural minorities (Moreton-Robinson 2013; Pallotta-Chiarolli 2016b, 2018; Smith 2013; Zavala 2013), yet these practices within studies of homeless young people are scarce. Within decolonizing practices, participants' lived experiences and insights are central, and the researcher is an active listener, building rapport, earning trust, and establishing credibility with the participant. Participants drive the research direction in a relationship with the researcher that is free of exploitation and appropriation (Smith 2013). Thus, decolonizing research practice is similar to other collaborative and participatory knowledge creation methods while recognizing and respecting that First Peoples have driven the need and movement to empower and foreground minority individual and community assets, expertise, and knowledges outside hierarchical knowledge systems in the academy and other structures of power.

Sensitivity to participant safety such as respecting their requests for anonymity is paramount in empowering participants to share their lived experience and raise and discuss issues of importance to the research even if, as will be presented in this paper, these issues have not been prompted or deemed significant through the initial interview questions. The use of participants' words, perceptions, understandings, and the ways in which

these understandings are formulated through language and acted upon, are integral to the reporting and recommendations of the research (Smith 2013). Another important factor in decolonizing research methods is the participants' rights to review the data as audio and/or transcript, own the data, and re-use it for their own future purposes.

Participant recruitment

Young people were recruited using purposive sampling, to ensure participants held insights and perspectives most relevant to the research questions (Minichiello et al. 2004). Young people were eligible to participate in the study if they were (a) between the ages of 16 and 25 years; (b) currently at-risk of or experiencing homelessness; and (c) attending one of the two organizations participating in the study. Specific forms of homelessness experienced by young people were not specified; rather, young people navigating the definition of homelessness provided at the outset of this study were eligible to participate. This included young people without accommodation (e.g. couch surfing, temporarily residing with peers), who were unsheltered (e.g. living directly on the streets), or who were currently in temporary, emergency or supported accommodation that is reserved for young people experiencing homelessness. Eligibility requirements were not placed on young people's gender identity, ethnicity, sexuality, or their history of exposure to physical violence.

In the weeks before commencing the interviews, the researchers spent time attending both organizations to establish familiarity and build rapport with staff and young people. Congruent with decolonizing research practices, this resulted in the researchers being identified as accepted and trusted visitors; elements imperative in research with vulnerable groups (Liamputtong 2010). Young people eligible to participate were first approached by their case managers, and those who expressed interest in the project were provided with verbal information and a consent form. Case managers then facilitated an appropriate interview time to meet with the researchers. Semi-structured interviews were conducted between July 2014 and November 2015.

Data collection

The research questions investigated how young people who experience homelessness are exposed to physical violence (both as perpetrators and as victims), the types of injuries incurred through this exposure, and how help is sought for these injuries from health professionals. These research questions were explored through the interview questions which asked young people to talk about their experiences perpetrating physical violence, being physically victimized, the causes and impacts of exposure to physical violence, and the utilization of health services.

Data was collected using a standardized open-ended interview comprising semi-structured interview questions. Given that some young people's reading abilities may be limited, both were read out aloud to each participant. The researchers explained that participation was voluntary, and that young people were able to leave the interview and withdraw their participation at any point. Assurances of confidentiality were given, and informed consent was then obtained in writing prior to commencement of the interview.

Interviews were dialogic and interactive, lasting 45–60 min. Participant demographic data was also collected. The interview was facilitated by probing phrases such as 'Can you tell me about … ', 'If you feel comfortable can we talk about … ', and 'Can you describe … '. At the end of the interview, young people were asked if there was anything else they wished to raise, discuss, convey to others or share. Each young person was reimbursed for their time with a $10AUD groceries voucher. Vouchers were provided to young people just prior to commencing the interview. This was followed by the researchers reiterating that the young people were able to leave the interview and/or withdraw their participation at any point without consequence. Given the structurally vulnerable position of participants, this process was important in ensuring young people did not feel pressured or coerced into participating in the interview in exchange for the voucher. All interviews were recorded on a digital recorder and professionally transcribed verbatim.

Considering the potentially triggering nature of asking young people to describe their experiences of exposure to violence and the high likelihood of their experiencing past child and adolescent trauma (Bearsley-Smith et al. 2008; Coates and McKenzie-Mohr 2010; Davies and Allen 2017; Kendall-Tackett 2002), ensuring young people were provided with access to debriefing or support services following the interview was paramount. The conduct of the interviews was supported by a distress protocol, developed to effectively respond to emotional distress expressed by participants during the interview (Draucker, Martsolf, and Poole 2009). The participating organizations also ensured a staff member was available should a participant become distressed during the interview and require support. Last, the project information provided to participants contained the contact details for two external support services for young people experiencing homelessness.

