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Mixed methods on adverse childhood experiences predicting transitional and recurrent homelessness

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Abstract

Aims: Research has associated lack of parental care, physical abuse, and parental substance abuse to homelessness, with the presence of two or more such factors dramatically increasing one's chances of becoming homeless as an adult. Less clear is which (cumulation of) factors may mediate the difference between transitional and recurrent homelessness.

Methods: Quantitative analysis of four risk factors—addiction, weak social network, criminal activity, psychopathology—among 69 transitionally and recurrently homeless (RH) adults, followed by in-depth qualitative analysis of adverse childhood experiences (ACEs) among 30 selected participants.

Results: RH participants had higher cumulative risk and a higher prevalence and broader range of ACEs than transitionally homeless participants, with the prevalence of childhood physical abuse marking the greatest difference between the two groups. Recurrent homelessness was also correlated with addiction to hard drugs, criminal activity, and weak social networks.

Conclusion: Longitudinal and intervention studies in larger groups are needed to assess causality.

KEYWORDS

addiction, adverse childhood experiences, mixed methods, social networks, transitional and recurrent homelessness

1 | INTRODUCTION

This mixed-methods explorative study focusses on the cumulative adverse childhood experiences (ACEs) that may predict transitional and recurrent homelessness in adulthood. Research shows that adverse experiences such as lack of parental care during childhood, physical abuse, and parental substance abuse are associated with homelessness in adulthood (Korkeila et al., 2010; McLeod & Almazan, 2003), while the presence of two or more such factors dramatically increases one's chances of becoming homeless (Boesveldt et al., 2019; Blankertz et al., 1993; Herman et al., 1997; Koegel et al., 1995). Recurrently homeless (RH) adults more often report experiences of severe childhood trauma (Morrell-Bellai et al., 2000) and early involvement in criminal activity (De Vet et al., 2017). While it is clear that complex needs are associated with homelessness in general, it is less clear which (cumulation of) childhood-related factors may mediate the difference between transitional and recurrent homelessness.

McQuistion et al. (2014, pp. 505–513) define recurrent homeless as: "having one or more new episodes of homelessness at some point after obtaining housing, for a specified period of time, following a previous episode of homelessness." Several studies (Aubry et al., 2013; Benjaminsen & Andrade, 2015; Kuhn & Culhane, 1998) have found that in northern welfare states, being non-White and having more complex needs (e.g., combined medical, mental health, and substance abuse problems) are associated with higher risk of recurrent or chronic homelessness. Yet, how more complex needs are mediated by factors that explain the relation between adverse childhood experiences and recurrent homelessness in adulthood remains unknown. This matters because although earlier life experiences cannot be undone, such mediating factors may be promising avenues for intervention (Masten et al., 2021). Our review of the literature suggests four factors that may mediate this association: (1) addiction (alcohol/substance abuse); (2) support from one's social network; (3) engagement in criminal behavior; and (4) psychopathology.

First, alcohol or substance abuse and addiction relapse rates among homeless people are higher for those who experienced a cumulation of ACEs, including such experiences as abuse, neglect, domestic violence, and separation from the family (Narendorf et al., 2020; Patterson et al., 2014). Interestingly, the cumulation of ACEs sems to be a better predictor of consequent substance abuse than one specific ACE, in particular (Liu et al., 2021). Studies have also shown an association between addiction to alcohol or drugs and recurrent homelessness. McQuistion et al. (2014) highlight the complexity of causes behind recurrent homelessness and find that alcohol and other substance abuse disorders are associated with recurrent homelessness only if they are linked to other risk factors such as arrest history and diagnosed antisocial personality disorder. The same study also found recurrent homelessness to be more common among individuals with only a high school education and among those who were initially rehoused by family members.

Second, Calsyn and Winter (2002) show that social contacts and the existence of a supportive social network can be key factors in preventing recurrent homelessness, increasing psychological well-being, and finding stability in independent housing. May (2000) similarly finds that a supportive social network can reduce substance abuse and encourage an active daily rhythm. Nevertheless, social networks play ambiguous roles in supporting RH individuals. Social contact often diminishes or disappears entirely during periods of homelessness (Calsyn & Winter, 2002; Shier et al., 2010). While most homeless persons sleep on the couches of friends and family before entering a shelter, most social networks cannot provide lasting shelter. Addiction, debt and feelings of shame often put pressure on these relationships; the longer an individual remains homeless, the smaller these networks become (e.g. Calsyn & Winter, 2002).

Third, studies show that ACEs can lead to engaging in criminal behavior. Delinquent and criminal behavior has been found to mediate between childhood abuse and neglect and adult substance use among women (White & Widom, 2008). Arrest history also links alcohol and other substance use disorders to recurrent homelessness

(McQuistion et al., 2014). Nikulina et al. (2011) show that adverse childhood experiences such as parental neglect and family poverty predict posttraumatic stress disorder (PTSD) and adult arrest. De Vet et al. (2017) find that previous involvement in crime is significantly related to relapse into homelessness and that the number of homeless people engaging in criminality is much higher than among people with stable housing.

Fourth, numerous studies have shown that adverse childhood experiences can contribute to different forms of psychopathology (Racine et al., 2023). A broad range of adverse childhood events have been established as risk factors for most mental health problems (Read & Bentall, 2012), physical health problems, social problems (Tzouvara et al., 2023), and homelessness (Liu et al., 2021). Susser et al. (1991) were among the first to find that among homeless psychiatric patients, 15% had childhood histories of foster care, 10% had been placed in group homes, and 20% had histories of running away, compared to 2%, 1%, and 5% in a sample of psychiatric patients who had never been homeless. "In the state hospital, the lifetime prevalence of homelessness in patients with any one of these childhood experiences was about threefold that of other patients" (Susser et al., 1991). Since then, 29 studies with homeless participants have been conducted, indicating that adverse childhood experience have a far higher prevalence among homeless people than among the general population, and that even among homeless people, the accumulation of adverse childhood experiences is predictive of more severe mental health issues (see review and meta-analysis by Liu et al., 2021).

We hypothesize that the relation between adverse childhood experiences and homelessness in adulthood is mediated by addiction, a weak social network, involvement in the criminal justice system, and psychopathology, as depicted in Figure 1.

While numerous researchers have sought to identify the risk factors associated with homelessness, we know comparatively little about why some previously homeless individuals relapse into homelessness. The current study aims to clarify which combinations of adverse childhood experiences may explain transitional and recurrent homelessness in adulthood. We first conducted a quantitative analysis of four risk factors—addiction, weak social network, criminal activity, and psychopathology—among 69 transitionally and RH adults in the Netherlands. We then pursued in-depth qualitative analysis of adverse childhood experiences among 30 selected participants.

We hypothesize that addiction, weak social networks, involvement in criminal activities, and psychopathology are more common among the RH than among the transitionally homeless (TH). Following a model of cumulative risk, we expect RH individuals in the aggregate to report more risk factors. We further expect a cumulation of adverse childhood experiences in both groups, including lack of parental care, physical abuse, and parental abuse of drugs and/or alcohol. We expect the cumulation of adverse childhood experiences to be more common among the recurrently homelessness.