As sensitivity to young people's safety and anonymity was crucial, any identifying information in the interview transcripts was removed. Names were replaced with pseudonyms, and the names of agencies or specific locations (e.g. suburbs, train stations) were either removed or replaced with fictitious names. To foreground the young person's lived experiences, and congruent with decolonizing research practices, interview transcripts (including the language used by young people) were deliberately not edited or 'cleaned'; speech habits (e.g. 'um') were edited, however participant's narratives, ideas and wording were not rephrased (Smith 2013). This process provides a linguistic insight into the culture of homelessness and situations encountered; these are integral in developing a comprehensive appreciation of how young people describe and reflect upon their lived experiences.

As stated earlier regarding decolonizing research practice, each young person was provided with the opportunity to make a follow-up time to listen to the digital recording of their interview or read and edit their interview transcript. All young people expressed satisfaction with the interview process and their interview responses when asked how they felt about the interview and did they have any suggestions regarding how to make the process easier or more comfortable. No young person chose to read and edit their transcript, hence contact details for the lead author were provided to each young person in the event they wished to review their interview transcript later. Over the course of the project, Dr Heerde received no requests to undertake this process. Although young people's time for reflection may have resulted in additional data following the editing process, their choice not to review their transcripts was expressed as due to their trust, mutual understanding and rapport developed with the researchers (Pallotta-Chiarolli

2016b, 2018). Participants were comfortable that their experiences and insights would be treated with respect, accuracy, and anonymity. Indeed, this comfort and trust is also exemplified in the way young people did not try to euphemize or sanitize their words during the interview. As outlined in the previous paragraph, this led to a deeper insight into their lives via their discourse.

Data coding and analysis

Data coding and categorization was supported by NVivo 11 software (QSR International 2016). As a method of qualitative analysis, and complementing decolonizing research practices, narrative inquiry was used to understand the lived experiences of young people in their own words; the social, cultural and environmental contexts in which these experiences occurred; and the meanings ascribed to these experiences (Brown 2012; Clandinin 2006; Haydon, Browne, and van de Riet 2018).

Each interview transcript was thoroughly read multiple times to elucidate patterns, themes, and categories in the participants' narratives. The identification of patterns, themes and categories in the data occurred through a categorical narrative approach, examining young people's exposure to violence both within a single interview and collectively across participant interviews (Earthy and Cronin 2008). Dr Heerde individually completed the coding and categorization of these patterns which involved several processes to ensure rigorous data analysis (Morse 2015). First, after reading the transcripts, the interview schedule was used as a framework by which to identify emergent themes that related to young people's exposure to violence both as perpetrators and as victims, as well as data indirectly related to the research questions such as conceptualizations of vulnerability, social and cultural norms attributed to homelessness and related-behavior. Next, a list of framing codes and categories were generated, and sub-categories and sub-themes were then devised.

The identification of connections and patterns across the data was aided by multiple re-readings of the interview transcripts. Data for sub-categories and sub-themes were then condensed, refined, and collapsed into higher-level, more detailed themes. Integral to decolonizing research practice which respects participant knowledges, any themes, critiques, and data the young people provided which was not part of the initial interview schedule but deemed significant by the participant for the researcher to understand in this project, were respected and developed as themes. Given the narrative approach, the use of multiple coders as measures of reliability and validity are not essential (Corbin and Strauss 1990), however over the course of the analysis and writing process, the authors discussed the emergent categories and themes, patterns in the data, and each other's interpretations of the data as well as their personal assumptions, beliefs and experiences.

'I'm not going to be the one that's getting chopped up': research results

Demographic characteristics

Out of the eighteen participants, ten young people identified as female and only one young person was born outside Australia. The sample consisted of White young people apart from the young person who was born in Southern Asia, and all were proficient in speaking and

understanding the English language. Young people ranged in age from 18 to 24 years, having first experienced homelessness between the ages of 12–18 years. Seven young people reported having no fixed address in the past 4 to12 months, while ten young people reported feeling unlikely they would have a place to stay for the next month.

'Someone punches someone in the face, you get up and punch them back': Perpetration of physical violence

Central to the narratives of most young people was perpetration of physical violence as a means of establishing internal hierarchies between homeless peers and associates through actions exhibiting ascendency and advantage over other persons. Young people's recollections conveyed their perpetration of physical violence did not originate from trying to confront, intimidate or commit an act of unprovoked violence. Rather, violence perpetration was described as necessary in response to having been assaulted: '*If someone hits me then I'll hit them, but they'll keep hitting me, so I'll keep hitting them back*' (Participant 8, male) and '*Someone punches someone in the face, you get up and punch them back*' (Participant 2, female).