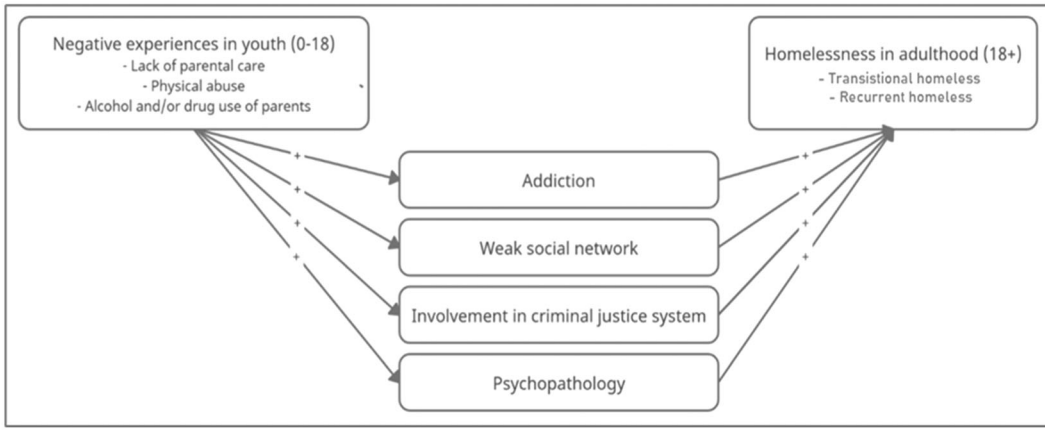

FIGURE 1 Mediation model: childhood experiences and recurrent homelessness in adulthood.

2 | METHODS

2.1 | Sampling and recruitment

The current study is based on the secondary analysis of data collected for a larger study on the drivers of recurrent homelessness, including the barriers experienced by homeless individuals in accessing night shelters and supported housing. To create representative samples per type of public service, this larger study first made an inventory of shelter and supported housing in the region. It was concluded that separate sub-samples would need to include a minimum of 30 participants who could be identified as RH at T0, and a minimum of 30 TH participants who had left a homeless shelter or protected housing within the past 8 months, or no more than 3 months before T0. The criteria about leaving or just having left the shelter/protected housing facility was to ensure that the drivers of recurrent homelessness could be identified in the following waves. A purposive sampling strategy was used as the non-governmental organization (NGO) stakeholders wanted a representative perspective.

The study was conducted in a medium-sized region in the center of the Netherlands, consisting of one central municipality and 15 smaller municipalities with shared policy responsibility for homelessness. As elsewhere in the Netherlands, services for the homeless usually include a night shelter, protected housing, and outpatient support in independent housing. Inclusion criteria for participation in this larger study included being over 23 years old, being single (and not having responsibility for underage children on the reference date), entitlement to services under the Dutch Social Support Act or health insurance, and the participant's consent. Many participants were recruited with the help of the services that provided them with housing. We also recruited participants on the spot in drop-in centers and day activity centers. Participants received a €10 gift card, regardless of whether they completed the interview.

In this way, we recruited a purposive sample of 69 adults (77% male, 23% female) who were currently using, or had recently used, services for the homeless. Out of this sample, 31 participants were RH while 38 were TH.

To analyze childhood experiences, we obtained additional data from the interviews with 15 recurrently and 15 TH individuals. Participants in both groups were selected based on matching criteria for sex, ethnicity, and age. Both groups contained individuals with war-related trauma, experienced either as refugees or by serving in war. Wartime experiences can lead to problems included as factors in our model (Bryant et al., 2018; Ivert & Magnusson, 2019), making it difficult to distinguish whether problems originated from childhood experiences or war trauma. Participants with wartime experience were equally represented in both groups, $p = 0.47$. Four respondents in the recurrent homeless group and three in the TH group mentioned war-related trauma.

2.2 | Questionnaire and interviews

Our mixed-methods, cross-sectional study made use of a questionnaire and interviews. The questionnaire contained both standardized and open-ended questions on items such as age, income/day occupation, and self-reported addiction. Each interview was conducted by two researchers: one academic researcher and one with lived experience of homelessness. Peer research is known for its ability to access hard-to-reach populations and to improve data validity (Elliott et al., 2002; Warr et al., 2011). During the interviews, peer researchers used strategies such as self-disclosure, establishing mutual recognition, and offering validation (Boesveldt, 2024).

Before the study, participants received an information letter and signed the consent form. On average, the interviews lasted for 1 h. Several open-ended questions invited participants to talk about their childhood, including: "Where are you from?," "Could you briefly tell us a bit about yourself?," "What is your background and how did you end up here?." Childhood experiences were spontaneously mentioned by some participants in response to open-ended questions about their social networks and contact with relatives. In such cases, interviewers probed further about their experiences in childhood.

3 | POSITIONALITY

The three researchers in this study have significant experience working with homeless participants. Be it through the involvement of persons with lived experience on homelessness in policy, involving peer-researchers in a larger research project on this topic or being trained as a social worker and a nurse. As a result, they all three have a familiarity with the issues facing homeless persons that informs their reflections of their observations when in the field and performing this analysis.

3.1 | Analysis

Content analysis of verbatim interview transcripts was used to deductively assign codes based on the literature and then to inductively generate new codes to reduce the complexity of the data (Thomas, 2006). During the primary analysis of the data, in this way, the risk factors addiction, social networks, involvement in the criminal justice system, and psychopathology were coded in the 69 interview transcripts.

In the secondary analysis of data, the codebook used for the first 20 interview transcripts contained codes for adverse childhood experiences, based on the literature. These were for example lack of parental care, physical abuse, and parental substance abuse. To ensure analytic rigor, we employed strategies including peer debriefing, independent and co-coding, memo writing, and prolonged engagement with study participants (Padgett, 2017).

Categories were first developed by studying the transcripts, considering possible meanings, and how these fit into emerging themes. Within the overarching category of "Adverse Childhood Experiences," nine subcategories were added based on both a review of existing literature and the specific incidents reported by respondents. A tenth subcategory, "other," was included to capture additional experiences not covered by the predefined subcategories. Some experiences such as physical abuse could unambiguously be coded as adverse; other experiences were not so clear. If a respondent did not report anything negative about a particular experience, we did not code these as adverse. For addiction, we added subcodes for alcohol, soft drugs, hard drugs, and "other" (which included medication, gaming, gambling, and stealing; in the Netherlands, "soft drugs" refers to marijuana and hashish, "hard drugs" to all other types of drugs). A subcode was also added to "Involvement in criminal justice system" for engaging in criminal activities but without police contact. The categories "Weak social network" and "Psychopathology" were not further subdivided into subcodes. We continued with the coding until no new codes emerged, suggesting that saturation had been achieved (Urquhart, 2013). In total, seven primary codes and 17 subcodes were used. Postcoding, the data were compared both within and between the groups, with prevalence rates calculated for most factors. Summaries and overviews of all reported adverse childhood experiences and other relevant factors for each group were created. These results facilitated a comparative analysis between the two groups.

4 | RESULTS

4.1 | Sociodemographic data

Among the 38 TH participants, 30 were male (79%). Their average age was 46. Six earned an income from paid work (16%); 13 lacked work or a meaningful occupation (34%). Among the 31 RH participants, 28 were male (90%). Their average age was 47. Two earned an income from paid work (6%); 20 had no work or a meaningful occupation (65%).

RH participants had relapsed into homelessness after a period ranging from 1 month to 10 years. Just over a third were homeless again within 6 months of leaving the night shelter, with 10% returning to the night shelter within 3 months. After becoming homeless for a second time, the vast majority did not stay with family, friends, or colleagues, but returned directly to the night shelter. Another 16% of RH participants became homeless again

TABLE 1 Prevalence of risk factors among transitionally and recurrently homeless participants.

	Transitional (n = 38)	Recurrent (n = 31)	Significant (p)
Addiction	15 (40%)	22 (71%)	0.009
Weak social network	11 (29%)	22 (71%)	0.001
Criminal justice	11 (29%)	17 (55%)	0.029
Psychopathology	18 (47%)	24 (77%)	0.011