Equally, several young people described their violence perpetration as being predicated by feelings of vulnerability and the need for self-protection: '*I got surprised and shocked just by the amount of shit that goes on*'. (Participant 9, male). The need to ensure physical safety was frequently described with a sense of its regularity and normality of violent occurrences. It is feasible that this perceived regularity and normality is a form of young people dissociating and detaching from emotional thoughts and reactions related to their perpetration of violence, or what De France et al. (2017) call 'freezing' in order to disengage with the feelings of stigma and shame remembering and communicating such occurrences might create. For example, young people's tones and expressions often reflected unease, yet somber acceptance, that perpetrating violence was appropriate and normal within their social circumstances:

> … I wasn't like I'm going to beat this person until they can't breathe, I was like I'm going to beat this person until they can't beat me anymore … they're worried about their own safety now more than beating me. (Participant 3, female)

> … if somebody's going to pull something on me I'm not going to be the one that's getting chopped up. (Participant 1, male)

> If someone's going to hurt you to the point where you're scared, well, I believe you deserve the right to defend yourself. (Participant 2, female)

Young people frequently spoke of their perceived need to carry a weapon and use this weapon where required. Some spoke about carrying a weapon as a principle by which they lived and behaved, while others spoke of carrying weapons which could be easily concealed yet quickly accessed (e.g. knives, sharp objects) '*as a defense type of weapon*' (Participant 8, male). Again, these behaviors were described unemotionally and pragmatically. Young people detached from their feelings of shame and stigma about the events being recalled, evident through their appearing numb when describing events, refraining from eye contact with the interviewer, and withholding the expression of emotion (De France et al. 2017). When asked why they carried a weapon, young people replied they

needed something with which to defend themselves, as a surety they would not be physically hurt, victimized, or forced to engage in unwanted experiences (e.g. sexual assault), and to instill fear in potentially harmful individuals.

> … I take a weapon … then I can't be forced into anything and the cunt's got to seriously think whether he wants to cut me up because he's going to cop the same thing I am. (Participant 1, male)

> That was just something I just generally kept [a knife], something sharp in my bag because it makes people think twice because they don't want to get hurt themselves. … I'd rather injure somebody else than get injured or hurt or have somebody do something awful to me again. (Participant 18, female)

> Just in case someone tries to sexually assault me [reason for carrying a knife]. (Participant 7, female)

After describing instances of violence perpetration, many young people proceeded to reflect on that behavior and its effect on their personal morals and values. As stated earlier, these unprompted contemplations contrasted with the dissociation and detachment evident in young people's narratives and body language (e.g. appearing numb) when recollecting experiences of physical violence perpetration. Rather, young people's tones and expressions reflected discomfort, shame, and timidity. These bodily and linguistic cues are referred to by De France et al. (2017) as 'The Shame Code' as they also found that shame is associated with fidgeting and 'freezing', both being social cues communicating discomfort or distress. Although holding specific beliefs and principles regarding the appropriateness and normality of their behavior within their specific non-normative social circumstances, upon reflection many young people re-considered the impact of their behavior, and expressed sadness and remorse; '*I don't really want to threaten anybody … '* (Participant 1, male) and '*I never wanted to hurt them; I just wanted to frighten them enough so they'd hand over what I wanted*'. (Participant 3, female). The responses of other young people conveyed a hesitation in threatening to use, or using, physical violence, despite the social norms of homelessness by which they had to live. These unprompted self-reflections negate an assumption of homeless young people's view of themselves as upholding violence, and repudiate media and other external representations and discourse of homeless persons as violent criminals (Barker and Barry 2013; Zufferey 2008, 2014):

> They normally back away [other people when threatened] and then they normally think I'm pretty serious, but I never really act on it. (Participant 8, male)

> I'm not a very violent person but when someone pushes me to the point – I think of doing it but I won't do it. (Participant 12, female)

> I'm not a violent person funnily enough. I might get a bit angry but no. I don't hurt people. (Participant 2, female)

'I got threatened a lot, probably at least 50 times': Physical victimization

Many young people described in detail their painful experiences of physical victimization and vulnerability. When asked how many times they had been threatened with serious

physical harm while homeless, young people replied with comments such as '*I watch my back 24/7*' (Participant 13, male) and '*It's a bad world out there. It's not a nice world*'. (Participant 18, female). Young people's recollections were often unclear in specifying whether the perpetrators of violence were homeless peers, other homeless persons, or non-homeless persons:

> Since I left home, that was probably like four years ago, probably about 100 times I reckon [been threatened with harm]. It was pretty regular. (Participant 1, male)

> I got threatened a lot, probably at least 50 times. I can't think of an exact or even rough number, just a lot of times … when I was younger and I was a bit more out on the streets and sort of hanging around other people [experiencing homelessness] it happened all the time. It was a daily sort of occurrence. That sort of thing just happens. (Participant 18, female)

Conversations about physical victimization consistently involved instances of having been threatened with weapons. The young person's relationship or association with the perpetrator was infrequently conveyed, with victimization occurring during both day and night, often unprovoked. As with descriptions of violence perpetration, young people described having been victimized with emotional detachment and dissociation, and a sense of 'acceptance', normativity, and regularity. Within many recollections were nuances of defenselessness, vulnerability, susceptibility to victimization and helplessness:

> I was walking down [street name], away from [train station] – you know where [building name] is and you go down the river down towards the little playground. My little sleeping spot was down in that circle of rocks down behind the playground, and on my way there, I saw some guys milling around under a street light and I made sure to give them a wide berth but they must have seen me and they followed me and when I got to the place, they came in from all sides, one pulled a knife – by this stage they had got their balaclavas down. (Participant 16, male)

Young people commonly described being physically assaulted, and the severity of these attacks varied. Lower severity assaults were often described as less confrontational involving behaviors such as pushing, hitting or chasing: '*It's just pushing or shoving or hitting me*' (Participant 14, female), and ' … *they ended up chasing me up the road and I copped a few hits*' (Participant 18, female). Participant 14's use of 'just' is an example of minimization of the actions and impact of violence.

Many young people described severe physical assaults, detailing that these assaults included being held at knifepoint, struck with objects (e.g. tree branch, glass bottle, bats, steel bars) and being kicked and punched. These incidents of greater severity often involved multiple perpetrators: '*It was multiple weapons, multiple people. It was glass bottles. I was targeted at a bus stop by a group of seven people*'. (Participant 13, male). Physical assault could occur while rough sleeping or following acceptance of an offer of shelter:

> I was sleeping under a bridge after the youth refuge had kicked me out for my marijuana habit, and a couple of dickheads came under the bridge where I was sleeping and they roughed me up pretty bad. Stole most of my stuff, most of my clothes, all my money. Black eye, almost dislocated my jaw, couple of cracked ribs, dislocated finger. (Participant 16, male)

> He threw me on his bed and I went through the mattress and through the slates of this bed and then he picked me up and locked me in his wardrobe and told me I was never going to get out of there and called me horrible names and said horrible things to me, he said he was going to kill me and shit like that. (Participant 3, female).

Nuances of attempts to offset feelings of defenselessness and susceptibility to victimization were present. These notions were illustrated in young people describing incidents of physical victimization in a routine and unemotional manner, yet simultaneously speaking unprompted of their fears and attempts to preserve and/or maintain their physical safety. For instance, '*You learn to not be scared anymore*' (Participant 3, female). Other young people spoke of actively seeking to maintain their personal safety when confronted with threats of physical harm and violence through adapting their body language: '*when you see the person going off their head you just kind of look away and don't involve yourself and then usually their anger doesn't turn to you*' (Participant 2, female) and '*… dressing up pretty cool, acting all tough and giving people an evil look when they walk by. Then they know not to mess with me*'. (Participant 8, male)

'I've been seriously bashed': Injuries resulting from exposure to physical violence

Sustaining injury was a typical consequence of exposure to physical violence while homeless: '*The longer you spend homeless the more damaged you become just by being homeless*'. (Participant 2, female). This summation reflected the narratives of many young people. General soreness, bruises, black eyes, cuts, suspected cracked or broken fingers, ribs and arms, head trauma and dislocation of joints were commonly described injuries sustained through violence perpetration. Many young people also described injuries resulting from being victimized and being unable to defend themselves:

> … I've always got some sort of injury unless it's really just a stupid fight. … when you actually punch on with someone you're always going to cop something. I've always had endless amounts of black eyes and I don't know if my nose has ever been broken but it's been real sore and bleeding and all sorts of fucked fat lips all the time. (Participant 1, male)

> I got a cut on my head. I just had a lot of bruising and grazing because we were on this sort of cement hill thing and they kept pushing me down. (Participant 18, female)

In most cases, injuries sustained because of victimization were greater in severity than those sustained because of violence perpetration. While young people seemingly accepted the circumstances in which their injuries were sustained, their narratives conveyed tones of sadness, shame and vulnerability (De France et al. 2017). Likewise, while some young people described injuries in an ordered or regulated manner, others shared their experiences with emotional immediacy:

> … bruises, a cut or laceration, dizziness, headache. I suppose not loss of consciousness but so much head trauma that I was like, "What is going on? I have not got a clue right now" … You don't remember blacking out, you just wake up and you're like, "What the hell!" It's not like you pass out and they're like, "Oh leave them alone now they've passed out", they're like, "Yes time to strike!" (Participant 3, female)

'I don't trust doctors and I don't trust hospitals': interactions with health professionals

Shame and stigma were feelings frequently described by young people when recalling their interactions with health professionals. Young people mainly described having sought assistance for violence exposure from counselors, nurses, and doctors. However,

many perceived being looked down upon and judged, and undeserving of treatment. These feelings and perceptions often led to an unwillingness to talk about, or be honest about, how injuries were sustained:

> You get less honest after time as well, so you go from telling someone the whole story to just bits and pieces after a while. It all just ends up getting lost in translation at the end. (Participant 18, female).

Many young people talked of having their identity devalued through their non-conformity to, and non-compliance with, socially acceptable standards of behavior and appearance and being situated in a system of unequal power. Several young people spoke of distrust in health professionals because of prior negative interactions; other young people conveyed the influence of judgment and distrust on their defensiveness and detachment from health professionals:

> they [health workers] don't understand why it is someone can be in that position [homeless] or why they can't help themselves … They don't quite fathom it … their job is to be neutral and not be sitting there and having a personal opinion and you can tell this in their forming a personal judgement. … When I was homeless I wasn't a derelict, I was just homeless. Often you get looked like a derelict though. People treat you as if you're incapable or you are wrong or – I don't know. You just get treated really horribly by – not bad treatment but you get looked upon as if you're an outsider of the real society when really, you're just struggling'. (Participant 2, female).

> He didn't do shit [doctor]. That's why I was so angry. I didn't want to tell them anyway. I said, "Oh no it was just like this" and they said, "Have you been fighting or anything?" I think probably said something like that. I would have said possibly, "I don't know", I sort of said I played footy or something. (Participant 1, male)

Despite the many negative experiences with health professionals, several young people spoke of nurses who were helpful and provided support in a respectful and caring manner. Experiences with these nurses were described positively, and although undertones of shame and embarrassment were evident, young people appeared appreciative of the assistance they received:

> They [nurses] did as much as they could and as much as I could take [in treating the injury and in response to pain experienced]. (Participant 12, female)

> They [nurses] talked to me about counselling, about pressing charges. The nurses were so lovely. I had really good nurses. I had a good night at the hospital. … They made me so much better. I had one of the nurses sat in there with me for about three hours in the shower because every time they turned the water off it just started stinging again and stuff. So, she just sat there the whole night looking after me and washing my hair and stuff. It was really lovely. (Participant 18, female)

Distrust in health professionals and young people's feelings of shame and stigma often resulted in them having minimal to no contact with health services, despite a recognized need for treatment: '*Sometimes it's easier to resolve things yourself. Not everybody knows what's good for you except for you*'. (Participant 18, female). Young people frequently described instances of self-managing and treating their injuries. Often, self-treatment involved the use of adaptive treatment strategies and the use of medical supplies which could be easily obtained from supermarkets and chemists (e.g. icepacks, bandages,

antibacterial cream): '*I stole all these bandages from Coles* [*supermarket*] *and I just bandaged up my knee*' (Participant 1, male), '*put an icepack on my ribs and that was about it*'. (Participant 13, male), and '*I just bit down on a tea towel and I set my finger back in place*'. (Participant 16, male).

'It was multiple weapons, multiple people': Discussion of the results

This research is one of a few contemporary studies examining exposure to violence among young people experiencing homelessness. Findings showed exposure to physical violence commonly included co-occurring perpetration and victimization, often involving the use of weapons. Violence perpetration, predicated on a perceived need for gaining an advantage over, and reducing vulnerability from, another person in response to a physical attack, was commonly described. The carrying of a weapon(s) was frequently described as a means of reducing personal vulnerabilities and the likelihood of victimization. Exposure to physical violence, as both perpetrators and as victims, resulted in young people sustaining a range of injuries of varying severity. Resultant interactions with health professionals were often described with feelings of shame and stigma and perceptions of unequal power relationships.

Dolezal and Lyons (2017) state 'there is a plausible case to be made for shame to be considered as a determinant of health' as 'there seems no good reason to disallow affective states from being regarded as significantly health impacting' as 'shame is so pervasive, so corrosive of the self and so potentially detrimental to health' (257). This is relevant to the treatment of young people experiencing homelessness in medical and broader healthcare contexts who may conceal, avoid or fictionalize their experiences of violence perpetration and victimization due to shame and/or anticipated shaming and judgment in these contexts (Dolezal 2015; Dolezal and Lyons 2017; Lazare 1987; Smith 2009). These young people may not seek treatment for injuries sustained or not disclose the full details of their physical or psychological ill-health or their experiencing homelessness, resulting in inadequate or ineffective treatment. Of further concern is how repeated experiences of shame can lead to 'chronic shame', persistent feelings of inferiority and social exclusion that become debilitating, thereby affecting long-term physical and psychological health outcomes (DeYoung 2015).

In response to the above concerns, programing efforts in health and support services need to recognize young people as having histories of violence and victimization often compounded by that experienced while homeless (Davies and Allen 2017; Heerde and Hemphill 2018; Hopper, Bassuk, and Olivet 2010; Thrane et al. 2006). Acknowledging the reasons for and grounds upon which violence is perpetrated and victimization occurs, may help in reducing risk for further violence perpetration and victimization. These programs should include health and social resources required for addressing higher rates of violence, violence prevention (for revictimization) and treatment services for those who have been victimized. Our findings are consistent with previous studies that report exposure to physical violence among homeless young people as including perpetration of violent behaviors (e.g. assault) and violent victimization (e.g. being assaulted with weapons) (Gaetz 2004; Heerde, Hemphill, and Scholes-Balog 2014; Kipke et al. 1997; McCarthy and Hagan 1991). Our study extends prior research by providing a deeper understanding of, specifically, homeless young people's perpetration of physical violence

as not unprovoked, but rather a response to perceived vulnerability or actual victimization; as a form of self-protection. Similar concepts of vulnerability and self-protection also arose in relation to carrying a weapon(s) and physical victimization. Maintaining personal safety when confronted with perceived or actual threats of harm and violence were common for both physical violence perpetration and victimization. Similar notions regarding maintaining personal safety have been reported in relation to young people's engagement in survival sex (Watson 2017, 2011).