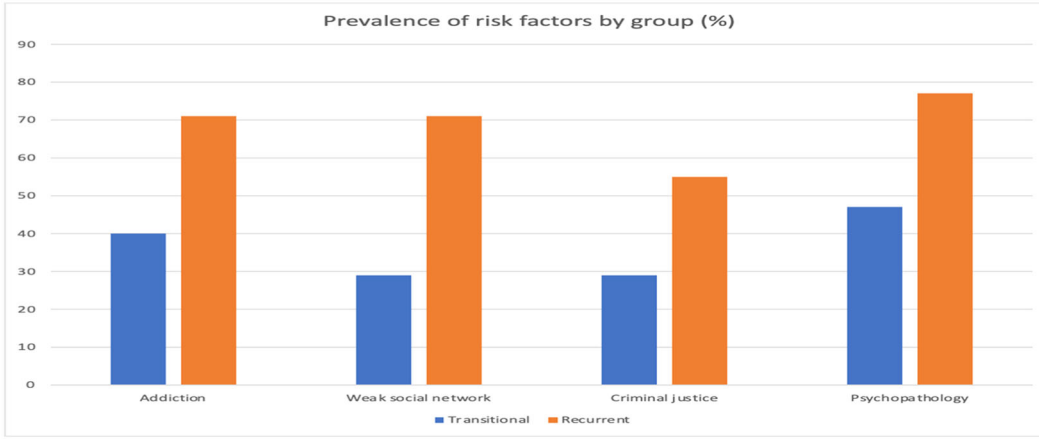

FIGURE 2 Prevalence of risk factors (%).

within 6–12 months, and a further 16% within 12–36 months; 19% managed to keep a home for at least 3 years before losing it again (average 5.1 years, spread between 3 and 10 years).

Table 1 and Figure 2 provide an overview of the prevalence of risk factors in our model. To test our hypothesis that these factors are more prevalent among the RH than among the TH, we conducted four χ^2 tests. Addiction was reported significantly more often by RH than by TH, $p = 0.009$. A weak social network and involvement in the criminal justice system were also reported significantly more often by RH, $ps < 0.001$ and 0.029, respectively. Psychopathology was also reported significantly more often by RH, $p = 0.011$.

To test our hypothesis that cumulative risk is higher in the RH group, we conducted an independent samples t test on the cumulative risk of these four factors. The RH had significantly higher cumulative risk than the TH, with respective means of $M = 2.74$ risk factors (standard deviation [SD] = 0.86) compared to $M = 1.45$ (SD = 1.17), T (1.67) = 5.11, $p < 0.001$. This is a large difference, effect size $d = 1.3$. Interestingly, accumulated risk factors differed greatly between participants, as SDs were large, and only addiction and criminal behavior were significantly correlated, $r = 0.30$, $p = 0.014$. Moreover, the risk factor of addiction includes addictions ranging from soft and hard drugs to gambling. To accommodate such individual differences, we examined the risk factors in participants' narratives in greater detail below.

4.2 | Addiction

As shown in Table 1, many participants in both groups reported addiction in their adult lives (40% among TH, 71% among RH). Group differences in their self-reported addictions can be seen in Table 2. A significantly larger proportion of RH participants were addicted to hard drugs, $p = 0.014$, while soft drug addiction was equally

TABLE 2 Self-reported addictions among transitionally and recurrently homeless participants.

Kind of addiction	Transitional (n = 38)	Recurrent (n = 31)	Significant (p)
Hard drugs (excluding alcohol)	5 (13%)	12 (39%)	0.014
Soft drugs	12 (32%)	13 (42%)	0.373
Alcohol	6 (16%)	11 (36%)	0.059
Gambling, etc.	5 (13%)	8 (26%)	0.181

prevalent in both groups. TH participants were more often addicted to soft drugs than to anything else: "My parents had a bad marriage, and my mom had a really hard time. Whenever my father was home, it was terrible. Because of all that I started smoking weed" (TH, 25). As seen in Table 2, the RH group has almost twice as many respondents with addictions involving alcohol and gaming, although these differences are not statistically significant in these small groups, with respective *p*s of 0.059 and 0.181. "My father was an alcoholic, so I was predisposed to addiction from him. I started gambling when I was 13" (RH, 23).