Young people were 'versatile' perpetrators–victims, who described their experiences with a sense of pragmatism, normality, and emotional detachment. These perceptions of normality are congruent with prior research (Kipke et al. 1997). It is reasonable to assume that ongoing social norms relating to physical violence contribute to exposure to violence among these young people (Heerde, Hemphill, and Scholes-Balog 2014; Kipke et al. 1997; McCarthy and Hagan 1991). Our findings, and this assumption, are consistent with prior suggestions that homeless young people's behaviors are related to ensuring survival (Baron 2003) within a culture where exposure to violence is commonplace (Heerde, Hemphill, and Scholes-Balog 2014; Schreck, Wright, and Miller 2002; Watson 2017).

Few studies have investigated injuries sustained by young people experiencing homelessness because of their exposure to physical violence (Cauce et al. 2000; Kipke et al. 1997). Our findings suggest these injuries include those sustained through both violence perpetration and victimization. Again, findings showed sustaining injuries was perceived as normal consequences of exposure to violence. These findings are important given existing concerns surrounding the short- and long-term health impacts of homelessness for young people. The relationship between experiencing homelessness and many health concerns has been widely noted over many years (Bearsley-Smith et al. 2008; Ensign 1998; Ensign and Bell 2004; Hwang et al. 2005). The implication of the findings presented here is that in addition to previously established health concerns, injury sustained because of violence exposure contributes to health morbidities among homeless young people. It is also reasonable to assume injuries sustained because of violence exposure extend well beyond the physical.

'I never wanted to hurt them': the duality between pragmatic recollection and emotional reflection

Constructs and performances of normativity and acceptance of exposure to physical violence belie the self-reflexive expressions of defenselessness, shame, and timidity of homeless young people. Our findings suggest exposure to physical violence, and attempts to survive these exposures, may result in short- and long-term psychological trauma, as evidenced in the reflective emotionality of homeless young people's narratives. Specifically, young people recalled experiencing close personal encounters with violence which posed significant risk to their bodies and lives, that is, traumatic experiences. Harms resulting from these experiences are likely to have short- and long-term negative effects on an individual's sense of safety, capacity for emotional regulation, feelings of self-control, and development of safe interpersonal relationships (Hamilton, Poza, and Washington 2011). Young people's acceptance of violence perpetration and victimization as normal and regular occurrences may arise not only as a function of the complexities of prior family experiences (e.g. childhood abuse; Heerde and Hemphill 2018), but also as a result of

the intricacies of street-based experiences (e.g. proximity to violence and susceptibility to victimization; Ferguson et al. 2011).

Young people in this study commonly described their environment as being unsafe and rationalized their violent behavior and experiences as appropriate within this setting. Exposure to physical violence was described as the rule rather than the exception. In being prepared for, and surviving this exposure, young people validated and normalized their behaviors and experiences. This validation, coupled with young people's emotional detachment in recalling their experiences, is a trauma-based coping mechanism (Davies and Allen 2017; Herman 1992). The duality between this normativity and young people's reflective emotionality is important within the context of long-term psychological trauma (De France et al. 2017; Hamilton, Poza, and Washington 2011).

'You get looked like a derelict': interactions with health professionals

Young people's interactions with health professionals are important in the context of addressing short- and long-term physical and psychological injuries sustained through exposure to physical violence. Distrust in some health professionals and being situated in a system of unequal power were also common. Many young people expressed feeling judged by doctors resulting in defensiveness and detachment from these professionals. Hudson et al. (2010) previously found social barriers, including perceived discrimination by health professionals, were dominant deterrents for homeless young people seeking medical care. Similar results have been reported elsewhere (Ensign 1998; Ensign and Bell 2004). Personal and social barriers influencing decisions to seek medical and health care may also be compounded by a low perceived problem severity and preferences of young people to self-manage injuries. A lack of social and medical resources, potential injury mismanagement, and the non-treatment of more serious injuries, are of concern and may further contribute to many of the health morbidities associated with homelessness among young people (Ensign and Bell 2004).

The pathways that lead homeless young people to seek assistance from health professionals, and the resultant interactions, appear complex. However, several young people spoke about the benefit of supportive nurses. Adaptable intervention strategies which provide support and maintain neutrality, and that acknowledge the social context of young people experiencing homelessness, have an important role in health service delivery (Davies and Allen 2017). Positive results have been reported for health-based programs involving homeless young people which recognize this social context (Bamberg, Chiswell, and Toumbourou 2011). Approaches that acknowledge exposure to violence as being related to survival within a culture where such exposure is commonplace, may begin to address feelings of shame, stigma, vulnerability, and disempowerment.

Importantly, given the critical connection between the normativity of exposure to physical violence and emotional detachment in recollecting these exposures, the adoption of a trauma-informed care framework in homelessness service settings may be beneficial. This framework

> is a strengths-based framework that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological and emotional safety for both providers and survivors and that creates opportunities for survivors to rebuild a sense of control and empowerment. (Hopper, Bassuk, and Olivet 2010, 82)

The continued development, implementation and evaluation of such approaches is required, and may assist in addressing the distrust and vulnerability experienced by homeless young people, thereby reducing their defensiveness and detachment in consultations with health professionals and challenging their internalized stigma.

'*Getting lost in translation*': implications for further research

There are several important next steps in examining and understanding homeless young people's exposure to violence. First, the use of decolonizing research practices among studies of homeless young people are uncommon despite its use with other marginalized groups (Moreton-Robinson 2013; Pallotta-Chiarolli 2016b, 2018; Smith 2013; Zavala 2013). Further use of decolonizing research practices is likely to contribute to enhanced theoretical and practical knowledge through encouraging the comfort, trust and non-euphemized initiation of themes and insights required to reveal the realities of homelessness without a veneer of defensive minimization. This also could be enhanced by engaging young people in the research processes as researchers as well as research participants, thereby becoming capacity-building, empowering and co-created research projects, the 'nothing about us without us' approach (Pallotta-Chiarolli 2018). These participant-centered approaches will also address the stigma and shame which may prevent or effect research participation by homeless young people.

Numerous contemporary studies have examined homeless young people's access to, and use of, healthcare (e.g. Barry, Ensign, and Lippek 2002; Edidin et al. 2012; Ensign 2004; Hudson et al. 2010). Importantly, this research emphasizes the need for healthcare providers and support services to acknowledge the social and cultural norms associated with experiencing homelessness (Barry, Ensign, and Lippek 2002; Ensign 2004) and the importance of trusting and positive interactions with healthcare providers (Barry, Ensign, and Lippek 2002; Zufferey 2017). As shown in the current study, social and cultural norms impact upon how young people see themselves (e.g. as unworthy of compassionate healthcare); views which were on occasion reinforced by stereotypical representations of homeless young people held by some health providers. The reinforcement of such stereotypes is likely to have lasting effects on the willingness of young people to access healthcare and their compliance with prescribed treatments (Edidin et al. 2012).

Thus, it is recommended that future research be more deliberately planned to examine homeless young people's interactions with health professionals. This should include further investigation of the influence of distrust, detachment and defensiveness in such interactions, subsequent provision of healthcare, and the implementation of trauma-informed care. Dolezal and Lyons (2017) propose several broad aims which we adapt, as follows, to specifically address the needs of homeless young people. First, identify the multiple and intersecting determinants and indicators of exposure to violence, shame and guilt, and their practical implications for policy and healthcare related to young people and their experience of homelessness. Second, build on the limited research that outlines the responses of young people experiencing homelessness to shame, including identifying perceptual, medical, cultural, institutional and socio-political factors that influence young people's reactions and physical and psychological outcomes. Third, quantitatively and qualitatively assess the burden from stigma and shame associated with homeless young people's exposure to violence (both as perpetrators and as victims)

and related physical and psychological health problems, both in terms of nature and magnitude. Last, improve knowledge about the functional impact of shaming, and the risk of furthering physical and psychological health problems through youth policy orientations and legislation that inadvertently or consciously promote stigma and shame in relation to homeless young people's exposure to violence.

Another area requiring much more research and resourcing is the intersectionality of multiple marginalities in the lives of homeless young people. For example, prior research has suggested gendered experiences of homelessness are associated with the behaviors in which they may engage (O'Grady and Gaetz 2009; Watson 2017), however few studies on this issue exist (Huey and Berndt 2008). A detailed examination and analysis of gender performativity among homeless young people was beyond the scope of this article. In this study, the narrations suggested differences in young women's and men's exposure to violence. The relationship between gender and exposure to violence appears complex, where the context in which violence occurs and a young person's reactions to this violence, fluctuate. Many young people were aware of gender performativity in their behaviors, countenances, words and idioms, in attempts to construct their identity (Butler 2004; Migdalek 2014; Watson 2017): '*dressing up pretty cool, acting all tough*' (Participant 8, male). For young women, this identity construction appeared to be an attempt to contradict socially constructed gender norms of femininity such as Participant 7 who carried a knife '*just in case someone tries to sexually assault me*'. Further research is needed to examine the role of gender performativity in the lives of homeless young men and women, in relation to navigating social norms and situational circumstances, including exposure to violence.