4.3 | Weak social network

Differences appeared between the two groups. Of the 30 participants selected for in-depth analysis, 11 (29%) of the TH and 22 (71%) of the RH reported having weak social networks, meaning they would like to have more (close) friends or reported having little or no contact with their parents or other family members. A number of participants indicated they had been damaged in their childhood and had difficulty with trust or attachment or feared being hurt again; they experienced social contact as difficult or uncomfortable. Some recurrent homeless participants drew attention to adverse childhood experiences when relating their struggles with social contact:

> "My parents didn't want me. There was no love. Eventually I ran away, to make sure I wouldn't bother anyone. Now I am afraid of making new friends. I try to forget my youth." (RH, 32)

> "I had a relapse and the choice to use [drugs] or not. I choose to use and therefore threw other things away. Whenever you are sober you start thinking this is very sad." (RH, 1)

Some TH participants also felt uncomfortable in social situations due to adverse childhood experiences. Others no longer had contact with family members:

> "My boarding school life was a very different way of life, and somehow I feel insecure, uncomfortable. Even when I'm with a buddy for his birthday and family comes to visit him, all the people I don't know and stuff [...] I'm just very quiet then. I feel uncomfortable. That is very annoying. It limits me in a lot of things." (TH, 61)

> "I was placed out of home when I was five. I lived in shelters and boarding schools for a few years. My brother and I were separated when I was 12, it was really hard. My parents didn't bring me to school and the kids at school didn't understand, so I was bullied a lot. That's why I didn't finish my school and started working when I was 16. It's hard that I can't count on my parents. I haven't had contact with my father since I was 12, and with my mother since I was 18. I haven't seen my brothers and sisters since then." (TH, 61).

4.4 | Involvement with the criminal justice system

This was more prevalent among the RH (55%) than among the TH (29%). Among the RH, 11 participants had been in prison once or multiple times. Seven others had been involved in criminal activities without entering prison. One participant recounted how his criminal activities began at a young age: "From age 11 to 17 I did all kinds of things that weren't allowed. I lived with my girlfriend at age 15, but it wasn't very much fun: there were shootings and many people died" (RH, 21). Among the TH, six people had been in prison; four others had been involved in criminal activities but were never in prison.

4.5 | Psychopathology

77% of RH participants and 47% of TH participants reported having one or more psychological disorders. Apart from PTSD, both groups mentioned the same mental illnesses. Participants often related psychopathology to their childhood: "I heard that I was diagnosed with borderline [personality] and that the reason for this was most likely the divorce of my parents when I was 9 years old" (TH, 28).

The four factors—addiction, weak social network, criminal activity, psychopathology—all to some degree related to homelessness, were all more prevalent among RH participants.

4.6 | Adverse childhood experiences

Of the 30 participants selected for in-depth analysis, 25 reported adverse childhood experiences. Only one RH participant and four TH participants did not report any adverse childhood experiences. RH participants reported an average of 2.27 adverse childhood experiences, whereas TH participants reported an average of 1.13 adverse childhood experiences.

The experiences most commonly mentioned by respondents in both groups sometimes intertwined: "After my father died, my mom got addicted to cocaine and she didn't care about us anymore. So we couldn't stay in the house and that was when I first went to a shelter" (RH, 13).

4.7 | Variety of adverse childhood experiences

Table 3 lists the adverse childhood experiences reported by the 30 participants selected for in-depth analysis.

Seven factors were reported just as often by both groups: lived with/raised by others than one's parents; problems between parents; one or both parents passed away; moving; and mental/physical illness of parents or other family members. Similar stories of strained childhoods were reported by participants from both groups: "I lived with my grandparents until I was three, then lived with my mother until I was six, but my mother couldn't handle it anymore. So I started living with my father. I left the house when I was 16 and then I screwed up really badly. I don't want to talk about my youth, because it was not good" (RH, 1). "At some point we moved, but that led to the divorce of my parents. It really had a negative influence on me" (TH, 27).

As mentioned, of the 30 participants selected for in-depth analysis, 29% of the TH and 71% of the RH reported having weak social networks. More TH participants also reported having little or no contact with their parents and other family members. While fewer TH participants reported having weak social networks, all those who did had little or no contact with their parents or other family members.