Due to constraints imposed during the initial institutional review of the project, the interview questions did not ask young people about their sexual identity or orientation, nor their gender identity beyond the cisgendered binary of male or female. This resulted in 'exclusion by inclusion' into homogenizing categories of gender- and hetero- normativity (Pallotta-Chiarolli 2016a). Similarly, further research is required into the significance of homeless young people's cultural background. The young people interviewed in this study were predominantly White with English as their primary language. Questions relating to ethnicity, class, and geographical location (urban/rural) were not examined. It is possible that exposure to physical violence, and the responses of health providers, differs among homeless young people of varying personal, family and social histories and identities, thereby requiring an intersectional approach (Crenshaw 1989; see also Durso and Gates 2012; Rew et al. 2005; Zufferey 2017). As described by Zufferey (2017), intersectionality in approaches to working with individuals experiencing homelessness 'allows for a more complex, fluid, multilayered analysis of diverse social identities (or subjectivities) and social locations, and for a more thorough reflexive exploration of how social processes and relationships intersect and continue to uphold social inequalities' (3). This approach demonstrates how social inequality, privilege and oppression manifest in interconnected domains of structural, political and cultural power relations (Crenshaw 1989).

Shame is frequently associated with multiple-minority stigma, where other salient aspects of one's identity – such as gender, disability, race, sexuality, or ethnicity – create multiple marginalities requiring recognition, resistance and reconstruction (Pallotta-Chiarolli and Pease 2014). Thus, multiple-minority stress and the intersections of various identities and social locations can further impact how young people experiencing homelessness manage various systemic and institutional culpabilities (Crenshaw 1989;

Pallotta-Chiarolli and Rajkhowa 2017). As Cyrus (2017) writes, members of multiple-minority groups 'are more likely to be exposed to experiences of stigmatization, discrimination, and fear of rejection' (194) and microaggressions across multiple facets of one's life and from multiple sectors and sites.

The minority stress model (Meyer 1995) provides a future perspective from which to examine the experiences of homeless young people in its analysis of the complex relationship between external (e.g. discrimination, abuse, exposure to violence) and internal (e.g. self-doubt, guilt, shame) stressors that shape the incidences these young people encounter and their health outcomes. Health service providers need to consider 'the impact of hypervigilance, personal identification with minority status, and negative self-perceptions on their clients' (Cyrus 2017, 195) who are faced with various intersecting categories of marginality and exclusion arising from a plurality of social, structural forces and circumstances. This entails refuting the neoliberal construct that the health concerns of young people experiencing homelessness are solely due to their being homeless, which in itself is often perceived as being due to the young person's inherent identity, chosen circumstances or agentic behavior (Pallotta-Chiarolli and Pease 2014). The intersectionality of two or more identity factors leads to a resulting identity which is increasingly complex and due to the interaction of the multiple components, including young people's internal 'conflict over incongruent values and belief' as Dominguez (2017, 210) writes in relation to LGBTIQ minorities, and as was demonstrated in the narratives of young people in this study. It is also important to undertake further research into the relevance of 'vicarious trauma' associated with homeless young people's exposure to violence whereby 'members of a non-dominant group must witness attacks on other group members' (Dominguez 2017, 212).

Another future research direction is the need to explore and understand homeless young people's contact with police and/or the criminal justice system in relation to violence exposure. Few young people in this study described these forms of contact. Preventing violence exposure is essential for reducing the likelihood of contact with these law enforcement authorities and legal institutions. Our findings suggest that experiencing homelessness does not afford young people the opportunity to adhere to laws that prohibit physical violence, nor do these laws provide young people with safety from physical victimization, and both these situations have implications for stigma- and shame-related avoidance of help-seeking from police and/or the criminal justice system.

'I'm not a violent person funnily enough': research conclusions

Young people's experiences of homelessness and violence are complex; they are frequently exposed to physical violence as both perpetrators and victims. Exposure to violence is a normative and expected occurrence in the daily lives of homeless young people, resulting in emotional detachment and pragmatism as coping mechanisms, and subsequent emotional reflections of shame, helplessness, and stigma. Perpetration of physical violence was frequently prompted by perceived vulnerabilities and a need for self-protection. Painful experiences of physical victimization were also described. Interactions with health professionals, for injuries sustained, were often underpinned by feelings of shame, stigma, and unequal power relationships. As Dolezal and Lyons (2017) conclude, shame is

> so insidious, pervasive and pernicious, and so critical to clinical and political discourse around health, that it is imperative that its vital role in health, health-related behaviours and illness be recognised and assimilated into medical, social and political consciousness and practice. (262)

Qualitative investigations of homeless young people's experiences of exposure to physical violence, including the personal and health impacts of these exposures, will provide deeper understandings which can inform homelessness prevention and early intervention strategies designed to improve homeless young people's health and social outcomes.

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