The RH reported not only more factors, but a broader range of factors. RH participants reported 10 factors that were not reported by TH participants, physical abuse being mentioned most often. One RH individual mentioned both

TABLE 3 Adverse childhood experiences reported by transitionally and recurrently homeless adults (multiple answers possible).

Factor	Transitional	Recurrent
Lived with/raised by others than parents (grandparents, foster family, streets, own house, etc.)	5	5
Problems between parents (fighting, cheating, divorce)	3	3
Mental/physical illness of parents or other family members	2	2
One or both parents passed away	2	2
Not further specified, mentioned as 'problems'	1	1
Parental drug use	3	2
Moving	1	2
Physical abuse	0	3
Serving in war at age 18	0	2
Criminal activity	0	2
Negative influences from family/friends	0	2
Lack of parental care	0	2
Addiction	0	1
Sexual abuse	0	1
Family secrets	0	1
No contact with parents from young age	0	1
Being unwanted	0	1
Parents very controlling	1	0

physical abuse and criminal activity: "My father was hitting my brother, there was blood everywhere, so I stabbed my dad, and my brother and I ran away. That was the first time I was sleeping on the streets, when I was 12" (RH, 20). Only one factor (very controlling parents) was reported by a TH participant, but not by any RH participants.

In line with our hypothesis, the prevalence of ACEs was higher among the RH than among the TH. This was the case for physical abuse (mentioned only by RH), substance abuse (71% prevalence among RH) and addiction to hard drugs ($p = 0.014$). In contrast, the experience of living with or being raised by others than one's parents (grandparents, foster family, on the street, in one's own house, etc.) was similarly prevalent in both groups. A similar pattern was found for psychopathology. While 77% of RH participants and 47% of TH participants reported having one or more psychological disorders, this difference is not statistically significant. With the exception of PTSD, both groups mentioned the same mental illnesses.

5 | CONCLUSION AND DISCUSSION

The current study examined whether ACEs—addiction, weak social network, criminal behavior, psychopathology, and the cumulation of these factors—predict transitional and recurrent homelessness in adulthood. In line with the literature (Van Everdingen et al., 2021; Herman et al., 1997), we found RH participants reporting a higher incidence for all of these factors than TH participants.

The prevalence of weak social networks among the RH was particularly striking and has hardly been addressed in the literature. Among the TH, individuals with weak social networks all reported having little or no contact with parents or family members. This finding is in line with Golembiewski et al. (2017), who suggest network decay may indicate recovery among the previously homeless as they discontinued unhealthy relationships. Many of the barriers in social networks appear to be based on experiences of how homeless individuals are seen by others. Thoughts like these can be very strong and turn into a form of self-stigma, in which prejudices or rejections are internalized and determine social behavior, causing participants to feel insecure and reluctant to make social contact.

While Van Everdingen et al. (2021) report that almost all (98.6%) homeless people in the Netherlands suffer from psychological disorders, our study based on self-reported mental health problems found that only 47% of the TH group and 77% of the RH group had sought or received care for mental health problems.

Dependence on hard drugs was another key factor distinguishing between transitional and recurrent homelessness. Almost half of RH participants were addicted to hard drugs, compared to less than a fifth of the TH. If transitional homelessness contributes to an escalating trajectory from soft to hard drugs, preventing such escalation during transitional homelessness seems crucial. The significant correlation of addiction and criminal behavior ($r = 0.30$, $p = 0.014$) supports McQuistion et al. (2014), who propose that alcohol and other substance abuse disorders are associated with recurrent homelessness only if they are combined with other risk factors (such as arrest history and diagnosed antisocial personality disorder). In our study, we found a correlation with arrest history.

The literature suggests that these factors likely mediate the relationship between adverse childhood experiences and homelessness in adulthood. Taken together, our findings on physical abuse (mentioned only by RH), substance abuse (71% prevalence among RH), and the significantly larger proportion of RH participants being addicted to hard drugs, $p = 0.014$, correspond with the findings of Garcia-Rea and LePage (2010) and Lansford et al. (2010) on the relation between childhood physical abuse and adult substance abuse. The adverse childhood experience of living with/being raised by others than one's own parents (grandparents, foster family, streets, own house, etc.) was evenly prevalent in both groups. A similar pattern was found for psychopathology.

Our study has several limitations. First, as most study participants did not literally state that addiction, weak social networks, criminal behavior, and psychopathology were the consequences of adverse childhood experiences and led to homelessness, a mediation effect is hard to ascertain in the absence of long-term prospective longitudinal data. Nevertheless, there are good reasons to believe that these factors may be mediators, as: (1) they occurred later in time than the childhood experiences, (2) the literature shows they are common consequences of adverse childhood experiences, and (3) our exploratory research showed them to be predictors of homelessness. Future longitudinal research is needed to see whether these factors can definitively be identified as mediators.

As our research was retrospective and respondents were not directly asked about their childhoods in the interviews, the information they provided is likely free of social desirability bias. However, a second limitation formed by the downside of not systematically asking about participants' childhoods is that they may not have shared everything: they possibly had more and/or other adverse childhood experiences than the ones they talked about. Not mentioning adverse experiences of course does not mean they did not experience them.

Third, the cross-sectional design of the current study did not allow testing mediation statistically; only statistical association with the recurrence of homelessness could be tested. Nevertheless, it seems likely that multiple mediating factors strengthen each other over time, with mental health problems contributing to drug dependence, which, in turn, contributes to social isolation and mental health problems, and so on. All of these factors together may perhaps best be seen as a self-strengthening causal network rather than as separate mediators. Again, hypotheses of interacting factors over time are best tested in a prospective longitudinal study.

Fourth, the over-representation of homeless veterans in our sample requires further research. Little to nothing has recently been published about this for the Dutch context, unlike in the United States where research is ongoing. The current study was only able to substantiate this association in general; future research should focus on the relationship between specific traumatic experiences underlying PTSD—including military service and childhood experiences—among RH persons in the Netherlands.

Fifth, longitudinal and intervention studies in larger groups are needed to assess causality. It is therefore necessary to continue researching this topic and to follow this specific cohort over time to find out what can predict homelessness and, specifically, recurrent homelessness.

Meanwhile, the present findings already suggest promising approaches to prevent recurrent homelessness through holistic cooperation of community practice, (preventive) mental health care, and municipalities. Importantly, the almost universal lived experiences of numerous adverse childhood experiences and isolation from (familial) social networks suggest that preventing recurrent homelessness should start early in life, with fitting support and care networks for children and families, specifically with regard to intergenerational transmission of poverty, mental health problems, parenting issues, and social supports. Fortunately, we know that such preventative work in childhood may have long-lasting protective effects (e.g., Menting et al., 2024) and is cost-effective (Heckman, 2006). In addition, the present findings suggest that—even though such supports are preferably given early in life—there still are many opportunities to prevent recurrence of homelessness even during the first periods of transient homelessness. The differences between transient and recurrent homeless participants in this study suggest a typical vicious cycle during transient homelessness, where increasing risks of addiction to hard(er) drugs and increasing social isolation may contribute to the recurrence of homelessness. This suggests that tailored support on these specific issues, in addition to housing first, may help to prevent this vicious cycle towards recurrent homelessness.

AUTHOR CONTRIBUTIONS

Nienke F. Boesveldt devised the project and was responsible for collecting the data. Nienke F. Boesveldt and Willemijn van Dungen conceived of the presented idea. Nienke F. Boesveldt, Willemijn van Dungen, and Bram O. de Castro developed the theory and Willemijn van Dungen and Bram O. de Castro performed the statistical analytical methods. All authors discussed the results and contributed to the final manuscript.

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CONFLICT OF INTEREST STATEMENT

The authors declare no conflict of interest.

DATA AVAILABILITY STATEMENT

The Atlas.ti database used and analyzed during the current study are available from the corresponding author upon reasonable request.

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